LEABHARLANN CHOLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH | TRINITY COLLEGE LIBRARY DUBLIN
Ollscoil Átha Cliath | The University of Dublin

Terms and Conditions of Use of Digitised Theses from Trinity College Library Dublin

Copyright statement

All material supplied by Trinity College Library is protected by copyright (under the Copyright and Related Rights Act, 2000 as amended) and other relevant Intellectual Property Rights. By accessing and using a Digitised Thesis from Trinity College Library you acknowledge that all Intellectual Property Rights in any Works supplied are the sole and exclusive property of the copyright and/or other IPR holder. Specific copyright holders may not be explicitly identified. Use of materials from other sources within a thesis should not be construed as a claim over them.

A non-exclusive, non-transferable licence is hereby granted to those using or reproducing, in whole or in part, the material for valid purposes, providing the copyright owners are acknowledged using the normal conventions. Where specific permission to use material is required, this is identified and such permission must be sought from the copyright holder or agency cited.

Liability statement

By using a Digitised Thesis, I accept that Trinity College Dublin bears no legal responsibility for the accuracy, legality or comprehensiveness of materials contained within the thesis, and that Trinity College Dublin accepts no liability for indirect, consequential, or incidental, damages or losses arising from use of the thesis for whatever reason. Information located in a thesis may be subject to specific use constraints, details of which may not be explicitly described. It is the responsibility of potential and actual users to be aware of such constraints and to abide by them. By making use of material from a digitised thesis, you accept these copyright and disclaimer provisions. Where it is brought to the attention of Trinity College Library that there may be a breach of copyright or other restraint, it is the policy to withdraw or take down access to a thesis while the issue is being resolved.

Access Agreement

By using a Digitised Thesis from Trinity College Library you are bound by the following Terms & Conditions. Please read them carefully.

I have read and I understand the following statement: All material supplied via a Digitised Thesis from Trinity College Library is protected by copyright and other intellectual property rights, and duplication or sale of all or part of any of a thesis is not permitted, except that material may be duplicated by you for your research use or for educational purposes in electronic or print form providing the copyright owners are acknowledged using the normal conventions. You must obtain permission for any other use. Electronic or print copies may not be offered, whether for sale or otherwise to anyone. This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

Drug Policy, Harm Reduction & Research in Ireland, 1996 – 2008

PhD Thesis, School of Social Work and Social Policy, University of Dublin, Trinity College.

2010

Eoghan Kevin Quigley.

Supervised by Shane Butler, PhD.

Contents

Declaration i

Acknowledgements v

Abstract vi

List of Tables viii

Glossary ix

Chapter 1: Introduction 1

Aims of the Thesis 3

Structure of the Thesis 4

The Research / Policy Interface 7

Epidemics and Policy Diffusion 12

Chapter 2: Methodology 32

From Selection to Examination – Stages in Documentary Research 32

Qualitative Interviews 43

Conclusion 52

Chapter 3: Norms in International Drug Policy 57

The United Nations and Drug Policy 59

Emergent Norms 60

Ambiguity in Legislation 66

A European Perspective on Drug Policy 72

European Action on Drugs 78

Conclusion 87

Chapter 4: The Managerial Turn in Irish Drug Policy 104

Management Science and Drug Policy 106

Irish Drug Policy before 1996 108

The Arrival of HIV 114

Research, Evidence and Drug Policy 119

Harm reduction and the SMI 124

Conclusion 131

Chapter 5: Drugs & the Political Agenda 143
Impression Management 145
Success and Failure 151
Drug Policy and Social Policy 156
The Diffusion of Drug Policy 162
Conclusion 171
Chapter 6: Linking EU & National Research: The ADRU 183
The ADRU: Its Origins and Work 183
The Epidemiology of Drug Use 189
Measuring Drug-Related Harms 196
Researching Sensitive Topics 201
Conclusion 208
Chapter 7: Researching Harm Reduction: The NACD 226
The Creation and Role of the Committee 227
Researching Needle and Syringe Exchanges 230
Cocaine Use as a Research and Policy Issue 240
Drug Use and Mental Health Policy 249
Structure and Performance 256
Conclusion 262
Chapter 8: Policy & Operational Structures 284
Innovation in Drug Policy 285
From Protests to Participation 296
Maintaining Hegemony 302
Needle & Syringe Exchange Programmes 307
Conclusion 319
Chapter 9: The Social Organisation of Drug Treatment 337
Drug Policy and Methadone 338
The Delivery of Methadone Maintenance Treatment 347
The Limits of Expansion 352
Methadone & the Prison System 358
Conclusion 368

Chapter 10: An Elusive Nexus: Drug Policy, Harm Reduction, & Research 386
The Research Process 387
The International Context 393
The National Context 397
Drug Policy, Harm Reduction & Research 403
Further Research 413
Appendix 1: Finalised Annotation Key, Thematically Grouped and Numeric-Bibliographically Tagged 420
Appendix 2: Respondents Consent Form 425
Appendix 3: Interview Schedules 426
Bibliography 432

Acknowledgements

I wish to thank Dr Shane Butler, who acted as my supervisor, for all of his guidance, help and support during the completion of this research. I am most grateful for the backing and direction that I have been given during my years as a postgraduate student from Dr Butler.

I am grateful to the Addiction Research Centre, Dr Shane Butler and Dr Barry Cullen for providing me with computing facilities and office space during this time.

I wish to thank all the individuals who helped me to complete my research by aiding me in tracking down and accessing materials.

I am most grateful to my family and friends for their support during the completion of this research. Most of all, I would like to thank my parents for all of their help and backing during this time. The completion of this project would not have been possible without the amazing and unwavering support that my parents gave to me. For this, I am deeply grateful.

While undertaking the study I received support at different times from a Trinity College Dublin Postgraduate Studentship and an Irish Research Council for the Humanities for the Social Sciences (IRCHSS) Government of Ireland Postgraduate Research Scholarship and am grateful to both sources.

Drug Policy, Harm Reduction & Research in Ireland, 1996 – 2008
PhD Thesis, Eoghan Kevin Quigley

This study is part of the small body of general documentary research concerned with examining different aspects and features of Irish drug policy. While the contemporary history of Irish drug policy has been characterised by a great deal of developments there has been a limited documentary analysis of these events. This study explores events during the years 1996 to 2008. It was concerned with documenting and examining some of the main developments that occurred during these years in policy, the treatment system, and the role of research in these changes. It looked at the international context in which these events were set and explored the defining features of drug policy during this time. In addition, the study discussed the work of indigenous research bodies, as well as developments in parts of the treatment system. It was largely focused on the evolving public health response to challenges posed by the human immunodeficiency virus (HIV) and injecting drug use (IDU).

In framing and examining the documentary material at certain points a number of analytic tools were drawn upon. Among these were Carol Weiss' models of the research / policy interface - the knowledge-driven model, the problem-solving model – with its two subtypes the purposeful commissioning and search routes – the interactive model, the political model, the tactical model, and the enlightenment model. They also included the concepts of critical mass, threshold of awareness, and the process of hierarchical diffusion. The study supported the search route sub-type of the problem-solving model, the enlightenment model, the concept of threshold of awareness, and the process of diffusion generally and hierarchical diffusion as most adequately characterising developments. A qualitative method was used, principally consisting of documentary analysis of a range of different records, reflecting its aim being to construct a contemporary history account of developments in policy. In addition, a small number of semi-structured interviews were conducted.

The study looked at the evolution of harm reduction as a norm in international drug policy in the work of the UN and EU and found that it occupied a strong position as a legitimate part of policy and treatment. This was despite there being a certain level of ambiguity surrounding its status in the work of the UN when compared with the EU. The drug policies launched in Ireland during the years studied broke with earlier strategy efforts as a result of the increased sophistication they displayed in their responses to drug

use and their strong support for the role of drug treatment. In supporting harm reduction, policy in Ireland gradually evolved inline with wider international norms in support of such treatment options during this time. Irish policy was shaped and influenced by a range of proximal and distal influences in these years. These ranged from community pressure and activism to complex information flows involving international policy forums where drug treatment research is examined and discussed.

During the time analysed Government backed research took on increased importance as more funding became available for it, with the work being completed generally supportive of developing treatment and harm reduction. The work undertaken displayed EU influences and the increased level of sophistication that indigenous drug research had come to be characterised by during the period. However, much of the research done had a marginal impact on the design of the treatment system as a result of its no longer being a structure in formation by the time this work was being carried out.

The new policy and coordination structures brought online at the start of the timeframe represented an innovative response to the drugs issue that was sustained across the period by successive Governments. They helped to deliver a more comprehensive drug policy and treatment response in the broader sense, but in some cases, such as the development of needle and syringe exchange programmes (NSPs), policy and coverage tended to remain somewhat static. This was partly an unanticipated and unintentional consequence of the innovative nature of the structures themselves and the attendant management complexities that they presented in addition to the fact that they were all brought online in a relatively short period of time together.

Within the period documented a shift occurred in the organisation of drug treatment, essentially involving a move away from a heavy reliance on centralised clinics towards greater provision of community based treatment. The policy push occurring since the early 1990s towards the greater use of methadone maintenance treatment (MMT) and the increased use of general practitioners (GPs), community pharmacies (CPs) and locally based clinics were integral to the facilitation of this change. The study found that policy was supportive of treatment and harm reduction and the use of and backing for research. It was found that several of the analytic models, such as the enlightenment model and the process of hierarchical diffusion, adequately reflected the events being documented.

List of tables

Table 1: National Availability of Needle Exchange Services by RDTF Area 282-283

Table 2: EHB treatment centres opened between 1988-1998 319

Glossary

ADRU: Alcohol and Drug Research Unit of the Health Research Board

AIDS: Acquired Immunodeficiency Syndrome

AOD: Alcohol and Other Drugs

BBVs: Blood Borne Viruses

BIC: British-Irish Council

BMI: Brief Motivational Interviewing

CBT: Cognitive Behavioural Therapy

CCSI: Cabinet Committee on Social Inclusion

CDC: Cabinet Drugs Committee

CDTs: Community Drug Teams

CGS: Coordinating Group of Secretaries

CPAs: Community Priority Areas

CICP: Centre for International Crime Prevention

CM: Contingency Management

CMHT: Community Mental Health Team

CND: Commission on Narcotic Drugs

COCAD: Coalition of Communities Against Drugs

COE: Council of the European Union

CPAD: Concerned Parents Against Drugs

CPMR: Committee for Public Management Research

CPNSP: Community based pharmacy needle and syringe exchange programmes

CTL: Central Treatment List

CWDCC: City Wide Drugs Crisis Campaign

DATOS: Drug Abuse Treatment Outcome Study

DBG: Delivering Better Government

DCRGA: Department of Community, Rural and Gaeltacht Affairs

DJELR: Department of Justice Equality and Law Reform

DMRD: Drug Misuse Research Division of the Health Research Board

DSU: Drugs Strategy Unit

DTCB: Drug Treatment Centre Board

DTFs: Drugs Task Forces

DTMS: Drug Trends Monitoring System

DTSR: Department of Tourism, Sport and Recreation

EHB: Eastern Health Board

ELDD: European Legal Data Base on Drugs

EGMH: Expert Group on Mental Health

EGPPM: Expert Group on a Protocol for the Prescribing of Methadone

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

ENF: Emerging Needs Fund

ESPAD: European School Survey Project on Alcohol and Other Drugs

EU: European Union

Europol: European Police Force

GMR: General Mortality Register

GRSOPHCS: Group to Review the Structure and Organisation of Prison Health Care Services

HAART: Highly Active Antiretroviral Therapy

HAT: Heroin Assisted Treatment

HBSC: Health Behaviour in School-aged Children survey

HBV: Hepatitis B Virus

HCV: Hepatitis C Virus

HIPE: Hospital In-patient Inquiry Database

HIV: Human immunodeficiency virus

HRB: Health Research Board

HSE: Health Service Executive

HWPD: Horizontal Working Party on Drugs

IACD: Interim Advisory Committee on Drugs

ICGP: Irish College of General Practitioners

ICON: Inner City Organisations Network

IDCCDA: Inter-Departmental Co-ordinating Committee on Drug Abuse

IDG: Inter-Departmental Group on Drugs

IDU: Injecting Drug Use

IDUs: Injecting Drug Users

IPS: Irish Prison Service

KPIs: Key Performance Indicators

LAS: Legal Affairs Section of UNDCP

LDTFs: Local Drugs Task Forces

MMT: Methadone Maintenance Therapy

MPIC: Methadone Prescribing Implementation Committee

MSRB: Medico Social Research Board

MTFMRDD: Ministerial Task Force on Measures to Reduce the Demand for Drugs

MTSRG: Methadone Treatment Services Review Group

NASC: National AIDS Strategy Committee

NACD: National Advisory Committee on Drugs

NAPSincl: National Action Plan Against Poverty and Social Exclusion

NCCDA: National Co-ordinating Committee on Drug Abuse

NDRDI: National Drug Related Deaths Index

NDTRS: National Drug Treatment Reporting System

NDC: National Documentation Centre on Drugs

NDSRSG: National Drugs Strategy Review Sub-Group

NDST: National Drugs Strategy Team

NPIRS: National Psychiatric In-Patient Reporting System

NSPs: Needle and Syringe Exchange Programmes

NTA: National Treatment Agency

NTORS: National Treatment Outcome Study

OR: Outreach work/workers

OR NSP: Outreach based needle and syringe exchange programmes

PG: Pompidou Group of the Council of Europe

RDTFs: Regional Drugs Task Forces

SGPBDT: Steering Group on Prison Based Drug Treatment

SIFs: Safe Injecting Facilities

SMI: The Strategic Management Initiative

SOGSI: Senior Officials Group on Social Inclusion

SGTFDA: Special Government Task Force on Drug Abuse

SLAN: Survey of Lifestyle, Attitudes and Nutrition in Ireland

SRAs: Strategic Results Areas

UNAIDS: UN Joint Programme on HIV/AIDS

UNDCP: United Nations Drug Control Programme

UNGASS: United Nations General Assembly Special Session

UNODC: United Nations Office of Drugs and Crime

UNODCCP: United Nations Office for Drug Control and Crime Prevention

WHO: World Heath Organization

WPDA: Working Party on Drug Abuse

YPFSF: Young People's Facilities and Services Fund

Chapter 1: Introduction

The diverse and sometimes strange ways in which policy interacts with research can be seen from the treatment of two substances, tobacco and LSD-25, between the middle and start of the Twentieth and Twenty First Centuries. Historically, social controls around the use of tobacco increased in Western Europe in tandem with the development of manners and social refinement, rather than in conjunction with health concerns and medical advancements.[1] This aspect of tobacco's social history can be regarded as an example of the long term social process that the sociologist Norbert Elias referred to as the 'civilizing process', which is concerned with the social constraint linked to increased self-restraint in Western European history.[2] When scientific knowledge was used to analyse the effects of tobacco consumption in the mid Twentieth Century, it started a long process in redefining the consumption of the substance.[3] The prime example of this occurrence was the research carried out in 1950 by Richard Doll on tobacco's ability to cause carcinoma of the lung, which demonstrated a feasible link, but had anything but a direct impact on policy.[4] As is generally the case when a high revenue generating product is under attack, it took over seven years before the relationship was to receive backing in the British House of Commons.[5]

Towards the end of the Twentieth Century the use of tobacco continued to undergo a process of international stigmatization in a similar fashion to the way opiates were demonised and discarded as a legitimate source of government revenue at the start of the same century.[6] One of the main symbolic turning points in this process was the creation of the World Health Organization's 'Framework Convention on Tobacco Control'. This convention was adopted at the 56th World Health Assembly in 2003.[7] Taking these two landmark events in the recent history of tobacco use and control, it is evident that despite the objective logic of science, policy makers can appear on the surface to be irrational and meandering in the manner and speed with which they respond to knowledge that is apparently 'policy relevant'.

LSD-25, which was discovered in 1943 by Albert Hoffman in Switzerland, travelled at a far more accelerated pace between approval and stigmatization than tobacco. Up to the mid 1960s LSD-25 was the focus of considerable medical attention, particularly in relation to psychiatric research.[8] Among those interested in its mind-

altering properties were psychiatrists and psychopharmacologists.[9] In total research was carried out on about 40,000 individuals and reported in over 1,000 scientific papers, clearly indicating that LSD based studies were far from being on the fringes of medical research.[10] The range of potential treatment applications which this research spanned was diverse, covering alcoholism, psychosomatic and neurotic disorders, schizophrenia, autism, and the rehabilitation of criminals identified as having psychopathic or sociopathic tendencies.[11]

However, the development of a moral panic around the drugs use for recreational purposes alongside an emerging body of research on the harmful effects of the drug, such as its detrimental impact on human memory, functioned to make its use in research untenable by the late 1960s.[12] Yet the main barrier to research involving LSD was not scientific, rather it was how the drug had been socially constructed as being a panapathogen, that is, a cause of evil, as opposed to a panacea, or a 'cure all'.[13] The shift in the drug's social status from being a neutral and potentially promising scientific substance to the psychedelic elixir of deviant subcultures devoid of potential medical merit was, like the length of time involved in the reaction to tobacco research, far from rational. LSD was never banned from being used in psychiatric research in most countries, though it was from clinical practice, rather its social stigmatization and potential to tarnish scientific reputations inhibited requests and responses for research funding.[14] Yet, roughly thirty five years after its therapeutic decline, around the time of its discoverer's one hundredth birthday witnessed increased calls for a re-examination of research using LSD.[15] This is a point that perhaps highlights the still unexplored therapeutic potential of the drug and the manner in which it was hastily removed from the research agenda for largely political reasons.

Tobacco's history of being a socially acceptable psychoactive drug delayed the impact of research on how it could negatively affect health. As a consequence, international moves towards phasing its use out have been marginal in terms of their overall bearing on the reduction of use and the extraction of revenue from it. Conversely, sensationalist media coverage of LSD's potential for recreational hedonism and by extension psychological and physiological health risks associated with the abandonment of self-control, overtook the still unexplored therapeutic potential of the drug. This

symbolically tainted the substance's reputation and by extension the standing of those associated with its use. Given the manner in which research on tobacco and LSD has interacted with policy, a number of questions arise concerning the potential ways in which this relationship between research and policy could be theorised or projected to occur.

Aims of the Thesis

There have been a small number of studies focused on different aspects and periods of Irish drug policy. Among the principal works in the area is Butler's analysis of events up to 1996, as well as his coverage of policy development in a range of other areas.[16] These have included methadone prescribing, drug courts, harm reduction generally and the work of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.[17] Outside of this body of work there have been few other studies devoted to exploring discernable periods of policy, or looking at specific timeframes within their international context so that the wider significance of events can be appreciated. There has been limited analysis of the contemporary history of recent Irish drug policy from a documentary perspective in general.

During the period from 1996 to 2008 there were a significant number of official actions aimed at addressing illicit drug use through the formulation, implementation, evaluation and modification of strategies and structures to deliver healthcare provision to injecting drug users. Globally, the same period witnessed a shift in international policy towards elements of harm reduction that displayed increased utility in controlling blood borne viruses. The present study stands back from the array of activity during this period and takes stock of how the Irish response to injecting drug use evolved.

The study seeks to make a contribution to knowledge by employing documentary analysis of a range of records to construct a contemporary history account of certain aspects of Irish drug policy during the years 1996 to 2008. In this respect, the main aim of the study is:

- To document some of the main developments in policy, the drug treatment system, and the role of research in these changes during this timeframe.

More specifically stated this overarching aim can be viewed as a set of interconnecting sub-aims:

1) Firstly, the study seeks to provide an account of the international policy environment in which the changes in Irish policy took place;

2) Secondly, it sets out to describe the main contours of Irish policy during the period studied;

3) Thirdly, it endeavours to give an account of the work of indigenous research bodies operating at this time;

4) Fourthly, it explores certain changes in two specific aspects of the drug treatment system during the time under analysis.

Throughout the study the main focus and object of concern is first and foremost on injecting drug use as a result of the project's concern with the policy response to the public health issues linked to blood borne viruses and injecting drug use.

Structure of the Thesis

The thesis is comprised of ten chapters in total, the contents of which are outlined below. Following the current chapter, which has presented the overall introduction to the study and its aims, chapter two provides a discussion of the methods used to conduct the study. Principally this portion of the thesis gives an account of documentary analysis and qualitative interviewing. Chapter three functions to provide the international drug policy context within which the events being analysed have taken place. Specifically, it considers the status of harm reduction as a feature of policy in the work of the two main international bodies operating in the drugs arena, the United Nations (UN) and the European Union (EU). This portion of the study considers how harm reduction has gained ground as a lead element of international drug policy since the advent of the HIV/AIDS epidemic. The differing extents to which the UN and EU can be seen as endorsing the use of harm reduction practices are analysed through a discussion of their policy statements on and legal investigations of these healthcare interventions. Chapter three allows us to consider the global context surrounding the expansion of drug policy towards the accommodation of harm reduction as a central element.

Following on from chapter three, chapters four to nine represent the core of the thesis. Chapter four is concerned with the role of 'management science' in Irish drug policy since the advent of the strategic management initiative (SMI). In particular, this part of the thesis looks at the degree to which the SMI, given the existence of the HIV epidemic, functioned to integrate and legitimate harm reduction practices as a set of healthcare interventions into drug policy. In this respect, the section examines some of the changes that can be seen in Irish drug policy before and after the start of the period being studied. It starts by discussing the main features of the SMI, before moving to an analysis of the Irish drug policy between the 1970s and mid 1990s. This is followed by an exploration of the policies that emerged after the arrival of the SMI.

Chapter five examines some of the external and internal influences that have a bearing on the formulation of Irish drug policy, as well as the way in which drug policy concerns have become a common feature of many other areas of social policy. In this sense, the section looks at how certain EU drug policy forums place pressure on the Irish Government to create a particular impression of their policy actions, as well as the image of their actions that they have attempted to construct on a national level. Subsequently, this part of the thesis analyses how policy development since the advent of the SMI has been increasingly receptive to the inclusion of drug issues across a wide range of policy areas. This is a situation that has ultimately helped to normalise drug policy as a core policy area, while also helping to create the impression that the drugs problem was being dealt with in a sophisticated manner on a number of policy fronts.

The sixth chapter of the thesis is the first of two chapters that is concerned with the work of national research bodies, and the first of four – chapters six, seven, eight and nine – that represent a move towards looking, *inter alia*, in further detail at drug research and treatment. Focused on the work of the Alcohol and Drug Research Unit (ADRU) this part of the thesis considers different aspects of their research output during the period and its engagement with treatment issues. Commencing with an exploration of the Unit's history and role, the chapter moves on to look at their work on the epidemiology of drug use. This is followed by a look at some of the research projects with a more harm reduction specific focus that were undertaken during this time. After this some of the more sensitive pieces of work that the ADRU have completed are discussed, such as their

work on the expansion of the National Drug Treatment Monitoring System (NDTRS) and alcohol policy.

The seventh chapter of the thesis is concerned with the work of the National Advisory Committee on Drugs (NACD). It explores some of the research they carried out during the period studied, the degree to which they backed the development of treatment, particularly harm reduction approaches to it, as well as looking at certain changes in their work over time. It starts by discussing the Committee's establishment and role and then considers their work on the role of needle and syringe exchange programmes (NSPs) and the backing given to this treatment option. This is followed by a discussion of their research projects on cocaine use and their work on dual diagnosis and its role in policy formulation. Subsequently, an evaluation of the NACD's structure and operations carried out a few years before the end of the period studied is discussed.

Chapter eight is the first of two chapters, along with the last substantive chapter of the thesis, number nine, which looks, *inter alia*, at issues related to specific aspects of the drug treatment system. This chapter of the thesis is focused on some of the operational dimensions of the new structures that came into being during the years analysed and some of the consequences that arose from the manner in which they evolved over time. The chapter begins by looking at some of the positive and negative attributes of the key policy structures that were brought online at the start of the timeframe understudy. It then proceeds towards a more detailed analysis of the structures deployed at the local and regional levels, as well as their policy link-in mechanisms, during this time. This is done by examining the National Drugs Strategy Team and the Local and Regional Drugs Task Forces. Following this, the chapter moves on to take a look the relationship between the development of needle and syringe exchange programmes (NSPs) during the timeframe studied and the Drugs Task Forces.

The ninth chapter of the thesis is focused on changes that occurred in the structural delivery of methadone maintenance treatment (MMT) during the years under analysis. It starts by looking at the relationship between drug policy and the development of MMT, before moving on to consider some of the ways in which the delivery of MMT changed over the years being studied. Subsequently, some of the problems and consequences that arose as a result of the process of modifying the MMT system are

considered. This portion of the thesis finishes by examining the nature of MMT within the prison system and how this has changed over the period examined. Following this, chapter ten presents the overall conclusions from the thesis.

The Research / Policy Interface

There are numerous theoretical explanations within the social sciences that attempt to elucidate the interaction between the formulation, implementation and evaluation of social policy with seemingly relevant advances in research. One omnipresent caveat that can be drawn out of these perspectives is that the relationship between social science and social policy is rarely, if ever, an entirely rational one. The complexity of these interactions, occurring through different periods of policy making concerned with different issues, do not easily fit into classification systems. Analytically, there is little to be gained from trying to construct one unified or overarching theory that can account for reality's chaos and diversity, in much the same way that one theory of drug use will never succeed in adequately encapsulating the multidimensional nature of the phenomenon.[18] Rather a range of theories, each accounting for partial aspects of the phenomenon being examined, can better help to illuminate and stimulate inquiry. Below I draw on the work of Carol Weiss to discuss a selection of the various models that attempt to account for the interactions between research and policy.[19] These are the knowledge-driven model, the problem-solving model, the interactive model, the political model, the tactical model and the enlightenment model.[20] At certain points throughout the thesis these models are returned to in order to help frame and discuss the events being documented.

The knowledge-driven and problem-solving models of research utilization are united in their conception of the research / policy interface as being linear in nature.[21] The former model revolves around the core assumption that once knowledge is created through research, initially at a basic or experimental level then refined at an applied stage, it will be used in the development of a solution or the modification of a practice.[22] This formula of research / policy interaction does not offer a very useful view of how the type of knowledge or research created by social scientists typically ends up contributing to policy, largely because this model is based on the manner in which physical sciences

draw on research.[23] For example, this model adequately accounts for the manner in which developments in an area of applied physics, such as spin electronics and magnetism, will have an impact upon the electronic storage industry, through the expansion of how much information can be held on magnetic tapes and what speeds it can be written and retrieved at.

The problem-solving model follows the same rational logic as the knowledge-driven model.[24] This model consists of two subtypes, that is, the 'purposeful commissioning' and 'search' routes.[25] In the former view of research / policy connections the fact that research is being carried out is not independent of policy and therefore potentially a contributing factor, rather it is dependent on policy to be commissioned in the first place.[26] In a linear manner, research is seen as being carried out in order to provide solutions to specific policy problems. When the research is completed it is seen as being directly translated into the decision making process of policy making.[27] The search route subtype of this model involves those engaged in policy making actively going out to find information on a problem that they are attempting to solve from existing sources, rather than directly commissioning new research.[28] In this variation of the problem-solving model a variety of information sources may be consulted, such as international and different national policy and research bodies, as well as professional journals.[29] They can also come across the information as a result of contacts with a range of actors, such as "...aids, staff analysts, colleagues, consultants or social science researchers."[30] Once acquired, the relevant knowledge is seen as being directly applied to the policy problem at hand, in so far as it is acceptably or workably relevant to the situation.[31]

The third view of how research potentially interacts with policy, the interactive model, departs from the linear view espoused in the two previous models.[32] Rather, the developments are more chaotic and less direct.[33] In this view, research knowledge derived from the social sciences is one of a number of potential information sources that intermingle and from which potential solutions and fragments of responses are drawn by policy makers.[34] In this case, there may well not be existing research or conclusions that directly relate to the issue being addressed.[35] Here various types of policy actors 'pool' their skill sets to grapple with an issue.[36]

The fourth model of the research / policy interface, the political model, looks at the way research is 'used' as being selective.[37] Central to this model is the view that many policy issues, such as drug issues, elicit reactions to potential decision making events that are predetermined and stubborn.[38] In this sense, those involved in making public policy are regarded as being very discriminating in terms of the research that they are receptive to and incorporate into their actions.[39] This in no way diminishes the role of research or casts aspersions on the quality of research; these are different issues, rather, the decision makers only see what they want to see.[40] Evidence that confirms pre-existing agendas without the call for drastic modification is incorporated and utilized as 'weaponry' against opposing viewpoints in the policy process.[41]

A slightly cynical view of the way in which research is used by policy makers is found in the tactical model.[42] Here the goal behind the commissioning of research, for example, is the opposite of what it might rationally be perceived to be, at least in a politically naïve view. Research is played as a card or used as a bargaining chip by politicians to ward off criticism of ongoing actions or the need to formulate new responses to a particular issue.[43] The ploy here can be to assert that decisions must be held off until 'the research' is finished or the project / policy is 'evaluated'.[44] This allows potential criticisms to be deflected.[45] In this view, whole bodies of research, like those conducted by the governmental advisory bodies that many countries have, can be geared towards a balancing act between genuine information seeking and giving the appearance of it.[46] In an era when public policies generally span longer and longer periods of time the tactical model offers a potentially useful critique of the array of (non)actions being carried out.

The enlightenment model of the interaction between research and policy is generally recognised as providing a relatively accurate account of the manner in which research tends to impact upon policy.[47] Indicating that analysis of the interactions between research and policy need to be conducted over an extended period, the enlightenment model stresses the cumulative and circuitous process by which research influences policy.[48] An important part of this form of interaction is channels of communication that facilitate the diffusion of information between specialists involved in both research and policy.[49] These may consist of, for example, policy networks or forums

organised as part of international bodies, such as the World Health Organisation (WHO), as well as professional journals and the mass media.[50]

A key point on the manner in which this model is considered to operate is the idea that no one piece of research or a body of studies will have a significant impact upon policy on its own.[51] Rather, as work is done and accumulates on a particular topic or set of issues, the ideas engendered by research start to filter through into the realm of policy making.[52] These ideas and approaches, or concepts and perspectives, may not be associated with any specific study *per se*.[53] In essence, it is the ideas and approaches arising from research that has an impact over time and this occurs in a cumulative way as work is completed and continues to stack-up.[54] As Berridge and Thom put it, "...the theories, concepts and findings of research filter in a diffuse way into the policy process".[55] However, this does not suggest that policy makers will share the ideological views of researchers, or vice versa.[56] On the contrary, the accumulation of work has the ability to override the differences of researchers and policy makers and filter into the policy process over time.[57]

In one sense, research can be seen as functioning as a ready made resource for decision makers to draw upon when a particular problem warrants action. Critically, the widespread presence of research on a set of practices and the ideas and approaches arising from it may be especially persuasive to policy makers when they are plunged into a period of crisis.[58] This is the case as at such times policy makers may have to respond to a phenomenon they have not previously encountered, as was the case with the HIV epidemic's emergence in the 1980s.[59]

Out of the different hypothetical modes of interaction between research and policy discussed, the enlightenment model appears to come closest to the manner in which developments generally occur and have an impact in drug policy. The stacking of research and the cumulative influence of the ideas arising from it approximates quite closely to the manner in which transformations in drug policy norms began to occur from the mid 1980s onwards in light of the links between HIV and injecting drug use. This granted, elements of all the models discussed above can function to simultaneously elucidate partial aspects of events, aspects that cannot be seen if we adopt an analytically rigid outlook or dogmatically adhere to one formula as offering 'the answer'. It is

important to remember that the different views that these models present are 'ideal types' to which events can be seen as approximating, rather than inflexibly following.[60] Reality is not neat and events often lie somewhere between the borders of several models and concepts.

In much the same way that a range of different models and concepts linked to the interaction between research and policy can help us to gain a clearer understanding of events, so too can the use to different sociological theories. In this respect, a number of sociological theorists are drawn upon at different points throughout the study to help frame and explore aspects of the developments and processes being looked at. Norbert Elias' work *The Civilizing Process* is used in this chapter while considering the historic development of tobacco and manners around its use as well as the consumption of food and hygiene practices.[61] Later, in examining the way in which policy actions are received and the manner in which those engaging in them wish to have their efforts perceived, Erving Goffman's idea of *impression management* from his dramaturgical analogy of social interaction is employed.[62] When issues of power and interaction between different sectoral actors are explored, both the ideas of Antionio Gramsci and Anthony Giddens aid our analysis. Specifically, the former theorist's concept of hegemony and the latter's theory of structuration are drawn upon.[63] Consequently, these theories are utilized as tools to allow a clearer consideration of the events discussed in the study. While representing different areas of and coming from different angles within sociology, together they can work in different ways to sharpen our understanding of the subject matter at hand. This is something that cannot be achieved if we lock ourselves solely into following one theory or school of thought.

The manner in which epidemic diseases impact upon the interface between research and policy, and the way in which new approaches can diffuse throughout policy circles internationally is examined in the following section. This part of the chapter also presents another set of concepts that are used throughout the thesis at certain points as well as the models discussed here for helping to frame and discuss the documentary history being presented.

Epidemics and Policy Diffusion

The development of manners around practices of consuming food and beverages throughout history would appear to represent a logical progression where medical and scientific knowledge has rationally impacted human behaviour to better protect health. Yet the sociologist Norbert Elias' work on the civilizing process in Western Europe found the opposite of this view to be the reality of developments in human manners.[64] Chiefly, practices that would today be referred to as hygienic were adopted in the past for purposes of social distinction and status, rather than health and longevity.[65] It was long after the introduction of practices such as the use of forks and the avoidance of spitting near food that they were given a legitimate medical rationale, which essentially fitted with the pre-existing habits rather than functioning as the driving force behind their creation.[66] To assert otherwise would be to view the past through perceptions grounded in the present and ignore the logic that provided the rationale for adopting habits as they were formulated.[67] A similar situation persisted for a long time in relation to attempts to understand and control the spread of diseases.[68]

Historically, the major epidemics that have affected the world did not have a direct and rational impact upon human interactions and habits as a result of there being few links asserted between disease transmission and unhealthy individual practices.[69] This is not to diminish the logic of conceiving of epidemics as choosing their victims as a result of their being evil or cursed at times when medical knowledge was not well advanced or widely trusted.[70] Rather it is to assert the relativity of such views to their historical context, which changed slowly over time towards the recognition of behavioural and environmental factors in disease transmission – often after adequate means of control had been devised and commonly used.[71] Following Goudsblom's work on the links between health concerns and social practices, below I consider the emergence of medical rationality in dealing with epidemic disease through a discussion of leprosy, the Black Death, and cholera.[72] Subsequently, the manner in which HIV/AIDS has been dealt with will be discussed in terms of its representing an important historical incident in the impact of rational medical science on epidemic disease, as witnessed through changes in policy norms associated with drug control. This section of the chapter also discusses three concepts – threshold of awareness, critical mass, hierarchical

diffusion – for helping to frame and discuss policy and the documentary history being presented. These concepts are used at certain points during the thesis alongside the models outlined in the previous section.

Leprosy provides an example of how factors other than contamination caused by proximity or interaction had an impact on perceptions of its spread through society.[73] Rather than being solely viewed as a communicable disease that an unfortunate individual could acquire, the illness was often perceived in moral terms as being a punishment of divine origin inflicted upon deviants for their transgressions.[74] Those who were afflicted with the illness were subjected to a double stigmatization, in that, not only were they regarded as 'unclean', but this labeling brought with it the consequence of banishment from the presence of those who were not ill.[75] Yet this very act of social exclusion as a result of the individual's disease status is what offers us a window into the lack of rationality involved in the segregation that was adopted, and the coincidental manner in which these measures also happened to generally stop the disease from spreading.[76]

As the social repercussions arising from having the status of leper conferred on an individual were extreme and permanent, it was suggested that the process of diagnosis only be carried out after the disease had become visible and spread to the face.[77] This indicates an implicit compassion in the decision not to confer the title of leper and remove the sick individual from the group, even though they might have the illness, but not at so advanced a stage as their facial complexion was corroded.[78] This probably arose out of the view that damaged flesh was representative of a tainted soul.[79] Similarly, the isolation that lepers were subjected to was periodically rescinded in line with religious festivals, during which they were permitted to enter the social spaces of those who were perfectly healthy.[80] The rationale behind their banishment probably had as much to do with spiritual contamination as it did with the spread of disease, given the condition's associations with sin.[81] Suffice to say, at this stage in the history of epidemics, rational medical views of how to manage disease played a minor role in reactions to leprosy.

While leprosy was a constantly present disease, the Black Death or bubonic plague, which began spreading across Europe towards the end of the fourteenth century, was more fleeting in its presence, tending to be in an area for a number of months and

then disappearing for extended periods of time.[82] Like leprosy, the disease was linked to the wrath of God amongst Christians.[83] The Black Death was responsible for a much higher rate of mortality than leprosy, in total causing the deaths of one third of all Europeans at the time.[84] The high death toll resulted in sustained efforts by local authorities to curb the disease's spread.[85]

Unlike leprosy, the disease was perceived as being particularly contagious, yet the means and routes of its transmission were far from clear.[86] Importantly, it was in dealing with the Black Death in Italy that focused attempts emerged to combat the spread of the disease, largely through segregation and the sealing of cities to avoid further contamination.[87] Indeed, the word quarantine has its origins in Italian procedures for isolating ships for forty days so as to check for and contain the disease.[88] These practices were refined over the fourteenth and fifteenth centuries in Italy and then began to diffuse throughout Europe amongst other social administrations as a form of 'best practice' for controlling the disease's movement.[89] Yet the apparent rationality of Italian actions is deceptive, as the notion of contagious disease that needed to be isolated intermingled with other perceived causal factors, such as astral and seasonal issues, as well as deviance and sin.[90] This granted, the emerging coordinated and pre-planned nature of action taken against epidemic disease can be seen from reactions to the Black Death.

Advancements were made on these early efforts at isolating or quarantining disease with the public health measures that were adopted to combat cholera, as well as other illness afflicting the urban poor.[91] As a disease, cholera had from its arrival in Europe prior to the middle of the nineteenth century created a menacing atmosphere and generated sustained action to combat its ravages.[92] Cholera's ability to produce intense fear arose from the highly accelerated process of physical deterioration leading to death caused by the disease, which was in turn accentuated by its occurrence on a mass scale in some communities.[93] Its devastation of working class areas highlighted the adverse social conditions of the poor in newly expanded industrial cities in Europe.[94]

During the nineteenth century public health campaigns were underway to improve the social situation of those at the bottom of the class structure, pursued in the main by the middle classes and focused on sanitary reforms designed to ameliorate a range of adverse living conditions.[95] While these advances in public health were partially driven

by a sense of revulsion towards the squalor within which the poor dwelled, the threat of cholera greatly quickened the pace with which events occurred.[96] The construction and improvement of water and sewage treatment systems was hastened by acceptance of bacteriological assertions on the role of the social environment in disease spread.[97] This is not to say that these mass health reforms would not have occurred in the absence of cholera, rather it is to assert the momentum generated by epidemic disease and the manner in which rational medical ideas were brought to bear upon it.[98]

The societal reaction to HIV/AIDS has continued this trend of applying rational medical knowledge to the treatment of epidemic disease. Moreover, the time between the identification of the disease and its transmission routes and the emergence of sustained medical interventions aimed at halting the virus's progression, occurred at an exceptionally fast pace when compared to the history of responses to other epidemics. The reaction to the epidemic was typified by a sense of urgency in which policy makers were influenced by existing and newly developed strategies and practices. This is representative of a temporally compressed cycle of the enlightenment model of the interaction between research and policy. In this sense, the time between the stacking up of research on treatment issues and the ideas and approaches engendered by it subsequently filtering into and having an impact on policy was significantly reduced as a result of the sense of crisis wrought by the conjunction of HIV and IDU. The special nature of this situation and its ability to legitimate what had hitherto been seen as marginal at best, if not plain anathema in drug policy generally, is the global context within which the period being analysed in this study is set. It represents a turning point where healthcare interventions generally referred to as harm reduction practices became an integral part of drug policy and provision internationally. However, this change has occurred with differing levels of intensity throughout the world, both in terms of the number and range of practices adopted and the manner in which they have been endorsed in policy in differing socio-political contexts – namely overtly or covertly.

As with most epidemic diseases, HIV elicited its fair share of hostile responses. The initial stigmatization attached to the disease arose out of its links with subcultures regarded as being deviant within mainstream society, such as homosexuals, prostitutes and injecting drug users. While the fear implicit in prejudicial reactions had somewhat

dissipated by the 1990s, its emergence was representative of a societal shock from the fact that in the era of high-tech medical advancements an epidemic disease had arisen again, and little was known about how its transmission could be curbed.[99] However, by the third decade of the HIV/AIDS epidemic the impact of medicine and research can be gleaned from the shift in which the disease was perceived.[100] Namely, from being a 'death sentence' to being a 'chronic illness' that could be 'managed', as a retrospective account by the World Health Organization phrased it in 2006.[101]

The enlightenment model of the interaction between research and policy contributes to our understanding of the rapid medical impact upon the epidemic. Central to this view of developments is the fact that parts of the ideas and approaches behind what came to be collectively termed harm reduction practices had been 'stacking up' for quite some time before the advent of HIV/AIDS.[102] The emergence of links between the disease and injecting drug use functioned to partially de-politicise the 'drug issue' in most countries, and remove many, though by no means all and in far from an even manner, of the ideological barriers to the way drug services had been progressing irrespective of the epidemic.[103] Essentially, the health issues conferred legitimacy upon the use of harm reduction strategies and bolstered healthcare perceptions of drug users rather than images of deviance warranting a solely punitive response.[104]

The advent of HIV/AIDS undoubtedly had a major simplifying effect on the debate about how to treat injecting drug use, because the virus was an actual disease that replaced the metaphorical disease to which drug use had long been referred as a result of the ensuing sense of urgency wrought by the epidemic's arrival.[105] Yet the spread of the epidemic, like the spread of drug use, was a truly international phenomenon, in that, every country in the world was touched by the consequences of the disease. It is this universal aspect of HIV/AIDS in a globalised world that has facilitated the rapid diffusion of harm reduction practices as a legitimate response to the epidemic in and from populations of injecting drug users. Historically, the development of controls for opiates, more so than alcohol, has involved the interaction of various countries in international forums to the extent that national drug policies have always been affected by international concerns.[106] The HIV/AIDS epidemic represents a period of drug policy making where endogenous or proximal and exogenous or distal influences on policy and treatment

formulation have become of equal importance in terms of their input into the response that occurs in any country.[107] In an international policy climate, facilitated by bodies such as the UN and the EU, national decision makers are exposed to the experiments, success and failures of other countries with increasing rapidity and within the context of evolving norms related to 'best practice' in handling the issues around injecting drug use.[108]

It would be naïve to suggest that policy makers uncritically adopt measures that are successful elsewhere or axiomatically translate them into their own national contexts in a purely robotic or mechanical manner. Rather, the existence of such information and mechanisms for its exchange facilitates the development of both a 'critical mass' and a 'threshold of awareness' in terms of policy makers being conscious of harm reduction practices.[109] The concept of critical mass relates to the way in which information and work on an area, such as the use of methadone maintenance treatment (MMT), builds up and becomes more refined over time.[110] Yet this rise in advancement occurs to such an extent that the practice or technology can no longer be dismissed as a fringe activity or unscientific.[111]

The idea of a 'threshold of awareness' being reached on a topic, such as the use of methadone in maintenance and detoxification, sees information as being increasingly accepted over time, through different studies, to the point that it diffuses throughout circles of interest.[112] In this sense, it is not confined to the scientific research networks where it was developed and refined or indeed the national treatment contexts where such work was pioneered.[113] As a result of this idea of increased consciousness, the concept of threshold of awareness indicates that awareness and adoption of a new policy option in turn accentuates the overall level of acknowledgement and experimentation; for example, the increased use of methadone maintenance and syringe exchanges globally. Both the idea of a critical mass and a threshold of awareness being reached in the spread of information regarding a practice feed into the manner in which social policies tend to diffuse internationally, particularly drug policies.[114]

In terms of patterns of diffusion, the role of international and national bodies and countries in popularizing harm reduction practices is adequately characterized by the idea of 'hierarchical' diffusion.[115] This concept can be seen as approximating somewhat to Norbert Elias's view of how manners diffused from elites down through the class strata

via those who wished to emulate their behavior and, over time, became established as norms to which increasing amounts of individuals subscribed.[116] Similarly, policy options, like heroin assisted treatment, are initially tested in larger and possibly more economically and politically powerful countries as feasible practices.[117] This occurs prior to their being experimented with and potentially adopted in other smaller nations where, in part, the existence of the practice in a more powerful country is seen as a legitimating or endorsing factor for local engagement with the practice if its use is deemed necessary.[118]

The adoption of healthcare interventions aimed at curbing the spread of HIV and reducing the level of harm experienced by the still-using drug service client in countries such as the Netherlands and Britain has spread throughout many other nations as a result of the effectiveness these options have displayed in combating disease transmission.[119] Though, the manner in which such policy and treatment options frequently spread is far from being linear and rational. It is hard to envision the development of substitution maintenance programs or syringe exchange schemes in a country like the Republic of Ireland prior to these options being legitimated by larger entities on the international research and political scenes.[120] Similarly, the Swiss and Canadian experiments with heroin assisted treatment owe much to the trials and proposals in other countries, such as Australia and the United Kingdom, in a manner that represents the circuitous routes by which policy options diffuse.[121]

The impact of HIV/AIDS and later HCV on the drug policy landscape has been significant. The movement towards harm reduction practices in many countries from the mid 1980s was accelerated by the linkages made between these viruses and injecting drug use. The manner in which earlier developments in treatment and user care became the focus of renewed attention, financing, expansion and international dissemination under the banner of 'best practice' was a significant occurrence in the history of reactions to epidemic diseases. The accelerated pace of developments and the extent internationally to which they spread can be seen as approximating to a compressed cycle of the relationship between research and policy set out in the enlightenment model. In essence, this represented a reduced time-lag between new practices and their widespread use and subsequent official endorsement by policy makers. The cumulative impact of the ideas

and approaches engendered by research filtered into the policy process in a relatively fast pace. The manner in which the tenets of harm reduction diffused and legitimately coalesced with supply reduction strategies was hastened by the uncertainty that accompanied the advent of HIV/AIDS. This contributed to the disease being framed as an urgent issue on which on there was a need for action to be taken. The culmination of these factors represents a period of transition in drug policy internationally, through which developments in national policies can be contextualised and analysed. It is within the context of this turning point or shift in policy norms towards these new drug services that the present study's period of analysis is located.

While there has been a dearth of documentary analysis of different periods of Irish drug policy generally, Butler has explored a range of different developments in a body of linked studies.[122] These works help us to consider different aspects of the Irish policy context. For example, his 2002 study *Alcohol Drugs and Health Promotion in Modern Ireland* provided the most comprehensive consideration of events from the 1960s up to 1996.[123] In this and earlier work he showed, *inter alia*, the way in which Irish drug policy progressed towards supporting the use of harm reduction as a response emerged and was developed to deal with the crisis represented by HIV and IDU.[124] In a number of other studies he analysed different features of how the treatment spectrum has evolved after 1996 and the nature of the policy making processes involved.[125] In his work on MMT he found that the policy making process surrounding the development of a protocol for the use of MMT was one characterized as being covert in terms of how the modifications to the system were achieved.[126]

In another study, Butler took a retrospective stock take of the new drug policy launched in 1996 by the Ministerial Task Force on Measures to Reduce the Demand for Drugs (MTFMRDD) and its lasting influence.[127] It was found that, *inter alia*, the ongoing tensions between healthcare and criminal justice approaches to drug use had been sidestepped, as opposed to being resolved, by Irish policy.[128] In an earlier piece of work by Butler looking at the creation of the drug courts in Ireland, it was also found that the strain between the healthcare and criminal justice sectors had equally not been settled in terms of this specific development.[129] The problems and differences between the sectors that might cause difficulties were not rooted out and dealt with.[130] In considering the

nature of Irish drug policy, Butler and Mayock have argued that it has been largely covert and cloaked in ambiguity.[131] This is reflected, for example, in how policy makers have not pushed visible debates on harm reduction and the wider political trend of dealing with sensitive issues in this manner.[132] The present study seeks to add to the documentary picture that has been built in these works, and in doing so aims to further illuminate our understanding of a range of different developments between 1996 and 2008.

[1] Hughes, J. (2003). 'From Panacea to Pandemic: Tobacco-Use in the West', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.219; pp.205-226.

[2] Hughes, J. (2003). 'From Panacea to Pandemic: Tobacco-Use in the West', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.219; pp.205-226; Ritzer, G. (2000). *Sociological Theory*. Fifth edition. London: McGraw-Hill, p.515; pp.509-518.

[3] Hughes, J. (2003). 'From Panacea to Pandemic: Tobacco-Use in the West', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.216-217.

[4] Edwards, G. (2002). *Addiction: Evolution of A Specialist Field.* Oxford: Blackwell Science/Addiction Press, p.196; Berridge, V. (2001). 'Altered states: opium and tobacco compared', *Social Research*, Vol.68, No.3, p.665.

[5] Edwards, G. (1993). Substance misuse and the uses of science, in Edwards, G., Strang, J. & Jaffe, J. (eds.). (1993). *Drugs, Alcohol and Tobacco: Making the Science and Policy Connections*. Oxford: Oxford University Press, p.8.

[6] Berridge, V. (2001). 'Altered states: opium and tobacco compared', *Social Research*, Vol.68, No.3, p.656.

[7] Retrieved 23.03.2010 from: http://www.who.int/fctc/signatories_parties/en/index.html

[8] Dyck, E. (2005). 'Flashback: psychiatric experimentation with LSD in historical perspective', *Canadian Journal of Psychiatry*, Vol.50, No.7, p.382

[9] Dyck, E. (2005). 'Flashback: psychiatric experimentation with LSD in historical perspective', *Canadian Journal of Psychiatry*, Vol.50, No.7, pp.383

[10] Bakalar, J.B. & Grinspoon, L. (1981). *Psychedelic Drugs Reconsidered.* New York: Basic Books, p.192.

[11] Bakalar, J.B. & Grinspoon, L. (1981). *Psychedelic Drugs Reconsidered.* New York: Basic Books, pp.192-237.

[12] Dyck, E. (2005). 'Flashback: psychiatric experimentation with LSD in historical perspective', *Canadian Journal of Psychiatry*, Vol.50, No.7, pp.382

[13] Szasz, T. (1975). *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers*. London: Routledge & Kegan Paul, pp.137-8.

[14] Bakalar, J.B. & Grinspoon, L. (1981). *Psychedelic Drugs Reconsidered.* New York: Basic Books, p.232.

[15] Boseley, S. (January 11th, 2006). 'Psychiatrist calls for end to 30-year taboo over use of LSD as a medical treatment',
retrieved 11/01/06 from :
http://www.guardian.co.uk/drugs/Story/0,2763,1683780,00.html

[16] Butler, S. (1991). 'Drug problems and drug policies in Ireland: A quarter of a century reviewed, *Administration*, Vol.39, No.3, pp.210-33; Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration.

[17] Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324; Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration; Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422; Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, pp.125-144.

[18] Bulmer, M. (1986). 'The policy process and the place in it of social research', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.5

[19] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). Social Science and Social Policy. London: Allen & Unwin.

[20] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin.

[21] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.33.

[22] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.32.

[23] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.32.

[24] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.33.

[25] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, pp.33-4.

[26] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy.* London: Allen & Unwin, p.34.

[27] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.34.

[28] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.33.

[29] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.33.

[30] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.33.

[31] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.33.

[32] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.35.

[33] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.35.

[34] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.35-36.

[35] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.35.

[36] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.35.

[37] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.36-37.

[38] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[39] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[40] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[41] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[42] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[43] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[44] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[45] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[46] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[47] Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.292.

[48] Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279; p.292.

[49] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.38; Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[50] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.38; Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[51] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[52] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.37-38; Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[53] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[54] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.38; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[55] Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[56] Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[57] Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[58] Banting, K. (1986). 'The social policy process', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.44.

[59] Banting, K. (1986). 'The social policy process', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.44.

[60] Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[61] Hughes, J. (2003). 'From Panacea to Pandemic: Tobacco-Use in the West', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.205-226; Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.163-169; Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.141-161; Ritzer, G. (2000). *Sociological Theory*. Fifth edition. London: McGraw-Hill, p.515; pp.509-518.

[62] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-18; pp.109-140; p.231.

[63] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41; Cuff, E.C., Sharrock, W.W., &

Francis, D.W. (1998). *Perspectives in Sociology*. Fourth Edition. London: Routledge, p.312; pp.317-318.

[64] Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.164; Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.143.

[65] Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.164; Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.143.

[66] Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.164; Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.143.

[67] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.141.

[68] Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.164; Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.143.

[69] Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.164;

[70] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.141-159.

[71] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.141-159.

[72] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.141-159.

[73] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[74] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[75] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[76] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[77] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.29.

[78] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.29.

[79] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.30.

[80] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[81] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.145.

[82] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.146.

[83] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.33.

[84] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.146.

[85] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.145-148.

[86] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.146.

[87] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.147.

[88] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.34.

[89] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.34.

[90] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, pp.34-35.

[91] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.153.

[92] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.152.

[93] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.152; Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.81.

[94] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.81.

[95] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.154-155.

[96] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.155.

[97] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.87.

[98] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, pp.154-155.

[99] Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage, p.158.

[100] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.302.

[101] Matic, S., Lazarus, J.V., & Donoghoe, M.C. (eds.). (2006). *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management*. Copenhagen: World Health Organization European Regional Office; Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.302.

[102] Berridge, V. (1992). 'AIDS, drugs and history', *British Journal of Addiction*, Vol.87, No.3, p.367; Hunt, N., Trace, M., & Bewley-Taylor, D. (2004). *Beckley Foundation Drug Policy Programme Report 4: Reducing Drug Related Harms to Health: An Overview of the Global Evidence*. London: Beckley Foundation Drug Policy Programme, p.3.

[103] Berridge, V. (1991). AIDS and British drug policy: history repeats itself?, in Whynes, D.K. & Bean, P.T. (eds.). *Policing and Prescribing: The British System of Drug Control.* London: Macmillan, p.188.

[104] Berridge, V. (1991). AIDS and British drug policy: history repeats itself?, in Whynes, D.K. & Bean, P.T. (eds.). *Policing and Prescribing: The British System of Drug Control.* London: Macmillan, p.187.

[105] Stimson, G.V. (1990). Revising policy and practice: new ideas about the drugs problem, in Strang, J. & Stimson, G.V. (eds.). *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s.* London: Routledge, p.121.

[106] Scott, J.M. (1969). *The White Poppy: The History of Opium.* London: William Heinemann Ltd., p.126.

[107] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.110.

[108] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.109.

[109] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[110] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[111] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[112] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[113] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[114] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[115] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[116] Ritzer, G. (2000). *Sociological Theory*. Fifth edition. London: McGraw-Hill, p.515; pp.509-518.

[117] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[118] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[119] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[120] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[121] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.112-114.

[122] Butler, S. (1991). 'Drug problems and drug policies in Ireland: A quarter of a century reviewed, *Administration*, Vol.39, No.3, pp.210-33; Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration; Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324; Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration; Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422; Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, pp.125-144.

[123] Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration.

[124] Butler, S. (1991). 'Drug problems and drug policies in Ireland: A quarter of a century reviewed, *Administration*, Vol.39, No.3, pp.210-33; Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration.

[125] Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324; Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of

Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration.

[126] Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324

[127] Buler, S. (2007). 'Rabbitte Revisited: The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs – Ten Years on', *Administration*, Vol.55, No.3, pp.125-144.

[128] Butler, S. (2007). 'Rabbitte Revisited: The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs – Ten Years on', *Administration*, Vol.55, No.3, pp.125-144.

[129] Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration.

[130] Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration.

[131] Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422.

[132] Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422.

Chapter 2: Methodology

In order to achieve the study's aims a qualitative research methodology was utilised. The principal approach adopted was documentary analysis of a range of records as a result of the study's main aim being to construct a contemporary history account of different developments in Irish drug policy. In addition, qualitative interviewing was also drawn upon in order to carry out the research. Specifically, a small number of semi-structured or focused interviews were undertaken. This chapter of the thesis provides a discussion of the research methods adopted to complete the project. It consists of two sections and begins by discussing the use of documentary analysis before moving on to consider qualitative interviews.

From Selection to Examination – Stages in Documentary Research

The use of any research method in the course of bringing a study to completion is a process that involves a series of steps and actions. These phases move from the initial selection of the method in question to its general application and the intricacies involved in this practice. As tools to aid carrying out research and the generation of analysis, each different aspect of the strategy chosen is of importance in achieving the end result of a completed piece of work. This portion of the chapter discusses the use of documentary analysis and explores the different points in the overall procedure. Specifically, it deals with the rationale behind the choice of method, the sampling frame adopted, intertextuality, document acquisition, the analysis procedure, as well as limitations of the method.

This study sought to make a contribution to knowledge through utilising documentary analysis of different records to construct a contemporary history account of a number of aspects of Irish drug policy from 1996 to 2008. As a result of this factor, the principal method adopted was documentary analysis of a range of written materials. In essence, the study was designed as being first and foremost a documentary analysis of the events been looked at. A key factor that shaped the rationale behind the study and the designation of documentary analysis as its main research method was the sheer volume of data that became available for analysis during this time.

One of the defining features of the period in question was the significant increase in the pace and number of official actions aimed at dealing with drug use. At the same time, the style of policy making in operation was marked by a tendency to make increased amounts of information available on the courses of action being taken. In addition, the years being looked at were characterised by a move towards increasing levels of support for the creation of indigenous research on policy relevant issues. These factors functioned together to create a situation where a large body of documentary material on the events and processes occurring within this timeframe was created. Yet while this body of source material existed there had been little documentary analysis of it, both in terms of individual occurrences or developments as a whole. In this sense, the present study identified and sought to address this issue by conducting a documentary analysis of some of the main developments that had happened so that an account of the period could be created. The documentary method provided a means by which the variety and depth of events could be collectively analysed and used to form a contemporary history of some of the key happenings. It functioned as an efficient means of both coherently handling the volume of developments and organising and analysing the material that had been generated by them.

In setting the parameters that were used to define the contours of the study a flexible approach was adopted towards the creation of a document sampling frame. The frame used centred on the study's concern with the official or Government actions during the years in question. In this sense, the project did not seek to utilise all possible genres of documentary material that emerged on these developments as its primary sources, though non-state or unofficial material was utilised. This arose from the way in which the research themes emerged and developed from the initial phases of the study through to the completion of data collection and analysis. A set of key issues and process linked to them had been identified as the basis for the study and sharpened during the early part of the project. In exploring these developments a range of different official materials linked to them was examined, such as policy documents, different types of reports, studies and evaluations.

The avenues for further consideration of the occurrences being looked at were increased and diversified as a result of this process of analysis. This typically involved

expanding and factoring out the source materials needed to create as detailed a documentary analysis as possible. In this respect, links between events and the thematic strands that emerged as feeding into their happening, were tracked and traced through the work of the different actors involved in them. For example, in analysing the drug policy documents created it was necessary to examine the unpublished and published background material that shaped and formed their development, as well as other pieces of work that fed into and provided different aspects of the policy context in which they were being generated. Accordingly, while the sampling frame was predominantly set at having official documentation as its main parameters, these were permeable boundaries in so far as they needed to be in terms of tracing developments wherever they led to in order to gain a fuller understanding of them. Contextually, for example, this involved looking at the macro drug policy environment in which the micro drug policy of the Irish nation was occurring by exploring material by key international actors that was relevant to national drug policy in direct and indirect ways.

The approach taken in this study was one that followed the traditions of documentary analysis in history and social policy generally. In utilising documentary analysis as a research strategy, the typology developed by Platt and refined by Scott provides a structured approach to categorising materials by considering the authorial origins of documents and restrictions surrounding the extent to which they can be accessed.[1] As in Duke's study of prison policy, a large part of the documentary evidence examined here may be considered of State origin and of an open access level, such as official policy documents and reports from different Government departments and bodies dealing with drug issues.[2] Though, as discussed below, a considerable amount of critically important unpublished State material was integral to the analysis as a whole. In general, the documents utilised in this study were: UN and EU policy papers and research reports; international and national legislation; Government reports; the output of international and national research bodies; the work of Government bodies, consultants' reports; public and private sector evaluations; newspaper articles; periodicals; electronic databases; grey literature; unpublished versions of Government reports, evaluations, and research.

Analysing a series of documents, affords us the chance to explore a vast range of issues in dynamic ways related to different events occurring before, during and after their production. This is the case whether they are directly interconnected or not in terms of genre, series, authorship or other compositional factors. For example, such an approach can allow us to examine diverse sets of events, such as the social organisation of a particular set of acts or practices.[3] In this study, for example, looking at the work of the different committees and specialist groups established by the Government to consider particular issues allows us to gain an extensive insight into different events and changes in policy that took place. The viewpoints and perspectives that we can acquire in this way are deepened through analysing changes, progressions, similarities and periods of static as occurrences are traced through a timeframe.

Central to the construction of a documentary historical account, observing processes and developments, as well as deconstructing and explaining change within a defined set of years, is the idea of intertextuality.[4] In much the same way that policy issues can be 'nested' or situated in wider contexts, documents related to policy issues are linked in direct and indirect ways to other texts that predate them.[5] The analysis of documentary evidence must take account of the intertextuality that exists between different sets and types of documents that bear upon a distinct issue.[6] In literary criticism intertextuality refers to the relationships documents have with each other as a result of their simultaneous existence in particular cultural and economic contexts.[7] As Prior states,

> "The term refers, in part, to the notion that the meaning of a single text is always bound up in its relations with others that are contemporary to it. The concept also implies that texts are never singular or unique but comprise bits and pieces of other texts written at other times and in other places."[8]

This interrelationship can refer to the tracing of a particular event through a number of sources, such as, the lifecycle of a drug or healthcare policy, through the various texts within which it was created, analysed and modified. Similarly, documenting and tracking the work of a particular agency can be explored through the output they have created and the materials that it is, in turn, featured in and interconnected to in direct and indirect ways.

The different types of documentary materials discussed above were gathered from a range of sources, such as the Government Departments that had produced them. When materials were unavailable from their original authors a number of different archives were consulted by physically visiting the records, accessing information in an electronic format via the internet or requesting documentation from librarians in repositories. The ready availability of a great deal of the information utilised in an electronic format significantly reduced potential access and analysis problems. Though there were access issues, as outlined later, around the use of key unpublished materials.

While a great deal of the material analysed in the study was readily available without the need for any form of request to be made for it, part of the material utilised was unpublished documentation. In this respect, the tracking and sourcing of this data was time intensive. Nearly all of this information fell into the categories of Government policy documents, different drafts of policies, and un-circulated evaluations and/or different versions of published evaluations. Frequently when requesting material of a sensitive unpublished nature from a Government department, for example, I would have made contact with one individual who would have started to send me documents, sometimes, without requesting any information as to why I needed them. At other times to engineer the initiation of a flow of documentation I was conscious of drawing on my status as a Ph.D. student and the use of an office facility that I had at the time where mail could be sent.[9] This enabled me to be perceived with an air of professionalism by those I was contacting.[10] As Duke has pointed out, highlighting these things can be to one's advantage in building yourself up as a 'proper researcher', especially when you are an unknown individual making requests from highly busy people.[11]

Typically, acquiring this unpublished material was an extremely long process involving multiple contacts and re-contacts with the individuals concerned. More often than not, they would either forget to send the requested items or come up against an internal block of some sort in the process of attempting to acquire and release it. This process involved a delicate series of negotiations that could not be rushed, and staggered the pace at which information could be collected. Frequently such an interaction could extend initially from a series of weeks to several months when the release of a particular document proved troublesome. However, the acquisition of such data almost always

proved fruitful in yielding material that helped to build and unlock a richer picture of the contemporary history that I was researching.

At other times, requests for unpublished information met with immediate and categorical rejections from individuals and departments. On the whole, in attempting to gain access to sensitive unpublished material, my status as an unknown researcher generally was to my advantage. More often than not I believe it resulted in the individuals in question deciding to release documents to me feeling that there would be little that could arise from their use. Duke has pointed out that perceptions about researchers can help make gaining access easier.[12] However, on occasions when I was refused materials this was simply as a result of my being unable to elicit a response from an individual or department, despite multiple time-lapsed attempts. The implication of this was that my relative unimportance warranted no response as a result there being no impetus to communicate on their part.

There were a range of reasons that arose in the course of conducting the documentary research that made it difficult to access information on particular issues. These ranged from the materials in question being restricted or lost, to those in possession of the information not being contactable or there simply not being a record of the particular contemporary historical fact that I wished to analyse. Overall a very limited number of these instances arose during the course of the research and had a very minimal impact on the documentary research methodology. In the situations where they did arise it was necessary to depart from the documentary approach and utilise an additional research method to bridge these gaps. In this study, qualitative interviews were employed in this regard and their use is the focus of the following section of this chapter.

A systematic approach was applied to the analysis of the documents used while undertaking the study. This was comprised of two main phases – identification and analysis, and organisation and analysis – both of which are respectively discussed in the following paragraphs. Working with a large volume of documentation allows a wide variety of issues to be explored in great detail. This facilitates the development of well grounded in-depth views and understandings of events and processes. It allows a rigorous and dynamic analysis of the topic under scrutiny to be conducted. In the present study the procedure adopted involved the initial identification of the areas to be examined, with

sets of key documents related to them subsequently being identified and analysed. The resulting work then gave rise to additional groups of documents that were linked to these materials and the themes being looked at. This snowball acquisition and analysis process continued until the study's main concerns had been thoroughly addressed and exhaustively explored. In essence, the procedure continued until the intertextuality of the areas being discussed had been factored out to its logical conclusion within the defined parameters of the study as discussed earlier. In this sense, the documentary analysis procedure facilitated the substantiation and development of the themes under examination, as well as raising new areas and issues for consideration that were linked in direct and indirect ways to them. This process helped clearly define the topics being engaged with. After this process had been completed for each of the study's thematic concerns the second phase of analysis – organisation and analysis – commenced.

Working with and across large tracts of information does, however, pose a number of challenges to the research process. Chief among these are the interrelated issues of data organisation and analysis. In order to efficiently reconcile the need to ground the analysis in as deep an understanding of events as possible with the large volume of documentation needed to facilitate a through examination, a multi-stage procedure was utilised. This involved three distinct steps: 1) generation of a draft annotation key; 2) development of a finalised annotation key; 3) creation of a micro-orientation file. Each of these three points in the process is discussed in the paragraphs below.

Once all of the relevant documentation needed to conduct the analysis for a particular area or theme had been assembled – following initial analysis to gauge its applicability and relevancy – the first phase of the process of examination was initiated: generation of a draft annotation key. This involved studying the materials to identify information relevant to the project's concerns as well as discovering new avenues and aspects of the topics. This consisted of analysing the data in its entirety a number of times in a row, essentially until it had been comprehensively reviewed on all of the dimensions of concern, as well as those that arose during the process. After the data had been reviewed a first time, coding of the material commenced.

It was necessary to code the information for a number of reasons. For example, to make working with a large amount of documentation and topics manageable the concerns being looked at had to be reduced from complex and sometimes lengthy statements, points and propositions down to tightly compressed acronyms. These smaller units of information provided a more versatile representation of the ideas that stood behind them for the purposes of carrying out the analysis. They could be applied to the texts in question at a rapid pace. Similarly, they facilitated the speedy identification of themes when reviewing the materials as well as being more amenable to the mapping and cross-referencing and examination of themes in and between large numbers of documents.

After the data had been reviewed a number of times, the generation of a draft annotation key commenced. This involved annotating the texts being examined with different codes. The core of this procedure revolved around analysing the information, identifying concerns, issues and themes and then creating 'exploratory codes'. These initial or exploratory codes were only occasionally applied to the texts themselves, but rather were collated into a file that formed the draft annotation key. At this stage in the process only a small amount of 'numeric-bibliographical tagging' took place. The numeric-bibliographical tagging involved listing the documents and the relevant parts of them alongside each code on the draft annotation key.

In the second stage of the overall process of analysis – development of a finalised annotation key – the steps achieved in the first point in the procedure were refined and developed. With the draft annotation key complete and the study's concerns exhaustively explored in the documents, the next stage involved scrutinising the exploratory codes in order to create 'identifier codes'. When analysing the texts during phase one a great deal of exploratory codes would be typically developed. However, as the examination progressed areas of overlap, similarity and divergence between these exploratory codes emerged. For example, several exploratory codes might have been developed that essentially referred to the same issue. In other cases, where one exploratory code had been used, it was clear that the issue warranted division into different aspects. Consequently the second point of the process revolved around honing the exploratory codes into a more coherent reflection of the themes they represented. The resulting finalised codes formed the identifier codes utilised in the finalised annotation key.

Once a full list of identifier codes had been created the finalised annotation key was complete. At this point work began on applying it to the documents. In this sense, the annotation key was now thematically grouped and numeric-bibliographically tagged. Here the identifier tags had been used to annotate the sections of text in the document to which they referred. In turn the documents to which they had been applied and the pages of the text annotated were logged in the finalised annotation key alongside the relevant identifier code. The identifier codes in the annotation key were grouped into thematic areas or sections on the finalised annotation key itself. This facilitated a greater ease of consideration of the different topics. An example of a finalised annotation key, thematically grouped and numeric-bibliographically tagged, is contained in appendix one.

The third and final stage of the process involved the creation of a micro-orientation file. With the finalised annotation completed the next phase in the overall process of analysis involved making it easy to use. One of the problems that arises in the examination of a large volume of documentation and the development of identifier codes is that a great deal of codes are generated. This can in turn present issues around the extent to which such codes are either manageable or overwhelming. At times there was no need to progress to the third phase of the process, as the finalised annotation key, thematically grouped and numeric-bibliographically tagged, was directly amenable to analysis as a prelude to final examination of the texts while writing. However, at other times the finalised annotation key could be lengthy and/or reflective of further analytic complexities that had to be taken into account. In such cases, a micro-orientation file was developed.

The main purpose of a micro-orientation file was to help provide a means of navigating the identifier codes contained in the finalised annotation key. In order to deal with a particularly lengthy annotation key a further guide was needed at times. In essence, this was a guide to the guide. Here the micro-orientation file was used to plot-out and consider the order in which the identifier codes were to be engaged with while analysing the texts and conducting writing. This consisted of listing groups of codes together with brief notes pointing out the order in which they were to be consulted. The sequence in which they were to be utilised could relate to their location on the finalised annotation key, such as dealing with one set of themes as a group first or second and so

on. It could also relate to their thematic grouping and numeric-bibliographical tagging in terms of certain types of documents in which these codes appeared. For example, dealing with all of one type of code where it arose in one genre or category of document before engaging with it or discarding it in others.

The three steps in the process of analysis - generation of a draft annotation key; development of a finalised annotation key; creation of a micro-orientation file - helped provide a systematic and efficient way of analysing a large volume of documentation. At either stage two or three – development of a finalised annotation key, creation of a micro-orientation file – the final step of using the identifier codes to help locate and analyse the relevant parts of the documents while engaging in writing, could be conducted. The third point in the procedure was only entered into where a particularly lengthy and/or complex finalised annotation key had been generated.

In applying any research method to a topic and in carrying out the subsequent analysis of the data generated, the researcher has to be mindful of their own and others' perspectives. In dealing with any category of information it is important to be aware of the perspectives and ideological positions that have a bearing on its creation. These include the views of those giving or producing the data, as well as the circumstances in which this activity occurs. As noted above, the sampling frame used to gather documentation for this study was based on the project's concern with official or Government action on drug issues drug the period analysed. In order to handle the information that emerged within these parameters it was necessary to be aware of its origins and conditions of production. Duke has written about the 'official line', that is, what can be regarded as the authorised or standard version of events or discussion of an occurrence.[13]

In analysing the documents utilised in this study it was important that their different compositional attributes be kept in mind while engaging with them. For example, policy documents and other types of Government published or backed materials present a particular type of account of events. This is the same as the way that written records from any sector are flavoured by the genre and type of authoring from which they have emerged. Accordingly, these are key factors that need to be kept in mind when examining such materials and extracting data used to build an analysis. In essence, the

process can be viewed as the need to absorb oneself in the data being scrutinised, while at the same time being conscious of the origins and nature of that information. This is so that the stances and perspectives of its creators are clear and not in danger of blurring, overwhelming or submerging your own.

While bearing in mind the nature of the data being worked with helps with the identification of and progression beyond an official line, the type of topics being studied and the manner of questions being asked on them also play this role.[14] In the present study, the nature of the issues being explored, and the form that their analytic exploration took, effectively helped the study identify and deal with the official nature of the source materials being worked with. Similarly, the examination of the intertextuality of the themes represented in the documents also provided this function, leading as it did on many occasions into the realm of, while still technically official, unpublished background evaluations, reports and versions of policies.

With any research method chosen there are certain benefits and limitations that derive from their use. These dimensions have to be considered and carefully weighed at the outset of a project. Such factors can have an impact on the way in which data are gathered and the types of issues that can be engaged with by the sort of information being generated. In this sense, the researcher's task is one of finding the approach that offers them the best means of answering the questions they have set out to ask. In this respect, documentary analysis presented the optimum way of addressing the central aim and sub-aims of the current study. One of the core benefits of employing documentary analysis arose from its ability to allow themes to be explored in great detail and for very large amounts of information to be efficiently handled in a way that ensured the analysis retained clarity and coherency within and between its different strands. This was a direct result of the type of questions that were being asked in this project.

If the current project had have been centred on dealing with a different set of questions or other types of issues the method utilised would have posed challenges that might have limited the extent to which other sorts research topics could have been addressed. For example, this study utilised documentary analysis as its main research tool and also drew on a small number of qualitative interviews. This approach would not have been conducive to fully exploring research areas such as the dynamics of how policy

networks operate. In addressing such an area and the types of questions that might be posed in and around it a different strategy would be required, most likely one that was based on a more extensive use of qualitative interviews. Similarly, the sort of conclusions that could be reached on this type of area would have been impacted by the research approach taken. For example, such a design is not conducive to generating any grounded theory about policy making that might be the aim or focus of another study. Such issues would emerge from and be generated by a greater use of qualitative interviews.

This section of the chapter has discussed the use of and different phases involved in documentary analysis. It has it focused on the rationale behind the method chosen, the sampling frame utilised, intertextuality, document acquisition, the analysis procedure, as well as limitations of the method. Together these different aspects of documentary analysis set out the way in which the study was undertaken. The following portion of the chapter is concerned with qualitative interviewing, as this was the other research method drawn on to carry out the work.

Qualitative Interviews

In carrying out a study a range of methods are available to the researcher to utilize within the defined parameters that they have to work. These boundaries are marked out in terms of what the project is concerned with, what it seeks to uncover about its topic and the resources available to actualize these aims. In the same way that different tools are needed at particular times to complete any piece of work, different methods may be required at certain points in the research process for a variety of reasons. This section of the chapter deals with the use of qualitative interviews, as this was the other research method drawn upon in this study. Accordingly, it looks at the rationale for their use, the selection of respondents, ethical considerations, the process of conducting the interviews and the limitations of their use.

The primary research method adopted in this study was documentary analysis. However, qualitative interviews were also drawn upon at certain points. Specifically, the project employed semi-structured or focused interviews with individuals involved in the events being examined. In this respect, in a similar way to Duke's study of prison policy,

at these points the project adopted triangulation between documentary analysis and qualitative interviews to construct its analysis.[15] Accordingly, individuals who were involved in the events that I wished to gather factual detail on, but could not obtain records about for one reason or another, were identified from the existing documentary sources that I had assembled and were written to requesting an interview. This was generally followed up by email and phone call interactions to try to confirm and arrange a time and date for the meeting.

Semi-structured interviews allow the interviewer to be flexible and reactive with the respondent in a manner that cannot be facilitated by the administration of a fixed set of questions or a totally undefined framework, as is the case with survey questionnaires or life history interviews.[16] Approaching each interview with a set of questions or an interview guide designed to target the unique experiences and contributions of the respondent to the general themes being researched allowed me to draw on the sophistication of each interviewee's contributions.[17] Similarly, addressing respondents with different questions focused on their involvements in the same events contributed towards triangulation within interviews and by extension between them and the documentary analysis.[18]

A number of reasons lay behind the rationale for using qualitative interviews in the research. Principally, these were based on the need to bridge gaps in the documentary records, to obtain new information, as well as a chance to discuss some of the key findings from the study. When a break emerged in the documentary records that I gathered I employed semi-structured or focused interviews with individuals involved in the events being examined and used the data generated to link between the existing records. These interviews provided an occasion where new details and issues related to the topics being looked at arose and fed into the overall account and analysis of the period. The sessions also afforded me the opportunity to present some of the project's key propositions to individuals who had been involved in the events. This allowed me to have a chance to obtain feedback that could confirm or dispute key points and help modify their formation.

A number of considerations fed into the process of respondent selection. The individuals involved in the study were from the public and community and voluntary

sectors. In this respect, the ones chosen were picked partly as a result of their representing different sectors and their having been linked into the official action taken on drug issues during the period being looked at. These people had participated extensively in the events that I wished to gather additional data on. Unlike other potential respondents, the ones that took part in the project had, in the course of their work, held a range of different involvements in critical events and processes. This allowed me to broach a variety of different issues with them and explore these topics in great detail. It was envisaged that the extent of their involvements would make them more conducive to discussing matters in which they had invested a lot of effort.[19]

All of the interviews were recorded with two different types of Dictaphones simultaneously – a digital and tape model placed at least one foot apart to avoid harmonic feedback. Two different recording methods were used to limit the possibility of one of the devices failing or the recording being spoiled in some manner. The interviews were conducted in one of two locations, either the office I had use of or the respondent's place of work. Each interviewee had received a letter co-signed by my supervisor and myself explaining the nature of the study and my request for their participation. I generally began by giving a brief explanation of the research to the respondent and then produced a consent form for them to read and sign. The different options on the form were explained to them. The consent form used in the study is contained in appendix two. After this step I would switch on the two Dictaphones and start the interview questions.

When utilizing qualitative interviews as part of the methodology for a study the respondent's identities are frequently not revealed. This is generally done by simply referring to the role or position that they hold, or the particular section of the cohort being interviewed that they belong to. This allows those taking part to have anonymity. In the present study a decision was taken when considering the use of interviews to name the respondents if they were amenable to this. A number of reasons lay behind this choice. One of the unique features of the Irish policy arena, compared with that found in many other countries, is its size. Specifically, by virtue of the small nature of the country its public administration is not that large.

In this respect, there are not a lot individuals working in areas related to or dealing with different aspects of drug issues when measured against other countries. Similarly,

there are an extremely limited number of Government bodies dealing with the drugs area and these are also of a small nature. As a result of this, the pool of policy actors involved in the drugs arena in Ireland is very limited. This has the effect of making individuals identifiable by default of the position that they hold. In essence, by simply referring to the post the incumbent's identity is revealed. This factor is accentuated when contextual details that need to be mentioned to underline the relevancy of the points being made are taken into account, such as the time period in which they occurred.

Consequently, in the study it was necessary at times to mention the post of the individual being referred to so as to highlight the relevancy and importance of their comments. As a result of the default un-masking that would have occurred through this process, it was decided to name those concerned if they consented. All of the individuals who agreed to be interviewed were mature adults who voluntarily consented to being named after being presented with the consent form being utilised. This form can be found in appendix two. It offered respondents three choices regarding the way in which the interview could be used. One of which allowed them to select that their identity had to be disguised in a manner agreed with them, so that they could remain anonymous. None of the respondents selected this option or raised any issues in relation to their being named in the study.

The main source that I used to develop the phrasing of my questions and hone my technique for interviewing was Rubin and Rubin's *Qualitative Interviewing: The Art of Hearing Data.*[20] The two methods interconnected with each other at this point, as the documentary evidence allowed me to construct interview schedules that helped me to acquire the additional data on the events that I wished to gather further detail on. Generally, the questions followed the same format in each interview. Between 6 and 12 main questions were prepared, though not all of these were always asked.[21] In addition a range of on the spot follow up questions and probes were utilized to further explore the respondents' answers where appropriate.[22] The interview schedules used in the study can be found in appendix three.

In preparing and phrasing main questions the format adopted was to try to avoid a situation where the respondent could give a yes or no or any other type of abrupt answer, unless this was desired, as was the case with some follow-up questions.[23] Typically, this

was achieved by starting questions in one of a number of ways by asking respondents to comment on a statement that I would make about something or asking them to talk about something in a general exploratory and discursive way such as 'Could you talk about...', 'Could you say a little about...', 'Perhaps you could comment on...'.[24] These approaches worked effectively in the interviews in terms of avoiding one word answers from interviewees and instead elicited rich and textured depth. Examples of these questions can be found in appendix three. As a result, all of the interviews overran their projected timeframes in a relaxed manner. For example, in my letter to respondents I requested between 40 and 60 minutes, but typically the interviews lasted 60 to 80 minutes.

Whether the interview schedule was actually followed or not very much depended on the dynamics of the individual interview and the flow of the conversation.[25] Frequently, the respondent would begin by making a comment that answered one of my questions without any prompt from me, thus negating the need for it to be asked.[26] Sometimes their comments answered several of my questions at once or revealed others to be unimportant.[27] As a result, the interview schedule was only followed in a linear fashion if the conversation needed to be kept on track or orientated back to the topic upon which I wished to focus.[28]

The timing of the interviews conducted as part of a study can be influenced by a number of different considerations. In the present study these were mainly related to the role of the interviews in the overall project itself and their resultant position within its methodological strategy, as well as issues linked to accessing respondents. As previously noted, the principal research method adopted in this project was documentary analysis, with qualitative interviews being employed at certain points. This was done to help bridge gaps that arose in the records assembled, to uncover new issues and themes related to the topics being explored, and to discuss some of the key findings from the research. In this sense, the content and coordination of the interviews was derived from the process of documentary analysis.

Specifically, the individuals identified, the different areas and concerns to be discussed with them, and the potential timeframe within which the interviews could be held was set by the documentary analysis and its progression. As a result, it was decided early on in the project that the interviews to be held would take place in the latter phases

of the study after the documentary analysis had been largely completed. This was a result of the study's goal to make a contribution to knowledge by utilizing documentary analysis of a range of records to look at some of the main developments in drug policy, treatment, and the role of research in these occurrences. In essence, the primary method directed the function, form and flow of the qualitative interviewing.[29] This approach efficiently facilitated triangulation between the two methods and the integration of the qualitative interview data into the documentary analysis.

The issue of gaining access to respondents influenced the timing of the interviews. Once a list of potential respondents had been identified and the key individuals selected from this group, they were written to, as noted above, with a letter co-signed by my supervisor and I. Consequently, once the process of contact had been initiated a range of outcomes emerged. For example, some respondents replied immediately upon receipt of the letter and were flexible in terms of their availability, while others replied a while after the letter had been sent. While a number of respondents who had been written to did not respond to the letter, others who contact was subsequently made with were unable to participate as a result of scheduling issues that impacted upon their availability.

The majority of the data that I wished to gather from respondents was factual information that helped me to build a fuller picture of the contemporary history I was researching. However, some of the events I asked them about could have been regarded as being sensitive topics to discuss with a non-work colleague, particularly as these individuals were not retired from their positions. In this respect, while attempting to probe for detail in interviews questions had to be formulated and asked in such a way that they delicately attempted to pass beyond the 'official line' or 'public relations' account of policy events.[30] The idea being that some respondents may not wish to divulge their personal opinions on issues for a number of reasons.[31] These could range from their not having a view, to their being uncomfortable with their private stances being potentially attributed to them.[32] In this sense, respondents may attempt to depreciate the extent or significance of their involvement in an occurrence or issue to evade questions or at least giving detailed answers.[33] However, those taking part in the interviews were typically relaxed, forthcoming, and unhindered in discussing in extensive detail all of the key events that I wished to explore with them.

In much the same way that caution has to be exercised in the way questions are phrased and asked in interviews, care has to be taken in analyzing the data that emerge from the sessions. Specifically, while the main and follow-up questions put to respondents have to be developed such a way that they can get 'beyond the official line', their interpretation also has to be conducted in a manner that is characterized by a constant awareness of this barrier.[34] In this sense, the researcher has to be mindful of the sectors from which their respondents come from and the way in which this can impact upon the comments they make and the perspectives that they hold. For example, in this study respondents came from the community and voluntary and statutory sectors. This had to be borne in mind when conducting and analyzing the interviews as a result of the way in which these individuals had been involved in the official action aimed at drug issues that the project was concerned with. In essence, when raising and looking at certain points or issues it was necessary to identify when 'the official version of events' was being presented, so that it could be probed beyond.[35]

During the interviews it was useful at certain points to produce hard copies of documents related to conferences that I was asking the respondents about in some way. For example, if I was raising an issue that was either a little complex or contentious I would adopt the tool of using someone else to say it for me rather than say it myself. This strategy essentially involved me putting a proposition on a topic to the interviewee and asserting that an individual, a person at a conference that they had attended and were familiar with, had made this remark. The purpose of this exercise was that rather than allowing the interviewee to think that I had made this comment myself, I had deflected the responsibility for the source of raising the issue or the irritation onto someone else, a third party. This allowed me to remain neutral and free to elicit a response from the interviewee and helped me avoid the possibility of them becoming defensive and simply shutting down and not answering. In interviews I came prepared with a collection of papers from a conference containing the text of the propositions I was putting to the respondents least they were to assert they could not remember attending the event or that they were to challenge that the individual had actually said what I was attributing to them. This proved to be a highly effective strategy and elicited interesting responses from the respondents.

A standardized approach was adopted when analysing the interviews. This consisted of listening to the recordings of each interview several times in order to locate and examine the different elements it broke down into. For example, parts of the interviews related to factual information that was needed to bridge gaps in the documentary analysis, the discussion of key findings and points from the study, and the emergence of new issues and pieces of information. Interviews were listened to in their entirety a number of times. After the initial review, the mp3 would be stopped repeatedly so that notes could be taken. These consisted of orientating comments relating to the type of information contained at certain points in the interview and the areas of the study to which they related. After this stage, the recordings were then listened to systematically while altering and creating new text that integrated their content with that of the existing documentary analysis. The interviews were not transcribed or coded. This was largely a result of the function that they played in the study and the nature of the project itself and the types of issues being addressed through its main aim and sub-aims.

As with any research method that can be drawn upon when undertaking a piece of work, a range of benefits and limitations arise from the nature of the strategy itself and the way in which it is used. The present study was primarily a documentary analysis of the events being looked at and it utilized qualitative interviewing at certain points to bridge gaps in the records, gather new information, and discuss key findings from the work. In this sense, it adopted triangulation between these two research methods.[36] The extent of this approach was a direct function of the type of research questions being asked in the project.

If the current piece of research had have been dealing with another set of concerns and themes, a different division of labour between the research methods drawn upon would have been required. As noted in the previous section, the method employed would have needed modification in order to fully deal with an area such as the intricacies of how policy networks function. To engage with the types of points that a focus on the ins and outs of a subject like that might explore, a different balance would have needed to be struck between the methods chosen. Specifically, a much larger number of semi-structured interviews would be required. This is a factor that filters into and has an impact upon the sort of conclusions that can be reached in a study. For instance, the research

strategy employed in the present piece of work would not have provided a sufficient platform for producing any grounded theory about policy making, which could be the main goal in a different project.

The current portion of the chapter has reviewed the use of qualitative interviews in this study. In doing so it has discussed a range of issues related to the rationale for adopting this method, choice of respondents, ethical concerns, the process of carrying out the interviews, as well as the limitations of the method. Consequently, this part of the chapter has shown how this methodological approach was utilized alongside documentary analysis in order to carry out the research for the study. The following section presents the overall conclusions for this chapter of the thesis.

Conclusion

This part of the thesis has discussed the method that was used to carry out the study. In this respect, it focused on the use of documentary analysis and qualitative interviews. The different phases of each research strategy were set out. In terms of the former method, the rationale for its use, the sampling frame adopted, intertextuality, the acquisition of documents, the process of analysis, and the limitations of the approach were reviewed. While in relation of the latter method, the rationale for employing it, the selection of respondents, ethical issues, the process of undertaking the interviews, and the limitations of the strategy were discussed.

This piece of research sought to make a contribution to knowledge through utilizing documentary analysis of a range of records in order to create a contemporary history account of some of the main developments in Irish drug policy between 1996 and 2008. As a result of its goal and the aims derived from it, which were discussed in chapter one, the primary research method drawn upon was documentary analysis. This method provided an efficient and effective means by which to handle and analyse the large volume of documentation drawn upon. It was complimented by the use of semi-structured qualitative interviews at certain points. Specifically, the interviews were drawn upon to gather information that was need when gaps materialized in the documentary records, to generate new issues related to the study's main themes, and to explore some of its findings with those involved in the events. Consequently, at these points the study utilized triangulation between the two approaches.[37]

[1] Duke, K. (2003). *Drugs, Prisons and Policy-Making*. Basingstoke: Palgrave Macmillan, p.25; Platt, J. (1981a). 'Evidence and proof in documentary research: 1 some specific problems of documentary research', *Sociological Review*, Vol.29, No.1, pp.31-52; Platt, J. (1981b). 'Evidence and proof in documentary research: 2 some shared problems of documentary research', *Sociological Review*, Vol.29, No.1, pp.53-66; Scott, J. (1990). *A Matter of Record: Documentary Sources in Social Research*. Cambridge: Polity Press.

[2] Duke, K. (2003). *Drugs, Prisons and Policy-Making*. Basingstoke: Palgrave Macmillan, p.25; Scott, J. (1990). *A Matter of Record: Documentary Sources in Social Research*. Cambridge: Polity Press, p.17.

[3] Prior, L. (1993). *The Social Organization of Mental Illness*. London: Sage.

[4] Duke, K. (2003). *Drugs, Prisons and Policy-Making*. Basingstoke: Palgrave Macmillan, p.26.

[5] Duke, K. (2003). *Drugs, Prisons and Policy-Making*. Basingstoke: Palgrave Macmillan, p.19; Atkinson, P. and A. Coffey (1997), 'Analysing documentary realities', in D. Silverman (ed.), *Qualitative Research: Theory, Method, And Practice*, London: Sage, pp.66-7.

[6] Duke, K. (2003). *Drugs, Prisons and Policy-Making*. Basingstoke: Palgrave Macmillan, p.26; Atkinson, P. and A. Coffey (1997), 'Analysing documentary realities', in D. Silverman (ed.), *Qualitative Research: Theory, Method, And Practice*, London: Sage, p.67.

[7] Atkinson, P. and A. Coffey (1997), 'Analysing documentary realities', in D. Silverman (ed.), *Qualitative Research: Theory, Method, And Practice*, London: Sage, p.68.

[8] Prior, L. (2003). *Using Documents in Social Research*. London: Sage, p.124.

[9] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.52-53.

[10] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.52-53.

[11] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.52-53.

[12] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.53.

[13] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.46.

[14] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.46.

[15] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.42; Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods*. London: Butterworth & Co. Ltd., pp.307-308.

[16] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.53; Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education*. London: UCL Press, p.227.

[17] Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education*. London: UCL Press, p.227.

[18] Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods*. London: Butterworth & Co. Ltd., pp.307-8; Ball, S.J. (1994). Political interviews and the politics of interviewing', in Walford, G. (ed.). *Researching the Powerful in Education*. London: UCL Press, p.97.

[19] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.43.

[20] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage.

[21] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.152-172.

[22] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.152-172; pp.173-200.

[23] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.156-164.

[24] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.164-172.

[25] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.129-151; pp.152-172; pp.173-200.

[26] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.129-151; pp.152-172; pp.173-200.

[27] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.129-151; pp.152-172; pp.173-200.

[28] Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data.* Second Edition. London: Sage, pp.129-151; pp.152-172; pp.173-200.

[29] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.43.

[30] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.46; p.48; Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press, pp.226-7.

[31] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.48-49.

[32] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.48-49.

[33] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.49; Ball, S.J. (1994). Political interviews and the politics of interviewing', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press., p.107.

[34] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.46

[35] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.46.

[36] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.42; Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods*. London: Butterworth & Co. Ltd., pp.307-308.

[37] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.42; Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods*. London: Butterworth & Co. Ltd., pp.307-308.

Chapter 3: Norms in International Drug Policy

During the twentieth century a number of significant international drug conventions were adopted, initially under the auspices of the League of Nations and later through the United Nations (UN). These treaties were originally created to regulate and control the licit trade in opium. As the decades of the twentieth century passed by, many other drugs that broadly fell within the category of substances referred to in pharmacological terms as psychoactive drugs became the focus of international attention. In this context, both narcotic drugs such as heroin and psychotropic substances such as amphetamines were subjected to international control, and illicit trafficking in these drugs was targeted through international law. Throughout these developments in the construction of a global system of drug control, one of the goals that international efforts have consistently focused on is limiting the availability of drugs to the amounts that are deemed necessary for legitimate medical and scientific uses in any particular country.[1]

The architecture of global drug control is laid out in three major UN conventions. These are the *1961 Single Convention on Narcotic Drugs as Amended by the 1972 Protocol*, the *1971 Convention on Psychotropic Substances,* and the *1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.[2] A number of UN bodies were created to help operate this system of international control. These include, *inter alia*, the International Narcotics Control Board (INCB), the United Nations Drug Control Programme (UNDCP), and the United Nations Office of Drugs and Crime (UNODC). Stepping aside from the myriad of events that paved the way towards the creation of this system, one of the most significant consequences that have emerged for national and international drug policies is that prohibition has become normalised as the legitimate core of policy.

The trade in psychoactive substances, both licit and illicit, is an industry of global proportions that traverses all geographical boundaries. This feature of drug commerce is hardly unique, yet it has played a pivotal role in ensuring that the production and consumption of substances has come under international attention.[3] As a consequence of the equally borderless nature of disease transmission, new elements have emerged and begun to solidify as additional norms within drug policy. Chief among these newer features of international drug policy is harm reduction, which can be regarded as a set of

healthcare interventions designed to limit the potential damage arising from drug use, such as, overdoses and the contraction of blood borne viral infections.

Among the most common harm reduction strategies used to achieve such goals are substitution maintenance therapies, needle and syringe programmes, drug consumption facilities, overdose prevention methods, the provision of varying combinations of these measures within prisons, drug courts and diversion to treatment programmes/arrest referral schemes, and outreach programmes. It is not within the scope of the present study to consider the technical utility of any of these interventions. Rather, our focus here is on the backing that some of them have received as a group of healthcare practices. More specifically, this study is concerned with the substitution treatment methadone maintenance therapy (MMT) and needle and syringe programmes (NSPs). This part of the thesis offers us a view of the global policy environment within which Irish policy is encapsulated.

This chapter is comprised of four sections. The first two parts of the chapter explore the status of harm reduction in UN drug policy, while the latter portions analyse its position in EU drug policy. The chapter starts by looking at the position of and backing for harm reduction in the work of some of the UN bodies that operate in the drugs area, such as the United Nations Office of Drugs and Crime (UNODC). It then moves on to discuss the UN's legal explorations of the status of harm reduction. Following this, the next section of the chapter considers the EU's views on the legal position of harm reduction. The final portion of the chapter presents an analysis of EU action on drugs since the 1990s. This section is followed by an overall conclusion.

The United Nations and Drug Policy

"The primary source of influence is nevertheless nations rather than persons. Only those individuals who are acceptable to their governments are chosen to represent them, and individuals often become influential because they represent governments."[4]

"But we have been told also of the informal existence of a gentlemen's club made up of persons. Our attention has been directed to the fact that, prior to the official opening of a Commission session, a small group of such persons meets in Geneva to settle, in advance, some of the issues which are expected to crop up at the coming session."[5]

The above quotes are drawn from Bruun, Pan and Rexed's classic 1975 study of international drug policy *The Gentlemen's Club: International Control of Drugs and Alcohol*. The book's main title is borrowed from an earlier and important study of global policy by Peter Lowes.[6] He adopted the phrase to refer to the way in which the composition of the United Nations' (UN) Commission on Narcotic Drugs (CND), the same body referred to by Bruun et al above, has since 1946 been dominated by representatives of those nations that were leading producers and consumers of narcotic drugs.[7] In considering the UN's drug control apparatuses it is sufficient for our needs in the present study to note that the CND is the central drug policy making body within the UN system. One of its main gatherings occurs each year when it holds an annual session. Read in conjunction, the quotes by Bruun et al draw attention to a consistent trend in the way the CND carries out its business and the way international politics operates generally; that is, those individuals who represent powerful nations in such bodies network with each other to facilitate particular policy outcomes. Whether this is a cynical method of undermining oppositional interests, or a pragmatic strategy fairly drawn upon in complex circumstances, matters less than the fact that it has consistently occurred in international drug control circles.

The persistence of this trend of prearranged perspectives and stances is, to use Goffman's terminology, very much 'backstage' behaviour that is seldom revealed to either the wider policy community or the general public.[8] On occasions when such covert

activities are exposed they can potentially cause controversy. One such instance when behind the scenes negotiations were made public knowledge occurred in March 2005, shortly after the CND's 48th session had been brought to a close.[9] The incident in question revolved around a letter dated 11th November 2004 written by Antonio Maria Costa, then head of the United Nations Office of Drugs and Crime (UNODC).[10] It was sent to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State. A copy of the letter was also sent to Mr George Glass, then Charge d'Affaires at the Permanent Mission of the United States of America to the UN in Vienna.[11] The document was also widely disseminated through the website of a British anti-prohibition policy think-tank, Transform Drug Policy Foundation, and attention drawn to its availability by various electronic substance use newsletters and editorials in academic journals.[12] It was also used as the centre piece of an introduction to the Dutch policy think tank Transnational Institute's 'Drugs and Democracy' programme's review of the CND meeting.[13] What was significant about this letter was that its contents appeared to reflect attempts to orchestrate events at the CND annual session planned for March 2005.[14] Below I build on some of the Transnational Institute's comments on this document, relating the contents of this letter to the wider UN approach to drug policy.

Emergent Norms

Amidst the mass of information that is created and disseminated by international bodies involved in the drugs field, it can be difficult to locate precise examples of how a new policy option can ricochet between being embraced and rejected in the process of becoming normalised.[15] Trying to uncover the point when the 'threshold of awareness' in support for a strategy first became visible can become a quest to obtain the elusive, unless we can locate fractures in the façade of policy statements that allow us to see the struggle involved in changing stances.[16] The letter written by Mr Costa offers itself as a valuable tool, a lens, through which we can view and understand some of the confusion and contradiction that surrounds the way new policy norms materialise within the

international system.[17] This section looks at the status of harm reduction in some of the UN's work related to drug issues.

The agency Mr Costa headed was founded in 1997 as the United Nations Office for Drug Control and Crime Prevention (UNODCCP), and was subsequently renamed the United Nations Office of Drugs and Crime (UNODC) in 2002. Near the end of his letter Mr Costa stated:

> "Nevertheless, and again taking our guidance from the conventions, CND and INCB, we neither endorse needle exchange as a solution for drug abuse, nor support public statements advocating such practices."[18]

Appearing as it did in late 2004 this apparently clear cut assertion of UNODC's stance on the use of needle and syringe programmes (NSPs) seemed to stand in contrast to some of the other work that UNODC had completed on the topic earlier in the same year.[19]

For the CND's forty-seventh session, which was held in March 2004, Mr Costa in his capacity as head of UNODC completed a report for the meeting titled *Strengthening strategies regarding the prevention of HIV/AIDS in the context of drug abuse*.[20] This document provided, *inter alia*, a discussion of the challenges posed by injecting drug use and the various viral transmission routes between drug users and the general population.[21] In discussing the healthcare interventions used to curb the disease's spread, the paper focused a significant amount of attention on NSPs:

> "Planners of effective programmes usually develop a hierarchy of interventions. Thus, those injecting drug users who cannot stop injecting can be provided with clean needles and syringes..."[22]

There appears to be a distinct change in the position espoused by UNODC over time, and this was confirmed by examining some of the work that Mr Costa showcased in his report, that is, projects UNODC had undertaken, or at that stage intended to, with other UN bodies.[23]

As a result of its being one of the UN's main drug-related bodies, UNODC conducts work in conjunction with other agencies within the UN system on matters related to illicit drug use. In this respect, some of the collaborative policy projects that it participated in and lent its name to in 2004 involved the World Health Organisation (WHO) and the UN Joint Programme on HIV/AIDS (UNAIDS). In June 2004 WHO,

UNAIDS and UNODC produced a series of joint policy position statements designed to illuminate a set of strategies that the UN system had deemed to be essential in meeting the public health challenges posed by the conjunction of injecting drug use and the HIV/AIDS epidemic. The five policy documents that they co-produced under the programme *Evidence for Action on HIV/AIDS and Injecting Drug Use* each focused on the research base for utilizing a particular harm reduction strategy. The briefs covered the provision of antiretroviral therapy to injecting drug users (IDUs), the reduction of HIV transmission through outreach, the provision of sterile injecting equipment to reduce HIV transmission, the reduction of HIV transmission through drug-dependence treatment, and the reduction of HIV transmission in prisons. The documents, which were widely disseminated and made available in English and Russian, came emblazoned with the three logos of the UN bodies that had created them.[24] In addition, the briefs were later followed by the publication of full length reports on some of the same subjects under the banner of the *Evidence for Action* programme as 'technical papers'.

It is interesting to note the inclusion in the series of a policy brief exclusively and explicitly devoted to the topic of NSPs. The document opened with the statement:

> "The provision of access to sterile injecting equipment for injecting drug users and the encouragement of its use are essential components of HIV/AIDS prevention programmes, and should be seen as part of overall comprehensive strategies to reduce the demand for illicit drugs."[25]

The paper moved on from this opening to assert that the acknowledgement of needle sharing as a HIV transmission route dated back to the start of the epidemic and it concisely detailed the different operational models of NSPs that exist.[26] In terms of drug policy norms, much of the paper was spent setting out the argument that there was a clear evidence base for the efficacy of such programmes and little to the contrary.[27] This was seen as robustly emerging from the research on NSPs to such an extent that the co-authors encouraged scaling-up in the coverage of these programmes and the alteration of national drug control laws that might inhibit NSPs through clauses on the possession of paraphernalia.[28]

Taken in conjunction, the comments made by Mr Costa in his letter and those explicitly backed by his agency appear to be at odds with each other, and this point was

stressed by the Dutch Transnational Institute.[29] On the one hand, UNODC appears to have played a key role in adding its weight to backing the *Evidence for Action* campaign, and significantly the call to embed NSPs as a feature of national drug policies. Yet on the other hand, the letter seemed to provide a guarantee that UNODC would not offer its support to such harm reduction strategies.[30] What is significant about these apparent contradictions in UNODC's policy stance is that they arise in relation to documents co-produced with other UN agencies.[31] Such policy briefs rarely detail radically new information, rather their purpose is ideological, an attempt to signal and marshal support for a particular option so that it might become a norm in action internationally. The potential for cross-organisational confusion within the UN arising out such occurrences is not unique.[32]

Mr Costa's letter contained references to other harm reduction strategies that, in a similar manner to his comments on NSPs, appear to offer clarity and precision.[33] Yet when his comments are viewed in terms of other products of UNODC's work, they emerge as being indicative of further confusion over the support for this new strand of healthcare interventions.[34] He stated:

> "As for the two specific issues of harm reduction, let me be clear. First and foremost, UNODC maintains a strong opposition to heroin maintenance, as well as drug injection and consumption rooms. Such initiatives run counter to the three UN drug conventions as reflected in the pronouncements of the Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB), from which we take our guidance."[35]

It seems clear that UNODC felt that the treatment option referred to as heroin maintenance, which is a type of substitution therapy, and facilities for the consumption of drugs, were clearly out of sync with UN law and the opinions of its core drug policy bodies.[36] This issue itself cuts to the core of the potential sources for confusion and clarification within the UN system regarding policy norms.[37] Later in this chapter I return to this topic in detail; below I discuss Mr Costa's statement on maintenance therapy.

In March 2004 WHO, UNODC, and UNAIDS released a landmark joint position paper on the use of substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention.[38] In a similar manner to comparable co-authored

briefs, the statement on substitution treatment was designed to provide an impact in terms of clarification rather than newly created innovations. In this sense, its content presented the unified view of how maintenance therapy could be used in national treatment systems as espoused by three of the UN's most important bodies dealing with drug issues. Central to its argument was the point that individuals with opioid dependence should be able to avail of a number of treatment options rather than being restricted to any single modality in a 'one-size-fits-all' manner.[39] By way of supporting their pro-substitution treatment contention, the authors drew attention to the sustained evidence base that stood as testament to maintenance therapy's various benefits. They also asserted that the use of such treatments was legally sound under UN law once it was being provided in a proper medical context that was permitted under national laws.[40]

Reflecting the detailed nature of the publication in question's treatment of the topic of substitution maintenance therapy, its discussion of the pharmacological agents that could be availed of spanned several pages. In this respect, it devoted individual sections to Methadone and Buprenorphine, the former being the leading substance used in treatment since the mid 1960s and the latter being an increasingly popular alternative to it.[41] Additionally, a section entitled "Other Pharmacological Agents", presumably to indicate the less popular nature of the substances, outlined the use of drugs such as levo alpha acetyl methadol (LAAM).[42] This section of the paper also contained an extended discussion of diacetylmorphine (heroin) maintenance, perhaps the oldest maintenance substance but also the most controversial. It is worth considering the words of WHO/UNODC/UNAIDS on this topic:

> "The approach of prescribing diacetylmorphine is complex and costly and has been evaluated only in countries with well-developed treatment systems. Results from such evaluations indicate that in comprehensive treatment systems it might be an alternative for a small proportion of severely dependent long-term patents for whom other treatment options have been ineffective."[43]

The summary of heroin maintenance did not discuss the political and ideological controversies that have surrounded programmes administering this substance for maintenance purposes in countries such as the Netherlands, Switzerland, and the United Kingdom. This was not surprising given the brief nature of the paper and the high profile

of its co-sponsoring bodies. Yet these same factors, when considered against Mr Costa's remarks quoted above, again seem to underline a sense of confusion as to what status such a harm reduction intervention should be afforded by a UN agency.[44]

The WHO/UNODC/UNAIDS statement asserted that this form of maintenance has a potential role to play in treatment systems, and considered in terms of the document's overall call for comprehensive multifaceted systems this could be regarded as a clear call for its use with particular populations of users. Generally this form of maintenance is reserved for service users described as 'treatment resistant' as a result of their unsuccessful engagements with other maintenance therapies. While heroin maintenance can be regarded as being at the more controversial end of the spectrum of treatments considered as harm reduction practices, the adoption of any such healthcare strategies in prisons closely follows it in terms of how it is perceived.

In August 2006 the UNODC launched an ambitious document aimed at curbing the spread of HIV in prisons at the International AIDS Conference that was held in Toronto that year. The document *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* was co-authored with WHO and UNAIDS. Significantly, the paper attempted to offer concrete actions that could be implemented in any national context to combat HIV transmission, and this feature appeared to set it apart from similar statements that were less overtly instructive. In this sense, the report made a sustained call for the adoption of through-care services for drug users and equivalence of treatment between custodial and community settings.[45] At a number of points the paper alluded to the use of NSPs as a beneficial means of curbing the transmission of viral infections. For example, action 60 of the 100 measures outlined in the document stated as a 'recommended action':

> "Ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are available in prisons. This should include providing access to the full range of prevention commodities to prevent HIV transmission through unsafe sex, needle sharing…".[46]

This could be viewed as a more vague call for NSPs than that which had been stated by these three UN bodies before, notably in their 2004 document *Policy Brief: Reduction of HIV Transmission in Prisons* as part of the *Evidence for Action* series

mentioned above.[47] Yet what is significant about this paper is that it asserts that NSPs should be used in prisons, which represents both an endorsement of this harm reduction measure and adds to the confusing nature of the UNODC's Executive Director's remarks on NSPs in 2004.[48] The paradoxical nature of this pro-NSP stance was further highlighted by a solo authored UNODC paper released at the same time on the topic of HIV prevention for female IDUs. It made seven points that were regarded as being part of a 'Comprehensive Approach', the fourth of which stated:

> "Access to essential prevention commodities such as male and female condoms, and sterile needles and syringes."[49]

The emergence of contradictory stances and the struggles over meaning that they can be indicative of are not limited to UNODC's work.[50] In the following section I discuss another area in UN drug policy where vagueness and inconsistency can arise.

Ambiguity in Legislation

Much of the foregoing discussion in this chapter, particularly the content's of Mr Costa's letter, could be construed as being evidence of active attempts by some countries, notably the US, to ensure the continued subordination of harm reduction to prohibition in the conceptual hierarchy of the UN's drug policy apparatuses.[51] It is self-evident that those espousing a pro-legalisation or anti-prohibitionist agenda would adopt such a view of the events analysed, and this interpretation may well form part of the overall reality of the situation.[52] However, when one considers what the aforementioned events are indicative of, another explanation for this apparent resistance and confusion over harm reduction can be found.[53] Concisely stated, harm reduction is an emergent norm that is slowly integrating into the UN system's operational philosophy as a lead element.[54] Given the complexities of international consensuses on drug issues generally, as reflected in the nature of the UN drug conventions, this is bound to be anything but a smooth process.[55]

In light of the potential for confusion arising out of the different and sometimes opposing policy messages espoused by separate UN bodies, it would appear somewhat unclear as to what the overall UN stance on harm reduction could be regarded as being.[56] Certainly, some agencies such as UNAIDS seem to have maintained a fairly consistent

position on this issue, while others such as UNODC have offered different messages at different times.[57] In attempting to better illuminate the extent to which harm reduction can be regarded as a norm in drug policy, this section of the chapter focuses on the manner in which this set of healthcare interventions is supported by international law.[58] Making recourse to UN law as a common dominator offers us a view of the guidelines against which the different UN bodies have available to them in verifying the legal implications of their policy recommendations.

The central core of UN law related to drug issues is comprised of three interlinked conventions. These are the *1961 Single Convention on Narcotic Drugs as Amended by the 1972 Protocol*, the *1971 Convention on Psychotropic Substances,* and the *1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. Given the interconnectivity between the three instruments in terms of their focus on different drugs and the trade in drugs, it may seem odd that they were enacted a decade or more apart from each other. This time lag instantly allows us to see some of the causes of ambiguity in UN drug policy, namely, the problematic and time-intensive nature of forging such agreements.[59]

One of the defining features of international legal treaties is that they are extremely complicated to draft and reach consensus on, even more so than largely symbolic policy position statements.[60] This is a direct result of the sheer number of governments and the accompanying array of perspectives involved in this type of law making.[61] For example, in November 2008 the number of countries that were party to the 1961, 1971, and 1988 conventions was 186, 183, and 182 respectively.[62] While this is undoubtedly an increase on the number of countries that were parties to the conventions when they were first created, of key importance is the fact that these legal tools were designed in such a way as to be prospectively accommodating to additional signatories.[63]

A core feature that the three conventions share, which facilitates their forward-looking qualities, is that their wording is set out in sufficiently vague language so as to ensure the accommodation of parties with divergent national laws and policies.[64] In essence, this allows the three conventions to acquire more signatories by not elaborating or specifying in precise detail articles that would potentially cause the exclusion of countries as a result of their national laws not being compatible with the UN

conventions.[65] In turn, this trait of the conventions has facilitated the creation of policy norms by providing the legal means for a large number of countries to converge on. Ultimately, the vague language used in the conventions allows those seeking to support a pro- or anti-prohibitionist reading, or a pro- or anti-harm reduction position, to view the articles as supporting their respective positions.[66]

The potential for many countries to unite on drug laws via the UN conventions is accentuated by the way the instruments' features are implemented. In this sense, the treaties do not function as 'structuring structures' that must be rigidly transposed into the national law of a signatory.[67] On the contrary, the three conventions respect the primacy of national laws and accordingly afford signatories a great deal of legal latitude in how they translate them into national legislation.[68] The extent to which the conventions can be read in different ways can also be seen from the different views cited above that show the Executive-Director of UNODC and the joint statement by WHO, UNODC, and UNAIDS using the same conventions to legitimate their different views of harm reduction.[69] This reveals the way in which the conventions can be seen as creating both room for legal manoeuvring and ambiguous meanings at the same time.[70] In a national context the leeway that countries have in reading how the conventions may facilitate the use of some of the harm reduction measures previously mentioned has, for example, centred on issues such as what UN law means by 'medical and scientific purposes'.[71]

If we examine the conventions in a technical manner to try and ascertain the way in which they could be cited to support or detract from harm reduction's role as a legitimate strand of drug policy there are a number of articles that need to be studied.[72] For example, if a country wanted to provide heroin as a maintenance drug to users this would have to be carried out within the context of 'legitimate medical and scientific purposes'.[73] Articles 2.5(b) and 4(c) of the 1961 Convention, and Articles 5 and 7 of the 1971 Convention relate to the use of controlled substances for medical and scientific purposes.[74] Accordingly, it is within these articles, or the sections that are related to these articles in the official commentaries that accompany UN treaties, that we could expect to locate an instructive elaboration of what was originally meant by medical and scientific purposes.[75] However, what this phrase was intended to mean is not defined anywhere in either the conventions or their commentaries.[76] As a CND report noted in 1997:

"Since each Party to the conventions must introduce its own implementing legislation, it is possible for States to reach different conclusions as to what legitimate scientific and medical purposes are".[77]

Another means of trying to obtain a clear technical view of how harm reduction could be seen from the legal viewpoint established in the treaties may be had from drawing on the provisions of the 1969 *Vienna Convention on the Law of Treaties*.[78] This convention sets out the UN view on how treaties are to be read by their signatories.[79] Generally, articles 31 and 32 within section 3 of this instrument assert that a treaty must be interpreted in good faith with the circumstances that caused it to be concluded and that special meanings can be fixed to terms if parties require this to clarify ambiguity.[80] In terms of offering a precise view of harm reduction's legitimacy as a feature of policy or otherwise there is little additional help to be found here.[81] However, article 31.3(b) can be seen as offering instruction on the position of those governments that read 'medical and scientific purposes' as supporting harm reduction practices given the advent of BBVs such as HIV and HCV.[82] It states:

"There shall be taken into account, together with the context... any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation..."[83]

It seems clear that the interpretation of 'medical and scientific purposes' as accommodating harm reduction interventions has become a practice that has emerged in some governments' drug policies.[84] If the number of national administrations about which this could be said is such that it may be considered a 'common practice', for example, among countries in the European Union (EU), then such a stance might be seen as a norm in how the conventions are interpreted. In this sense, the norm of interpreting 'medical and scientific purposes' as facilitating the healthcare strategies in question could in turn be thought of as representing "...the agreement of the parties regarding its interpretation...".[85]

A final route towards trying to establish what the UN system's view on these issues can be found by analysing the organisation's own examination of the conventions. In this sense, one report in particular is of key importance. The unpublished document in question was prepared by the UNDCP's Legal Affairs Section (LAS) for the INCB's

seventy-fifth session in November 2002 and was made publicly available by the Transnational Institute in 2005.[86] The report titled *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches* provided an assessment of both harm reduction as a norm in policy generally, as well as specific features of it such as maintenance therapy, drug consumption facilities, NSPs, and the testing of pills in party settings.

The paper offered circumspect interpretations of the legality of particular healthcare interventions, but nonetheless made no attempt to leave the main issues unresolved.[87] In this sense, as the Transnational Institute have noted, the LAS asserted that the use of substitution drugs such as methadone could not be seen as being out of sync with the conventions.[88] Significantly, the LAS also asserted that heroin maintenance could be regarded as a legitimate extrapolation of 'medical use' under the drug treaties as a form of 'treatment'.[89] This topic again reveals the ambiguity that exists within the UN system on such treatment approaches and the acceptance of this uncertainty by the LAS:

> "As is the case with the concept of medical use, treatment is not treaty-defined, therefore the Parties and the Board have enough flexibility to adopt a definition of the term for their own use".[90]

This clearly shows that the LAS felt not only was there the potential for ambiguous readings of the conventions, but that they would definitely arise and are reflective of the legal latitude that different players in the system, here individual nations and the INCB, have in pursuing their respective agendas.[91]

The report also concluded that NSPs and drug injection facilities could be seen as permissible under the UN Conventions, a point highlighted by the Transnational Institute.[92] In relation to these two treatment options they noted,

> "It might be claimed that this approach is incompatible with the obligations to prevent the abuse of drugs, derived from article 38 of the 1961 Convention and article 20 of the 1971 Convention. It should not be forgotten, however, that the same provisions create an obligation to treat, rehabilitate and reintegrate drug addicts, whose implementation depends largely on the interpretation by the Parties of the terms in question."[93]

This is, again, reflective of the way different readings can be made of the conventions by different parties, as a result of key terms like 'treatment' remaining unelaborated.[94] The LAS' observations on norms in drug policy are of equal importance.[95]

The report contained a number of conclusions on the way in which the UN drug conventions could be seen as endorsing the utilization of harm reduction strategies and, in turn, establishing such interventions as norms in drug policy.[96] For example, the LAS noted that the preambles of the conventions expressed the UN's anxieties with the health and social consequences of drug use.[97] They asserted that those seeking to find a legitimating basis for harm reduction could interpret this as supporting their arguments.[98] A more fundamental perspective on the leeway contained in the conventions is, however, found in their comments on the interconnection between the 1988 convention and the *Declaration on the Guiding Principles of Drug Demand Reduction* that was adopted at the twentieth UN General Assembly Special Session in 1998.[99] The extent to which the LAS viewed the *Declaration on the Guiding Principles of Drug Demand Reduction* as supporting the adoption of harm reduction measures has been stressed by the Transnational Institute.[100] In terms of providing a linkage between UN law and the General Assembly resolution in question, article 14.4 of the 1988 convention asserts that parties may use UN recommendations to guide their demand reduction strategies.[101] What becomes significant in this respect is that (b) (i) of the *Declaration on the Guiding Principles of Drug Demand Reduction* states that:

> "Demand reduction policies shall... Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse..."[102]

The legitimating power that this statement affords harm reduction as a policy norm when linked to the 1988 convention as outlined above is significant.

As a final reflection of the importance of the abovementioned linkage it is worth considering the words of UNDCP LAS on the issue:

> "Although General Assembly resolution A/RES/S-20/4 does not carry the legal weight of a treaty, and is in fact non-legally binding, it does reflect the evolution in the outlook of Parties on the drug abuse problem and the best means to cope with it. It also reflects a consensus of the international community on how to deal with drug abuse prevention and treatment".[103]

It seems clear from this statement that the use of the *Declaration on the Guiding Principles of Drug Demand Reduction* by parties to the UN drug conventions to support their adoption of harm reduction strategies can be regarded as drawing on a norm in drug policy.

Harm reduction is a relatively new development in drug policy, particularly when compared with prohibition, and it can be regarded as gaining ongoing and increased acceptance and pronounced support within drug control circles since the 1980s. The fact that this set of healthcare practices are not clearly established as being legitimate beyond dispute is reflected to some extent in the confusion present in the work of key UN bodies involved in drug issues.[104] Despite the existence of this uncertainty of harm reduction's status, it would appear to be the case that such treatment and prevention options are permissible under UN drug control laws.[105]

Irrespective of whether one opts to consider a technical examination of the 1961, 1971 and 1988 conventions or the expert opinion of UN bodies on these treaties, it is hard to avoid the conclusion that the law affords ample room for different interpretations.[106] Accordingly, the readings that parties may make of the conventions in favour of policy options such as harm reduction can be seen as contributing to the creation of new norms in international drug policy. In the next section of this chapter I consider the way in which the drug policy activities of the EU can be seen as having impacted upon the development of harm reduction as a norm in drug policy. The importance of the EU's approach to drug issues arises from its being the other major international organisation operating in drug control circles after the UN.

A European Perspective on Drug Policy

In relation to the present study some of the most important EU bodies working in the drugs area are the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Pompidou Group (PG). While both of these organisations deal with the collection and analysis of epidemiological data they are differentiated by their respective focuses on different parts of the process. The EMCDDA is the main data-gathering body on drug issues in the EU and it works with the Member Sates to create a

detailed picture of the EU's drug situation. While the PG was heavily involved in the collection of data from 1982, it reduced its efforts in this area when the EMCDDA became operational in 1995 and has centred its work more on analysis. Both bodies, but in particular the EMCDDA, create information that is utilised by the EU's three main institutions, the Commission of the European Communities, the Council of the European Union and the European Parliament. It is also consulted by the groups that work on drug matters within the institutions such COREPER, or the Committee of Permanent Representatives, and the Horizontal Working Party on Drugs (HWPD) in the Council.

This part of the chapter begins by exploring the outcome of EU investigations into the compatibility of harm reduction with international law and considers the ramifications of their stance on the legitimacy of these healthcare interventions. Below, I analyse the positions taken by the EMCDDA and the PG, the two research bodies operating at EU level, on the adoption of harm reduction strategies. While the opinions put forward by such organisations do not represent definitive EU stances, they afford us a view of the EU's outlook on such healthcare practices and the legal logic upon which this position is based.

In March 2004 the EMCDDA prepared a policy briefing for the Horizontal Drugs Group (HDG) on issues related to drug use and the prevention of HIV/AIDS. The paper was designed to give a concise summary of issues that were deemed relevant to the EU's involvement at the CND's forty-eighth meeting to be held a year later in March 2005.[107] Interestingly, the document made a number of references to the existence of a European viewpoint on drug policy. In setting out some of the characteristics of this shared stance on policy, the EMCDDA asserted that the rise of IDU across the EU in the 1980s had created a situation where all countries had experienced some level of problem drug use. In reacting to this scenario they asserted that a common demand reduction response had emerged, which was increasingly typified by its being strongly based upon research evidence.[108]

In cautiously putting forward their view that evidence of a collective reaction could be witnessed in drug policy they stated:

> "Although the national policies of Member States vary, reflecting their individual drug situation and political context, there is also increasing evidence of a

consensus emerging at the European level on the key elements necessary for an effective response to combating HIV among injecting drug users."[109]

The document emphasized that the European outlook on drug policy could be regarded as being in harmony with the views espoused in important international drug policy texts. Significantly, they singled out the UN *Guiding Principles on Drug Demand Reduction* discussed in the previous section of this chapter in order to illustrate their point.[110]

The brief went on to state that the European approach to drug policy contained important lessons that could contribute to international discussions on curbing the spread of HIV. For example, they discussed how epidemic spread of the virus was avoided in some EU countries as a result of their prompt establishment of harm reduction measures such as, *inter alia*, NSPs.[111] The policy briefing noted:

> "In recent years, European countries have created a firmer legal basis for the provision of sterile injecting equipment to drug injectors. Needle exchange is the predominant approach to the prevention of infectious diseases among drug users in two thirds of EU Member States and a common approach in a further five... and it is considered a priority policy response to infectious disease in at least every second country."[112]

The EMCDDA were clearly pointing out that at both the level of the EU as a whole and on a national level among the Member States, there had been an increase in drug policy actions that provided support for harm reduction practices.

The above statement can be seen as having a particular importance in relation to the evolution of drug policy norms when we bear in mind that it appears in the text after it has been stated that the EU approach concords with the position supported by the UN. The point becomes all the more significant when considered in relation to the separate comments of the Executive Director of UNODC and the UNDCP LAS in the previous sections. In effect, it offers us another view of how the UN drug conventions can be interpreted as legitimating practices such as NSPs.[113] The backing evident in the statement is also indicative of the way norms are established in drug policy, particular when article 31.3(b) of the *Vienna Convention on the Law of Treaties* discussed above is taken into account.[114] In this sense, the fact that this strong assertion of EU drug policy

values was put forward in a briefing intended to inform those sent to the CND to represent the EU is noteworthy.

In backing up their assertion that a level of consensus on harm reduction as a feature of policy had clearly begun to emerge, the EMCDDA briefing drew attention to a statement by the Council of the European Union (COE) from 2003.[115] Recommendations passed by the COE can be seen as carrying a special symbolic weight and can reasonably be regarded as representing the outcome of the evolution of norms in EU social policy.[116] In this respect, *Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence* is indicative of the way harm reduction strategies have been viewed in the EU. The recommendation noted that the *Treaty Establishing the European Community*, which is commonly referred to as the *Treaty of Rome*, called for Community action to facilitate the development of health protection in Article 3(1)(p). They also pointed out that within Article 152(1) of the same treaty the third subparagraph called for Community action to work in a complementary fashion to the measures taken by the Member States in attempting to minimize drug related harms.[117]

The COE recommendation went on to assert that research had shown that the adverse health consequences of drug use have impacted upon the lives a large number of Europeans. As a consequence, the COE stressed that such morbidity and mortality clearly represented a serious public health challenge to the entire Community.[118] Significantly, they stated:

> "In accordance with the principle of subsidiarity, any new measure taken in an area which does not fall within the exclusive competence of the Community, such as prevention and reduction of risks associated with drug dependence, may be taken up by the Community only if, by reason of the scale or effects of the proposed action, the objectives proposed can be better achieved by the Community than by Member States. Prevention and reduction of risks associated with drug dependence cannot be confined to a geographical region or Member State and action therefore requires coordination at Community level."[119]

The manner in which the recommendation built up to this point clearly facilitated the COE in asserting the legitimacy of EU wide developments in advancing the creation of norms in drug policy.

The COE recommendation called on Member States to provide a number of harm reduction measures as part of their respective national efforts to prevent and treat drug use. Among the measures outlined was the creation of through-care or equivalence of care between the community and custodial settings for the treatment of drug use as well as the establishment of NSPs. They requested that provision be made for:

> "...where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange."[120]

Such a request symbolises EU endorsement of this harm reduction strategy among the Member States. Considering the contentious status of NSPs as a healthcare practice, such a high level EU comment expressing their legitimacy was significant. The recommendation also requested that Member States should utilize research evidence to help evaluate the efficacy of their policies on drug use. To this end, the COE drew attention to the work of the EMCDDA in establishing indicators that would help Member States perform the task of evaluation and additionally contribute to EU-wide data gathering and diffusion as a consequence of the adoption of standard measures.[121]

The Pompidou Group (PG) of the Council of Europe has also analysed the relationship between harm reduction practices and the UN drug conventions, and their work on the subject offers itself as an ideal point of comparison with the interpretations arrived at by the UNDCP. As part of its working structure, the PG hold a Ministerial Conference once every three years. The meeting is attended by government ministers with responsibility for the policy areas related to the PG's work. In addition to considering specific topics, the conference primarily focuses on the work that has been carried out prior to the event and the strategy for future work. October 2000 saw the PG hold its Ministerial Conference in Sintra, Portugal. The gathering revolved around the theme of "Risk reduction as a component of a comprehensive multidisciplinary approach to drug abuse problems".

In preparation for its conferences the PG normally produces a number of briefing papers on subjects related to its work, which it refers to as 'technical files'. Since the

EMCDDA became fully operational in 1995 the PG has progressively moved away from epidemiological data collection to more of an analytic role. Reflecting their declared focus on evidenced-based policy and the interaction between research and policy the PG commissioned a paper for the Conference from the Institute for International Research on Criminal Policy (IRCP) in the University of Ghent, Belgium. The paper, *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction*, examined the legality of different harm reduction strategies in a nearly identical manner to the UNDCP LAS report *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches* discussed earlier. Consequently, consideration of the views espoused in this document affords us another perspective on the same issues, but from a more European outlook.

Staying with the issues of NSPs and substitution maintenance therapy that we have discussed in relation to other key international drug policy documents up to this point, the PG briefing can be seen as largely drawing the same conclusions as the UNDCP LAS. The paper observed that from a public health perspective the adoption of NSPs can be clearly justified under the three UN drug Conventions:

> "On the other hand, next to the desire to prevent and combat drug abuse and addiction, the international drug control conventions also express the general concern with public health and welfare of mankind in their preambles. This means that governments can deviate from the above-mentioned articles on the basis of this expression in the preambles. Therefore, governments are allowed to implement exchange and distribution programmes in order to prevent the spread of blood-borne viruses, such as the human immunodeficiency virus (HIV), Hepatitis B and/or C."[122]

Additionally, the report went on to state that such interventions had received a great deal of backing from UN bodies such as WHO and UNAIDS.[123]

In relation to maintenance therapy, and specifically the divisive subject of heroin maintenance, the PG reached a similar interpretation of UN law as the other bodies discussed above. They stated that 'medical and scientific purposes' is not elaborated anywhere in the text of the conventions and as a result:

> "The Conventions do not mark out the boundaries of its use and thus do not substantially restrict the individual parties in their regulation of activities in these fields".[124]

Another strong indication of the flexibility contained within the UN drug conventions can be seen from their comments on the provision of any one or a number of harm reduction services to individuals within custodial settings:

> "According to international laws and organisations, the states' duty towards health does not end at the prison gates. Methadone treatment, heroin prescription and/or exchange and distribution of sterile injection equipment may be provided within the penal system."[125]

In much the same way as the report investigating the compatibility of harm reduction measures carried out by the UNDCP LAS found that there was enough scope to support their use in a national context, the PG's exploration of the core issues appears to provide us with the same set of answers.

Overall the EU's exploration of harm reduction is quite clear in establishing the legitimacy of these healthcare interventions.[126] While the findings of the reports discussed above could be seen as providing support for standardizing such strategies as features of policy, the actions of the EU as an entity may also play an important role in establishing harm reduction as a norm internationally. This chapter ends by considering whether the EU has attempted to foster support for such interventions within its own drug policies and examines their potential impact upon the Member States of the EU in terms of shaping drug policy norms.

European Action on Drugs

This section of the chapter looks at some of the EU action on drug use through an examination of a number of high level responses that have emerged since the 1990s. In this respect, I discuss some of the ways in which the EU can be seen as encouraging the adoption of harm reduction practices as standard features of national drug policies within the Member States of the Union. In this respect it is important to remember that the EU does not possess the legal capability to instruct the Member States on the exact nature of

the drug policy measures that they should adopt. However, this does not hinder the EU from providing its backing for particular approaches. We have seen that the EU has found harm reduction measures to be compatible with UN law, and it is thus to be expected that they are discussed in a positive way in Union work on drug policy and treatment methods.[127] While the Member States have adopted different approaches to drug policy, certain core features have been gaining ground as norms between these national approaches, most notably the adoption of harm reduction practices. Accordingly, EU policy work which furthers the legitimacy and footing of such common features is of great importance in how norms evolve in European drug policy. Below I analyse the role played by the EU's engagements with coordination mechanisms and Union-wide strategies in furthering the creation of norms in drug policy.

The EU has attempted to pursue coordination since the 1980s in drugs policy, with *Comite Europeen de Lutte Anti Drogue* (CELAD) being an early example of such efforts.[128] This body arose out of a call by the French President Francois Mitterrand in 1989 to convene a group where those responsible for coordination of drug issues at a national level could meet.[129] In addition to its consistent presence in Community-wide drug strategies, the sustained focus that the EU has placed on the subject of coordination can be seen from a 2003 report by the Commission of the European Communities.[130] The Commission approached the sensitive topic of justifying the need for Community action in much the same way as the COE had done in their recommendation on health-related harm associated with drug use. They stressed the importance of coordination between both the EU's structures and those of the Member States for achieving success in combating drug problems.[131] In this sense, they pointed out that EU's 2000-2004 action plan on drugs strongly encouraged coordination in a number of ways. For example, it suggested utilizing the Presidency of the Council as a bi-annual meeting point for national coordinators, as well as calling for the EMCDDA to examine the strength of existing coordination measures and for Member States to create coordination structures if they did not already have them.[132] This was a request that was repeated in the EU's 2005 – 2008 action plan on drugs.[133]

The Commission's communication placed a lot of emphasis on the creation of norms in EU drug policy. They stated their desire to see the adoption of research to

inform policy choices become a standard practice among the Member States as part of an 'evaluation culture'.[134] In elaborating this position they made reference to the Council Recommendation on health-related harm associated with drug use and its request for policies to be evaluated prior to and after their implementation.[135] The document also called for the creation of a more unified EU approach to drug policy at an international level and related the success of this to the synchronization of national policies. They stated:

> "The Commission considers that reinforcement of the European identity in external action depends on better coordination of national policies to achieve genuine European coordination. Stronger Union coordination in its external relations is urgently needed as a means of boosting the Union's presence and profile on the international scene."[136]

It seems quite clear that the Commission has used its communication to express a strong desire to see the common aspects of the EU approach to drug policies take on a more distinctive and united appearance in the international arena. The call to create national drug strategies that reflected the overall aims of the EU's regional strategy was repeated in the 2005 – 2008 EU action plan on drugs and gives us an indication of the importance being placed on shaping a united, albeit loosely coordinated, policy outlook.[137]

In light of the EMCDDA policy briefing mentioned in the previous section and its presentation of what they felt were the core elements of a European 'perspective' on drug issues, the Commission's professed agenda appears quite significant. Especially, when we consider that some of the main points of convergence among the policies of Member States include a trend towards evidence-based strategies and the adoption of harm reduction practices. In this light, the Commission's call to consolidate the EU identity on drug issues throws into sharp focus the favourable manner in which the healthcare strategies in question are viewed within the EU's institutions. Such a stance has the potential to shape drug policy norms in the EU through its promotion of one particular type of approach to policy and treatment strategies over other alternatives, such as encouraging a move away from harm reduction generally.

The issue of coordination in the Member States' drug policies has also been examined on a number of occasions by the EMCDDA. In 2002 they produced a report on

the functionality of coordination measures within the EU in order to meet a request issued under the European action plan to combat drugs 2000-2004.[138] While they issued a number of warnings against accepting policies at face value throughout their report, they did see the formulation of such statements as being a positive trend in itself.[139] They stated:

> "...the single fact that the majority of member states in the last few years have adopted a national drug strategy... can be interpreted as the endeavour to produce more and concrete results in the field of drugs."[140]

Reflecting the size of the drift towards the production of a policy document representing the national approach to drug issues, the report noted that in the five years up to and including 2002 roughly 25 such texts were implemented in the EU at both the regional and national levels.[141]

The EMCDDA drew attention to a number of characteristics that the national drug strategies of the Member States had in common. One of these norms in the structuring of a national drug policy that they identified was the use of several 'pillars' to represent core areas of concern and activity.[142] Among the subjects that had received an increased amount of attention as a strand of policy in this sense was harm reduction. In addition, the goals of many strategies also focused on achieving harm reduction as opposed to the traditional aim of obtaining a society totally free from drug use. On this theme, the EMCDDA pointed out:

> "An increasing number of national strategies, while targeting the principle of a society as free as possible from drugs, reveal the growing importance of interventions designed to limit and reduce the harm caused by drugs."[143]

While the content of national policies has moved in a direction which favours the incorporation of harm reduction measures into the overall structure, both in terms of the guiding philosophy and the actions designed to carry it out, the Community level strategies adopted by the EU have also evolved in this way.

Between 1990 and 2005, the EU enacted five separate drug strategies and two action plans. These strategies allow us to see how the EU stance has evolved over time. In essence, we can observe the different positions that have been taken or progressions within the same outlook by analysing a consistent medium, the drug policy strategy. One

feature that emerges over time is that the length and complexity of the strategies increased significantly throughout the 1990s and the start of the twenty-first century. However, this is in keeping with the international trend towards the adoption of drug policies that run over lengthy periods of time and involve an array of actors in the implementation of tasks which are designed to be monitored by sets of key performance indicators (KPIs).

The extent and complexity to which harm reduction practices have featured as aspects of EU drug policy has increased considerably over time. In the 1990 European Plan to Combat Drugs there was a request to the Members States to implement harm reduction measures generally, although it was stated in a somewhat cryptic manner when contrasted with later strategies. The action plan called for:

> "...policies on drug use to set intermediate objectives as well as the primary objective of putting an end to drug use, taking account above all of the need to reduce, through appropriate treatment, disease and death related to the intravenous use of narcotic drugs."[144]

Two years later the Community's second regional plan showed that while the adoption of harm reduction measures was being endorsed, it was not being spelt out in the type of blunt and systematic manner that we could find in strategy documents towards the end of the twentieth century. In mentioning harm reduction, the strategy pointed out:

> "Several Member States reported similar actions, including HIV/AIDS counselling as a permanent feature at drug treatment centres, automatic vending machines for hypodermic needles and work to raise awareness amongst pharmacists."

1994 saw the launch of the EU's first long term drug strategy, which was designed to run from 1995 to 1999. This action plan was set out in a communication from the Commission of the European Communities to the COE and the European Parliament. It can be regarded as standing in contrast to the action plans that followed in 1999 and 2005 as it did not explicitly set out in detail any of the harm reduction measures it wanted to see being implemented in a national context within the EU.[145]

A distinct break in the expression of both the structure and content of EU drug policy can be seen in the strategies launched in 1999 and 2004. In terms of structure,

these two strategies both consisted of an overarching strategy and a separate action plan designed to implement the strategy. For example, the EU Drug Strategy 2005 – 2012 was comprised of two separate action plans set to run from 2005 – 2008 and 2009 – 2012 respectively.[146] The adoption of two separate action plans in the 2005 – 2012 strategy reflected continuity with the way in which the 2000 to 2004 action plan was operated, which was analysed in terms of its initial implementation, a mid-term evaluation and a final evaluation.[147] In this sense, the adoption of two separate plans was aimed at allowing a proper analysis of how successful each had been as well as the entire strategy.[148] Overall, the increased complexity of the EU's drug strategies reflects a shift in the purpose of such documents from being largely rhetorical to a situation where identifiable results – and the bodies responsible for them – are spelt out in considerable detail.

In terms of the content of the 2000 – 2004 and 2005 – 2012 EU Drug Strategies one of the more visible changes that we can observe is the extent to which harm reduction is focused on as a central aspect of policy. The former strategy states that one of its 'general aims' is:

> "to give greater priority to drug prevention and demand reduction, particularly new recruitment to drug use, as well as the reduction of the adverse consequences of drug use..."[149]

The strategy's action plan went on to emphasise the importance of harm reduction to the EU's overall goals. It intended to:

> "...reduce substantially over five years the incidence of drug-related health damage (HIV, Hepatitis, TB, etc.) and the number of drug related deaths..."[150]

The degree to which harm reduction and the interventions typically employed to achieve this form of damage limitation were given a clear role in EU drug policy was greatly increased in the 2005 – 2012 EU Drugs Strategy.

In a similar manner to its predecessor, the 2005 – 2012 strategy asserted that one of its main objectives was to help reduce the health related damage caused by drug use. The document stated:

> "the EU aims at a contribution to the attainment of a high level of health protection, well being and social cohesion by complementing the Member States'

action in preventing and reducing drug use, dependence and drug-related harms to health and society."[151]

The first of the two action plans designed to achieve the objectives of the strategy allow us to see a complete change in the way the EU has set out its agenda and the extent to which harm reduction is a central component of it. In a similar manner to the way many of the Member States' national drug strategies list their measures, the EU Drugs Action plan 2005 – 2008 contained 46 specific tasks. Within these actions numbers 7 to 17 represented the area of demand reduction and several of the measures explicitly referred to harm reduction practices. Among the interventions and objectives mentioned were the need to reduce drug related deaths, improve access to treatment, the implementation of harm reduction measures in prisons and efforts to prevent the transmission of blood borne viruses.[152] Ultimately, the EU stance on harm reduction as a feature of policy that they would like to see emulated in the specifics of the Member States' policies has gained considerable ground between 1990 and 2005.

Another key feature that has emerged in the EU's drug policies is their increased reliance on and promotion of research and evaluation based evidence to inform policy. This is clearly visible in the 2005 – 2012 EU Drugs Strategy and the 2005 – 2008 Action Plan in terms of the importance placed on the work of bodies such as the EMCDDA.[153] In this sense a great deal of information that can be seen as feeding into policy in direct and indirect ways has been generated by the EU's two research bodies, the EMCDDA and the PG. The EMCDDA was established in 1993 but did not become properly active in the field of epidemiological monitoring, analysis and reporting until 1995. It is interesting to note a comment from the EU's 1995 – 1999 drug strategy on the organisation:

> "The EMCDDA – which will be able to contribute to the political decision making process through the important information and analysis role it will perform in conjunction with its associated network of national centres (REITOX)."[154]

While the EMCDDA does not hold a direct political function, the way in which it could have potentially influenced policy is encapsulated by the above quote. In essence, this research body and the PG can be seen as performing an 'enlightenment function' – broadly in line with model of the research/policy interface set out in chapter one – for the

EU's institutions and the Member States. These research bodies generate policy relevant knowledge that has the potential to feed, in a circuitous manner, into the way norms are shaped through the utilization of the ideas and approaches arising from research that have stacked up to the point where a 'threshold of awareness' in support of them has been reached.

In this respect, it is revealing to examine the types or streams of information being created by the EU's research centres. The EMCDDA can be seen as playing the lead role in the collection and dissemination of data on many aspects of drug use that stretch beyond epidemiological monitoring and reporting to encompass the dissemination of information on best practices and work with the administrations of the Member States. One of its most important tasks is the development and implementation of its 'five key epidemiological indicators'. It does this through the help of the 'national focal points' in each Member State, which together comprise the REITOX network (Reseau European d'Information sur les Drogues et les Taxicomanies). The indicators help create a picture of events in the EU as a whole through their collection of data on drug use among the general population, problem drug use, drug-related infectious diseases, drug-related deaths and mortality of drug users, and the demand for drug treatment. Central to the quality of the information gathered by the REITOX network is their implementation of the indicators as this allows harmonized information to be distilled from the various surveys and registries linked to the areas of concern.

The PG has moved from initiating the first multi-city epidemiological studies within the EU to the adoption of work programmes and the production of policy relevant materials on a broad range of issues. As with the information being generated and disseminated by the EMCDDA their focus has been broad and reflective of the EU's support for harm reduction practices. This can be clearly seen from their output – reports ranging from treatment options within custodial settings to consideration of polydrug use, as well as their work on the nature of the interface between research and policy. Considered in tandem the work of both EMCDDA and the PG has been mostly affirmative in its treatment of harm reduction as a legitimate aspect of policy. Their coverage of and stances on key issues have been widely disseminated throughout the EU and impact on policy work at both the regional and national levels to differing extents.

The EU's Monitoring Centre has identified harm reduction approaches to policy and treatment as being common features of national policies in the EU, and while their work may not be the initial or proximate cause of this focus, it can be regarded as providing support for this outlook. This could be argued as feeding into the development of norms in EU drug policy through the ideological consequences of providing support for such approaches to drug policy. In other words, it legitimates such healthcare interventions and the philosophy that guides them by giving them the 'EU stamp of approval', so to speak. Additionally, the agency's REITOX network and their implementation of the five key epidemiological indicators have both increasingly involved national administrations in EU work and helped to create a situation where moves towards loose coordination are visible through the adoption of similar structures and mechanisms in the Member States. The following section presents the overall conclusions from the chapter.

Conclusion

In discussing harm reduction's status as a norm in international drug policy, this chapter has shown that it occupies a relatively strong position within the work of international bodies such as the UN and the EU. In this respect, there does appear to be some confusion and hesitation in terms of expressing unambiguous support for harm reduction within the drug policy work of the UN.[155] This can be seen as standing in contrast to the more definite and united presence of policy that endorses such healthcare interventions in the work of the EU institutions and bodies involved in the drugs arena.

It is important to see this distinction in terms of the pace with which harm reduction has integrated into policy, rather than as a diametric opposition to it with the UN and EU on different sides of the divide. The various UN positions discussed above confirm that this is not the case, as does the near identical conclusions drawn by the UN and EU on the legality of harm reduction practices under international law. Ultimately, the acceptance of any new feature of policy as a staple, a norm that has started to diffuse throughout all geographical regions, is a complex and ongoing process that does not lend itself to neat moments of transition among policy makers. The accommodation of such perspectives and practices on how to mange the adverse consequences of drug use are more likely to be forged and arrived at over time as the various systems and players involved in drug control internationally adjust to change.

This portion of the thesis has set out some of the international events that can be seen as indicative of harm reduction's rise as a policy norm. It is within this period of expansion among the lead elements of drug policy to include harm reduction as legitimate component that the events discussed in the rest of the thesis have occurred. In this sense, the thrust of international support towards the adoption of any number of the range of harm reduction practices, at both the global level and the European level, is beyond doubt. Considering Ireland's geopolitical location within the EU its own national engagement with harm reduction as a feature of policy allows us to observe the way this process of change has occurred at a more micro level. The next section discusses long-term trends in Irish policy and specifically looks at the extent to which it has developed some of the features that this chapter has asserted are characteristic of EU national policies.

[1] De Ruyver, B., Vermeulen, G., Vander Beken, T., Vander Laenen, F., & Geenens, K. (2002). Multidisciplinary Drug Policies and the UN Drug Conventions. Antwerp: Maklu, pp.8-9.

[2] De Ruyver, B., Vermeulen, G., Vander Beken, T., Vander Laenen, F., & Geenens, K. (2002). Multidisciplinary Drug Policies and the UN Drug Conventions. Antwerp: Maklu, p.8.

[3] Nadelmann, E.A. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organization*, Vo.44, No.4, p.481.

[4] Bruun, K., Pan, L., & Rexed, I. (1975). *The Gentlemen's Club: International Control of Drugs and Alcohol*. Chicago: University of Chicago Press, pp.128-129.

[5] Bruun, K., Pan, L., & Rexed, I. (1975). *The Gentlemen's Club: International Control of Drugs and Alcohol*. Chicago: University of Chicago Press, p.122.

[6] Lowes, P.D. (1966). *The Genesis of International Narcotics Control*. Geneva: Librairie Droz.

[7] Lowes, P.D. (1966). *The Genesis of International Narcotics Control*. Geneva: Librairie Droz, p.181.

[8] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.109-140.

[9] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[10] Costa, A. (11 November, 2004). *Letter to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State*. Retrieved January 23 2006 from: http://www.tdpf.org.uk/LETCOSTA2004.pdf; Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[11] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

Costa, A. (11 November, 2004). *Letter to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State*. Retrieved January 23 2006 from: http://www.tdpf.org.uk/LETCOSTA2004.pdf

[12] The page containing the original letter can be accessed on Transform Drug Policy Foundation's website; Retrieved January 23 2006 from: http://www.tdpf.org.uk/MediaNews_LatestNews_25_01_05.htm

One of the most popular drug policy news letters that covered the letter's release was the *Daily Dose* of March 26th 2005; Retrieved January 23 2006 from: http://dailydosearchive.wiredin.org.uk/daily_archives2005/daily05-march26.htm

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[13] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[14] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[15] Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[16] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[17] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526.

[18] Costa, A. (11 November, 2004). *Letter to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State*. Retrieved January 23 2006 from: http://www.tdpf.org.uk/LETCOSTA2004.pdf

Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006 from: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, p.2.

[19] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[20] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[21] ECOSOC (2004). *Commission on Narcotic Drugs Forty-seventh Session. Strengthening Strategies Regarding the Prevention of HIV/AIDS in the Context of Drug Abuse: Report of the Executive Director*, pp.3-5 (The UN reference for this document is: E/CN.7/2004/3).

[22] ECOSOC (2004). *Commission on Narcotic Drugs Forty-seventh Session. Strengthening Strategies Regarding the Prevention of HIV/AIDS in the Context of Drug Abuse: Report of the Executive Director*, p.6 (The UN reference for this document is: E/CN.7/2004/3).

[23] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

ECOSOC (2004). *Commission on Narcotic Drugs Forty-seventh Session. Strengthening Strategies Regarding the Prevention of HIV/AIDS in the Context of Drug Abuse: Report of the Executive Director*, pp.12-13 (The UN reference for this document is: E/CN.7/2004/3).

[24] The *Evidence for Action on HIV/AIDS and Injecting Drug Use* policy briefs can be accessed at: https://www.who.int/hiv/pub/idu/idupolicybriefs/en/

[25] WHO, UNAIDS, & UNODC (2004a). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. Geneva: WHO, p.1.

[26] WHO, UNAIDS, & UNODC (2004a). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. Geneva: WHO, pp.1-2.

[27] WHO, UNAIDS, & UNODC (2004a). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. Geneva: WHO, p2.

[28] WHO, UNAIDS, & UNODC (2004a). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*. Geneva: WHO, p3.

[29] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[30] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[31] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[32] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[33] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[34] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[35] Costa, A. (11 November, 2004). *Letter to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State*. Retrieved January 23 2006 from: http://www.tdpf.org.uk/LETCOSTA2004.pdf

[36] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[37] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[38] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[39] WHO, UNODC, & UNAIDS (2004). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO, p.2; p.9.

[40] WHO, UNODC, & UNAIDS (2004). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO, p.13.

[41] WHO, UNODC, & UNAIDS (2004). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO, pp.14-15.

[42] WHO, UNODC, & UNAIDS (2004). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO, p.16.

[43] WHO, UNODC, & UNAIDS (2004). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO, p.17.

[44] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[45] UNODC, WHO & UNAIDS (2006). *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response.* New York: UN, p.vii; p.23; p.26; p.35.

[46] UNODC, WHO & UNAIDS (2006). *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response.* New York: UN, p.24.

[47] WHO, UNAIDS & UNODC (2004b). *Policy Brief: Reduction of HIV Transmission in Prisons.* Geneva: WHO, pp.1-2.

Page two of this document stated, under the heading 'Policy and Programming Implications':

> "The evidence show that such programmes should include all the measures against HIV transmission which are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment".

[48] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[49] UNODC (2006). *HIV/AIDS Prevention and Care for Female Injecting Drug Users*. Vienna: UNODC HIV/AIDS Unit, p.3.

[50] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[51] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[52] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-2.

[53] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[54] Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526.

[55] Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526; Krajewski,

K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[56] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[57] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[58] Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526.

[59] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[60] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[61] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[62] INCB (2009). *Report of the International Narcotics Control Board for 2008*. New York: United Nations, p.13; p.20; p.27.

[63] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[64] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[65] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[66] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[67] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.331.

[68] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.331.

[69] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330; Transnational Institute (2005).

'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[70] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[71] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, pp.229-330.

[72] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3; p.4; p.5; p.6.

[73] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.332.

[74] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8; UN (1972). *Single Convention on Narcotic Drugs, 1961, As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961*. Geneva: UN, p.3; p.4. Retrieved January 23 2006 from: http://www.incb.org/pdf/e/conv/convention_1961_en.pdf; UN (1971). *Convention on Psychotropic Substances, 1972*. Geneva: UN, p.5. Retrieved January 23 2006 from: http://www.incb.org/pdf/e/conv/convention_1971_en.pdf

[75] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8.

[76] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4.

[77] Pompidou Group (2000). Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper. Strasbourg: Pompidou Group, p.8; UN ECOSOC (1997). Commission on Narcotic Drugs Fortieth Session. Effects on Individuals, Society

and International Drug Control of the Prescription of Narcotic Drugs to Drug Addicts: Report of the Secretariat. (The UN reference for this document is: E/CN.7/1997/7), p.5.

[78] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8.

[79] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8.

[80] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8; UN (1969). Vienna Convention on the Law of Treaties. Geneva: UN, pp.12-13. Retrieved January 23 2006 from: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf

[81] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8; UN (1969). Vienna Convention on the Law of Treaties. Geneva: UN, pp.12-13. Retrieved January 23 2006 from: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf

[82] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8; UN (1969). Vienna Convention on the Law of Treaties. Geneva: UN, p.13. Retrieved January 23 2006 from: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[83]Vienna Convention on the Law of Treaties. Geneva: UN, p.13. Retrieved January 23 2006 from: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf
[84] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8.

[85] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8; UN (1969). Vienna Convention on the Law of Treaties. Geneva: UN, p.13. Retrieved January 23 2006 from: http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf

[86] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[87] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[88] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d
UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4.

[89] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d
UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4; p.7.

[90] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330; Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[91] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[92] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), pp.5-6.

[93] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.5; p.6

[94] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4; p.5; p.6; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[95] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p3.

[96] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[97] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[98] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[99] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[100] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[101] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[102] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[103] UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3.

[104] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[105] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[106] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper.* Strasbourg: Pompidou Group, p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP.* Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.3; p.4; p.5; p.6; Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[107] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.2.

[108] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.2.

[109] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.3.

[110] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.2.

[111] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.4

[112] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, pp.6-7.

[113] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[114] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper.* Strasbourg: Pompidou Group, p.8.

[115] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users.* Lisbon: EMCDDA, p.8

[116] EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users*. Lisbon: EMCDDA, p.8

[117] Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, p.31.

[118] Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, p.31.

[119] Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, p.31.

[120] Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, p.32.

[121] Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, p.32.

[122] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, pp.5-6.

[123] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.6.

[124] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.8.

[125] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.4.

[126] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[127] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[128] EMCDDA (2004b). *Coordination of Drug Policy in the European Union 2000 – 2004*. Lisbon: EMCDDA, pp.3-4.

[129] EMCDDA (2004b). *Coordination of Drug Policy in the European Union 2000 – 2004*. Lisbon: EMCDDA, pp.3-4.

[130] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities.

[131] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities, p.2.

[132] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities, pp.2-3.

[133] Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, C 168, p.3.

[134] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities, p.6.

[135] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities, p.6.

[136] Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union*. Brussels: Commission of the European Communities, p.8.

[137] Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, C 168, p.3.

[138] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.7.

[139] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.8; p.13; p.16.

[140] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.15.

[141] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.15.

[142] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.20.

[143] EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA, p.21.

[144] 'European plan to Combat Drugs, approved by the European Council meeting in Rome on 13-14 December 1990, on CELAD proposal (CELAD 126)', EMCDDA (1993). *Inventory of EC (Legal) Texts on Drugs*. Lisbon: EMCDDA, p.739.

[145] Commission of the European Communities (23.06.1994). *COM (94) 234 Final: Communication from the Commission to the Council and the European Parliament on a European Union Action plan to Combat Drugs (1995-1999)*. Brussels: Commission of the European Communities, pp.1-53.

[146] Council of the European Union (19.12.2004). *14702/04 REV 1 CORDROGUE 76 ENFOPOL 167 SAN 178 RELEX 524 EU Drugs Strategy (2005 – 2012)*. Brussels: Council of the European Union, p.7.

[147] Commission of the European Communities (08.06.2001). *COM (2001) 301 Final: Communication form the Commission to the Council and the European Parliament on the Implementation of the EU Action Plan on Drugs (2000 – 2004)*. Brussels: Commission of the European Communities.

Commission of the European Communities (04.11.2002). COM (2002) 599 Final: *Communication form the Commission to the Council and the European Parliament on the Mid-term Evaluation of the EU Action Plan on Drugs (2000 – 2004)*. Brussels: Commission of the European Communities.

Commission of the European Communities (22.10.2004). *COM (2004) 707 Final: Communication form the Commission to the Council and the European Parliament on the Results of the Final Evaluation of the EU Drugs Strategy and Action Plan on Drugs (2000 – 2004)*. Brussels: Commission of the European Communities.

[148] Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, C 168, p.2.

[149] Council of the European Union (01.12.1999). *12555/3/99 REV 3 LIMITE CORDROGUE 64: European Union Drugs Strategy (2000 – 2004)*. Brussels: Council of the European Union, p.4.

[150] Council of the European Union (01.12.1999). *12555/3/99 REV 3 LIMITE CORDROGUE 64: European Union Drugs Strategy (2000 – 2004)*. Brussels: Council of the European Union, p.11.

[151] Council of the European Union (19.12.2004). *14702/1/04 REV 1 CORDROGUE 76 ENFOPOL 167 SAN 178 RELEX 524: EU Drugs Strategy (2005 – 2012)*. Brussels: Council of the European Union, p.6.

[152] Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, C 168, pp.6-7.

[153] Council of the European Union (19.12.2004). *14702/1/04 REV 1 CORDROGUE 76 ENFOPOL 167 SAN 178 RELEX 524: EU Drugs Strategy (2005 – 2012)*. Brussels: Council of the European Union, p.7; p.8; p.20.

Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, C 168, p2; p.3; p.4; p.6; p.16; p.17; p.18.

[154] Commission of the European Communities (23.06.1994). *COM (94) 234 Final: Communication from the Commission to the Council and the European Parliament on a European Union Action plan to Combat Drugs (1995-1999)*. Brussels: Commission of the European Communities, p.vi.

[155] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

Chapter 4: The Managerial Turn in Irish Drug Policy

"The marchers were a risen people. These were the very streets of 1916 but people didn't come out like this for the Rising. They didn't come out like this against poverty, against the IRA, against rape, against emigration, against TB. But for this – against the drug dealers who are ruining their children – they have come out."[1]

At the start of the period under study there was a deep sense of crisis in Irish society about how drug issues were being dealt with by the Government. The statutory response to drug problems was perceived as being an abject failure by many people, particularly those residing in the areas most affected by heroin use. In the mid 1980s the communities suffering the consequences of heroin use took to the streets to express their anger and frustration at the perceived failure of the authorities to curb the supply of drugs and help drug users. This action was spearheaded by the Concerned Parents Against Drugs (CPAD) movement, which organised anti-drug protest marches. In 1996 the tensions within communities still suffering from the presence of drug dealing and drug use again found their way on to the streets of Dublin. Mirroring the action of CPAD were the Inner City Organisations Network (ICON), and the Coalition of Communities Against Drugs (COCAD), both of which organised numerous anti-drug demonstrations. The sheer frequency of these marches allows us to see how important drug issues had become. For example, there were over 14 large-scale anti-drugs demonstrations between August and December 1996.[2] Typically, these protests involved in the region of 500 individuals, however, there were many others that were attended by up to 1,000 people. The pressure being placed on politicians can be seen from the largest protest that occurred that year, when over 3,000 marchers attempted to embarrass the Government by trying to descend on the meeting of European Justice Ministers at Dublin Castle organised as part of the Irish Presidency of the European Union.[3]

Reflecting the intensity which drug problems had gained during 1996, a range of other issues besides protest marches added to the overall sense of crisis that ultimately lead the Government to focus more resources on the problem through the work of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (MTFMRDD), or Task Force. Many local communities had started to take action against drug dealing in the

form of mounting patrols of estates and flat complexes where users were known to be purchasing and consuming their supplies. While this form of community action was predominantly non-violent, the groups carrying it out were under suspicion of being infiltrated by vigilantes and individuals associated with the Irish Republican Army, a paramilitary organisation linked to the political party Sinn Fein. The validity of these groups and their plans of action came sharply into question in May 1996 after a drug user, Josie Dwyre, was attacked and beaten to death in Dublin city by a group of anti-drugs vigilantes on the 14th of that month. As a result of the trend represented by that incident, relations between the Garda Siochana and anti-drugs community groups deteriorated. On a number of occasions when members of such groups were taken into police custody for questioning in relation to shootings and beatings, large groups of protestors gathered outside the Garda stations in which they were being held.[4] Ultimately, a strong sense of antipathy developed among these groups towards the Garda as a result of what they perceived to be a police strategy of focusing more on their actions than those of drug dealers. In November 1996 this resulted in anti-drugs groups considering a boycott of all cooperation with the Garda, as well as over 800 people marching in protest of police harassment on the 21st of November through O'Connell Street to Fitzgibbon Street Garda station.[5]

The continued presence of hard drug use in Dublin's inner city undoubtedly helped to create the feeling that drug problems were out of control in these areas. While the spectacle of marches and patrols drew the attention of the country at large to the problem, the murder of the journalist Veronica Guerin on the 26th of June 1996 accentuated the extent to which the country as a whole was indeed perceived to be in a drugs crisis by the general public. Mrs Guerin was an investigative journalist who had been working on a series of high profile articles for the Sunday Independent newspaper aimed at exposing and examining Ireland's criminal underworld and illicit drugs trade. Reflecting the national mood at the discovery of her murder, the Taoiseach suspended the business of the Dail on the day of the murder to allow politicians to make statements about the tragedy. The event was seen as a direct attack on democracy and a reflection of how drug-fuelled crime had spiralled out of control.[6] The illicit drugs trade has always been characterised by a degree of violence, however the increased use of firearms by

criminals in Ireland has in part functioned to keep drugs and crime high on the political agenda, a fact borne out by the results of a 2007 Eurobarometer survey on 'social reality' that found Irish people were more concerned with crime than any other Europeans.[7]

This chapter of the thesis discusses the impact of 'management science' on drug policy since the advent of the Strategic Management Initiative (SMI). Specifically, it analyses the extent to which the SMI, in the context of the HIV epidemic, has facilitated the integration of harm reduction into drug policy as a legitimate set of healthcare interventions. This is done by examining changes in the characteristics of Irish drug policy before and after 1996. The chapter begins by outlining the main characteristics of the SMI and then moves on to a consideration of the core features of Irish drug policy between the 1970s and mid 1990s. Subsequently, the focus shifts to the defining attributes of drug policies launched in the wake of the SMI.

Management Science and Drug Policy

Between 1996 and 2006 one of the most significant features to emerge in public policy making in Ireland was the Strategic Management Initiative (SMI), an indigenous version of the emerging international norm in social administration known as 'the new managerialism'. The defining and overarching characteristic of this style of policy formulation and implementation was its enthusiastic use of ideas and structures borrowed and adapted from the private business sector. In Ireland the Fianna Gael / Democratic Left / Labour rainbow-coalition Government in power at the start of the period under study eagerly pursued the adoption of the SMI and the transformation of how the civil service operated. In this respect, the work of a group of senior civil servants known as the Coordinating Group of Secretaries (CGS), allows us to consider some of the main attributes of this new style of administering public policy. This section looks at some of the main features of the SMI.

Launched in May 1996 and endorsed by the Taoiseach at the time John Bruton, *Delivering Better Government* was the second report produced by the CGS and by far the most important in terms of the evolution of the SMI. The impact of the report on the SMI arose from the Group's view that the programme of change aimed at modernising the

civil service could be best achieved through building on the foundations already laid by the SMI.[8] Among the important changes that resulted from the report was the creation of the Public Service Management Act a year later in May 1997. The Act was chiefly aimed at enshrining the new approaches to setting out how authority and accountability would operate in the civil service, ultimately, by replacing the Ministers and Secretaries Act, 1924.[9] The clear assigning of responsibility was a key issue discussed by the CGS in their report, as they believed it would ensure the delivery of better services and policy advice by the civil service.[10]

One of the other central concerns addressed in *Delivering Better Government* was how policy issues that transcended departmental boundaries should be addressed. The CGS noted that a major difficulty in addressing these types of issues was the traditional working structure of the civil service, which had resulted in departments being quite territorial and opposed to sharing power and resources with other 'competing' departments.[11] According to the Group, a way of addressing this was the creation of strategic results areas (SRAs) for key sections of policy, so as to provide a framework within which a number of departments could work together by focusing on their individual and shared agendas. Ultimately, the CGS envisaged SRAs as being the shared ground where these multi-dimensional policy matters, which they referred to as cross-departmental issues and later as cross-cutting issues, could be effectively handled.[12] In this respect, one of the key cross-cutting issues identified in the report was drug policy. The CGS wanted to apply a number of 'tools' to such issues. Principally, these consisted of the creation of cabinet sub-committees, the designation of explicitly defined management responsibility to Ministers and Ministers of State, and the identification of one department as being the 'lead' on a particular issue.[13]

As we will see throughout this chapter and the thesis many of the measures discussed in *Delivering Better Government* came to have an impact on drug policy. However, we can grasp the synergy that emerged between drug policy and the SMI from the work of the Committee for Public Management Research (CPMR). The Committee, which was comprised of civil servants and academics, produced a series of 'discussion papers' aimed at examining best practices and leading approaches to policy issues.[14] One of the CPMR's volumes focused on the *Management of Cross-Cutting Issues* and,

perhaps unsurprisingly, it showcased the approach to policy outlined in *Delivering Better Government*. In examining the topic they made extensive reference to the drugs policy and structures launched by the Ministerial Task Force on Measures to Reduce the Demand for Drugs (MTFMRDD), or Task Force, in 1996. In particular, the paper focused on the creation and work of the National Drugs Strategy Team (NDST) as a successful example of a cross-departmental team deployed to manage a cross-cutting issue. In this sense, among the issues they discussed was the way in which the drugs problem had been identified in the Task Force's work, how the structures were created to deal with it, and the way in which the NDST had to develop trust with the local communities.[15] The depth to which the drug arena was explored shows us how it was seen as resonating with the SMI as expressed in *Delivering Better Government* and the overall importance which drug policy had taken on.

In order to observe the way in which drug policies have changed over the years, we will take the various national drug strategies that have been launched as our unit of analysis. In the same way that this approach allowed us to observe the emergence of harm reduction as a feature of EU drug policy in the last chapter, our aim here is to track the emergence of several themes in drug policy discourse. The increasing degree to which particular issues are focused on and integrated as core aspects of policy affords us a view of how harm reduction has evolved as a norm at the national level, in contrast to our international focus in chapter three. In this respect, the remainder of this chapter is divided into an analysis of Irish drug policies prior to and after the emergence of SMI in 1996.

Irish Drug Policy Before 1996

"Nothing classifies someone more than the way he or she classifies"[16]

In this part of the chapter our focus is on the main characteristics of Irish drug policy from the 1970s to the mid 1990s. While Ireland's first national drug strategy *per se* was launched in 1991, the work of a number of policy making groups concerned with drug

issues allows us to see the way in which drug use and the official response to it was framed prior to then. Observing the extent to which transformations have occurred in how drug problems and their treatment are discussed in policy documents allows us to see the ways in which Government thinking has shifted or remained static. In essence, the acts of categorisation that result in the creation of policy positions partially reveal the logic by which Government was operating at particular times. In this respect, the present chapter traces the gradual emergence of harm reduction as norm within Irish drug policy. Our aim here is not to consider the technical utility of one drug strategy's impact over that of another. Rather, it is to observe the changes that have occurred in their composition. Below I examine a number of key documents produced by the Working Party on Drug Abuse, the Special Government Task Force on Drug Abuse, and the National Coordinating Committee on Drug Abuse.

The first Government committee formed solely for the purpose of examining drug issues was the Working Party on Drug Abuse (WPDA). Set up in the December of 1968, the WPDA had met on 43 occasions by the time it produced its 1971 report on drug use in Ireland.[17] One of the most striking features of the 1970s when compared with the nature of drug use that emerged in the 1980s is the small scale on which it was occurring and the absence of opiate use and associated injecting drug use. While there was evidence of the use of amphetamines, barbiturates and tranquilisers, the most widely used illicit drugs during this time were cannabis and LSD.[18] Accordingly, the WPDA was able to confidently report that there was no significant heroin use in Ireland, though they stressed that this scenario could change.[19] It is against the backdrop of the type of drugs being used and the lack of any disease epidemics associated with the methods of consumption that the WPDA's views must be seen.

The minimal role of research on drug issues in the formulation of policy during the 1970s can be gleaned from WPDA's use of epidemiology. In carrying out their work the group was content to have a general idea, as opposed to a scientifically arrived at estimate, of the prevalence rates for drug use in Ireland.[20] At this time there was no large scale monitoring and reporting systems directed at the use of drugs. Accordingly, the WPDA had to utilise data from the Garda Siochana arrest records in order to arrive at a prevalence level.[21] However, the WPDA was aware of the need for increased research on

the nature of drug use. In their interim report they had stressed the need for research on the causes and extent of drug use. As a result, a survey of users in the Dublin area was carried out, though it was not completed by the time the WPDA drafted their final report.[22] As we will see later in this chapter, the epidemiology of drug use was to take on an increasingly important role in Ireland as the Twentieth Century wound to a close, which departed from its low-key role in the 1970s.

Standing in contrast to the progressive system of drug treatment that emerged in the 1990s, the approach to managing drug dependence advocated by the WPDA was quite restrictive. Marking the start of what would remain a consistent concern in Irish drug policy, the WPDA noted that there was a small number of doctors involved in the inappropriate prescription of drugs. In the 1970s there was no system of registration for users receiving maintenance treatment and this created a situation which was exploited by a small number of individuals obtaining prescriptions from a number of doctors simultaneously.[23] Accordingly, the WPDA called for the creation of legislation to cover how maintenance treatment should operate.[24] In setting out their views on the practicalities of running such treatments, the WPDA vested their support in a predominantly centralised, specialist-led location of services. They felt that GPs should only administer maintenance doses as an emergency 'holding' measure, prior to referring patients to a specialist service where doses would be exclusively administered on site to avoid diversion to the illicit market.[25] At this time, the only treatment centre was located in the Jervis Street Hospital in Dublin city centre.

The way in which treatment services were categorised in the 1970s offers us a view of how Irish drug policy was influenced by developments outside of its own geographical boundaries. Principally, the restrictive direction of the WPDA on the nature of treatment services was a result of their adopting the received wisdom of British services at the time. The late 1960s and 1970s witnessed an environment in which the British authorities opted to curtail GP prescribing rights as a result of the second Brain Report in 1965. In that policy environment the role of drug treatment clinics overshadowed the use of primary care as a setting for the treatment of drug use. This period marked the end of a phase in British drug policy that can be traced back to the

work of the Rolleston Committee in 1926, which favoured the autonomy of GPs regarding the prescription of maintenance drugs.

The adoption of British perspectives in Irish drug policy shows us how treatment modalities and their organisation diffuse from one country to another. Decisions about how to formulate treatment are not taken in isolation. Rather they occur as a result of different interactions with channels of information, including the policy environments of other countries. This is a situation that bears out the reality of the 'search route' of the 'problem-solving' model of the research / policy interface discussed in chapter one.

Compared with developments later in the Twentieth Century, the WPDA can be seen as having raised important issues relating to the operation of drugs as a policy area. Significantly, the working party stressed the multi-dimensional nature of the drugs issue and the necessity of cross-departmental work in dealing with it. In this respect, they drew attention to the inter-linked roles of the Departments of Education, Health, Justice, Posts and Telegraphs, as well as the Revenue Commissioners, in managing drug policy. While they did not have a significant influence on the creation of new structures, they did call for the establishment of a permanent advisory body to monitor the drug use situation and report to government.[26] Consequently, the Inter-Departmental Co-ordinating Committee on Drug Abuse (IDCCDA) was established in 1972 on foot of the WPDA's recommendation.

The transformation in Ireland's drug scene that occurred between the end of the 1970s and the start of the 1980s can be clearly seen from the work of second Government committee charged with considering drug policy, the Special Government Task Force on Drug Abuse (SGTFDA). Established in 1983, the committee held its first session in the April of that year and delivered its report, which was never published, in August after having twelve meetings.[27] Upon reading the SGTFDA report, what is most apparent is the break between the type of drug problem being discussed by their predecessors in 1971 and the situation they were analysing. The period from 1979 to 1983 had seen a shift in the type of drug use occurring in Ireland move towards heroin use and the rise of injecting drug use (IDU). While the timing of this development broadly corresponds to the emergence of large-scale heroin use in other European countries during the early 1980s, it had taken the Irish authorities by surprise. The creation of SGTFDA was in part

a reaction to the public pressure being placed on the Government by the communities worst affected by heroin use in Dublin city. In this sense, the committee's inception was long overdue as a result of the IDCCDA's failure to identify the problem.[28] IDCCDA's inattentiveness was, in part, a by-product of the fact that the committee was never placed on a statutory basis and not properly engaged in monitoring the situation.[29]

The SGTFDA's work was characterised by a more sophisticated view of how to manage drug problems than the ideas espoused by its predecessor, yet clear elements of traditional drug policy thinking were also present in their opinions. Reflecting the near ubiquitous tendency of governments to externalise drug issues, the task force felt that more emphasis should be placed on drug interdiction efforts.[30] It was asserted that cutting off the supply of drugs such as heroin would have a significant impact on the situation in Dublin.[31] Again, mirroring a common leaning among policy makers internationally, the task force was emphatic that a criminal justice response to the problem would be a key part of any success, and this was a view that was widely represented to SGTFDA in the submissions they received.[32]

When they came to consider the issue of drug treatment the task force did not offer any structural suggestions that were radically different from the ideas of the 1970s. This is particularly clear on the macro level of how treatment services are organised and delivered across large geographical areas, in that, the task force reaffirmed the model espoused by WPDA, which relied on centralised, specialist-led services.[33] Yet, the SGTFDA was critical of how these services, still principally based at the Jervis Street Hospital, had failed to evolve in a manner consistent with the extent of drug use occurring. Crucially, they stressed the need for rehabilitation services to be scaled-up, with a particular focus on those under 18 years of age.[34] Like the WPDA, the task force was concerned with the issues of irresponsible prescribing, and called for the Misuse of Drugs Act to be altered so it could be enforced more easily.[35] At this time the links between IDU and HIV were only beginning to be established, and therefore had no discernable impact on the SGTFDA's views of treatment.

Significantly, the SGTFDA asserted that there was a clear link between heroin use and acquisitive crime.[36] This was the first time that such a declaration had been emphatically stated in Irish drug policy. The gravity of its implications for policy

transformation were heightened by the Task Force's call for the creation of better treatment facilities in Irish prisons, though they did not elaborate as to what these might be.[37] This aside, their call for the establishment of prison based treatment services was ahead of its time as it represented an issue – the use of the criminal justice setting for healthcare interventions – that would take on increased importance after the links between IDU and HIV became apparent.

One of the key features of the task force's report was their use of, and call for, research as an aid to policy. Drawing on the epidemiological work of the Medico-Social Research Board (MSRB), the SGTFDA drew attention to the localised nature of the heroin problem in Dublin's North Inner City and explicitly linked its presence there to socio-economic deprivation.[38] As the Twenty First Century approached, the interconnection between drug use and poverty became increasingly accepted by the Government, but for its time, the task force's acknowledgement of it marked a watershed in the idea being endorsed in drug policy.

Representing a clear interaction between research and policy formulation, the SGTFDA used this epidemiological data to recommend that the areas worst affected be designated as Community Priority Areas (CPAs) for the purposes of tackling the heroin epidemic.[39] As part of this plan of action they called for funds to be set aside for social infrastructural development in the CPAs in order to rejuvenate the living conditions of young people who were deemed to be 'at risk' by the MSRB's research.[40] While these recommendations were not acted upon, they did represent the one of the first direct impacts of research on the formulation of illicit drug policy in Ireland. Further, the task force explicitly stated the importance of conducting research in order to orientate the construction of the policy response and called for the MSRB to carry out more projects.[41] As we shall see later in this chapter, what would come to be designated as Local Drugs Task Force Areas (LDTFs) and the creation of the Young People's Facilities and Services Fund (YPFSF), closely mirror the ideas of the SGTFDA. This is a point which highlights the circuitous route that new ideas often take in drug policy before they are officially embraced and presented as a 'magic bullet' approach to the problem at a particular time.

In emphasising their views on the importance of information and monitoring the SGTFDA was critical of the way the WPDA's recommendations had been acted upon.

Specifically, they took the IDCCDA to task as a result of its failure to effectively function and track changes in the drug situation. As a result, the task force called for a new body to be established in order to monitor events and report to Government.[42] This led to the creation of the National Co-ordinating Committee on Drug Abuse (NCCDA), which is explored in the following section.

The Arrival of HIV

This portion of the chapter discusses the work of the National Co-ordinating Committee on Drug Abuse (NCCDA) as well as the launch of Ireland's first official drugs strategy in 1991. After being set up in the March of 1985 the NCCDA had held eight sessions by the time it produced its initial annual report in June 1986.[43] Perhaps the most significant feature of NCCDA's work, in terms of our focus, is their being the first Government committee on drug issues to acknowledge and deal with the links between IDU and HIV. While HIV had been discovered in 1981, its transmission routes were not clearly recognised at first and serological surveillance of the virus was not established for a number of years after this in many countries. In Ireland, monitoring became possible in September 1986.[44]

In considering the interconnections between IDU and HIV the NCCDA enlisted the help of Dr. J.H. Walsh in the Department of Health, who was the National AIDS coordinator at the time.[45] The committee was informed by Dr Walsh that the rate of HIV infection linked to drug use was a serious concern. In elaborating the escalating nature of the epidemic, he provided the NCCDA with information from two studies on infection rates among users attending Jervis Street Hospital and those who were incarcerated in Mountjoy prison. In the former study 27.8 percent of 636 users tested were found to be positive, while the latter research revealed that 22% of 190 users tested were positive.[46] Despite their being presented with epidemiological data on the rising nature of HIV among IDUs in both the community and the custodial settings, at this stage there was little discussion of harm reduction practices. Such healthcare interventions were only starting to gather momentum in diffusing throughout policy circles internationally and therefore had not become part of the common currency of drug treatment systems *per se*.

The issues that the NCCDA dealt with on the nature of drug treatment did not radically depart from those of the committees that came before them. As had been the case in the 1970s and early 1980s the issue of irresponsible prescription practices by GPs was a key concern for the NCCDA. The Pharmaceutical Society of Ireland was an important stakeholder in the drugs area that helped to place the issue of prescribing on NCCDA's agenda. Their submission to the committee called for the prescribing rights of GPs to be curtailed to the extent that only those attached to a specialist centre would be in a position to prescribe drugs for maintenance purposes.[47] The NCCDA did not agree with the Pharmaceutical Society of Ireland's calls for a more restrictive set of practices around prescribing, as they felt the issue was under adequate control as a result of amendments that had been made to the Misuse Use of Drugs Act 1984.[48] Consequently, the committee asserted that the prescribing rights of GP's outside of treatment centres should not be curtailed, but doctors not affiliated with specialist services should endeavour to refer users to centralised treatment locations.[49] At this time, the Jervis Street Hospital was still the main specialist treatment centre.

The Pharmaceutical Society of Ireland's submission also suggested that a register of drug users be created to further help inhibit the potential for irresponsible prescribing by GPs. The NCCDA asserted that the creation of such a database would not be easy to achieve, partly because it would have required another amendment to the 1984 Misuse of Drugs Act as well as the consent of both the GP and the user to the storing of data. It was asserted that those in treatment would most likely resist such a request as a result of their apprehension towards the authorities and the possible uses to which their details could be put.[50] Ultimately, the committee did not offer its support for the creation of such a register for drug users. While the NCCDA was critical of the fact that the outpatients facility called for by the SGTFDA had not been established, their views on the organisation of drug treatment services did not represent any significant departure from those espoused by their forerunners. The HIV epidemic had clearly become a policy issue at this time, yet its conflation with drug issues and resulting transformation of them was still in its infancy at this stage in the evolution of Irish drug policy.

The NCCDA's work continued on the trend started by their predecessor in engaging with research, though to a less extensive degree. In considering the use of

epidemiological statistics the committee drew attention to the fact that a number of stakeholders in the drugs area were part of NCCDA and this provided ease of access to data from the Department of Justice, the Jervis Street treatment centre and Coolemine Therapeutic Community.[51] While NCCDA made no calls for the establishment of an official drug treatment reporting system or made any reference to the MSRB's participation in piloting the Pompidou Group's multi-city study of drug use, they did refer to the research body's work. In this respect, the committee asserted that they were keeping themselves informed of developments in the drugs area through the MSRB's epidemiological reports.[52] While this did not represent a major increase in support for the MSRB's work, it was indicative of the way in which research information had now become somewhat more of an embedded feature of the drugs policy discourse in Ireland.

The NCCDA also played a key role in the creation of the first official national drug strategy that was launched in May 1991. A year earlier the Minister for Health at the time Dr. Rory O'Hanlon reconvened the NCCDA, placing Noel Tracey the Minister for State at the Department of Health as its Chairman, so that it could make recommendations for a new drugs policy. Consequently, the NCCDA's work, along with the outcome of requests for submissions from interested parties including, *inter alia*, the community and voluntary sectors, was used in creating the national drugs strategy.[53] In addition to discussing EU cooperation on drugs issues through CELAD, the 1991 strategy highlighted the fact that the work of international bodies had in informing its contents. This allows us to observe the increasing importance of international policy influences upon Irish drug policy.[54]

The 1991 drugs strategy represented continuity and change with the policy positions that had been taken during the 1970s and 1980s. On the one hand, the strategy mirrored the style of planning that characterised the work of the WPDA, the SGTFDA and the NCCDA. In this sense, no clear indication was given of what policy actors were to carry out particular actions, or what sort of timeframes would govern the delivery of these plans. This ultimately left the implementation of the strategy largely undefined and rather vague. On the other hand, the 1991 drugs policy introduced elements that would become staple features of Irish drug policies. Chief among these characteristics was the adoption of a pillar model, though in a very loosely defined manner, in order to construct

the architecture of the strategy. The 1991 policy was based around the areas of supply reduction, demand reduction, treatment and rehabilitation, and coordination.[55] While these areas and those responsible for them were not specified in the sort of precise terms that came to typify drug policies internationally during the late 1990s, their emergence marked a turning point in how policy was being articulated with an increased level of sophistication.

By the time the *Government Strategy to Prevent Drug Misuse* was launched the HIV epidemic had begun to have a much clearer impact on Irish drug policy. In part, this change was caused by the increased use of epidemiological information. At this time a range of data sources were being used to estimate the incidence and prevalence of drug use. The 1991 strategy drew on the information generated by the Dublin Drug Treatment Reporting System, which had been created in 1989 by the Health Research Board. Reflecting the potential for increased interaction between research and policy, it called for this monitoring system to be extended to the whole country, and stated that part of the rationale for this was the generation of information to feed into the policy making process.[56]

Critically, this epidemiological information, in addition to that derived from HIV surveillance, helped further the conflation of a number of interrelated aspects of drug use. This included the role of localized pockets of socio-economic deprivation in facilitating concentrations of both IDUs and HIV positive drug users.[57] While the SGTFDA had identified the localized links between IDU and poverty, the 1991 strategy made important connections by noting from the data that there were high rates of IDU and needle sharing among IDUs. As a result, the strategy stated in unequivocal terms that IDU was the main HIV transmission route in Ireland, and that this phenomenon was clearly located in parts of Dublin's inner city.[58] This epidemiological information, the increased quality of which they attributed to Ireland's involvement with the Pompidou Group, had an impact upon the extent to which harm reduction practices were considered in the drugs strategy.[59]

The document made reference to harm reduction practices in a number of areas, though this approach to drug treatment was discussed in a very cursory manner. In considering the changing nature of drug policies internationally, the strategy noted that the traditional approach of solely focusing on supply reduction had now given way to a

recognition that demand reduction policies must comprise an equal proportion of the overall response to drug use. Among the programmatic elements they saw as comprising the demand reduction aspects of policy were harm reduction, outreach, and treatment and rehabilitation.[60] This was the first time that harm reduction measures were raised and endorsed in Irish drug policy. In addition to elaborating the necessity of low-threshold outreach work and the role of the Eastern Health Board's clinic on Baggot Street, the strategy also pointed out that measures aimed at drug use must include methadone maintenance and needle exchange.[61]

The structural arrangements related to the treatment and management of drug use that were put forward in the 1991 drugs strategy represented the start of a move away from how services had been organised since the 1970s. In stressing the need to integrate HIV and drug treatments, the drug strategy asserted that services should be based in the local community setting, as opposed to being the exclusive preserve of centralised treatment centres.[62] While the responsibility for the bulk of treatment, in terms of funding and provision, was placed with the Health Boards, with the Drug Treatment Centre at Trinity Court being the leader in specialist services, the strategy also raised the issue of utilising the primary care setting for drug treatment.[63] In this sense, they saw the GP's role as being to refer patients to a centralised service, which would then return the patient to the care of the GP for maintenance treatment.[64]

In addition to discussing what would later emerge as a core part of the drug treatment system, particularly after the methadone protocol discussed in chapter nine was passed, the 1991 strategy also made reference to the location of treatment services. In further elaborating the view that treatment should now move towards the user's area of residence in order to attract more clients and improve overall accessibility, the strategy called for the creation of Community Drug Teams (CDTs) in the worst affected areas. These teams were envisaged as being multi-disciplinary in terms of their composition and aimed at establishing the extent of drug use in an area and linking users into the treatment services, including those being released from prison.[65] While the *Government Strategy to Prevent Drug Misuse* can be seen as representing continued change with the policies that went before it, the period of policy making that emerged in the mid 1990s was typified by

even more far reaching transformations. These developments are focused on in the following section.

Research, Evidence and Drug Policy

A distinct change in the type of drug policy being created in Ireland, in terms of the composition and expression of strategies, can be noted after 1996. The mid 1990s marked a period where the policy environment created by the Strategic Management Initiative (SMI), its compatibility with the use of research and evidence-based solutions, and the sense of crisis surrounding the conjunction of IDU and HIV converged to transform the drug policy landscape. Principally, the union of these contextual factors facilitated a transition to a style of drug policy that was characterised by its integration of harm reduction practices as a legitimate set of healthcare interventions that were regarded as playing a key role in drug policy. The remaining two sections of this chapter examine the emergence of this phase of policy through the creation of a national drugs strategy in 1996 and its subsequent restatement and modification in 2001. The present section focuses on the work of Ministerial Task Force on Measures to Reduce the Demand for Drugs (MTFMRDD), or Task Force.

As with the formulation of policy during the 1970s and 1980s, the mid 1990s saw the continued use of Government committees to examine drugs issues. In this respect, the drug policy that was launched towards the end of 1996 arose out of the work of the 1996 Task Force. The Task Force was created in the July of 1996 and had held seven sessions by the time its first report was launched in October of the same year. Below I examine some of the characteristics that marked their work out from the committees that had preceded them, such as their use of epidemiology, their approach to the delivery of drug policy and drug treatment.

The Task Force's first report was solely concerned with the issue of heroin use, while their second report considered the use of other illicit drugs. Within this targeted focus on opiate use the Task Force broke new ground in developing the sophistication of how drug use was understood and framed in Irish drug policy through their conflation of key issues. They were acutely aware of the fact that the vast majority of heroin use was

taking place within specific areas of Dublin's inner city, and that these localities were typified by high rates of socio-economic deprivation. Consequently, their first report clearly stated that there were indisputable links between poverty, crime and drug use on the one hand, and between injecting drug use, HIV and hepatitis C (HCV) on the other hand.[66] They also stressed the highly destructive consequences that arose from the intermingling of these factors for individuals and communities.[67] However, their assertions, while reflective of the points that started to be raised from the time of the SGTFDA on, were strongly based on epidemiological data and thus carried more weight, in terms of their policy impact.

The Task Force's work utilised epidemiological information to a far greater extent than any of the committees that preceded it, and this was partially a result of the social policy climate arising from the SMI. The policy environment at this time was becoming more and more receptive to the use of evidence and research in order to create 'rational public policy'. In attempting to gauge the prevalence of heroin use the task force pointed out that there was no existing quantitative assessment of the scale of use when they were conducting their work. As a result, they focused their attention on the picture that could be derived from the statistics on the level of demand for drug treatment.[68] While there were no fully comprehensive treatment demand statistics, the available data facilitated the Task Force in obtaining a strong picture of, *inter alia*, the geographical location and extent of heroin use. The principal data source that they drew upon was the Eastern Health Board's information on the numbers presenting for treatment at its clinics in Dublin, where the use of heroin was greatest.[69] Reflecting the international diffusion of policy and research practices, the Task Force acknowledged that the existence of the Health Research Board's monitoring system had its origins in the work of the Pompidou Group and was based on the epidemiological indicators devised by the group.[70]

Signifying the increasing impact of research and evidence on the formulation of drug policy, the Task Force stressed the need to improve epidemiological monitoring of drug use. In addition to stating the necessity of this information for quantifying the number of users, they also emphasised that it had a key role to play in orientating services to the right areas and facilitating an assessment of how much Government revenue needed to be invested in treatment.[71] Crucially, the Task Force asserted that the data

being generated by the monitoring and mapping of drug use via health information systems highlighted the need to conduct research as an aid to the construction and modification of drug policy.[72] Reflecting their views on the role of epidemiology, they called for compatible information systems to be established in all of the health boards, as well as the creation of a system designed to monitor the emergence of new drugs on the market – a task that would ultimately be completed in conjunction with the EMCDDA through its REITOX network in 1997.[73]

The work of the 1983 SGTFDA had broken new ground in acknowledging the connections between drug use and poverty in the targeting of interventions via the use of epidemiological data, and this trend was continued in the 1991 strategy.[74] However, the 1996 Task Force's first report represented a milestone in Irish drug policy as it clearly highlighted the interaction between socio-economic deprivation on a geographical basis with drug use and HIV, and unlike the SGTFDA and the 1991 drugs strategy, its work was published, highly visible and the structures it recommended were put in place. In this respect, the Task Force used epidemiological data to establish that the same areas where those seeking treatment were living were also the areas most affected by the use of heroin.

Through the information available to them, the Task Force identified ten areas in Dublin and one in Cork city at which interventions would be targeted.[75] While the SGTFDA had put forward rather innovative proposals for their time in the form of Community Priority Areas (CPAs) their recommendations were not acted upon by the Government. However, the Task Force asserted that each of the eleven areas they identified from treatment demand data should have a LDTF established in them. The similarities between the recommendations of the two task forces from 1983 and 1996 are clear. They are reflective of the way the statutory response to drugs had not fully dealt with the issues at stake outside of the period studied given that the areas identified in 1983 were among those mentioned in 1996. What is most important about the Task Force's recommendations is that they were acted upon and the LDTFs were established. Given that they were identified via epidemiological data, their creation represented a clear example of the interaction between research and policy in an Irish context. Perhaps the definitive nature of this link can be gleaned from the fact that a Pompidou Group

monograph published in 2006 on the issue of whether health information systems were having an impact on policy showcased the creation of the LDTFs as an example of this process in action.[76]

The Task Force's work had a much more significant effect on the structures used to deliver drug policy in Ireland than any of the committees that tackled drug issues before them. In order to understand the sophistication of their approach to the management of policy it is necessary to consider it in the context of the SMI. Earlier we examined the approach to the design and delivery of public policy set out in *Delivering Better Government*, which emphasised the need for accountability and clear allocation of tasks to actors within structures that reflected the realities of managing public policy. In their first report the Task Force's thinking on how to revise the machinery of Irish drug policy clearly resonated with the ethos of the SMI.

The Task Force made explicit reference to the SMI's method of framing policy areas as 'cross-cutting issues' when they came to discuss the management of drug policy as involving a range of Government departments in a coordinated way.[77] This represented a move away from the way in which Government departments had traditionally operated, in that, they were accustomed to pursuing their own individual agendas rather than cooperating and sharing power. Overall the committee recommended the creation of a range of new structures to facilitate the design and delivery of policy at local, regional and national levels.[78] In addition to the LDTFs, the Task Force created a Cabinet Drugs Committee, a National Drugs Strategy Team, and called for the NCCDA to setup Regional Coordinating Committees prior to its disbanding – these new structures are examined in chapter eight.[79] These new mechanisms for managing drug policy represented the first time that a range of hierarchically linked structures, involving actors from the statutory, community and voluntary sectors in a way that linked them into central Government, had been used in Irish drug policy.

The extent to which the Task Force engaged with the organisation of the drug treatment system also represented a significant departure from the type of discussion held on the topic prior to 1996. The mounting public pressure for an adequate statutory response to heroin use, the sense of crisis surrounding HIV's links to IDU, and the change in policy making as a result of the SMI all functioned to cause the Task Force to

explicitly deal with harm reduction issues. The shift in policy that their views were indicative of can be clearly seen from their discussion of methadone maintenance therapy (MMT). The Task Force gave their full support to the use of pharmacotherapy in the treatment of drug use by asserting that MMT was central to stabilising IDUs and restricting the negative consequences of their behaviour.[80] While previous policy groups had dealt with methadone, the Task Force clearly set a new limit in the explicit nature of their support for MMT.

Throughout their report the Task Force made reference to an evaluation that had been carried out on the Eastern Health Board's drug services by two international consultants.[81] This marked the first time that an evaluation was cited in a drug policy document as evidence in support of a recommendation. Its presence reflected the increasing influence of management science on drug policy and its ability to reframe politically difficult topics, such as MMT, and present them as rationally being the correct choice as a result of their having being evaluated and subjected to scientific scrutiny. In this sense, the Task Force used the consultant's report to help justify their calls for the expansion of MMT. In a manner broadly reflective of the impact of the enlightenment model of the research / policy interface, they stressed that internationally the weight of research 'evidence' supported the use of MMT and proved its efficacy in reducing criminality and risk behaviours and was therefore a cost effective use of public money.[82] Critically, they went further than merely justifying the use of MMT by calling for a change in the way it was being delivered on a geographical basis. In this respect, the Task Force gave its support to the expansion of the number of GPs and pharmacists involved in the MMT scheme, and the continued role of a mobile clinic in Dublin inner city.[83] This reflected an unprecedented level of support for the delivery of treatment in the community setting through the primary care network, marking a move away from the dominance of centralised drug treatment clinics in the provision of services. The following section looks at some of the main developments that occurred in the years after the Task Force's work was first completed.

Harm Reduction and the SMI

The work carried out by the 1996 Task Force undoubtedly ushered in a new era of drug policy making in Ireland, one that was characterised by its engagement with the SMI. This portion of the chapter discusses some of the key features of the period looked at in the aftermath of the Task Force's work. Specifically, it looks at the emergence of the 2001 drugs strategy. After Fianna Fail and the Progressive Democrats were elected in July 1997 another defining feature of drug policy's harmony with the SMI emerged when they created a new department in the form of the Department of Tourism, Sport and Recreation (DTSR). Reflecting the value placed on clearly identifying the actors responsible for managing and carrying out policy in the SMI, the DTSR was designated as the lead department on drug policy. This represented the initial instance of one Government department being assigned overall coordinating responsibility for drug policy. In the past, the division of labour for managing drug policy generally rested between the Department of Health and the Department of Justice. Roughly a month after receiving its new brief, the DTSR commissioned an evaluation of drugs policy and the structures created in 1996 from the PA Consulting Group. This was the first time that a firm of management consultants had been drafted in to analyse drug policy as a whole, and as we will see throughout this study, marked the start of an increasingly common trend.[84] The PA evaluation argued that while the policy created in 1996 lacked many of the quantifiable features favoured by the SMI, there was no doubt that the creation of the various structural arrangements were the prototype of the SMI in action in Irish social policy.[85] The extent to which management science impacted upon the drugs arena continued to increase throughout the 1990s and the strength of its influence was clearly evident by the time the 1996 strategy was reviewed and reformulated at the start of the Twenty First Century.

One of the initial and long lasting changes that the new Government introduced to drug policy in 1997 was the reconstitution of the Cabinet Drugs Committee (CDC), which had been created by the Task Force, into the Cabinet Committee on Social Inclusion (CCSI). This modification represented the Government's decision to reframe drugs policy as being part of the wider area of social exclusion policy.[86] Arising from commitments made in the review of the programme for government, *Action Programme*

for the Millennium, and the social partnership agreement the *Programme for Prosperity and Fairness*, the CCSI initiated the process of reviewing the drugs strategy in April 2000.[87] This resulted in the Inter departmental Group (IDG), one of the structures retained from the work of the Task Force, creating a subgroup simply known as 'the Review Group'.[88] Indicative of the norms emerging since the launch of the SMI, this group contracted in the help of two consultancy firms, Farrell Grant Sparks and Nexus Research Co-operative, to carryout the review.[89] The resulting strategy was the most comprehensive drug policy created in Ireland.

Launched in May 2001 *Building on Experience: The National Drugs Strategy 2001 – 2008* retained both the focus of its predecessor on heroin use and the structural arrangements that had been devised to deliver policy, however, its format and content marked a first in Irish drug policy. Standing in contrast to all of its forerunners, the 2001 drugs strategy was presented in a glossy folder containing two separate publications alongside the main document. These additional booklets consisted of a guide to the main strategy, which was 138 pages in length, and an executive summary of the policy. The sleek production of the drugs strategy, its highly accessible and clearly structured layout and the additional 'easy-to-read' materials convey a key point; this was a document that was designed to be read and consulted by an array of interested parties ranging from the individual citizen to those working in the drugs arena. Below I discuss some of the factors that distinguished *Building on Experience* from the policies that came before it. Namely, the increased influence of the SMI on drug policy, the extent to which harm reduction and drug treatment systems moved to the forefront of policy, and the degree to which epidemiology and research generally were endorsed by the strategy.

The structures created in 1996 to deliver drug policy represented one of the first applications of the SMI to a social policy area. Yet the 2001 drugs strategy embodied even more of the features that typified the new managerial style of social policy formulation and implementation that emerged in Ireland towards the end of the Twentieth Century. In this sense, one of the SMI-era norms that were present in the construction of the drugs policy was the holding of a large-scale consultation process. Nearly all of the government committees that dealt with drug issues from the 1970s onwards invited input in the form of written submissions and meetings with interested parties, yet *Building on*

Experience surpassed the scale on which this form of public engagement had been carried out. Circa 190 written submissions were made to the Review Group, alongside oral presentations by 34 separate groups and bodies.[90] However, the most prominent feature of the consultation process was the holding of 8 regional discussion forums on the strategy. These meetings were advertised in the national media and attended by over 600 people. The importance being placed by the Government on involving the public and instilling in them a sense of ownership of the strategy can be seen from the fact that on each occasion the meetings were chaired by the Minister of State with responsibility for the strategy.[91]

The new drugs strategy, as its name implied, recognised the merit and sophistication of the structural arrangements created by the Task Force. Accordingly, the different mechanisms for designing and delivering policy that had been devised were maintained in the new strategy, albeit with some modifications. As already mentioned, the CDC was restructured into the CCSI to reflect the incorporation of drugs policy into the wider overarching area of social exclusion policy. This saw the CCSI draw its membership from an array of Government departments with a role in delivering drug policy, reflecting the way drugs was framed as an SMI-style cross-cutting issue, and was chaired by the Taoiseach. The Inter-Departmental Group on Drugs (IDG) and the National Drugs Strategy Team (NDST) were also kept on as key structures in the delivery of policy. Both of these bodies, which are discussed in chapter eight, are essentially concerned with the implementation of the strategy, with, hierarchically speaking, the NDST reporting upwards from its liaison with the LDTFs to the IDG, which in turn reported to the CCSI.[92] One of the first new structural mechanisms for delivering policy crated by the new government came in 1998 when the Young People's Facilities and Services Fund (YPFSF), broadly aimed at enhancing the physical and social environments of areas typified by a death of recreational resources, was established.[93] In 2001 the new strategy laid the basis for the creation of an additional structure in the form of the Regional Drugs Task Forces (RDTFs), which essentially mirrored the work of the LDTFs on a country-wide scale.[94] While these two additional mechanisms marked an increased progression in the tactical nature of how the drugs strategy was delivered, they

also marked continuity with the past, particularly, as the YPFSF and the DTFs mirrored ideas put forward by the 1983 SGTFDA and the 1991 drugs strategy respectively.

Internationally, the start of the Twenty First Century saw an increasing number of national drug strategies utilise a set of interlinked pillars to govern and arrange demand and supply reduction policies.[95] In Ireland the 1991 drugs strategy introduced the idea of arranging policy according to this type of organising theme. However, it was not until *Building on Experience* that this method of structuring policy began to strongly reflect the ethos of managerial public policy that was espoused in the SMI. In endorsing the new structure for delivering policy the Review Group pointed out that the adoption of a pillars model was indicative of the characteristics of drug policies internationally. This marked a trend within the document of drawing on the experiences of other countries, which was clearly visible from their devoting a whole chapter to an *Overview of International Responses to Drug Misuse*.[96]

Their review, which covered the policies of the EU and eight individual countries, is indicative of the 'search route' sub-type of the problem-solving model of the research / policy interface, whereby policy makers consult existing information resources as part of constructing their own response. This view was supported by Jimmy Duggan, a Principal Officer in the DoHC.[97] He had been, amongst various involvements during the period – including the development of MMT policy, the NACD, prison healthcare policy – a member of National Drugs Strategy Review Sub-Group (NDSRSG), which helped the Inter-Departmental Group on Drugs (IDG) complete the review.[98] As had been the case at other times prior to this during his time in the drugs area, policy makers consulted and searched out information from a range of sources and networks that they were connected to.[99] These included different UN and EU agencies, such as the EMCDDA and the PG, and the policy and treatment systems of other administrations.[100] Their analysis of the aspects and structures of other policies also shows us how features such as pillar models and harm reduction practices diffuse internationally as a result of their being popularised by a number of initial 'experimenter' countries.[101]

Overall the strategy consisted of four pillars covering the areas of supply reduction, prevention, treatment and research. Resonating with the managerial approach to policy making set out in *Delivering Better Government*, the strategy defined a series of

objectives and key performance indicators (KPIs) under each of its four pillars.[102] Additionally, the strategy included a detailed action plan consisting of 100 individual actions to be carried out by different policy actors, again reflecting the SMI-style tendency to clearly define what actors should be doing particular tasks in the delivery of policy.[103] The implementation of these actions was designed to be monitored through the creation of a *Critical Implementation Path*, which was launched in 2004 and modified in 2006 by the Department that took over control of the drugs brief from DTSR, the Department of Community, Rural and Gaeltacht Affairs (DCRGA).[104] Alongside launching a report on the general progress of the strategy in 2005, the DCRGA also produced a mid-term evaluation of the strategy's objectives, KPIs, and the degree to which its 100 actions had been implemented.[105] The mid-term review, which was carried out by a 'Steering Group' within the DCRGA with the help of PA Consulting Group, the firm who had worked on drugs policy in 1998 as well as evaluating the SMI as a whole, arose out of *Building on Experience*'s call for continuous monitoring of the strategy.[106]

While the adoption of a range of objectives, KPIs, action plans, implementation paths, and evaluations reveals the increased impact of the SMI on the 2001 drugs strategy, these same features also show us the extent to which harm reduction had been embraced by policy makers. The inroad that harm reduction had made into being part of the legitimate core of policy can be seen from its location within the strategy: "The overall strategic objective of the National Drugs Strategy 2001 – 2008 is: To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research."[107] The strategy asserted that there had been a shift in drug policies towards the adoption of harm reduction practices as a result of the health threats posed by IDU and the spread of HIV and HCV. In this sense, the Review Group went on to legitimate their explicit support for harm reduction by noting that many calls had been made for its expansion in the public consultation forums, as well as its being a core part of all the national drug strategies that they analysed.[108] They also stressed the key role that evidenced based harm reduction practices had to play in safeguarding the health of both individuals and the wider community against the dangers posed by HIV and HCV through IDU.[109] Further, the Review Group highlighted the fact that utilising a harm reduction approach to policy and

provision clearly resonated with the position endorsed in the National AIDS Strategy that was launched in 2000.[110]

SMI's ability to provide a policy climate in which rational evidenced based measures could be employed, alongside the threat posed by the continued spread of BBVs, functioned to accelerate the degree to which harm reduction became a core feature of treatment policy. This can be clearly seen from the extensive discussion of drug treatment contained in *Building on Experience*. A wide range of issues related to the operation and modification of the drug treatment systems were debated by the Review Group in a manner that signified the increased complexity of Irish drug policy's appreciation of harm reduction issues. The practices being reflected upon ranged from the permissibility of drug consumption rooms and heroin assisted treatment under UN law, to the expansion of needle and syringe programmes (NSPs).[111] There was also a very strong degree of support for the creation of a throughcare system in order to facilitate equivalence of treatment options between the community and custodial settings, as well as backing for the utilisation of a drug court system.[112] In addition there was a clear expression of the need to expand community based treatment involving GPs and pharmacists in the delivery of MMT, which was robustly defended as being a key example of international best practice in drug treatment.[113] Taken together the totality of these measures marked a shift in the extent to which formal policy engaged with harm reduction. This was particularly visible in the sense that the discussion in *Building on Experience* moved beyond the largely rhetorical and unplanned level of previous policies to the point that specific detailed actions and those responsible for completing them were set out on implementing harm reduction strategies.[114]

Reflecting the fact that research was designated as one of the four pillars in the national drugs strategy, epidemiology and research in general began to take on an increasingly important role in the new national drugs strategy. This can be seen from the creation of a new Government backed research structure in the form of the National Advisory Committee on Drugs (NACD), and the increased role of health monitoring systems and the data generated by them. Throughout the strategy the Review Group made reference to the need for more information on the causes of drug use and the need for scientifically based responses, or what is sometimes referred to as 'evidenced based

medicine', in the treatment of drug use.[115] Reflecting the extent to which research was impacting on policy, they stressed that high quality information on drug issues was necessary to guide the efforts of policy makers and those delivering services, as well as facilitating the diffusion of best practices.[116]

In this context, the NACD and the HRB were designated key roles in the generation and dissemination of research and information on drug issues. Specifically, the NACD were charged with carrying out a wide range of work on different aspects of drug use, ostensibly aimed at, *inter alia*, informing and re-orientating aspects of the drugs strategy.[117] The HRB, and particularly its Drug Misuse Research Division (DMRD), was involved in the epidemiological monitoring of drug use through the first large scale health reporting systems devoted to the area, the National Drug Treatment Reporting System (NDTRS) and later the National Drug Related Deaths Index (NDRDI).[118] In addition, the DMRD was designated as the host and curator of a national clearing house on drug related information known as the National Documentation Centre on Drug use (NDC). The DMRD was renamed the Alcohol and Drug Research Unit (ADRU) in 2007. As with drug treatment systems, the 2001 drug strategy set out in detailed actions the way in which research and epidemiology were to play a part in the ongoing implementation and reformulation of policy.[119] While many of these SMI-styled policy features can be found in other Irish social policies – and as we shall see in the next chapter, many policies that interlink to drugs policy - *Building on Experience* had many of the initiative's associated attributes.

Conclusion

Irish drug policy's design and delivery was transformed significantly between the 1970s and the start of the Twenty First Century. This alteration occurred as a result of a number of factors, including changes in the patterns and forms of drug use arising in Irish society and the way in which social policies were being designed generally. The type of drug policies produced in the 1970s and 1980s were indicative of the relatively new nature of widespread illicit drug use in Irish society and, as a result, their somewhat unsophisticated structures and arrangements represented the lack of experience policy makers had in dealing with drug issues. From the mid 1990s on the discussion of drug problems and the statutory response to them took on an increased air of complexity. This can be seen from the way topics were framed, the mechanisms that were brought to bear on them, and the extent to which these responses integrated knowledge from research and other drug policies and forums internationally.

The increased air of sophistication that came to characterise Irish drug policy, which reached its peak with the launch of *Building on Experience* in 2001, was strongly influenced by the advent of the Strategic Management Initiative (SMI) and the crisis wrought by the conjunction of HIV and IDU. The context created by these factors aided the extent to which the politically sensitive aspects of drug policy could be framed and presented as rational courses of action. Overall, this resulted in harm reduction's incorporation as a central feature of national drug strategies on the basis of its being a legitimated set of healthcare interventions supported by scientific research and its normalisation in drug policies within the EU. The following chapter explores the extent to which drug issues have become a sustained critical concern for Irish policy makers. In this respect, I discuss a number of the Irish Government's involvements with international drug policy, as well as the extent to which drug concerns have been incorporated into an increasing amount of social policy areas.

[1] O'Faolain, N. (12th October, 1996). 'Citizen army fights to save the children', The Irish Times, Retrieved 23.02.2007 from:
http://www.ireland.com/newspaper/newsfeatures/1996/1012/archive.96101200054.html

[2] Maher, J. (August 9th, 1996). 'Drug protest in Clondalkin', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0809/archive.96080900058.html

Haughey, N. (August 23rd, 1996). 'Summerhill residents demand action', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0823/archive.96082300033.html

Kilraine, J. (August 29th, 1996). 'Anti drugs protest group says other areas interested', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0829/archive.96082900017.html

Gallagher, P. (September 19th, 1996). '300 march in Dublin inner city anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0919/archive.96091900018.html

Editorial (September 20th, 1996). '1,000 march in anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0920/archive.96092000042.html

Editorial (September 24th, 1996). 'Drugs protesters hold two marches', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0924/archive.96092400063.html

Maher, J. (September 27th, 1996). 'Protest crowd mobs taxi carrying major Dublin drug dealer', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0927/archive.96092700022.html

Maher, J. (September 28th, 1996). 'Anti drugs march highlights anger on failure to tackle city dealing', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0928/archive.96092800031.html

Maher, J. (October 8th, 1996). 'Alleged dealers are named at city anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1008/archive.96100800013.html

Editorial (October 11th, 1996). '800 march over drugs in Dublin', retrieved from:
http://www.ireland.com/newspaper/ireland/1996/1011/archive.96101100032.html

Editorial (October 16th, 1996). '300 in march against drugs', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1016/archive.96101600030.html

Editorial (October 30th, 1996). '300 in city anti-drugs protest', retrieved 23.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/1030/archive.96103000004.html

Editorial (November 8th, 1996). 'Anti drug groups plan GPO protest', retrieved 23.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/1108/archive.96110800031.html

Maher, J. (December 13th, 1996). 'Anti drugs protesters besiege home', retrieved 23.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/1213/archive.96121300006.html

[3] Maher, J. (September 28th, 1996). 'Anti drugs march highlights anger on failure to tackle city dealing', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/0928/archive.96092800031.html

[4] Maher, J. (August 3rd, 1996). 'Protest at arrest of anti-drugs campaigner', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/0803/archive.96080300011.html

Maher, J. (August 15th, 1996). 'Protests at arrest of anti-drug activist', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/0815/archive.96081500048.html

[5] Maher, J. (November 20th, 1996). 'Anti-drug campaigners may boycott Garda', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/1120/archive.96112000020.html

Maher, J. (November 22nd, 1996). 'Anti drugs campaigners march against "Garda harassment"', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/1122/archive.96112200058.html

[6] Kennedy, G. (June 27th, 1996). 'Stunned political leaders see killing as attack on democracy', retrieved 12.03.2006 from: http://www.ireland.com/newspaper/ireland/1996/0627/archive.96062700039.html

[7] European Commission (2007). *Special Eurobarometer: European Social Reality.* Strasbourg: Author, p.46.

[8] Department of the Taoiseach (1996). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service.* Dublin: Department of the Taoiseach, p.52.

[9] Department of the Taoiseach (1996). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service.* Dublin: Department of the Taoiseach, p.21.

[10] Department of the Taoiseach (1996). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service*. Dublin: Department of the Taoiseach, p.6.

[11] Department of the Taoiseach (1996). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service*. Dublin: Department of the Taoiseach, p.16.

[12] Department of the Taoiseach (1996). Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service. Dublin: Department of the Taoiseach, pp.11-12.

[13] Department of the Taoiseach (1996). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service*. Dublin: Department of the Taoiseach, pp.16-17.

[14] Boyle, R. (1999). *CPMR Discussion paper 8: The Management of Cross-Cutting Issues*. Dublin: Institute of Public Administration, p.vii.

[15] Boyle, R. (1999). *CPMR Discussion paper 8: The Management of Cross-Cutting Issues*. Dublin: Institute of Public Administration, pp.16-22.

[16] Bourdieu, P. (1990). *In Other Words: Essays Towards a Reflexive Sociology*. London: Polity Press, p.132.

[17] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.9.

[18] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.14.

[19] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.15.

[20] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.10.

[21] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.14.

[22] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, p.25.

[23] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse.* Dublin: Stationery Office, p.29.

[24] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse.* Dublin: Stationery Office, p.30.

[25] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse.* Dublin: Stationery Office, p.30.

[26] Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse.* Dublin: Stationery Office, p.52.

[27] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.1.

[28] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.18.

[29] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.18.

[30] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.3.

[31] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.3.

[32] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.4.

[33] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, pp.12-15.

[34] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.12.

[35] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.5.

[36] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.3.

[37] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.4; p.6.

[38] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.9; p.16.

[39] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.10.

[40] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.11.

[41] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.16.

[42] Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished, p.18.

[43] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.5; p.6.

[44] National AIDS Strategy Committee (1992). *Reports and Recommendations of the Sub-Committees of the National Strategy Committee on: Care and management of Persons with HIV/AIDS; HIV/AIDS Surveillance (Interim Report); Education and Prevention Strategies; Measures to Avoid Discrimination Against Persons with HIV/AIDS – Adopted by the Main Committee on 13th April 1992.* Dublin: NASC, p.52.

[45] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.7.

[46] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.7.

[47] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.8.

[48] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, pp.9-10.

[49] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.9.

[50] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, pp.8-9.

[51] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.10.

[52] National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report.* Dublin: Stationery Office, p.14.

[53] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.1.

[54] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.1; p.24.

[55] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.2.

[56] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.2; p.6, p.9.

[57] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.8.

[58] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.17.

[59] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.6; p.9.

[60] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.14.

[61] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.16; p.17.

[62] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.17.

[63] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.18.

[64] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.19.

[65] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, pp.18-19.

[66] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.5.

[67] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.7.

[68] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.6.

[69] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.9.

[70] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p25.

[71] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.9.

[72] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.10; p.26.

[73] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.16.

[74] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.8.

[75] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.27.

[76] Pompidou Group / Sinclair, H. (2006). *Drug Treatment Demand Data: Influence on Policy and Practice.* Strasbourg: Council of Europe, pp.21-24.

[77] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.12.

[78] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.15; pp.44-46.

[79] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.15; pp.44-46.

[80] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.41.

[81] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.11; p.31; p.34.

[82] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.11; p.34.

[83] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.16; p.33; p.41.

[84] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.2.

[85] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.3; p.6.

[86] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.8; Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008.* Dublin: Stationery Office, p.60; p.96; p.105.

[87] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008.* Dublin: Stationery Office, p.12.

[88] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008.* Dublin: Stationery Office, p.13.

[89] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008.* Dublin: Stationery Office, p.13.

[90] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.3.

[91] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.13.

[92] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.61.

[93] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.49.

[94] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.106.

[95] An interesting slection of EU Member States' drug policies can be found at: http://www.emcdda.europa.eu/?nnodeid=1360

[96] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, pp.65-80.

[97] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[98] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[99] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[100] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[101] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[102] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, pp.114-117.

[103] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, pp.118-129.

[104] Department of Community, Rural and Gaeltacht Affairs (2004a). *National Drugs Strategy 2001 – 2008: Critical Implementation Path*. Dublin: Stationery Office; Department of Community, Rural and Gaeltacht Affairs (2006). *Critical Implementation Path for New and Amended Actions in the National Drugs Strategy*. Dublin: Author / published online at: http://www.pobail.ie/en/NationalDrugsStrategy/CriticalImplementationPathsforNewAmendedActions/file,7280,en.xls

[105] Department of Community, Rural and Gaeltacht Affairs (2004b). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office; Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office.

[106] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.108; PA Consulting Group (2002). *Evaluation of the Progress of the Strategic Management Initiative / Delivering Better Government Modernisation Programme*. Dublin: Department of Taoiseach; Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.3; p.4.

[107] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.108.

[108] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.104.

[109] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.104.

[110] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.104.

[111] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.79; p.88.

[112] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.58.

[113] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.87; pp.94-95; p.100; p.101.

[114] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.114; pp.116-118.

[115] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.100; p.104.

[116] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.100; p.104.

[117] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.105.

[118] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.105.

[119] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.123.

Chapter 5: Drugs & the Political Agenda

A range of different influences have an impact on the formulation of drug policies at both the international and national levels. Within international policy making circles, as well as the localised public sphere in which a Government's actions are ultimately received and scrutinised, those charged with producing and delivering policy strive to create a particular image of their actions. As a result of the way a large amount of public policies are made after the emergence of problems, particularly drug policies, social administrations struggle to instil in the general public and their international peers the impression that a particular situation is being handled competently. In creating a positive image of policy action Governments are faced with many pressures. These include the need to appear in sync with the leading approaches internationally, that is, to be following 'best practice', as well as being sensitive to emerging and sustained social problems and appeasing the disquiet they generate.

In observing the way in which policy makers can be affected by a range of endogenous and exogenous pressures, the work of Erving Goffman offers itself as a useful analytic tool.[1] It allows us to consider the influence of the international drug policy climate favourably disposed to harm reduction and the utilization of research and evidence to drive policy, as well as the pressure brought to bear upon the Irish Government by those living with the consequences of drug use. Principally, the idea of 'impression management' arising from his dramaturgical analogy of social interaction affords us a view of how the Government has strived to create, maintain and repair an image that conveys it is capable of effectively dealing with drug issues.[2] Impression management can be regarded as the active attempts that individuals make through regulating their verbal and non-verbal behaviours in order to project a particular image of themselves, which they desire others to accept or 'buy into'.

A central aspect of the framework for understanding and observing impression management is that one of the main settings it takes place in is a social establishment. As Goffman put it:

> "A social establishment is any place surrounded by fixed barriers to perception in which a particular kind of activity regularly takes place. I have suggested that any

social establishment may be studied profitably from the point of view of impression management"[3]

The international and national drug policy environments can be seen as sharing some of the same characteristics as the settings Goffman focused on. In this sense they may be regarded as roughly corresponding to a particular type of social establishment that is analogous in certain respects to the locations Goffman analysed and suggested for examination. A key basis for this assertion is the clearly visible presence of a number of defining barriers and a range of conventional behaviours that are performed within them. For example, in international drug policy circles much work is carried out through the holding of conferences, such as the CND and UN meetings discussed in chapter three. At such gatherings a range of pressures, like the difficulty of coordinating numerous participants and following customary standards of debate, require delegates to play their roles with a degree of precision and predictable consistency. In other words, they must carefully manage or choreograph the impressions others foster of them. At either the international or national levels, the presentation of policy positions on particular issues represents the 'front stage' area or publicly visible aspects of the policy work that takes place out of view in the 'backstage' region of Government administrations.[4] In this respect, the need to conform and avoid controversy is a strong influence on the actions of small Governments on the international stage, particularly in terms of the way contentious issues, such as the different types of harm reduction strategies, are dealt with.[5]

In attempting to instil in others the impression that a Government wants, generally one which casts them in a favourable light in relation to a particular issue, the success of the endeavour rests on their ability to control others' 'responsive treatment' of their actions, that is, the extent to which an impression is accepted or rejected.[6] In this sense, the way in which a Government's behaviour is perceived and acted upon arises out of a mix between the impression that they *give*, and the impression that they *give off*.[7] The difference between these two acts of communication being that one is intentionally transmitted and more readily manipulated, while the other emerges unintentionally from their actions and is more complicated to control.[8] In scrutinising behaviour, Goffman asserted that these 'ungovernable aspects' of conduct provide a means of gauging the

impression being communicated through those which are more readily governable.[9] Here, a case in point would be the difference between rhetoric and action on drug issues in the form of the promises made and the results delivered. As we will see below, the occasion of international conferences affords us a valuable chance to witness both of these aspects – the success and failure – of impression management in action through discussions on drug policy.

This chapter of the thesis consists of four sections and considers the impact of external and internal influences on the creation of Irish drug policy and the extent to which drug issues have become commonplace in many areas of social policy generally. This is done by considering how a number of EU drug policy forums function to place pressure on the Irish Government to create a particular impression of their policy actions, as well as the image of their actions that they have attempted to construct on a national level. In essence, our attention is focused on the outcome of a two way communicative process whereby policy makers are influenced and in turn project their own influence onto others. Following from this, we will observe the way in which policy formulation since the advent of the Strategic Management Initiative (SMI) has facilitated the inclusion of drug issues in a range of different policy fields. This incorporation of drug issues can be seen as furthering the extent to which drug policy has been legitimated as a key policy field.

Impression Management

Drug issues have taken on an increased level of importance in the work of Governments at both the international and national levels, particularly since the emergence of links between IDU and the spread of HIV and HCV. Accordingly, the positions on drug policies adopted by national administrations have become more significant in terms of their bearing on political success and survival. The decisions taken, the actions supported, and the impressions created have an impact on how voters and international actors in policy arenas perceive a Government to be performing. Below I examine the influence of a number of EU drug policy forums on the formulation of Irish drug policy. In this sense,

I focus on the Irish Government's role in the British-Irish Council and the Council of Europe's Pompidou Group.

One of the key bodies that shows us how drug issues have become a sustained high-level concern for the Irish Government is the British-Irish Council (BIC). On the 10th of April 1998 the Good Friday Agreement was signed reflecting the consensus reached in the multi-party talks designed to end the sectarian violence, commonly know as 'the troubles', in the North of Ireland. As part of this, the British and Irish Governments signed the British-Irish Agreement, which upon its activation on 2nd December 1999 created the BIC.[10] The express aim of the BIC was to help develop and strengthen relationships between the people of the islands represented on the council, which included the devolved institutions in Northern Ireland, Scotland and Wales, as well as representatives from the Channel Islands, Jersey and Guernsey, and the Isle of Man.[11]

The way in which the BIC operates creates opportunities for its members to influence each other's policies, as well as potential pressure for the participating administrations to appear to be acting in accord with the policy norms favoured by the majority. The Council can be regarded as functioning as a forum for the exchange of information and in this sense it meets in three different structural configurations. These consist of *summit level meetings*, which bring together the heads of the administrations and Governments, *sectoral gatherings* focused on particular policy areas, such as drugs, and *Ministerial and official level* – by far the most frequently held meetings – involving those with responsibility for particular policy areas.[12] In addition, individual members of the BIC host conferences on drug issues for the other members, such as, the meetings held respectively by Guernsey and the Isle of Man Government on 'emerging trends in drug misuse and treatment modalities' in 2003 and 'drug and alcohol strategies – progress in action' in 2002.[13]

The BIC's work focuses on a number of core areas within social policy that are deemed to be of mutual importance to all the members. Chiefly, their work programme covers the environment, indigenous, minority and lesser-used languages, the knowledge economy, social inclusion, telemedicine, tourism, transport, and drug issues. Significantly, the Irish Government was given the responsibility of being the lead administration on the consideration of drug policy. Accordingly, at the second BIC

summit level meeting the area of drug policy was examined in detail.[14] This gathering was held in Dublin in November 2001 and chaired by Bertie Ahern the Irish Taoiseach, and was attended by, *inter alia*, Tony Blair the British Prime Minister and Eoin Ryan the Minister with responsibility for Ireland's national drugs strategy at that time. At the meeting a framework to guide the BIC's focus on drug issues was formulated, which was aimed at considering both the demand and supply sides of drug policy. Within the framework itself, three areas were singled out in which progress was deemed to be important. Interestingly, these included a focus on the dissemination of information, research and best-practices between the members of BIC.

Noel Ahern the Minister of State with responsibility for the drugs strategy, who took over the brief after Eoin Ryan, has pointed out while endorsing drugs as an area of BIC's work that:

> "The British-Irish Council provides a unique opportunity to share information, ideas and experience in order to develop our policies on this critical issue for all members."[15]

His comments are reflective of the potential for the exchange and cross-fertilisation of best-practice immanent in the BIC's work, as well as the importance placed on drug issues by the Irish Government. The impression being created by the Irish Government in Council of the necessity of carrying out research and encouraging information exchange is borne out by the reality of developments arising from the BIC. For example, between October 2002 and April 2003 the first all-Ireland drug prevalence survey was carried by the Republic of Ireland's NACD and Northern Ireland's Drug and Alcohol Information and Research Unit (DAIRU) at the Department of Health, Social Services and Public Safety (DHSSPS). The survey, which was administered using an EMCDDA designed questionnaire and sampled 8,442 individuals, was a direct result of the BIC's attempts to foster cross-border/Governmental research endeavours.[16] In considering the potential for exposure to innovative policies it is also interesting to note, in the context of collaborative projects involving British and Irish drug policy structures, that the DHSSPS had started to make moves towards increased integration between licit and illicit drug policies. Principally, this can be seen from their launch in May 2006 of their *New Strategic Direction for Alcohol and Drugs 2006-2011*.[17]

The structure of BIC and the professed aims of its work bear a close resemblance to a number of the different models of how research interacts with policy. In particular, the Council can be seen as a forum where a range of policy measures are presented, analysed and drawn upon by the members. This type of policy interface represents the dynamic search for information discussed in the search route sub-type of the problem solving model of the research / policy interface set out in chapter one. In this model policy makers are seen as consulting a wide array of information from different sources in order to help formulate positions, and one of the resources they use is international forums. Chiefly, because such arenas allow them to gain insights into the work of how other administrations deal with the same sets of problems and what they are considering trying out.

Generally speaking, the British Government has adopted a favourable stance on the utilisation of harm reduction measures in its drug policy and treatment system since the 1980s. As a result the atmosphere within BIC, in terms of its constituting a social establishment, has been influenced by their policy stance on such issues. One of the main reasons for this influence being that the British Government is the most politically powerful player in the BIC as a result of its international economic and political power. Consequently, the BIC can be seen as a forum favourably disposed to the use of harm reduction in drug policy as a result of the stances of its key players on such issues and this is a policy environment in which the Irish Government has been continuously involved. As we have seen in chapter three, the pro-harm reduction view is clearly the leading norm throughout the EU, let alone the BIC. The extent to which similar international policy forums function to create circumstances within which Governments feel pressure to sound their agreement with harm reduction can be seen in the functioning of the Pompidou Group (PG) of the Council of Europe.

As previously mentioned, the Irish Government has been involved with the PG since the early 1980s, when the Health Research Board began participating in the Multi-City Study on drug prevalence aimed at developing indicators for epidemiological monitoring systems. One role in particular that the Irish Government has played in the PG allows us to consider how policy makers here have been exposed to an array of harm reduction measures and how they in turn can be reasonably assumed to have felt pressure

to support such strategies – the presidency of the PG. Established in 1971 and incorporated into the Council of the European Union (COE) in 1980, the PG is an inter-Governmental body focused on the utilization of research in drug policy through the creation of a multidisciplinary dialogue and discussion forum. As part of its working structure the PG holds a Ministerial conference once every three years, at which it reviews progress made in achieving its programme of work and sets out objectives for the years ahead. This meeting also functions to mark the start and the end of the presidency of the PG.

Between 2000 and 2003, the Irish Government held the presidency of the PG and its term of office came to an end on the occasion of the 13th Ministerial conference. The high-level gathering was held between the 16th and 17th of October 2003 in Dublin Castle and was attended by representatives from the PG's 34 member countries. The importance of the session can be gleaned from the range of speakers present, which included the Secretary General of the Council of Europe, the European Commissioner for Health and Consumer Protection, and the Executive Director of the UNODC. In his opening speech to the conference the Irish Minister for Health and Children, Micheal Martin, who had been Chairman of the PG during the Irish presidency, drew attention to the important work of the PG. In particular, he emphasised the role played by the inter-Governmental body in facilitating the diffusion of knowledge and best-practices related to drug policy among its members, and in doing so he asserted that this had been an important influence on Irish drug policy.[18] The Minister's words displayed the extent to which support must be verbalised, regardless of whether it is acted out, so that an appropriate impression can be created of a Government's stance.

The conference was focused on the theme 'New Challenges for Drug Policy in Europe', and it presented a range of information that allows us to consider the type of interaction between research and policy that was being encouraged by the PG. Among the sub-themes that the sessions looked at were the issue of polydrug use, the integration of policy, practice and science through evidenced-based policies, improving coordination efforts within and outside of the EU, as well as the overall role of the PG.[19] Illuminating these themes the PG had commissioned papers from consultants on topics including *Polydrug use – the use of drugs in combination*, *Treatment and care issues related to*

polydrug use, and *Public health policy in evidenced based management of drug addiction*. During the period under review at the conference it was noted that a number of seminars had been organised by the group, the results of which were disseminated through publications, on issues such as drug use and prisons, drug courts, harm reduction, and substitution treatments.[20] The meeting also examined the work programme that had been carried out under the Irish Presidency. In this sense developments were considered under the four 'fields' around which the PG's actions were structured, which included research and epidemiology in field one and treatment, rehabilitation and the social aspects of drug abuse in field three.[21] Overall, the conference's focus on expanding the use of epidemiology and examining changes in the both types of drug use and the interventions aimed at providing treatment, shows us how the PG has attempted to create a forum within which the leading views are supportive of research based decisions and strategies.

While the range of issues covered in the conference's technical materials and the PG's work programme revealed the atmosphere of support for the integration of research and policy, there was also a significant level of support for harm reduction at the conference. This can be seen from the comments made by the European Commissioner for Health and Consumer Protection, an Irish man named David Byrne. While the Commissioner's brief address covered a number of aspects related to demand and supply reduction issues, it devoted a large amount of space to showcasing the Council of the European Union's 2003 recommendation on harm reduction measures, which was discussed in chapter three.[22] In this sense, he noted the primary aim of the recommendation and the actions it supported was to reduce the spread of blood borne viral infections such as HIV, and that the interventions being backed were both commonly found among the EU Member States and well evaluated.[23] There has been a broad level of support within the PG generally for harm reduction measures and at the conference the discussion of issues in the technical files prepared for it was at the vanguard of drug policy formulation. Accordingly, it would be hard to envisage a situation in which the Irish presidency would not have backed such measures.

It is also worth noting the manner in which the PG's engagement with research in their endeavours to promote its use in policy can be viewed as performing an 'enlightenment function' – in terms of the research/policy interface models set out in

chapter one. In essence, while research builds up on a particular issue or intervention slowly before it has a wide impact, forums such as the PG facilitate the emergence of a 'threshold of awareness' in support for such strategies through their popularisation of and support for them. This can be seen as adding to the cumulative impact over time of the ideas and approaches engendered by research. Given the Irish Government's longstanding engagement with the PG and the need to be seen to be in sync with international best practice, the PG can be seen as having had an influence on policy development in Ireland. In essence, it represents one channel through which policy makers continuously came into contact with a range of information on policy, treatment and research.

This view of research and policy information acquisition was supported by Jimmy Duggan, a Principal Officer in the DoHC who had been centrally involved in developments related to the scale-up in MMT during the years studied and, *inter alia*, the NACD, NDST, prison healthcare policy, and the development of the 2001 drugs strategy.[24] He felt that the PG's work, like that of other EU and UN bodies and the work going on in other countries, had been important during the formative years of developing the treatment system.[25] Essentially as at this time there was a limited amount of indigenous research on the issues being looked at and as such policy makers were looking to and influenced by international forums and bodies with the PG being a longstanding structure into which they had been effectively connected for information networking.[26] The following section looks at the influence of EU policy forums and social tensions at the national level in the Government's efforts at managing impressions of its drug policy actions.

Success and Failure

One of the other high-level international forums that the Irish Government is involved in where drug issues arise is the European Council, and more specifically, the presidency of the Council. The European Council is the six monthly summit held for the heads of EU Member's States' Governments, the presidency of which rotates between them. Many Governments set out to prioritise particular issues during their holding of the presidency

and drug issues have been one of the policy areas focused on by the Irish Government. In the second half of 1996 the Irish Government held the presidency for the fifth time and during this period it presided over the creation of a number of important international developments on drug policy culminating in the Dublin Summit from the 13th to the 14th of December. This part of the chapter discusses the role of EU policy forums and social tensions at the national level in placing pressure on the Government to create a particular impression of its drug policy actions.

Broadly speaking, the presidency aimed at establishing initiatives in the areas of demand and supply reduction as well as international cooperation.[27] In the area of demand reduction the presidency presided over the adoption in November 1996 of the *Community Action Programme on the Prevention of Drug Dependence in the Field of Public Health*, the first such EU action plan, by the Health Council and the European Parliament.[28] On the supply side of policy, the presidency oversaw the inception of the European Union Customs Information System and the signing of the EU Convention on extradition in Dublin in September, as well as introducing measures against drug tourism, and domestic cultivation.[29] Among the other high-level initiatives that the Irish Government created during its presidency was a seminar on the *Prevention of Urban Delinquency linked to Drug Dependence*, organised in conjunction with the European Commission and Parliament in Brussels in November.[30] Overall, the Irish Government created a favourable impression among the EU Member States with its handling of drug issues, and their efforts were positively endorsed by the Drugs Expert Group (now the HWPD) at their meeting prior to December's summit in Dublin.[31] However, we can best see the Government's effort to manage impressions of its work at both the international and national levels, and their success and failure to do so, from one event in particular – the seminar and citizens' hearing.

As part of the Irish Presidency a two day event, consisting of a seminar and a citizen's hearing, was held in conjunction with the European Commission and the Department of Justice on the 5th and 6th of November 1996. The gathering, which took place in Dublin Castle, was aimed at showcasing the actions being taken by the EU on drug issues and creating an increased level of awareness of these efforts amongst politicians, administrators and the general public.[32] The extent to which the occasion was

aimed at fostering a positive impression amongst the public in particular can be gleaned from the Moderator's introduction, in which the journalist Brian Farrell stressed how the seminar and hearing would illuminate for the public the good work being done.[33] The importance of the event can be seen from the wide range of representatives in attendance, which included individuals from over twenty countries, the European Parliament, the European Commission, and the Irish voluntary and community sectors.[34] An array of different speakers addressed those present, including the Director of International Coordination Secretariat General of the European Commission, the Coordinator of the Europol Drugs Unit and the German Ministry of the Interior.[35] In addition, a presentation on the EMCDDA's annual report on the epidemiology of drug use was made by Georges Estievenart, the institution's executive director at the time.[36] Following on from the talks that were given a series of three workshops was held on the reintegration of young drug users, cooperation at the national level, and drugs in society.[37]

The event was opened by the Minister for Justice at the time Nora Owen, and her opening speech typified the Government's efforts to create a favourable impression of their policy work at both the international and the national levels. Symbolising the importance that the Irish Government had placed on international drug policy during its six month presidency, the Minister devoted a large amount of her address to initiatives instigated prior to the conference. Among these were the Presidency's hosting of the Justice and Home Affairs meeting at which the EU Convention on Extradition was signed, its work in strengthening EU borders against drug traffickers, and expediting the introduction of the full Europol Unit. She also noted how the Irish Government was actively pursuing the extension of agreements aimed at controlling the trade in precursor chemicals and that the internationally focused supply side 'Dublin Group', created during the fourth Irish presidency in 1990, had met a week earlier.[38] Further epitomizing her efforts to give a favourable impression to the representatives from other countries and the EU present, the Minister went on to note that September had seen Ireland ratify the 1988 *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.[39]

Highlighting the increased pace of drug policy developments at the national level, the Minister also focused her address on some of the new measures created by her Government, in part to generate a positive impression amongst the representatives from

the community and voluntary sectors present. In this sense, she actively showcased the establishment of a range of criminal justice measures including the setting up of the Garda National Drugs Unit, the Criminal Assets Bureau, increases in the number of Garda and the initiation of *Operation Dochas*, which targeted street level drug dealing. In addition, Mrs Owen briefly outlined some pieces of legislation that had been enacted, such as, the *Proceeds of Crime Act*, the *Criminal Justice Act*, and the *Disclosure of Certain Information for Taxation and Other Purposes Act*. She also drew attention to the Task Force's report and the structures that had been recommended in it, including the Local Drugs Task Forces (LDTFs). Reflecting the impact of the SMI on the way in which drug policy had started to be characterised in 1996, the Minister made extensive reference to drug issues as being cross-cutting issues. In particular, she noted how the management of drug policy at the national level defied neat compartmentalisation and involved a whole host of Government departments.[40]

The Minister had clearly outlined a number of positive developments at both the national and international levels to support her attempt to *give* a good impression of the Government's track record on drug issues. However, the way in which her words were received, that is, the impression she *gave off*, shows us the animosity that existed at the local level towards the statutory response to drug problems at the start of the period under study. This air of hostility was typified by the input of a number of representatives from the community and voluntary sectors who were present in the audience. In particular, Sheila Fogarty, a representative from Dublin AIDS Alliance, the Inter Agency Drug Project and the Green Party Health Committee, questioned the Minister in a way that functioned to undermine and destabilise the impression she had been attempting to create. Mrs Fogarty pressed the Minister for Justice to know whether the Cabinet Drugs Committee's work would be open to those in the community and voluntary sectors or would be kept confidential, ultimately masking the way in which the problem was being handled.[41] Given the array of high-level international guests at the event it was not surprising that her question was met with a rather evasive response from Mrs Owen. The Minister started by discussing the other structures recommended by the Task Force and the cross-cutting nature of coordinating drug policy before eventually asserting:

> "So you have no fear of not getting any information out of the policy group. And perhaps, because this is such an international Conference here, getting into very strong detail about those structures may well be of not huge interest to all of the people here."[42]

The Minister's was obviously unhappy at having the 'example-setting' structures she had outlined tarnished in front of an international audience that she had earlier asked to examine their own structures so as to ensure they adequately facilitated power flows from top to bottom. However, undeterred by Mrs Owen's detour through the structures of the drugs strategy and taking another question, Mrs Fogarty interrupted the Minister to demand an exact answer to her question. At which point, the Minister for Justice confirmed what had been obvious as a result of her diversion, that the CDC's work would be confidential, as are all Cabinet level discussions.[43]

The sense of acrimony amongst the community and voluntary sectors towards the Government's responses to the drugs problem, and the distance that official effort would have to travel before they could create an impression that things were being adequately handled, can also be seen from the words of a community worker from 'Addiction Response Crumlin' at the event:

> "We ignore it for too long. And only that there were a couple of killings here within the last couple of months, we would still be ignoring it. There is no point in putting your head in the sand. We have seen kids in the inner city die at the age of 16 and 17, hang themselves because of their addiction because no one gave a shit. Now we are seeing it because a journalist gets murdered, I am very sorry for her, and a Garda gets murdered and then every politician wants it to be known that they are doing something about the drugs problem. In 6 months time when the murderers are caught, will we be forgotten about again, once more?".[44]

In one sense the impression that various Governments have *given* over the years, as we saw in chapter four, through the creation of various committees to examine drug issues, was that they cared and were managing the problem.[45] However, the impression that their actions have *given off*, in the sense Goffman discusses, has also been one tarnished at times by elements of inaction and mismanagement.[46] In considering the antipathy towards the statutory response expressed at the citizens' hearing, a case in point would be

the length of time between the 1983 SGTFDA's call for the designation of problem areas as CPAs and the eventual creation of such a response in the form of the LDTFs in 1996. The main mechanism that has been used to turn the negative sentiment typified by the above comment around has been the creation of the national drugs strategy and structures to deliver it. In chapter eight we will, *inter alia*, explore the extent to which these structures have been successful. In the following section we will observe the extent to which drug issues have, since this time, been prioritised by Government and linked into a range of other social policy areas.

Drug Policy and Social Policy

While drug policy has taken on an increased level of sophistication in both its expression in national drug strategies and the range of measures being created, it has also branched out into many other areas of social policy. The last two sections of the chapter look at how drug issues have diffused throughout Irish social policy generally. In order to observe the extent to which drug issues have been incorporated into a number of policy areas the analysis focuses on four broad genres of social policy in Ireland. In the present section the discussion begins by firstly examining the agendas Governments have set themselves through their election manifestos. It then moves on to discuss drug issues in their agreed programmes for Government. The final section of the chapter starts by shifting our focus to drug issues in relation to socio-structural policies such as the Social Partnership Agreements. After this the discussion centres on healthcare policy generally, including health promotion policy, HIV/AIDS policy and mental health policy. Following this, our analysis will rest on how drug issues are discussed in social inclusion policy, in terms of anti-poverty and social exclusion policies.

One of the key impacts that the SMI has had on social policy generally has been to foster an environment where policies are framed in increasingly interconnected ways. Considering that drugs policy was one of the first areas to have SMI 'applied' to it, it is perhaps unsurprising that it has also been incorporated into a range of other policy areas. In this respect it is worth pointing out that many of the policies covered in this section share structural similarities. Particularly in relation to the use of consultants, the holding

of consultative forums with the public and the mapping of their contents and the measures of their progress onto targeted actions and key performance indicators, as well as specifying who is responsible for carrying out each aspect of policy. As with drug policy, Irish social policy generally has been greatly influenced by the SMI in terms of its being a structuring structure.

The different pre and post election agendas that have been adopted by Governments allow us to see the type of impression they were keen to give of their ability to manage drug issues and the degree of importance accorded to this policy area. While Governments frequently launch a number of different pre-election policy documents covering key areas, in addition to their general manifestos, 1997 was significant for Fianna Fail, in that, they devoted a whole document over thirty pages in length to the topic of drug policy. Perhaps the political significance that drug issues had taken on can be seen from the number of areas covered in *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium*. Flavoured by the critical nature of being a party in opposition, though this changed in the summer of 1997 when Fianna Fail and the Progressive Democrats took and held power for the remainder of the period under study, the document criticised existing policy.

Among the issues Fianna Fail focused on were the structures implemented to manage drug policy. These arrangements were seen as being isolated efforts, born out of the 1996 Task Force's work, which was in turn characterised as hectic and the result of panic induced by the sense of crisis and outrage over the drugs problem that existed in 1996.[47] Throughout the document, the position was adopted that the arrangements for delivering drug policy were not handling the matter effectively as a cross-cutting issue. In critiquing this alleged scenario it was asserted that Fianna Fail would ensure an integrated approach was adopted, involving all departments and state agencies.[48] Irrespective of the criticism expressed in relation to the Task Force's work, Fianna Fail maintained the basic structural arrangements that had been put in place in 1996, though they made a number of modifications. *A Radical Approach to Drugs* went on to discuss a range of issues in great detail. Among these were the underlying causes of drug use in social exclusion, the need to acknowledge the links between licit and illicit drug use, the importance of carrying out research, the role drug courts could play, and the need to further involve the community

and voluntary sectors. We can cull the intensity that drug issues had gained in Irish politics from one area that Fianna Fail focused on extensively, the role of drug treatment.

Throughout their position paper, Fianna Fail framed the use of drug treatment as a case of being for or against the use of methadone maintenance (MMT). In this respect, they attacked the Government's policy as overly reliant on the use of MMT and interpreted this as a tacit acceptance that little could be done to halt the drugs problem.[49] To this end, they asserted that MMT was only useful as a form of treatment in the short-term and that it ultimately had to be recognised that it inhibited users from becoming drug free.[50] In criticising existing policy and setting out their own agenda Fianna Fail adopted the view that drug treatment should be predominantly abstinence-orientated, based on detoxification and aimed at rehabilitating users. Accordingly, they stressed that while MMT would play a role in the overall treatment system it would be subordinated to the aforementioned elements and its long-term prescription to individuals would be limited to five years at which point it would have to be reviewed.[51]

However, despite the harsh tones resonating from the paper about the use of MMT, there was also a clear acceptance of its merits by Fianna Fail. In part, this acknowledgement of the important role MMT was already playing and had to fulfil in the future was evident in their assertion that the mobile clinic operating in Dublin's city centre was a positive development that needed to be further examined. Similarly, the support they expressed for the use of primary care to deliver MMT and the extensive discussion they provided of this development revealed their implicit support for MMT.[52] Perhaps what was most significant about their discussion of treatment, and the existence of the document itself, is its being indicative of the importance drug policy had acquired in Ireland. The creation of such a pre-election position paper was deemed a political necessity in order to give concerned sections of the electorate the impression that Fianna Fail possessed the ability to competently handle the problems linked to drug use.

1997's general election saw Fianna Fail form a coalition Government with the Progressive Democrats and after they entered into office their desire to give the impression that drug issues were being taken seriously was evident in their high-level strategy statements. Accordingly, the five year agenda for the Government's term of office launched in 1998's, *Action Programme for the Millennium*, identified drug issues

as being one of the key concerns of the general public along with crime and the construction of an inclusive society.[53] Within the action programme, the use of and trade in drugs was identified as being one of the main causes of crime in Ireland. In this sense, it was asserted that drug use and its associated crime would be dealt with by a strategy focused on prevention, education, detoxification and rehabilitation, reflecting the tone of *A Radical Approach to Drugs*. The document went on to identify the use of criminal justice based measures, such as Operation Dochas and the role of drug courts, at the expense of discussing treatment in a detailed sense.[54]

The sustained level of importance that drug issues had taken on is also evident from their continued inclusion in the progress reports designed to monitor the implementation of *Action Programme for the Millennium*. In their first review of the action plan the Government continued to downplay the role of MMT and stressed that more resources would be put into the development of residential care aimed at successfully rehabilitating users. They also went on to note that the national drugs strategy was being reviewed and that all Government departments would be following an integrated approach to managing drug issues.[55]

In later progress reports, the discussion of drug policy had started to broaden out to showcase the existence of the LDTFs, the National Drugs Strategy Team, and the Criminal Assets Bureau. In 1999 their discussion of the funds from the National Development Plan being delivered through the YPFSF and the expansion of treatment facilities for heroin users had stated to be framed within the overarching context of regenerating the urban environment.[56] The final progress report before the general election in 2002 indicated the importance the Government placed on creating an impression internationally that it was active against the spread of HIV. In this sense, it drew attention to the fact that the Taoiseach had headed the Irish delegation attending the UNGASS on HIV/AIDS in the summer of 2001 where an increase in Irish Government spending of 30 million in US Dollars on international HIV/AIDS measures was announced. Given the increased political focus on HIV and the need to tackle epidemic disease, it was perhaps unsurprising that the national drugs strategy was discussed as playing a key role in the delivery of health services at the national level.

2002 saw the Fianna Fail / Progressive Democrat coalition contest their second general election together after coming to power in 1997. At this time a more intense and clearly visible managerial approach to drug policy had started to be adopted, particularly since the launch of *Building on Experience*, and as a result it had also come to be a consistent feature of high-level Government policies. This can, in part, be seen from the discussion of drug issues in the Fianna Fail pre-election manifesto *A Lot Done. More to Do*. The section of the policy guide that dealt with the drugs arena outlined the framework of the Government's response as being based on the four interlinked pillars of prevention, supply reduction, treatment and research. This represented a departure from the way policy was framed in *A Radical Approach to Drugs*, as it considered policy as consisting of an even division of labour between these four areas, reflecting the structure adopted in the 2001 drugs strategy. In addition, the document asserted that *Building on Experience* was the most thorough and well coordinated drug policy endeavour undertaken in Ireland.[57]

The manifesto showcased a number of developments that revealed the Government's desire to be perceived as competently handling the drugs area. While reaffirming that the thrust of efforts was aimed at heroin use and the tackling of social exclusion, the document drew attention to some of the financial investments that had been made. In this respect, it was noted that over Euro 280 million had been targeted at disadvantage areas through the YPFSF and the Revitalising Areas through Partnership Investment and Development (RAPID) programme.[58] The area of drug treatment was also singled out for discussion, and Fianna Fail's comments showed the extent to which their ideological stance on the issue had shifted. Whereas in 1997 they appeared reluctant to accept its role in the drug treatment system, in 2002 they drew attention to the fact that under their leadership the number of treatment slots for MMT had doubled to more than 6,000 places.[59] Displaying the now acceptable nature of such harm reduction measures, they went on to note how Ireland's MMT network was quite sophisticated by international standards, and declared that it would be further expanded so that a place could be offered to everyone coming forward for treatment.[60]

As had been the case in 1997, Fianna Fail and the Progressive Democrats produced a five year agenda upon re-entering office, and the *Agreed Programme for*

Government Between Fianna Fail and the Progressive Democrats and its progress reports continued to hold drug policy as a key area of concern. The programme restated that drug policy would continue to be focused on heroin use as a result of its causing the most harm to individuals and society. In relation to prisons, it was asserted that a new strategy would be devised and implemented to end the use of heroin in the state's detention centres.[61] While a strategy was eventually released in 2006 its continued restatement in the programme's annual reports allows us to see that while the inclusion of drug issues in such documents is significant, the content is often repeated and static.[62] Similarly, the programme for Government allows us to observe the sustained focus on epidemiology and its use in policy. In particular, the Government had asserted that it would create an early warning system to track the geographical spread of heroin use throughout the country.[63] This issue was touched on each year in a manner that revealed a low level of action had occurred until the 2005 progress report noted that the NACD was in the process of developing a Drug Trends Monitoring System (DTMS) to achieve this aim.[64]

The extent to which harm reduction practices had become not only an acceptable, but a core feature of drug policy can be gleaned from the programme's discussion of treatment services. For example, in the 2004 progress report it was noted that there had been an increase in the numbers of GPs and pharmacists involved in delivering MMT in the primary care / community setting to 309 and 298 respectively.[65] While the 2005 annual report noted the Government's intention, on the back of the mid-term review of the national drugs strategy, to expand the number of needle and syringe programmes (NSPs) in operation.[66] The showcasing of such characteristics of and designs on the treatment system in a high-level document allows us to see the way in which the Government was actively concerned to create a favourable impression of its development of services for drug users.[67] The following section looks at the way in which drug issues have spread throughout a range of other areas of social policy during the time studied.

The Diffusion of Drug Policy

This portion of the chapter discusses the extent to which drug policy issues can be seen as having become part of a number of other areas of social policy. Specifically, it looks at their inclusion in Social Partnership Agreements, healthcare policy generally, HIV/AIDS policy, mental health policy and social inclusion policy. The sustained importance of drug issues for Irish policy makers can also be observed in some of the macro level socio-structural policies that have been created during the period under study. Between 1996 and 2008 four social partnership agreements were launched, representing the fourth, fifth, sixth and seventh such agreements adopted since 1987's *Programme for National Recovery*. Broadly speaking these agreements have been aimed at improving the economic development of Ireland by making the economy competitive in a global context and improving the standard of living in Ireland, as well as forging a more inclusive society. To this end, Governments have held negotiations with various sectors of Irish society, typically including employers, trade unions, farmers, and the community and voluntary sectors, to agree objectives for micro and macro economic social policy in the years covered by each respective agreement. The overarching aim being that these agreements will bring stability to the country thus aiding its economic growth, which will in turn benefit society as a whole. One characteristic that these policies – *Partnership 2000*, *Programme for Prosperity and Fairness*, *Sustaining Progress*, and *Towards 2016* – had in common was that they all contained some form of discussion on drug policy.

Given the focus on improving the quality of peoples' lives in social partnership agreements and the overtly acknowledged links between socio-economic disadvantage and drug use in Government policy, it is perhaps unsurprising that drug issues were touched on in these agreements. *Partnership 2000* looked at drug issues briefly within its overall discussion of reducing social exclusion within Irish society, essentially asserting that allowing disadvantage to grow would contribute to, *inter alia*, increased levels of drug use.[68] The agreement also went on to showcase the shift occurring in how Government was now responding to drug use at the local level in the areas most affected through the creation of the LDTFs and the establishment of community-based treatment services.[69]

The first social partnership agreement forged under the Fianna Fail / Progressive Democrat coalition Government, *Programme for Prosperity and Fairness*, continued the trend of discussing drug policy in relation to poverty and urban disadvantage. In this sense, it pointed out that the LDTFs were being kept in operation and that the YPFSF was supporting the redevelopment of areas where children were considered to be at risk of drug use. The agreement also noted that the overall strategy was being reviewed and that drug treatment services were being expanded.[70] In particular, later progress reports on the agreement stressed the creation of *Building on Experience* and its SMI-styled attributes, such as its use of clearly defined actions, objectives, and the four integrated areas within which results were to be achieved.[71] Also, the degree to which the Government had begun to openly embrace harm reduction and create the impression that it was using innovative healthcare approaches to treating drug use were visible from their follow-up reports, which focused on the expansion of MMT and HIV/AIDS services.[72]

The focus on drug policy within the social partnership agreements created during the period under study received a significant amount of attention in 2003 when *Sustaining Progress* was launched. One feature of this partnership's structure marked it out from its predecessors and successor, namely its inclusion of a 'special initiatives' area. The topics discussed in this part of the agreement were all characterised as being cross-cutting issues that required an integrated response from a range of state and non-state actors.[73] Significantly, both the reduction of alcohol and drug-related harms to health were targeted as one of the ten special initiatives.[74] In assessing the progress made in achieving the special initiatives it was noted that the main mechanism being used to reduce drug related harm was the national drugs strategy.[75] Accordingly, the progress reports discussed the role of the CCSI, the LDTFs, the RDTFs, the launch of the Critical Implementation Path for the strategy's 100 actions, as well as the expansion of treatment services and the level of expenditure under the strategy.[76] Similarly, the two reports produced by the Strategic Task Force on Alcohol (SGTFA) were also discussed by the special initiatives reviews, as was the carrying out of lifestyle surveys aimed at informing alcohol policy making. It was also asserted that the STFA reports would be used to create a successor to 1996's National Alcohol Policy, though this never materialised.[77] While the 2004 progress report noted that *Building on Experience* made provision for the

formulation of linkages between alcohol and drug policies, it did not mention that this was mainly in the area of prevention.[78] However, the 2005 review made the more critical observation, on the back of the mid-term review of the national drugs strategy, that interaction between licit and illicit policies had largely been hindered by a lack of comparable structures.[79]

Unlike its immediate forerunner *Towards 2016* did not contain a special initiatives section and it adopted a slightly different structure for the agreement. While it contained extensive sections on macro and micro economic policy it also discussed the impact of the agreement in terms of a 'lifecycle approach'. This essentially revolved around grouping individuals according to their being children, people of working age, older people, and individuals with disabilities. Drug issues emerged within the context of both young people and people of working age's lives. In terms of the former group, drug issues were only briefly mentioned, focusing on intervening as early as possible in the lives of children suffering from socio-economic disadvantage as a result of drug use being a key risk associated with deprivation.[80] When it came to discuss people of working age, particularly young adults between 19 and 29, the agreement began by reaffirming the approach adopted in the national drugs strategy, before noting how this was now being modified to include a new pillar focused on rehabilitation. In emphasising the SMI-style features of the policy, principally its being subjected to a re-orientating mid-term review, the document also asserted that the Department of Health and Children was examining how the national drugs and alcohol strategies could be better coordinated. The presence of drug policy within social partnership agreements is indicative of the importance drug issues had taken on and the extent to which they had diffused throughout other types of social policies.

The increased level of importance attached to drug policy is also evident in a number of aspects of healthcare policy, in particular, general health policy, health promotion policy, HIV/AIDS policy and mental health policy. Launched in November 2001 *Quality and Fairness: A Health System for You* was, like the national drugs strategy, the most comprehensive strategy in its arena created up to that date. The policy was aimed at setting out in detail how the health services would be invested in and structurally reformed, and it bore a number of similarities to *Building on Experience* in

terms of its adhering to the ethos of the SMI.[81] For example, in formulating the policy a large-scale consultation process was held with the public called the National Consultative Forum on the Health Strategy, as had been the case with the national drugs strategy's regional discussion forums. The public consultations also resulted in the publication of a document entitled *Your Views about Health*, representing the Government's desire to foster the impression that the public's views were helping to drive policy design.[82] As part of this process over 1,500 written and 300 oral submissions were received.[83]

Also in a similar vein to the drugs policy, *Quality and Fairness* was designed to approach the health area as a cross-cutting initiative requiring multi-departmental and multi-sectoral collaboration in order to achieve its goals. As we will see below, this was an attribute that can be seen as partially helping the inclusion of drug policy in other aspects of the healthcare arena. Its goals were, like *Building on Experience's,* designed to run over a ten year period, reflecting the tendency for such policies to stretch over increasing lengths of time.[84] Among the other similarities that the 2001 health strategy bore to the drugs policy launched the same year were its conceptualisation of ill health and the risk of disease as being clearly linked to an individual's socio-economic status.[85] Such a view represented a clear compatibility with the acknowledgement of the social and physical environments' roles in generating drug use.

The influence of the SMI was clearly evident in the way the health policy had been formulated, particularly in relation to its stressing how the strategy was going to be implemented, monitored, evaluated and reported upon according to a range of targets.[86] In this respect, *Quality and Fairness* identified four goals, the first of which, 'better health for everyone', was in turn underpinned by four objectives. Among these was the aim that 'health inequalities are reduced', and this intention was, in part, regarded as being fulfilled by the national drug strategy through its focus on improving the health of drug users through the improvement of the drug treatment system.[87] In this sense, *Building on Experience* was also noted as being a key part of the overall strategic development of health services along with the National Health Promotion Strategy 2000-2005.[88] Given the drugs strategy's development of local treatment and policy structures and the health strategy's aim to reform and expand primary care a clear contextual

synergy between the policies can be seen in terms of the overall shift towards the delivery of services in the community setting occurring at this time.

While the national drugs strategy was regarded as fulfilling the requirements of action 22 in *Quality and Fairness*, the National Health Promotion Strategy was also seen as a key strategy in the delivery of healthcare policy. In this respect, it was discussed as meeting the requirements of action 5 in the strategy.[89] Reflecting the influence of international policy on Irish social policy, part of the impetus for the National Health Promotion Strategy arose out of Ireland's obligations from the Mexico Ministerial Statement for the Promotion of Health agreed at the fifth Global Conference on Health Promotion in the summer of 2000.[90] Like *Building on Experience* and other policies from that time, the strategy's tone resonated with the ideas that epitomised the SMI. In particular, it clearly set out strategic aims and objectives, as well as stressing the need for cooperation in and between different departments and sectors in order to achieve its goals. Similarly, the importance of carrying out research, monitoring the implementation of the strategy and evaluating its results was asserted as being critical to its overall success.[91] Reflecting the importance placed on the interplay between research and policy in the drugs strategy, it also called for policy to be based on evidence and adopt best practices.[92]

The National Health Promotion Strategy made reference to drug policy in a number of ways that allow us to see how these two areas were interconnected. In the same way that drug policy had progressively come to accept the influence of factors other than the individual's choice to use, the health promotion strategy adopted the view that a range of factors impacted upon health. In this sense, the social and economic environments were conceptualised as being key influences on the determination of health.[93] One of the most significant changes in the delivery of drug policy since 1996 was the increased involvement of local communities in the strategy, principally through the LDTFs. In stressing the importance of empowering communities to improve their health and identify examples of successful projects, the health promotion strategy made a number of references to the LDTFs as being a successful model of such involvement.[94] In discussing how substance use could be avoided the strategy discussed both licit and illicit drug use and the increasing incidence of polydrug use involving both categories of

drugs.[95] This pattern was repeated in the progress review of the health promotion strategy carried out in 2004, where it was asserted that the national drugs strategy fulfilling the requirements of health promotion in relation to substance use. In this sense, the review noted that at a regional level this was now being achieved through the RDTFs.[96]

Like the drug and health promotion policies, the National AIDS Strategy, which was designed by the National AIDS Strategy Committee (NASC), was also seen as playing a key part in the delivery of *Quality and Fairness*, in which it was discussed as fulfilling action 33.[97] The NASC was established by the Minister for Health Mary O'Rourke in December 1991.[98] Upon its inception the NASC decided to split itself into four sub-committees aimed at the care and management of persons with HIV/AIDS, HIV/AIDS surveillance, education and prevention, and measures to avoid discrimination against persons with HIV/AIDS. Their initial report in 1992 and the strategy launched in 2000 represented the consolidated work of these sub-committees. The NASC's first report pointed out that there was a clear link between areas characterised by socio-economic deprivation and drug use on the one hand, and HIV/AIDS on the other. Accordingly, they identified IDU as the main transmission route for the spread of HIV and Dublin's inner city as the geographical hub of the epidemic.[99] As a result of this the committee called for the implementation of a range of harm reduction measures and the decentralisation of treatment services to the areas worst affected. To this end, they drew attention to the 1991 *Government Strategy to Prevent Drug Misuse* as being in support of such a reorganisation of services.[100]

By the time the NASC came to produce the National AIDS Strategy in 2000 drug policy issues had become a central concern in their work. In supporting and furthering the claims that they had made in 1992, the committee stressed in great detail the interconnection between IDU and HIV.[101] In this sense they examined a range of data from the national virus reference laboratory on HIV relating to trends between 1992 and 1998, from which they pointed out 32 percent of cases were transmitted by IDU and this route was the main risk channel in the Eastern Health Board (EHB) area.[102] The importance of drug issues in the committee's work can be seen from their discussion of harm reduction practices. For example, they asserted that MMT and NSPs had proved themselves, as verified by epidemiological monitoring, as being key to the reduction of

HIV transmission among and from IDUs.[103] The NASC went on to discuss various aspects of the drug treatment system, such as the EHB's network of clinics, the evolution of the MMT protocol, and the need for equivalence of care between the community and custodial settings.[104] In supporting the increased use of MMT they stressed that it was internationally regarded as a successful treatment modality and that the EMCDDA's annual report for 1998 had confirmed this view.[105] Overall, the 2000 National AIDS Strategy was permeated by drug policy issues, reflecting the intrinsically linked nature of the two policy areas.

Drug issues have also been a consistent feature of mental health policy and the report released by the Department of Health and Children's Expert Group on Mental Health policy (EGMH), *A Vision for Change*, allows us to see some of the ways they have been discussed. During the period under study *A Vision for Change* was the most significant mental health strategy launched, as well being the most important policy document aimed at modernising mental health services since *The Psychiatric Services: Planning for the Future* was released in 1984. It had its origins in the 2001 health strategy *Quality and Fairness*, which discussed the need for reform in the provision of mental health services, as well as recognising the increasing pressure being placed on services by, *inter alia*, drug use.[106] Like the national drugs strategy and a great deal of policies launched in the wake of the SMI, the 2006 mental health strategy held a widespread consultation process as part of its formulation. Chiefly, this involved the holding of consultation forums with key stakeholders, receiving submissions from interested parties and – reflecting the client-centred ethos of the strategy – the issuing of a questionnaire to service users.[107] Replicating the practice adopted in the 2001 health strategy's consultation process the expert group on mental also published two documents enshrining the views expressed during consultations, reflecting the Government tendency to instil a sense of ownership in the public of the policies being formulated.[108]

In the same way that *Quality and Fairness* placed new importance upon the utilization of the primary care network to deliver services, *A Vision for Change* also reflected the move occurring in a range of policies towards the delivery of services in the community setting. Drug treatment services in Ireland gradually moved away from centralised provision throughout the 1990s and 2000s, epitomised by the increased

utilization of local clinics and primary care to deliver MMT, which is explored in chapter nine. An equivalent move towards community treatment permeated and was a central aim of *A Vision for Change*, and in this respect the role of Community Mental Health Teams (CMHTs) gained importance and was discussed in relation to a range of issues, including drug use. In this sense the EGMH asserted that the management of addiction services generally was not within the remit of the mental health system. However, it pointed out that the majority of individuals with drug use and serious mental health problems, known as 'co-morbidity' or 'dual diagnosis', should be treated by general adult CMHTs rather than in centralised in-patient settings.[109] The strategy also called for the creation of specialist CMHTs in catchment areas of 300,000 to treat individuals referred from the general CMHTs with long-term co-morbidity where drug use was the driving factor behind their illness.[110] In addition, the EGMH stressed that there should be a national policy coordinator to establish clear objectives and linkages between primary care interventions for alcohol and other drugs (AOD) and community mental health services.[111]

During the period under study a number of different policies were launched to tackle social exclusion in Irish society and drug issues have consistently arisen within the context of poverty. As a result of the consensus reached by Governments to significantly reduce poverty at the UN Summit for Social Development in March 1995, the Irish Government – reflecting the influence of international policy and the need to manage impressions – established the *National Anti Poverty Strategy – Sharing in Progress* in 1997. In addition to its being designed to run over a ten year period, a number of the features that typified policies launched after the SMI were present in the formulation of the strategy. For example, a consultation process was held to gather the views of service providers and their clients to inform the policy's construction, which was designed to operate as a cross-departmental initiative as a result of the multi-dimensional nature of poverty.[112] Echoing the work of the 1996 Task Force, the anti poverty strategy stressed that geographical concentrations of poverty gave rise to a range of social problems, including drug use.[113] Accordingly, within the context of 'disadvantaged urban areas', the creation of the LDTFs and the expansion of community based drug treatment was acknowledged in the strategy.[114]

Mirroring the influence of international policy on the creation of the anti poverty strategy in 1995, Ireland created a *National Action Plan Against Poverty and Social Exclusion 2001-2003* (NAPSincl) as a result of the 'Lisbon pledge' made at the Lisbon European Council in March 2000. The promise made in Portugal committed the EU Member States to making a significant impact on the eradication of poverty by the year 2010. The NAPSincl was designed as a cross-cutting policy initiative and in this sense it adopted a range of structures that bore similarities to the ideas of the SMI. Principally, these included the already existing CCSI, the National Anti Poverty Unit at the Department of Social, Community and Family Affairs, the Inter-Departmental Policy Committee, and the Combat Poverty Agency.[115] In discussing how the risk of social exclusion could be prevented the NAPSincl noted the creation of *Building on Experience*, and drew attention to the four pillars that its activities were based around.[116]

When the second NAPSincl was launched in 2003 the same focus on drug policy via the prevention of social exclusion was maintained.[117] In this respect the NAPSincl 2003-2005 showcased a number of the drugs strategies features, such as the funding given to LDTFs and the expansion of the drug treatment system.[118] Like the social partnership agreement *Sustaining Progress* the NAPSincl 2003-2005 asserted that drug use was being tackled through the implementation of *Building on Experience*, though it did not add any new input to the process. In a similar way it also noted that *Sustaining Progress* included drug issues as a special initiative, which as discussed above, only consisted of an assertion that drug problems were being handled through the drugs strategy.[119] While this shows us that some policy documents in other areas simplistically reiterated the existence of the drugs strategy and reaffirmed its goals as being aligned with their own designs on drug issues, it nonetheless displays how drug policy had become part and parcel of a diverse range of social policy areas. The following section presents the chapter's overall conclusions.

Conclusion

A variety of different proximal and distal influences have the potential to shape the way in which a Government responds to drug issues.[120] In this sense, national administrations face pressures from sections of the electorate that are concerned with how drug issues are being responded to, as well as their international peers in different policy making forums. The Irish Government has been involved in a number of cross-national forums either specifically aimed at drug policy making, such as the Pompidou Group, or where drug issues arise, as is the case with the British-Irish Council and the Presidency of the European Union. Such engagements can be seen as placing pressure on the Government to appear in sync with norms in policy formulation and best practices in the implementation of drug strategies and treatment systems. Their roles in these forums have functioned to expose Irish policy makers to a wide range of different approaches to managing drug issues. Such policy making environments function as another arena within which administrations strive to create a favourable impression of the way in which they are responding to drug issues.

While drugs have undoubtedly become a consistent area of concern for Irish policy makers at both the international and national levels, the period under study also saw drug issues progressively move more and more into the terrain of mainstream healthcare policy. This change in the way drug strategies came to be perceived and presented arose, in part, as a result of the HIV epidemic and the launch of the SMI, which encouraged a style of policy making where strategies in different areas became increasingly interconnected. The degree to which synergies and connections between policy areas were fostered was a direct result of the way in which social issues came to be framed as cross-cutting issues involving a range of departments and multi-sectoral collaboration. These policy areas ranged from macro level socio-structural frameworks such as the national development plans and social partnership agreements to various aspects of healthcare and social exclusion policy.

However, it is possible to detect a degree of superficiality in some of the measures adopted on drug problems in different strategies. A case in point being the way successive social partnership agreements have asserted that drug issues were being dealt with through the implementation of the national drugs strategy without adding any new

initiatives within their own frameworks. This aside, the continued inclusion of drug issues in other policy areas is both a sign and a cause of the way in which illicit drug policy became a legitimated and critical area of public administration during the period studied. This shift in the way in which drug policy and provision came to be regarded was reflected in the extent to which funding has been made available to research bodies to examine drug issues in Ireland. The following two chapters, which are concerned with the role of the ADRU and the NACD, focus in on this issue.

[1] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.109-117; Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin.

[2] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, p.231.

[3] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, p.231.

[4] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.109-140.

[5] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.109-117.

[6] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-15.

[7] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-15.

[8] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-18.

[9] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, p.18.

[10] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.4.

[11] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.4.

[12] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.4; p.5.

[13] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.10.

[14] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, pp.9-10.

[15] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.8.

[16] British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs, p.10; General information on this survey and the publications arising from it can be found at: http://www.nacd.ie/activities/population.html

[17] Department of Health, Social Services and Public Safety (2006). *New Strategic Direction for Alcohol and Drugs 2006-2011*. Belfast: Author.

[18] Pompidou Group (2004). *Pompidou Group Ministerial Conference, 'New Challenges for Drug Policy in Europe', Proceedings, Dublin, 16-17, October, 2003*. Strasbourg: Council of Europe Publishing, p.11.

[19] Pompidou Group (2004). *Pompidou Group Ministerial Conference, 'New Challenges for Drug Policy in Europe', Proceedings, Dublin, 16-17, October, 2003*. Strasbourg: Council of Europe Publishing, p.11.

[20] Pompidou Group (2003). *Activity Report 2000 – 2003, Ministerial Conference Dublin (Ireland, 16-17 October 2003)*. Strasbourg: Council of Europe Publishing, p.4.

[21] Pompidou Group (2003). *Activity Report 2000 – 2003, Ministerial Conference Dublin (Ireland, 16-17 October 2003)*. Strasbourg: Council of Europe Publishing, pp.7-9; pp.14-16.

[22] Pompidou Group (2004). *Pompidou Group Ministerial Conference, 'New Challenges for Drug Policy in Europe', Proceedings, Dublin, 16-17, October, 2003*. Strasbourg: Council of Europe Publishing, pp.23-27.

[23] Pompidou Group (2004). *Pompidou Group Ministerial Conference, 'New Challenges for Drug Policy in Europe', Proceedings, Dublin, 16-17, October, 2003*. Strasbourg: Council of Europe Publishing, p.26.

[24] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[25] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[26] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[27] EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA, p.1.

[28] EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA, p.1.

[29] EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA, p.1.

[30] EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA, p.2.

[31] EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA, p.2.

[32] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.2.

[33] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.13.

[34] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.14.

[35] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, pp.2-3.

[36] EMCDDA (1997). *Drugnet Europe*, No.3. Lisbon: EMCDDA, p.4.

[37] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.4.

[38] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, pp.16-17.

[39] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.19.

[40] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.14; pp.17-18.

[41] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.22.

[42] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.23.

[43] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.24.

[44] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, p.69.

[45] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life.* London: Penguin, pp.14-15.

[46] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life.* London: Penguin, pp.14-15.

[47] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, pp.1-2.

[48] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, p2; p.9; p.11.

[49] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, p.3.

[50] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, p.11.

[51] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, p.3; p5; p.22.

[52] Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium.* Dublin: Author, p.2; p.5; p.21; p.22.

[53] Department of the Taoiseach (1998). *Action Programme for the Millennium.* Dublin: Author, p.2.

[54] Department of the Taoiseach (1998). *Action Programme for the Millennium.* Dublin: Author, p.4.

[55] Department of the Taoiseach (1999). *Action Programme for the Millennium – As Reviewed by Fianna Fail and the Progressive Democrats in Government.* Dublin: Author, p.7.

[56] Department of the Taoiseach (2000a). *Action Programme for the Millennium – Progress Report at the End of Year Three.* Dublin: Author, p.21; p.26.

[57] Fianna Fail (1997). Fianna Fail (2002). *A Lot Done. More to Do. Fianna Fail Manifesto 2002-2007.* Dublin: Author, pp.79-80.

[58] Fianna Fail (2002). *A Lot Done. More to Do. Fianna Fail Manifesto 2002-2007.* Dublin: Author, p.80; p.81.

[59] Fianna Fail (2002). *A Lot Done. More to Do. Fianna Fail Manifesto 2002-2007.* Dublin: Author, p.80.

[60] Fianna Fail (2002). *A Lot Done. More to Do. Fianna Fail Manifesto 2002-2007.* Dublin: Author, p.80; p.81.

[61] Department of the Taoiseach (2002a). *An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.29.

[62] Department of the Taoiseach (2003a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.70; Department of the Taoiseach (2004a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.104; Department of the Taoiseach (2005a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.190.

[63] Department of the Taoiseach (2002a). *An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.29.

[64] Department of the Taoiseach (2005a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.188.

[65] Department of the Taoiseach (2004a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats.* Dublin: Author, p.104.

[66] Department of the Taoiseach (2005a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author, p.190.

[67] Department of the Taoiseach (2004a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author, p.104.

[68] Department of the Taoiseach (1996). *Partnership 2000*. Dublin: Stationery Office, p.12.

[69] Department of the Taoiseach (1996). *Partnership 2000*. Dublin: Stationery Office, p.21.

[70] Department of the Taoiseach (2000b). *Programme for Prosperity and Fairness*. Dublin: Stationery Office, p.82; p.94.

[71] Department of the Taoiseach (2002b). *Programme for Prosperity and Fairness – Progress Report 8*. Dublin: Stationery Office, pp.76-77.

[72] Department of the Taoiseach (2002b). *Programme for Prosperity and Fairness – Progress Report 8*. Dublin: Stationery Office, pp.98-99.

[73] Department of the Taoiseach (2003b). *Sustaining Progress – Social Partnership Agreement 2003-2005*. Dublin: Stationery Office, p.17.

[74] Department of the Taoiseach (2003b). *Sustaining Progress – Social Partnership Agreement 2003-2005*. Dublin: Stationery Office, pp.31-32.

[75] Department of the Taoiseach (2004b). *Sustaining Progress 2003-2005 – Progress Report on Special Initiatives*. Dublin: Stationery Office, p.73.

[76] Department of the Taoiseach (2004b). *Sustaining Progress 2003-2005 – Progress Report on Special Initiatives*. Dublin: Stationery Office, pp.75-77; Department of the Taoiseach (2005). *Sustaining Progress 2003-2005 – Final Report on Special Initiatives*. Dublin: Stationery Office, pp.78-81

[77] Department of the Taoiseach (2005b). *Sustaining Progress 2003-2005 – Final Report on Special Initiatives*. Dublin: Stationery Office, p.75.

[78] Department of the Taoiseach (2004b). *Sustaining Progress 2003-2005 – Progress Report on Special Initiatives*. Dublin: Stationery Office, pp.79-80.

[79] Department of the Taoiseach (2005b). *Sustaining Progress 2003-2005 – Final Report on Special Initiatives*. Dublin: Stationery Office, p.82.

[80] Department of the Taoiseach (2006). *Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015*. Dublin: Stationery Office, p.47.

[81] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.2; p.11.

[82] Department of Health and Children (2002). *Your Views about Health - Consultation report for the Health Strategy*. Dublin: Stationery Office.

[83] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.4.

[84] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.3; p.4.

[85] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.31.

[86] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.175.

[87] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, pp.59-61; p.69.

[88] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.44.

[89] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, pp.189-190.

[90] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, p.3.

[91] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, p.3.

[92] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, p.14.

[93] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, p.10.

[94] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, p.7; p.11.

[95] Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office, pp.57-58.

[96] Department of Health and Children (2004). *Review of the National Health Promotion Strategy 2004*. Dublin: Stationery Office, p.43.

[97] Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.194.

[98] National AIDS Strategy Committee (1992). *Reports and Recommendations of the Sub-Committees of the National Strategy Committee on: Care and management of Persons with HIV/AIDS; HIV/AIDS Surveillance (Interim Report); Education and Prevention Strategies; Measures to Avoid Discrimination Against Persons with HIV/AIDS – Adopted by the Main Committee on 13th April 1992*. Dublin: NASC, p.5.

[99] National AIDS Strategy Committee (1992). *Reports and Recommendations of the Sub-Committees of the National Strategy Committee on: Care and management of Persons with HIV/AIDS; HIV/AIDS Surveillance (Interim Report); Education and Prevention Strategies; Measures to Avoid Discrimination Against Persons with HIV/AIDS – Adopted by the Main Committee on 13th April 1992*. Dublin: NASC, p.12; p.17.

[100] National AIDS Strategy Committee (1992). *Reports and Recommendations of the Sub-Committees of the National Strategy Committee on: Care and management of Persons with HIV/AIDS; HIV/AIDS Surveillance (Interim Report); Education and Prevention Strategies; Measures to Avoid Discrimination Against Persons with HIV/AIDS – Adopted by the Main Committee on 13th April 1992*. Dublin: NASC, p.18; p.19.

[101] National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office, p.13; pp.16-19.

[102] National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office, p.13.

[103] National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office, p.20; p.46.

[104] National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office, p.46; pp.50-51; p.63.

[105] National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office, p.62.

[106] Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office, p.6; Department of Health

and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office, p.35.

[107] Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office, p.7; p.12.

[108] Expert Group on Mental Health (2004a). *Speaking Your Mind: A Report on the Public Consultation Process*. Dublin: Department of Health and Children; Expert Group on Mental Health (2004b). *What we Heard: A Report on the Service User Consultation Process*. Dublin: Department of Health and Children.

[109] Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office, p.146.

[110] Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office, p.148.

[111] Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office, p.147.

[112] *National Anti Poverty Strategy – Sharing in Progress*. (1997). Dublin: Stationery Office, p.i; p.2.

[113] *National Anti Poverty Strategy – Sharing in Progress*. (1997). Dublin: Stationery Office, p.6.

[114] *National Anti Poverty Strategy – Sharing in Progress*. (1997). Dublin: Stationery Office, p.16; p.18.

[115] Department of Social, Community and Family Affairs (2001). *National Action Plan Against Poverty and Social Exclusion 2001-2003*. Dublin: Stationery Office, p.1.

[116] Department of Social, Community and Family Affairs (2001). *National Action Plan Against Poverty and Social Exclusion 2001-2003*. Dublin: Stationery Office, p.25; pp.30-31.

[117] Office for Social Inclusion (2003). *National Action Plan Against Poverty and Social Exclusion 2003-2005*. Dublin: Stationery Office, p.9.

[118] Office for Social Inclusion (2003). *National Action Plan Against Poverty and Social Exclusion 2003-2005*. Dublin: Stationery Office, p.19.

[119] Office for Social Inclusion (2003). *National Action Plan Against Poverty and Social Exclusion 2003-2005*. Dublin: Stationery Office, p.30.

[120] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.109-117.

Chapter 6: Linking EU & National Research: The ADRU

The years analysed in the present research witnessed a notable change in the drug policy research landscape in Ireland. During this timeframe a transition occurred whereby indigenous knowledge generation on drug issues entered into a new phase of increased productivity and importance. Principally, this period was marked by a greater utilisation of research, an enhanced and broader research project agenda that gave rise to a greater diversity of work and more Irish involvement in international collaborative efforts, particularly at the EU level. The present chapter of the thesis is concerned with an examination of the work carried out by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB). In particular, this portion of thesis provides a discussion of some of the different streams of work that they completed during the years analysed and the degree to which they backed the development of treatment and harm reduction practices in it.

The present chapter is comprised of four sections. It commences with a look at the background and role of the ADRU. The chapter then discusses their engagement with the epidemiology of drug use, before moving on to a consideration of their some of the research projects with a specific harm reduction focus that they have completed. Following this the chapter presents a discussion of some of the more sensitive areas of research that they carried out work on during the period studied. Specifically, it looks at their research on the expansion of their epidemiological monitoring systems and alcohol policy.

The ADRU: Its Origins and Work

The period between 1996 and 2008 saw an unprecedented amount of government resources being devoted to research on drug issues. During this time epidemiological monitoring systems were developed and advanced, numerous research projects were carried out and working relationships were strengthened with a number of key international bodies with a role in drug research. In order to appreciate the significance of the ADRU's multifaceted output, against the background of a general dearth of indigenous policy relevant research prior to the period studied, it is necessary to consider

a number of factors. Below I examine the origins of the HRB, the evolving nature of the funding made available for healthcare research, the way HRB's work on drug issues slowly expanded, EMCDDA's influence in shaping the ADRU, and the potential its defined role afforded it to create policy relevant research.

The ADRU is one of the four research units housed within the HRB's health information and in-house research directorate, its other two directorates being focused on corporate functions and research strategies. Prior to the creation of the HRB all Government funded healthcare and drug research was carried out by two separate bodies, the Medical Research Council (MRC) of Ireland and the Medico-Social Research Board (MSRB), with the latter having the main interest in drug related issues. Established in 1937, the MRC was mainly a grant-giving body aimed at funding Irish healthcare research. While it was not until 1968 that the MSRB commenced its work, it was initially founded in 1965 by the Minister for Health Mr. Donagh O'Malley.[1] Unlike the MRC, the MSRB was not heavily focused on clinical and laboratory biomedical research, rather it was concerned with the utilisation and provision of healthcare and related problems. Another difference between MSRB and its older counterpart was its being directly in charge of the research it funded, as it was not a grant aid body. It had also been involved in epidemiological research on drug issues at the European and national levels since the early 1980s.

In 1985 the Minister for Health at the time, Mr. Barry Desmond, initiated a process of streamlining the Government's small level of investment in healthcare research through the merger of the two research bodies. Initially, this strategy was presented as merely being a possibility to the MRC, rather than a definite eventuality.[2] The MRC was against being amalgamated with the MSRB as it feared its own research funding activities would be curbed. As a result of this it proposed the creation of an overarching body to coordinate both research organisations, which would have effectively allowed MRC to function unhindered in the manner it had as before.[3] However, this was not to be as the Minister more forcefully asserted his plans to merge both bodies by informing the MRC that it could continue on as it had up until 1985, but it would no longer be in receipt of government funding after 1986.[4] While the MRC was notably bitter at its forced union with the MSRB, the latter body appeared to be much

more at ease with the situation and expressed its support for the upcoming merger in its annual report for 1985.[5] This refocusing of Government spending was a reflection of the wider economic downturn experienced by Ireland in the 1980s and the implementation of cutbacks across the public sector in general.

August 1986 saw the creation of the HRB from the merger of the MRC and the MSRB become a reality as both bodies and the Department of Health reached agreement on the establishment of the new structure.[6] Accordingly, the HRB was created under statutory instrument 279 of 1986 and had its initial meeting in January 1987.[7] Upon its inception the HRB was given a wide-ranging set of functions in health research. Among its five key tasks was the instigation of epidemiological research, to cooperate and work with international bodies in carrying out research, and to undertake any other work that the Minister for Health deemed appropriate.[8] This shows us how some of the features of the ADRU – epidemiology, international involvement, assisting Government/generating policy relevant information – have been present since the start of the HRB.

During its first year the HRB had a range of different research concerns underway. The main drug policy related research that the HRB was conducting at the time was the epidemiological work it had inherited from the MSRB, which had been involved with the European Pompidou Group (PG) since the early 1980s in developing epidemiological indicators for monitoring drug use. Certain aspects of this work such as their participation in the PG's multi-city study of drug use was showcased in their first annual report and reveals the long-term influence of Europe in supporting Irish drug policy research.[9] This was a forerunner of the work that was later undertaken by the EMCDDA.

Upon its inception the HRB had been given an expanded remit above and beyond the roles of the two bodies it arose out of, yet the extent to which it could carry out its new activities in health research and health services research were curtailed by its funding situation. The limitations that were placed on the HRB's activities before they had even begun were catalogued in its annual report for 1987.[10] In his opening comments Dr W.A. Watts, the HRB's first Chairman, noted that research was undervalued in Ireland and that money assigned to it was generally expected by Government not to yield any useful returns.[11] The financial difficulties the Board found itself in were evident in the mismatch

between the HRB's initial budget of 2.3 million Irish Pounds and the increased level of work its was supposed to be conducting. In this respect, it had to reduce the level of financial support it gave to its grant holders and research units as well as leaving staff vacancies unfilled and vacating one of its buildings on Baggot Street in Dublin City.[12]

The HRB's financial situation continued to worsen throughout the late 1980s and it was not until the mid 1990s that things started to improve in any real sense. The financial crisis that the board found itself in was reflected in its budget of 2.3 million Irish Pounds being cut by nearly half to 1.3 million Irish Pounds in October 1988.[13] The effects of this cut led to the board negotiating with Dr Rory O'Hanlon, Minister for Health, to transfer the responsibility for funding their health information systems to the Department of Health so that they could continue to function.[14] The board's work on the epidemiology of drug use was more fortunate and survived the financial crisis largely as a result of funding being made available from the European Commission and the PG to help establish the Dublin Drug Treatment Reporting System.[15] At that stage their epidemiological work was the mainstay of their work on drugs in general, as a full unit devoted to drug issues had not quite come into being.

The HRB's financial situation started to improve in the 1990s, though it took most of the decade before it received a significant increase in support. The board's budget grew in an incremental manner, for example, it rose by 300,000 Irish Pounds in 1990.[16] In 1991 their budget increased by 23 per cent to 1.6 million and again by 6 per cent to 1.7 million in 1992.[17] In 1993 the Minister for Heath Mr Brendan Howlin announced that the board's budget for 1994 would rise by 30 per cent to 2.303 million. Despite the recommendations of the Government commissioned Science Technology and Innovation Advisory Council that the HRB should be given funding of 5 million, its budget for 1995 only grew by 9 per cent to 2.505 million Irish Pounds.[18] However, the HRB's fortunes improved in tandem with those of the wider economic situation which Ireland found itself in during the late 1990s and the start of the Twenty First Century. This can be seen from their Government funding having been increased to 13.2 million Euro in 2001 from 9.3 million in 2000, which when combined with their other incomes represented four times the level of funding it had at its disposal in 1995 to 22.5 million Euros in 2002.[19]

Along with the board's improved finances in the mid 1990s came an increased level of support for research on drug issues. While its expanded budget left more resources free to develop its capacity in drug research, its sustained and greatly intensified involvement with European bodies such as the PG and later the EMCDDA had a metamorphic effect on the HRB's drug section. Throughout the 1990s the drug section continued to be involved with the PG and, inter alia, its multi-city study of drug use and expert group on epidemiology. However, reflecting the way in which the EMCDDA started to take over the main focus on the advancement of epidemiology from the PG in mid 1990s, the drugs section started to work more and more with the Monitoring Centre.

A significant development in the influence of European perspectives on the research being carried out by the ADRU was its being designated as the Irish REITOX (European Information Network on Drugs and Drug Addiction) focal point for the EMCDDA. As the creation of the Monitoring Centre became a reality in 1993 the Department of Health designated the HRB's drug section as the Irish centre in the network.[20] The impact of this development is clear from the increasing level of work carried out by the board's drugs section in their new role. By the end of 1995 they had completed two projects that the EMCDDA had assigned to them. These involved taking stock of the drug policy landscape in Ireland and the different state and non-state actors involved, as well as creating an inventory of the different sources of information that were and were not available at the time.[21] In 1996 the drugs section coordinated a project on electronically integrating the REITOX network and had played an active role in a range of other EMCDDA projects mostly aimed at increasing the comparability of a range of epidemiological data sets.[22]

Mirroring the way in which the PG had partially helped to sustain drug research during the lifetime of the MSRB, the EMCDDA played a key role in enhancing both the volume of the drug section's output in the latter half of the 1990s. 1997 saw the drugs section, now referred to as the Drug Misuse Research Division (DMRD), take on an increased amount of tasks. For example, at that stage it was completing a yearly report on drug use and policy in Ireland, supplying the EMCDDA with annual epidemiological data on treated drug use, participating in a range of other projects, as well as establishing the

Irish parts of both the Early Warning System on New Synthetic Drugs and the European Database on Demand Reduction Activities.[23] The DMRD's involvement in all of this European work can be seen as aiding the extent to which its own research practices evolved to fit with EU norms on the creation of epidemiological data.

Perhaps the strength of the EMCDDA's influence over the division can be gleaned from the five core objectives that were set out for DMRD. While the division was to conduct research, establish a national drugs information clearing house, expand the NDTRS, and work with practitioners in the Irish drugs field, it was also "to respond in a timely and appropriate manner to the annual work plan of the EMCDDA".[24] In this sense, cooperating with and reacting to the needs of the EMCDDA had become a core part of DMRD's work plan. The Unit's links to the EMCDDA have functioned to position them as key player in the dissemination of information and the diffusion of drug policy and research norms. More specifically, the ADRU has asserted that it acts as a channel for EMCDDA and PG information, and by extension influence, to travel into the Irish policy and practice spheres.[25]

One of the most critical influences that the EMCDDA has had upon the development of ADRU was its functioning to encourage the Unit's expansion into the area of licit drugs research. The EMCDDA was established as one of the EU's decentralised agencies in 1993 by a regulation adopted by the Council of the European Union (COE).[26] The 1993 document, which set out the EMCDDA's role and functions over 19 articles, was subsequently revised on a number of occasions. Principally, these revisions were made to adjust the centre's operations in line with changes such as the enlargements of the EU, alterations to EU financial regulations, and the formalisation of aspects of its work, such as, REITOX's operation and their involvement in monitoring new synthetic drugs.

One of the most significant revisions, or 'recasts' as the COE refers to them, took place in December 2006 when the EMCDDA's operations were extended to include the analysis of polydrug use, involving licit and illicit drugs.[27] The revision possessed the potential for a significant impact on the EMCDDA's work as it afforded them a means of traversing the licit/illicit drug barrier in their research. Prior to this time various parts of ADRU's output, such as its *Occasional Papers* series on the National Drug Treatment

Monitoring System (NDTRS) and its research/communications periodical *Drugnet Ireland* had touched on polydrug use and alcohol issues. However, the alteration in the EMCDDA's focus had a clearly identifiable impact on the Unit in acting as a force to legitimate their intention to crystallise the direction they had slowly been moving in for a while into a clear expansion to cover alcohol and illicit drug issues.

The Unit's action in following the lead of the EMCDDA was obvious from a series of brief articles that they featured in an issue of Drugnet Ireland. The volume in question looked at the modification of the EMCDDA's role as well as the extent of the tendency towards the integration of licit and illicit drug policies in EU Member States that was covered in the EMCDDA's 2006 report on drug use in the EU.[28] Following these stories the DMRD, as it was known at that stage, announced that it was taking the opportunity to change its name to ADRU in order to reflect the expanded role it had taken on in January 2007 – one month after the EMCDDA recast.[29] The coincidental timing of this transformation and its being announced in the context of a range of stories essentially supporting the adoption of such a shift clearly reveals the continued influence of the EMCDDA on their structure and work. It is clear that the ADRU's involvement with the Monitoring Centre functioned to increase the volume of work they were completing. In this respect, it is not surprising that the ADRU's longest running area of concern, the epidemiology of drug use, received a significant boost as a result of it also being the core of the EMCDDA's work. The following section is concerned with the ADRU's output in this area, and considers the ways in which it can be seen as policy relevant and supportive of harm reduction measures.

The Epidemiology of Drug Use

Internationally, the late Twentieth and early Twenty First Centuries saw an increase in the level of importance placed on health information systems. In part, the rise of managerialism and the use of evidence based measures in public policy making have functioned to sustain the pace with which epidemiological systems have grown. This section looks at the type of epidemiological work carried out by the ADRU during the period under study, their development of monitoring systems and the way in which their

support for treatment, in particular harm reduction, can be seen in this work. Principally, this process can be seen in the degree to which such issues are raised and the manner in which they are discussed through their epidemiological work. In the following pages I consider the operation of health information systems aimed at monitoring drug use in Ireland and some of the areas that these systems have generated data on.

The centrepiece of Irish epidemiology on drug use, and consistently the core of the ADRU's work throughout its existence, has been the maintenance of a drug treatment reporting system. Commencing operation in August 1989 and having 19 treatment centres making returns to it in its initial year, the Dublin Drug Misuse Reporting System (DDMRS) was the first large-scale monitoring system in Ireland. Reflecting the long-term influence of EU sources in assisting Irish drug research, the Department of Health was originally assisted by a European Commission grant to fund the DDMRS.[30] Showing how the ADRU's work has consistently attempted to be policy-relevant, the information generated by the DDMRS was seen as feeding into the continuous development of drug treatment policy in Ireland as well as being utilised by the PG's multi-city study of drug use.[31]

In 1991 the *Government Strategy to Prevent Drug Misuse* recommended that the reporting system should be extended to cover the country as a whole and as a result the DDMRS was slowly expanded during the first half of the 1990s. By 1993 all of the eight Health Boards had agreed to take part in the new system and had appointed coordinators to oversee data returns.[32] While the system was officially extended to the country as whole in 1995, it was not until 1997 that the first report presenting a national data picture was launched.[33] During the period under study the National Drug Treatment Reporting System (NDTRS), as it was called after 1995, continually expanded its coverage of treated drug use as more statutory and non-statutory treatment providers, as well as GPs operating under the 1998 methadone protocol, became involved. The NDTRS operates along the same lines as monitoring systems in many EU countries and in this respect its development shows us the way in which EU drug research bodies have shaped Irish epidemiology and how monitoring norms have diffused throughout the EU via the EMCDDA. This can be seen from the NDTRS being initially designed to correspond to the PG's Treatment Demand Indicator Definitive Protocol and later the EMCDDA and

PG's collaborative advancement on this operating structure, the Treatment Demand Indicator Standard Protocol 2.0.[34]

The ADRU has produced a range of reports from the data generated by the NDTRS and this information has created a detailed picture of drug treatment services' activities. Amongst these are the *Occasional Papers* it published from 2000 to the end of the period under study. The papers depicted a range of critical issues, such as, the type and location of centres within which treatment was being provided, the variety of treatment policies and modalities predominating in different geographical areas, the drugs for which treatment was sought, as well as the way in which these substances were being administered.[35] Crucially, in terms of being policy relevant, these reports showed the temporal and geographical spread of treatment demand, which is a proxy for drug use, throughout the country over an extended period of time.[36] This type of information can play a key role in correctly targeting the provision of drug treatment services to the areas where they are required.

On many occasions the ADRU's papers have shown the emergence of critical issues, such as the rise of cocaine use, the normalisation of polydrug use, the status of alcohol as a problem drug, the extent of IDU and the persistence of risk behaviours.[37] Frequently the way these topics were highlighted involved no comments being made about the specifics of what alterations to policy needed to occur to deal with them. Rather, the approach taken by the Unit was to adopt a more subtle style whereby they underlined the problems that needed rectifying by policy makers. An example of this style of presentation can be seen from their focus on the sharing of injecting equipment amongst IDUs. At times their papers would note that clients in a particular region were engaged in these risk practices and assert that this was a 'source of concern' and a 'challenge to service providers' or 'could not be ignored'.[38] In this sense, we can see their support for the development of treatment services and specifically the scaling-up of harm reduction services such as NSPs.

During the years analysed the ADRU developed epidemiological research that was policy relevant and has used this to focus attention on a range of harm reduction issues. In this sense, the way in which they discussed these topics was reflective of the style frequently adopted by the EMCDDA in its coverage of such policies. As a result of

its being a body that generates policy relevant data, but does not create policy itself, the Monitoring Centre has tended to adopt somewhat of a non-directive stance in its work, which is in keeping with the fact that the EU cannot construct binding social policies in the drugs field. This has, however, not stopped the Monitoring Centre from attempting to diffuse particular policy norms, as we have seen in chapter three, by highlighting the efficacy of certain measures in reducing the harms of drug use and thus offering a more subtle, if sometimes indirect, backing for them. The ADRU has emulated the same operational style as that assumed by the EMCDDA, but it has modified it to suit the Irish policy context, and as a result of this their approach is slightly more subdued than that of the Centre's in drawing attention to potential courses of action on the back of epidemiological data. Nonetheless, the ADRU's work can be regarded as mirroring the direction adopted by the EMCDDA, if for no other reason than their contractual obligations to the Centre to complete particular pieces of research. This has resulted in them focusing on and directly and indirectly asserting support for harm reduction policies.

The ADRU experienced difficulties in expanding its monitoring system, which in itself reveals some of the complexities in the EMCDDA's task of constructing a full data set from harmonised systems throughout the EU's 27 Member States. One of the problems with the NDTRS and the information it generates is the extent to which it is truly reflective of events occurring on the ground. In this sense, one of the main issues to have hindered the expansion of the system over the years was the challenges that the Unit faced in ensuring the participation of all treatment providers. It has already been noted that one of the most significant developments in the provision of drug treatment services in Ireland has been the expansion of MMT via the incorporation of community based general practitioners into the methadone protocol of 1998. Accordingly, the NDTRS should have been able to draw these GPs into its existing framework as a result of their having become one of the main ways in which MMT was being delivered outside of centralised clinics. However, a major gap in the NDTRS's ability to provide a complete picture of treated drug use was that a majority of GPs were slow to take part in the NDTRS.

The detrimental impact of this situation on the ADRU's work can be seen from the fact that in 2002 circa 45 per cent of clients being prescribed MMT by GPs in the seven Health Board Areas outside of the then ERHA were not reported to the NDTRS.[39] A similar situation pertained in the ERHA itself, where only 24 of the 244 GPs prescribing MMT made returns to the NDTRS in 2002.[40] Across all Health Boards there were 293 GPs providing MMT in 2002, yet only 28 or 10 per cent of these made returns to the NDTRS.[41] In addition to simplifying the completion of the NDTRS form in order to help maximise the number of GPs taking, part the ADRU also deployed a researcher to actively recruit doctors into the system in 2005. This action went a long way in filling the gap in the NDTRS's coverage as 2006 saw circa 75 per cent of GPs return data for the period between 2001 and 2005.[42] The effort invested in enhancing the coverage of the NDTRS was, in part, reflective of the Unit's attempts to satisfy the requirements of the 2001 drug strategy's action 65, which called on all service providers to take part in the system.[43]

The NDTRS's ability to provide a complete picture of drug treatment was adversely affected by problems in getting all treatment providers to make returns, but the returns it did receive have also been incomplete. While some centres could not return data at all, others were only partially completing their returns to the NDTRS. In both instances the root of the problem lay beyond the control of the ADRU and rested with the limited resources of many agencies.[44] An example of the impact this has had on the NDTRS can be seen from the delay in the publication of data for 1997 and 1998. While 68 treatment centres submitted data in 1997 and 100 did so in 1998 more agencies could have made returns. However, they were inhibited from doing so because of a lack of resources allowing them to complete the forms on time. Ultimately, the data for 1997 and 1998 was published in 2000 in a joint statistical bulletin format.[45] Like the missing data from GPs, the delay in gathering and disseminating this information also represented a problem to the development of the NDTRS during the period studied.

A lack of participation altogether or an under reporting of treatment cases have, however, not been the only issues to adversely effect the NDTRS. Other problems with the system have been its omission of alcohol as a primary drug, its exclusion of tobacco, as well as data on clients exiting treatment, which has hindered the creation of a picture

on treatment outcomes.[46] Another significant gap in the system has been its non-inclusion of data on clients receiving NSP services from treatment agencies.[47] Within the timeframe being examined the Unit did, however, take important steps to close some of these gaps in the picture created by the NDTRS. This allows us to see the way in which they were actively working to continually develop the nature of the system. For example, 2004 saw alcohol become a main problem drug for which treatment could be recorded, as well as data on those who were assessed but did not progress to treatment being recorded. Later on at the end of the period under analysis, the Unit also created a form aimed at recording treatment exits and piloted this during 2007 in the HSE Southern Region.[48]

Throughout the period studied the data created by the Unit's NDTRS has been drawn upon by a range of different policy-making working groups and committees. The extent to which this epidemiological information has been utilised offers us a picture of their information systems' policy relevance. As part of the review the Steering Group charged with carrying it out commissioned a report on the progress made from PA Consulting. Within the consultant's report there were a range of instances where the ADRU's work was used to illustrate points. In showing the spread of opiate use outside of the ERHA the authors drew upon ADRU's treatment demand data from 1998 to 2002, as well as information on drug markets from the Unit's REITOX annual reports to the EMCDDA.[49] They also utilised statistics from the ADRU's submission to the review process to highlight the rate of opiate-related deaths and the proportion of new treatment clients with dual diagnosis in 2001.[50] Action 49 of the 2001 drug strategy called for the creation of a protocol for the treatment of those under 18 years of age to be established and the consultants examined the progress made in achieving this. In discussing the issue they utilised unpublished NDTRS information from 2002 to show how the number of under 18 year olds getting treatment was declining in the ERHA but rising elsewhere at the time.[51]

When the Working Group charged with designing the protocol for the treatment of under 18 year olds published its report in September 2005, its was clear that the ADRU's data had been consulted. In this sense, nearly the whole of the second chapter in the Working Group's report was based on information from the NDTRS on treated drug use for those less than 18 years of age.[52] The pattern of key working groups arising from

the drug strategy drawing on the ADRU's output was maintained after the 2004 mid-term review called for rehabilitation to become the fifth pillar of the drugs strategy as a result of the strong calls for this modification during their consultation process.[53] Consequently, in their final report the Rehabilitation Working Group used NDTRS data to provide an extensive picture of treated drug use up to 2005, as well as socio-demographic information to highlight the complexities of providing rehabilitation.[54] In 2004 the Government also launched a progress report on the strategy prior to its mid-term review. Reflecting the way in which the Working Group mentioned above utilised ADRU's work, the progress reports' discussion of the nature and extent of drug use drew on NDTRS data a number of times. In this respect, the document pointed out the delay of almost four years between commencing opiate use and taking up treatment that had been highlighted in the Unit's *Occasional Papers*.[55] It also noted the rising number of users availing of treatment and the geographical location of these increases from published and unpublished NDTRS data.[56]

The 2001 drugs strategy, *Building on Experience*, also utilised a range of statistics from the NDTRS to present a picture of various aspects of drug use. In this sense, national and regional trends in treated drug use, as well as the age, gender, educational attainment, age of initiation into drug use and administration routes of those receiving treatment were all set out in the strategy.[57] This trend of incorporating NDTRS information into drug policy discussion and formulation can be clearly traced back to the Ministerial Task Force on Measures to Reduce the Demand for Drugs in 1996, whose work laid the foundations for later strategies. In this sense, as already noted in chapter four, the Task Force used the NDTRS to verify that the areas where individuals were presenting for treatment were the same locations that were most affected by heroin use. On this basis they went on to establish ten Local Drugs Task Forces (LDTFs) in these areas to deal with the drug problem.[58]

This part of the chapter has looked at the main work carried out by the ADRU during the period studied on the creation of epidemiological monitoring systems for drug use. The most significant piece of work completed by the Unit in this period was the initiation of National Drug Treatment Reporting System (NDTRS). During this time the Unit developed and refined the NDTRS in line with European norms on the operation of

monitoring systems set out by the PG and the EMCDDA and established an effective national level of coverage. The ADRU utilised the data generated by the NDTRS to create standardised reports, which they used to explore a diverse range of issues related to the treatment of drug use. On the back of this information the Unit adopted a subtle style of policy commentary that saw them underline key issues where action was needed without setting out the specifics of what change should take place. While doing so they were displaying their support for harm reduction treatments and the way in which they were to a degree emulating the manner in which the EMCDDA sometimes adopts a more indirect norm-shaping approach to advisory work. The Unit's ability to provide as comprehensive an epidemiological picture of drug treatment as possible during these years was not without problems. In particular, they faced difficulties in ensuring the participation of all treatment providers and the return of full data by those taking part. Among the key changes they faced were getting all GPs to become involved in the system.

Measuring Drug-Related Harms

Much of the epidemiological research carried out by the ADRU during the period under study revolved around the NDTRS and the production of standardised reports, but, the Unit also carried out a range of ad hoc pieces of work. While their other projects generally had an epidemiological focus they differentiated from the Unit's *Occasional Papers* in their more in-depth coverage of issues which had not been the target of Government funded research previously. In this sense, our concern in the present section is with some of the instances where they produced research focused on specific harm reduction related issues and the type of projects that they carried out. Below I examine the ADRU's work on drug-related deaths and blood-borne viral infections.

One of the ways in which the Unit dealt with the issue of drug related deaths (DRDs) during the time studied has been in their work on the construction of a mechanism capable of measuring the number of direct and indirect DRDs. They set out to establish the National Drug-Related Deaths Index (NDRDI) in 2005 after being requested to do so by the Department of Health and Children and the Department of Justice

Equality and Law Reform in February of that year.[59] The initial call for the establishment of an epidemiological system to monitor the number of deaths linked to drug use arose from the community sector in late 2000. In November of that year the Citywide Drugs Crisis Campaign's Family Support Network was organising its first annual service of 'commemoration and hope' in memory of those who had passed away from drug use. In preparation for the event the group attempted to find out the number of DRDs that had occurred but were unable to do so as a result of their being no system for recording them. Consequently, Dr Joe Barry, the National Drug Strategy's medical advisor at the time, gained the consent of parents whose children had died to examine their death certificates. Upon consulting them he found that many of the deaths had been incorrectly recorded or recorded as being a result of misadventure rather than being due to drug use. This discovery led to the creation of a group to examine the issue and the eventual submission of a proposal for the instigation of a NDRDI to Government in 2004.[60]

While the launch of the index in September 2005 represented the fruition of community sector efforts for its creation, it also reflected the partial fulfilment of one of the 2001 drugs strategy's aims. Action 67 of *Building on Experience* called upon the Coroner's Service and the Central Statistics Office (CSO) to jointly develop a means of tracking the number of DRDs occurring in Ireland.[61] This can be seen as a logical extension of the work that they were already undertaking prior to 2005. As the EMCDDA's REITOX focal point in Ireland the Unit was charged with gathering and returning data to the Monitoring Centre on its five key epidemiological indicators of drug use, which we discussed in chapter three. One of these core monitoring tools was the recording of the number of DRDs. The ADRU obtained this data from the CSO, which had extracted it from the General Mortality Register (GMR), and reported it to the EMCDDA in a standardised format, again revealing the influence of the Monitoring Centre on the Unit's work.

In addition to its work on the creation of the NDRDI, the ADRU also touched on the issue of DRDs a number of times in other aspects of its output. Since 2000 the Unit had provided coverage of DRDs through various articles in its *Drugnet Ireland* magazine. In this respect, they focused attention on trends in deaths through data from the GMR and the HIPE scheme and discussed these in a national and a European context, as well as

local responses to overdoses, such as the use of naloxone.[62] However, one of the more substantial pieces of work on the topic that the Unit completed during the timeframe under study was their coverage of DRDs between 1990 and 2002. As part of their *Overview Series* of publications launched in 2005, which were specifically aimed at informing policy makers and practitioners, the Unit released a paper on DRDs over a twelve year period.[63] Representing a compendium of Irish research on the subject, the report presented a mixture of data from the GMR and previously published research studies that had drawn on a range of other information sources.[64] It provided a valuable picture of the geographical location and rate of such deaths over time, while showing that the majority were linked to opiates as well as the numbers attributable to AIDS as a result of IDU as a risk factor.[65]

The Unit's aim of gathering the available research and analysis on DRDs together into one single document shows us how their actions can be seen as generally reflective of the enlightenment model of the research / policy interface. In this sense, the way in which their research centralised and represented existing studies as a collective body of work under the banner of their own organisation functioned to reenergise the potential cumulative impact of the individual pieces of data and the ideas and approaches arising from the research. This added to the stacking process that is part of the enlightenment model of the research / policy interface, by allowing these individual pieces of work to act was a unified whole on the topic, while presenting policy makers with clear stock-taking information on DRDs. Consequently, we can see both the Unit's support for the development of interventions in this area from their focus on the issue and the policy relevant nature of their work from the analytic compendium style of their research project.

While the ADRU had focused on various aspects of the epidemiology of blood-borne viral infections (BBVs), such as HIV, HBV, and HCV, in earlier work and consistently in their *Drugnet Ireland* magazine, 2006 saw the Unit launch a major paper on the topic.[66] Reflecting the way in which their coverage of DRDs had sought to synthesise existing data from different sources into a unified whole, their report on BBVs brought together a range of information from the ten year period 1995 to 2005. In the main, this consisted of disease notifications that had been made to the Health Protection

Surveillance Centre (HPSC) and a range of other previously published research studies, resulting in the document being the most comprehensive discussion of BBVs available up to that time.[67] Consequently, in a manner that is generally reflective of the enlightenment model of research / policy interactions, the Unit's action can be seen as playing a key role in sustaining and reinvigorating the collective impact of the ideas and approaches arising from the research involved on drug policy.

The ADRU's report on BBVs created a detailed picture of the status of HIV, HBV and HCV in relation to drug use and the state of responses to them. Among the issues it drew attention to were the difficulties being encountered by services in reducing the prevalence of these diseases from the fact that one tenth of users in treatment were HIV positive and nearly 70 per cent of IDUs receiving treatment were HCV positive.[68] The report pointed out that HCV was endemic amongst IDUs in Ireland and was the most common BBV among them.[69] In this respect, we can see the way in which the Unit has used their work as a vehicle for highlighting the need to modify existing service models. This intention was evident from the way in which they discussed how a range of studies had shown that there were poor levels of treatment uptake for HIV and HCV, yet that this could be improved, along with compliance rates, if the care was offered in a decentralised way through drug treatment centres.[70] Similarly, they pointed out that there should be no discrimination in the provision of treatment for HCV on the basis of how the disease was acquired and there should be a clear equivalence of care across all groups.[71]

The Unit's report also drew attention to the issue of BBVs among drug users within the prison system. In this respect, they noted how IDUs in jails had a higher prevalence of HIV than the general population and that this form of drug use was the main risk factor for the contraction of both HBV and HCV among prisoners, with one study finding 81 per cent of prisoners who injected to be HCV positive.[72] They also discussed how the sparse data on co-infection with one or more BBVs that existed showed that 38.5 per cent of IDUs in a study of prisoners were suffering from a number of diseases and that other studies had found a lack of treatment available in the custodial setting for HCV in particular.[73] While they observed some of the advancements that had been made in moving towards equivalence of care between custodial and community settings, their focus on these statistics showed their support for the development of

treatment and harm reduction services. Specifically, they had underlined the grounds legitimating the need for the further scale up of such interventions.

Mirroring the way in which the ADRU had been placing attention on the epidemiology of DRDs and attempting via the NDRDI to generate policy relevant data, their work on BBVs saw them express a range of comments on the need to improve reporting systems. Chief among these were the Unit's call for the establishment of a register that would allow the incidence and prevalence of HCV among problem drug users, as well as the risk factors involved in acquiring the illness, to be recorded and analysed.[74] In this respect, they noted that there was a need to establish the utility of different harm reduction practices, such as NSPs and MMT, on the transmission of HCV among IDUs.[75] This was a point that displayed their backing for the progressive development of such interventions within the treatment system.

Their push for the creation of a system to monitor HCV represented the Unit adopting a proactive stance in establishing a means of generating data that would offer a direct view of the efficacy of certain policies in reducing the incidence and prevalence of HCV. This course of action also reveals the influence of the EMCDDA on the ADRU's work, in that, they noted how Ireland was unable to return data to the Monitoring Centre on both HBV and HCV prior to 2005 because the risk factors linked to their acquisition were not recoded before that time.[76] They went on to note that the Monitoring Centre utilised information on the number of new cases of BBVs as a proxy measure to estimate the incidence of these diseases and how Action 39 of the EU's Drugs Action Plan placed an onus on Member States to help the EMCDDA develop its key epidemiological indicators.[77]

This part of the chapter has discussed some of the ADRU's work on harm reduction issues. Their research on DRDs and BBVs shows us how they have actively dealt with some of the more complex issues related to harm reduction and drug policy within their overall research agenda. These pieces of work saw the Unit merging existing research with their own projects in the form of compendium publications. Such work is broadly reflective of how research has an impact in the enlightenment model of research / policy interactions. Specifically, the Unit gathered together a range of data and presented it as a unified whole under their own auspices, thus adding to the incremental impact of

the ideas and approaches engendered by the research on policy. Their reports presented policy makers with a clear view of events in these areas of concern that displayed their policy relevance. Their focus on these areas of policy also reflected their backing for the development of interventions in these areas of drug treatment.

Researching Sensitive Topics

Throughout the period studied a large part of the ADRU's work was focused on the epidemiology of drug use and issues related to its development. During this time the Unit was engaged in developing the NDTRS and the production of standardised reports based on the data extracted from the system, as well as various other pieces of ad hoc research on different issues related to drug treatment. Within their other projects centred on aspects of drug treatment and policy the Unit dealt with a number of areas of concern where a certain amount of policy tension surrounded the topics being looked at. This was a result of these areas being issues that were still being worked through or unresolved in drug policy generally. This part of the chapter looks at the Unit's work on the expansion of the NDTRS and alcohol policy.

In 1998 one of the most significant developments in the expansion of drug treatment services in Ireland came in the form of the methadone protocol. This statutory instrument for the provision of methadone maintenance treatment (MMT) functioned to incorporate GPs operating in local communities into the national drug treatment system in a highly structured manner. As a result, the extent to which MMT could be provided greatly expanded upon the protocol's entry into force, which effectively guaranteed that substitution treatment would become the mainstay of the Government's harm reduction approaches to drug use. One of the core difficulties facing the ADRU in ensuring that the NDTRS was truly reflective of events occurring in drug treatment facilities was the degree to which they could make sure that all service providers were returning information to them. In this sense, the Methadone Protocol represented a double-edged sword for the Unit. On the one hand, it offered them the potential to create a data set that was truly representative of treated drug use, while on the other hand, it presented them with a significant challenge in terms of establishing this coverage. While we will look at

the provision of MMT in more detail in chapter nine, for our purposes in the current section it is critical to note that the 1998 Protocol left epidemiologists with a major problem. In essence, the operating guidelines *requested* that all GPs providing MMT return data to the NDTRS. Consequently, as a result of the protocol not *requiring* GPs to make returns as part of their obligations under the instrument few GPs took part in the system prior to 2007.

In addition to this gap, the ADRU also faced the prospect of its ability to provide complete coverage of treated drug use becoming less likely as a result of the prison system not being part of the NDTRS. The omission of data from the Irish Prison Service (IPS) was the result of the fact that many of the GPs working in prisons were, prior to 2005, operating without contracts setting out their specific obligations. The absence of a means of requiring these GPs to return data represented a problem for the NDTRS, as prisons were providers of treatment but were not returning data on the services provided.

In attempting to counteract the problems with its monitoring system, the ADRU carried out a study in 1998 for the Community Health Division of the Department of Health on the potential for including GPs from the community and prison settings in the NDTRS. The Unit's study also had a range of other aims. For example, it set out to provide an overview of treatment services in both settings, as well as the opinions of the doctors towards drug users and the NDTRS, and the risk behaviours of their clients.[78] On the basis of their research, the Unit listed a detailed set of recommendations in their report, naming both the individual policy actors responsible for carrying them out, as well as timeframes for their potential completion.[79] In this respect, we can see the presence of a vein of more policy assertive research within their work generally from early on in the period studied.

Consequently, it was evident throughout the report from their continual highlighting of both the detrimental impact of gaps on the NDTRS and their project's ability to close them and directly shape policy and provision, that the ADRU's intention was to establish a basis for the alteration of existing policy.[80] Critically, they also noted how the NDTRS's expansion was reliant on the 'goodwill' of the GPs in question and this situation was a result of the problems with the 1998 protocol that did not place a statutory obligation on doctors to return data.[81] The necessity of including the two groups

of GPs in the system was clear from the study's finding that their overall data returns would rise by between 10 and 30 per cent upon their participation in the NDTRS.[82]

Given the growing importance of GPs within the drug treatment system after 1998, one of the unique features of the ADRU's study was the insights it offered, through the survey it produced, into the attitudes and operations of doctors working with drug users.[83] A mix of positive and negative responses towards epidemiology and drug users emerged from the research. For example, most doctors in both the prison and community settings indicated that they were happy to take part in the NDTRS and felt their patients should be included, and would either complete the forms themselves or have an administrative assistant do it.[84] Yet the majority of GP's asserted that they perceived drug users as problematic patients that absorbed more time than others. Also, while 65 per cent of the doctors agreed that the primary care setting was the right place to be treating drug use and they were qualified to do so, they paradoxically indicated that such work was not meant for family GPs and was more the preserve of specialists.[85] The existence of such perspectives reveals the significant achievement of the 1998 protocol in getting large numbers of doctors to participate in treating drug users.

The data produced by the pilot run of the NDTRS in both treatment settings as part of the research showed how the Unit was urging a move towards greater adoption of harm reduction practices. The issue of IDU indicated that there were important differences between clients in prisons and the community. For example, 27 per cent of community doctor's clients were currently engaged in IDU, while 55 per cent of prison GPs patients were still injecting. Similarly, a higher proportion of users in prison reported having ever injected, 95 per cent, compared to those in the care of community GPs.[86] The report also found that one third of clients in both settings were engaged in the sharing of injection materials.[87] On the basis of these results the ADRU asserted that harm reduction practices should be adopted in prisons.[88]

Alongside providing an account of how the existing drug treatment system was operating at the community level, one of the study's main aims was to present a picture of how drug treatment was operating in the prison system.[89] In this sense, the Unit took the opportunity to discuss a range of issues regarding prison drug treatment policy. Among the points they highlighted were the Mountjoy Visiting Committee's assertion that the

lack of proper treatment arrangements in prisons were negating the successes being achieved by treatment centres in the community, given that both organisations were, at different times, dealing with the same people.[90] In this sense, the Unit set out in some detail the background to the introduction of NSPs in Swiss prisons before asserting that such measures should be adopted in Ireland given the role of prisons in spreading BBVs.[91]

The comments made by the Unit in relation to the presence of IDU in prisons and the need for harm reduction measures such as NSPs and MMT revealed their support for these harm reduction measures. Further, given that these remarks were made on the basis of data generated by a pilot run of the NDTRS within prisons, we can also see the ADRU's intention to use their epidemiological systems as a means of generating data that could be used to highlight the need for policy change in the direction of harm reduction measures. Consequently, their actions in discussing international research evidence on the utilisation of NSPs within prisons can be seen as approximating to an attempt to initiate the process of hierarchical diffusion by placing options on the policy making agenda.

The Unit's work on the area of alcohol policy during the time being examined was another area where they completed a piece of research that saw them adopt a policy assertive style. In this respect, 2007 saw the ADRU publish a major report on the topic of alcohol's impact on health. The research set out to gather existing information into a compendium and to consider what measures could be taken to reduce the health related harms of alcohol use.[92] To achieve this aim, the Unit drew on three strands of data. Firstly, they analysed patterns of alcohol consumption at both the population and individual levels through figures from the Revenue Commissioners, the Central Statistics Office and a range of different surveys that were either aimed at alcohol use or included it as part of their brief. They also examined a range of unpublished information on levels of morbidity and mortality linked to alcohol use during a nine year period from the HIPE scheme and the GMR. In addition, the report discussed data on treated alcohol use from the NDTRS and the National Psychiatric In-Patient Reporting System (NPRIS).[93]

They noted from these statistics how Ireland had developed one of the highest levels of per capita alcohol consumption in the EU with 13.36 litres of pure alcohol being consumed per adult aged 15 years or over in 2006.[94] The Unit pointed out how this figure

represented a 17 per cent increase from 11.38 litres per adult in 1995.[95] Further, they discussed how the type of drinking being engaged in, by both adults and adolescents, was characterised by heavy levels of consumption and a higher frequency of binge drinking occasions than in other EU countries.[96] This was graphically relayed by the ADRU's detailing how EU-wide research had shown that 54 per cent of Irish respondents versus 28 per cent of other Europeans asserted that they consumed five or more drinks on the same occasion at least once per week.[97]

Rather than simply setting out the trends in alcohol use from the different studies they had drawn together, the Unit went on to provide an account of how the most widely used licit drug was creating and capable of causing an array of severe health problems. One way in which we can gauge the tone of the ADRU's first full length research project into licit drug use was from the way in which they reiterated at several points in their report that alcohol was, in the same light as many illicit substances, a dangerous drug of dependency.[98] They highlighted how alcohol was responsible for 4 per cent of the global burden of disease, and conceptualised the harm it caused, in terms of its impact upon individuals, families, communities and the State, along the same lines as illicit drug-related harms were generally presented.[99] In this context, the report noted that there was a directly verifiable correlation between levels of alcohol consumption and harms linked to alcohol from the fact that the two highest years of consumption, 2001 and 2002, were also the same years in which mortality and morbidity linked to alcohol use respectively peaked.[100]

In light of their having presented alcohol as being a dangerous drug, the Unit catalogued a variety of indicators of how it was impacting upon Irish society. For example, they noted that hospital discharges with liver disease caused by alcohol rose by 147 per cent from 1995 to 2004, how mortality linked to alcohol more than doubled during the same period and that alcohol played a role in 36 per cent of road deaths in 2003.[101] The report continued to present a critical picture of alcohol by drawing attention to the extent to which the adverse effects of drinking were more likely to impact women as a result of their physiological make-up than they were men. In elaborating this point the Unit asserted that women were more susceptible to physical alcohol dependence, cirrhosis of the liver, as well as being more vulnerable to a range of cancers and

reproductive disorders a result of daily consumption of alcohol.[102] In addition, they focused particular attention on how the use of alcohol during pregnancy could cause one or a number of Fetal Alcohol Spectrum Disorders, as well as being clearly implicated in large amount of unplanned pregnancies.[103]

The utility of the ADRU's study, in a manner that is generally reflective of the enlightenment model of the research / policy interface, can be seen from the way in which their report drew together the existing data on alcohol use and its consequences into a critical synthesis. This can be seen as adding to the cumulative impact of the ideas and approaches arising from the research. The report functioned to present policy makers with a clear and concise picture of alcohol-related health issues from a number of different sources, highlighting the key issues and areas for action. Accordingly, the Unit's work can be regarded as having a deeper impact as a result of its having performed this task. Principally, it allowed them to make a range of policy-assertive comments about the nature of Irish alcohol policy.

A more engaging style of policy work in the Unit's report can be seen from the way in which they drew on the data they had assembled to comment on how alcohol policy could evolve to meet current challenges. This can be seen from the way in which the Unit expressed support for a range of politically unpopular policy measures, such as expanded breath testing and increases in taxation, throughout their report by discussing the efficacy of these responses and international support for them.[104] In this respect, they noted how the second report of the Strategic Task Force on Alcohol (STFA), which was created in 2002 to formulate policy measures, called for these same population-level strategies to be utilised.[105] Accordingly, the Unit adopted a pro-public health stance on alcohol policy when it expressed support for the need to implement the recommendations originally set out by the STFA when it came to make its own policy suggestions at the end of its report.[106]

In addition to pointing out how existing measures, such as the national age card and penalties for breach of the licensing laws, were having little or no impact, the report also noted how Ireland's national alcohol policy from 1996 had not been implemented adequately.[107] In this sense, while calling for the creation of a new national alcohol policy the Unit made the case that there should be an integrated licit / illicit drug policy covering

both drugs in general and alcohol.[108] They added weight to the case for merging licit and illicit strategies when they observed that an Oireachtas committee and the mid-term review of the drugs strategy had both called for the issue of amalgamation to be considered.[109] They pointed out that one of the reasons behind the problems with the 1996 alcohol policy was the lack of structures in place to deliver it.[110] Consequently, they asserted that one of the key reasons for conflating licit and illicit drugs into a single strategy was the existence of a robust set of structures for delivering policy in the illicit drugs area that would be able to incorporate alcohol into its operations. This would, in effect, negate the need for an entirely new set of arrangements for the administration of licit drug policy.[111] The increasing focus on alcohol policy around the time of the Unit's report in the weeks and months after it was released can be seen from heightened media coverage of the issues.[112] Ultimately, the Unit's remarks on the nature of what was wrong with existing alcohol policy measures and what could be done to tackle these areas of concern was reflective of a more policy-assertive style in their research output.

This section of the chapter has focused on some of the more sensitive and unresolved areas of policy that the Unit conducted research on during the time under analysis. Specifically, it has looked at their research on the expansion of the NDTRS and alcohol policy. While these two pieces of work occurred at the start and the end of the years being examined here, they shared a common theme in terms of their representing a departure from the more subtle style of policy work engaged in by the Unit. In these studies the ADRU adopted a more policy assertive mode of analytic delivery and communication. In addition to presenting a highly detailed view of the respective areas being examined, the reports also set out the basis for change by presenting clear options and alternative courses of action. In underling the need to develop treatment, for example in prisons, the Unit expressed its support for the expansion of harm reduction services.[113] Similarly, they endorsed the utilisation of a range of population-level measures aimed at controlling drinking.[114]

Conclusion

This chapter has discussed some of the different areas of work completed by the Alcohol and Drug Research Unit (ADRU) during the years being examined and the extent to which they expressed support for drug treatment and harm reduction in their output. Over the course of this timeframe the Unit completed a range of different projects. Much of its work revolved around its role as the EMCDDA's REITOX focal point in Ireland and the establishment and development of a national epidemiological monitoring system – the National Drug Treatment Reporting System (NDTRS). This was created and refined in line with EU norms on the operation of such epidemiological monitoring systems as set out by the PG and the EMCDDA. As part of their work on the NDTRS, the Unit produced a series of standardised reports based on its data that created a valuable picture of drug treatment. This information was utilised as a vehicle for underlying areas of concern in drug treatment and expressing support for the development of harm reduction services. In doing so the Unit pursued a subtle mode of policy discussion typified by drawing attention to key issues for action without elaborating the specifics of change needed.

The Unit's backing for harm reduction generally was also present in their focus on some of the more complex issues related to drug treatment in their work, such as their research on drug related deaths (DRDs) and blood borne viruses (BBVs). These projects saw them merge a range of pre-existing data to present policy makers with detailed views of events as they stood in unified compendium reports. This course of action was broadly reflective of the way in which research is seen as having an impact in the enlightenment model of the research / policy interface. Essentially, it re-presented this data, building the cumulative impact of the ideas and approaches arising from the research, and added to the stacking process occurring over time. In contrast to some of their other output, in both their work on the expansion of the NDRTS and alcohol policy the Unit adopted a more engaging and policy assertive style of analysis. In this they were characterised by a different approach than their other projects by their laying out options for change as well as underling the issues of concern and presenting a detailed view of events.

During the years analysed the ADRU grew from a relatively small section to a fully developed drugs research Unit carrying out a wide range of drug research. As one of

the two Government linked research bodies operating during this time the output it produced had a considerable impact on filling gaps in the indigenous knowledge base as a result of the pre-existing lack of research on many key areas. In this sense, the Unit's work, particularly its epidemiological output, was influenced by EU involvement with the EMCDDA through its role as their REITOX focal point. As a result their work had a more epidemiological focus during this period, though they did complete a range of other research projects beyond this remit. The following chapter is concerned with the work of the other Government linked research body in operation during the timeframe studied, the National Advisory Committee on Drugs (NACD).

[1] Medico-Social Research Board (1985). *Annual Report 1984*. Dublin: Medico-Social Research Board, p.3.

[2] Medical Research Council of Ireland (1986). *Annual Report for the Year Ended 31st December 1985*. Dublin: Medical Research Council of Ireland, p.7.

[3] Medical Research Council of Ireland (1987). *Annual Report for the Year Ended 31st December 1986*. Dublin: Medical Research Council of Ireland, p.7.

[4] Medical Research Council of Ireland (1987). *Annual Report for the Year Ended 31st December 1986*. Dublin: Medical Research Council of Ireland, p.7.

[5] Medico-Social Research Board (1986). *Annual Report 1985*. Dublin: Medico-Social Research Board, p.8.

[6] Medico-Social Research Board (1986). *Annual Report 1985*. Dublin: Medico-Social Research Board, p.8.

[7] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, p.3.

[8] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, p.6.

[9] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, p.23.

[10] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, pp.4-5.

[11] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, p.4.

[12] Health Research Board (1988). *Annual Report for 1987*. Dublin: Health Research Board, p.5.

[13] Health Research Board (1989). *Annual Report and Accounts for 1988*. Dublin: Health Research Board, p.3.

[14] Health Research Board (1989). *Annual Report and Accounts for 1988*. Dublin: Health Research Board, p.3.

[15] Health Research Board (1989). *Annual Report and Accounts for 1988*. Dublin: Health Research Board, p.22.

[16] Health Research Board (1991). *Annual Report and Accounts for 1990*. Dublin: Health Research Board, p.4.

[17] Health Research Board (1992). *Annual Report and Accounts for 1991*. Dublin: Health Research Board, p.5; Health Research Board (1993). *Annual Report and Accounts for 1992*. Dublin: Health Research Board, p.5.

[18] Health Research Board (1996). *Annual Report and Accounts for 1995*. Dublin: Health Research Board, p.4; p.6; p.8.

[19] Health Research Board (2003). *Annual Report and Accounts for 2001*. Dublin: Health Research Board, p.5.

[20] Health Research Board (1993). *Annual Report and Accounts for 1992*. Dublin: Health Research Board, p.19.

[21] Health Research Board (1996). *Annual Report and Accounts for 1995*. Dublin: Health Research Board, p.29.

[22] Health Research Board (1997). *Annual Report and Accounts for 1996*. Dublin: Health Research Board, p.29.

[23] Health Research Board (1998). *Annual Report and Accounts for 1997*. Dublin: Health Research Board, p.22.

[24] Health Research Board (2003). *Annual Report and Accounts for 2001*. Dublin: Health Research Board, p.24.

[25] Health Research Board (1998). *Annual Report and Accounts for 1997*. Dublin: Health Research Board, p.22; O'Brien,, M. & Moran, R. (1998). *Overview of Drug Issues in Ireland 1997*, Dublin, Health Research Board, pp.108-109; Health Research Board (1999). *Annual Report and Accounts for 1998*. Dublin: Health Research Board, p.18.

[26] Council of the European Union (12.02.1993). 'Council Regulation (EEC) No 302/93 of 8 February 1993 on the establishment of a European Monitoring Centre for Drugs and Drug Addiction', *Official Journal of the European Union*, Series (L) 036 Luxembourg: COE.

[27] European Parliament & Council of the European Union (12.12.2006). 'Regulation (EC) No 1920/2006 of the European Parliament and of the Council of 12 December 2006 on the European Monitoring Centre for Drugs and Drug Addiction (recast)', *Official Journal of the European Union*, Series (L) 376/1 Luxembourg: COE, p.1.

[28] Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 21. Dublin: Health Research Board, pp.29-30.

[29] Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 21. Dublin: Health Research Board, p.32.

[30] Health Research Board (1991). *Annual Report and Accounts for 1990*. Dublin: Health Research Board, p.20.

[31] Health Research Board (1990). *Annual Report and Accounts for 1989*. Dublin: Health Research Board, p.20.

[32] Health Research Board (1994). *Annual Report and Accounts for 1993*. Dublin: Health Research Board, p.22.

[33] Moran, R. O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland - National Report 1996*. Dublin: Health Research Board, p.1.

[34] Hartnoll, R. (1994). *Drug treatment reporting systems and the first Treatment Demand Indicator: Definitive Protocol*. Strasbourg: Council of Europe Press; EMCDDA / PG (2000). *Scientific Report: Treatment Demand Indicator Standard Protocol 2.0*. Lisbon: EMCDDA.

[35] Moran, R. O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland - National Report 1996*. Dublin: Health Research Board, p.7; p.12; O'Brien, M., Kelleher, T. & Cahill, P. (2002b). *Occasional Paper No.2. Trends in Treated Drug Misuse in the North Western Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002c). *Occasional Paper No.3. Trends in Treated Drug Misuse in the Midland Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002d). *Occasional Paper No.4. Trends in Treated Drug Misuse in the Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.2; p.3; O'Brien, M., Kelleher, T. & Cahill, P. (2002e). *Occasional Paper No.5. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002f). *Occasional Paper No.6. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.2; p.4; p.5; O'Brien, M., Kelleher, T. & Cahill, P. (2002g). *Occasional Paper No.7. Trends in Treated Drug Misuse in the South Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002h). *Occasional Paper No.8. Trends in Treated Drug Misuse in the Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P., Kelly, F., & Long, J. (2003). *Occasional Paper No.9. Trends in Treated Drug Misuse in the Republic of Ireland, 1996-2000.* Dublin: Health Research Board, p.2; p.5; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No.11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.2; p.3; p.5; p.6; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004c). *Occasional Paper No. 12. Trends*

in Treated Problem Drug Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002. Dublin: Health Research Board, p.1; p.12; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004d). *Occasional Paper No.13. Trends in Treated Problem Opiate Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.10; Kelleher, T., Long, J., Kelly, F., & Sinclair, H. (2004). *Occasional Paper No. 14. Trends in Treated Problem Cannabis Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998-2002.* Dublin: Health Research Board, p.1; Kelly, F., Lynn, E. & Long, J. (2005). *Occasional Paper No. 15. Treatment demand in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board, p.1; p.4; p.8; Long, J., Lynn, E. & Kelly, F. (2005a). *Occasional Paper No. 17. Trends in Treated Problem Drug Use in Ireland, 1998 to 2002.* Dublin: Health Research Board, p.2; p.16.

[36] O'Brien, M., Kelleher, T. & Cahill, P. (2002b). *Occasional Paper No.2. Trends in Treated Drug Misuse in the North Western Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002c). *Occasional Paper No.3. Trends in Treated Drug Misuse in the Midland Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002d). *Occasional Paper No.4. Trends in Treated Drug Misuse in the Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.3; O'Brien, M., Kelleher, T. & Cahill, P. (2002e). *Occasional Paper No.5. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002f). *Occasional Paper No.6. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P. (2002g). *Occasional Paper No.7. Trends in Treated Drug Misuse in the South Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; p.5; O'Brien, M., Kelleher, T. & Cahill, P. (2002h). *Occasional Paper No.8. Trends in Treated Drug Misuse in the Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.2; p.4; O'Brien, M., Kelleher, T. & Cahill, P., Kelly, F., & Long, J. (2003). *Occasional Paper No.9. Trends in Treated Drug Misuse in the Republic of Ireland, 1996-2000.* Dublin: Health Research Board, p.3; p.4; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No.11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.3; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004c). *Occasional Paper No. 12. Trends in Treated Problem Drug Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.5; p.8; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004d). *Occasional Paper No.13. Trends in Treated Problem Opiate Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; Kelleher, T., Long, J., Kelly, F., & Sinclair, H. (2004). *Occasional Paper No. 14. Trends in Treated Problem Cannabis Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998-2002.* Dublin: Health Research Board, p.1; Kelly, F., Lynn, E. & Long, J. (2005). *Occasional Paper No. 15. Treatment Demand in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research

Board, p.1; Kelly, F., Long, J. & Lynn, E. (2005). *Occasional Paper No. 16. Trends in Treated Problem Drug Use in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board, p.1; p.2; p.6; Long, J., Lynn, E. & Kelly, F. (2005a). *Occasional Paper No. 17. Trends in Treated Problem Drug Use in Ireland, 1998 to 2002.* Dublin: Health Research Board, p.1.

[37] O'Hare, A. & O'Brien, M. (1992). *Treated Drug Misuse in the Greater Dublin Area 1990.* Dublin: Health Research Board, p.64; p.65; Moran, R. O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland - National Report 1996.* Dublin: Health Research Board, pp.10-12; p.13; O'Brien, M., Kelleher, T. & Cahill, P. (2002b). *Occasional Paper No.2. Trends in Treated Drug Misuse in the North Western Health Board Area 1996-2000.* Dublin: Health Research Board, p.5; O'Brien, M., Kelleher, T. & Cahill, P. (2002c). *Occasional Paper No. 3. Trends in Treated Drug Misuse in the Midland Health Board Area 1996-2000.* Dublin: Health Research Board, p.4; p.5; p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002e). *Occasional Paper No.5. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board, p.4; p.5; p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002f). *Occasional Paper No.6. Trends in Treated Drug Misuse in the North Eastern Health Board Area, 1996-2000.* Dublin: Health Research Board, p.5; p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002g). *Occasional Paper No.7. Trends in Treated Drug Misuse in the South Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.5; p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002h). *Occasional Paper No.8. Trends in Treated Drug Misuse in the Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.4; p.5; p.6; O'Brien, M., Kelleher, T. & Cahill, P., Kelly, F., & Long, J. (2003). *Occasional Paper No.9. Trends in Treated Drug Misuse in the Republic of Ireland, 1996-2000.* Dublin: Health Research Board, p.4; p.5; p.6; p.7; Long, J., Jackson T., Kidd, M., Kelleher, T., & Sinclair, H. (2004a). *Occasional Paper No. 10.* Treatment Demand for Problem Alcohol Use in the South Eastern and Southern Health Board Areas, 2000-2002. Dublin: Health Research Board, p.2; p.3; p.5; p.7; p.11; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No. 11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.6; p.8; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004c). *Occasional Paper No. 12. Trends in Treated Problem Drug Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.2; p.12; Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004d). *Occasional Paper No.13. Trends in Treated Problem Opiate Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.1; p.2; p.10; Kelleher, T., Long, J., Kelly, F., & Sinclair, H. (2004). *Occasional Paper No. 14. Trends in Treated Problem Cannabis Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998-2002.* Dublin: Health Research Board, p.2; Kelly, F., Lynn, E. & Long, J. (2005). *Occasional Paper No. 15. Treatment Demand in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board, pp.1-2; Kelly, F., Long, J. & Lynn, E. (2005). *Occasional Paper No. 16. Trends in Treated Problem Drug Use in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board,

p.2; p.3; Long, J., Lynn, E. & Kelly, F. (2005a). *Occasional Paper No. 17. Trends in Treated Problem Drug Use in Ireland, 1998 to 2002.* Dublin: Health Research Board; p.2; p.16.

[38] O'Brien, M., Kelleher, T. & Cahill, P. (2002a). *Occasional Paper No.1. Trends in Treated Drug Misuse in the Southern Health Board Area 1996-2000.* Dublin: Health Research Board, p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002c). *Occasional Paper No.3. Trends in Treated Drug Misuse in the Midland Health Board Area 1996-2000.* Dublin: Health Research Board, p.6; O'Brien, M., Kelleher, T. & Cahill, P. (2002g). *Occasional Paper No. 7. Trends in Treated Drug Misuse in the South Eastern Health Board Area 1996-2000.* Dublin: Health Research Board, p.6.

[39] Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004d). *Occasional Paper No.13. Trends in Treated Problem Opiate Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.5.

[40] Kelly, F., Lynn, E. & Long, J. (2005). *Occasional Paper No. 15. Treatment demand in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board, p.5.

[41] Long, J., Lynn, E. & Kelly, F. (2005a). *Occasional Paper No. 17. Trends in Treated Problem Drug Use in Ireland, 1998 to 2002.* Dublin: Health Research Board, p.5.

[42] NACD (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.12.

[43] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008.* Dublin: Stationery Office, p.118

[44] Moran, R. O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland - National Report 1996.* Dublin: Health Research Board, p.1.

[45] O'Brien, M., Moran, R., Kelleher, T. & Cahill, P. (2000). *National Drug Treatment Reporting System, Statistical Bulletin 1997 and 1998. National data and Data by Health Board Area.* Dublin: Health Research Board, p.iv; p.1.

[46] Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No. 11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.3.

[47] Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No. 11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board, p.3.

[48] NACD (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.12.

[49] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 2, p.10.

[50] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 4, p.11; p.18.

[51] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.117; PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 4, p.10.

[52] Department of Health and Children (2005). *Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems*. Dublin: Stationery Office, pp.18-27.

[53] Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.36; p.37; p.38; p.64.

[54] Department of Community, Rural and Gaeltacht Affairs (2007). *Report of the Working Group on Drugs Rehabilitation*. Dublin: Stationery Office, p.10; p.20.

[55] Department of Community, Rural and Gaeltacht Affairs (2004). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office, p.16.

[56] Department of Community, Rural and Gaeltacht Affairs (2004). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office, pp.17-18; p.23.

[57] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.21; p.22; p.32; p.102.

[58] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.27.

[59] Long, J., Lynn, E. & Keating J. (2005b). *Drug-related deaths in Ireland, 1990-2002. Overview 1*. Dublin: Health Research Board, p.15.

[60] Drug Misuse Research Division (2005a). *Drugnet Ireland*, Issue 14. Dublin: Health Research Board, p.17; Drug Misuse Research Division (2005b). *Drugnet Ireland*, Issue 16. Dublin: Health Research Board, p.1.

[61] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.118.

[62] Drug Misuse Research Division (2000). *Drugnet Ireland*, Issue 2. Dublin: Health Research Board, p.1; Drug Misuse Research Division (2003). *Drugnet Ireland*, Issue 7. Dublin: Health Research Board, p.5; Drug Misuse Research Division (2003). *Drugnet Ireland*, Issue 9. Dublin: Health Research Board, pp.7-8; Drug Misuse Research Division (2004). *Drugnet Ireland*, Issue 10. Dublin: Health Research Board, p.12; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 13. Dublin: Health Research Board, p.22; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 15. Dublin: Health Research Board, p.10; Drug Misuse Research Division (2006). *Drugnet Ireland*, Issue 18. Dublin: Health Research Board, pp.20-21; Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 21. Dublin: Health Research Board, p.2; Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 23. Dublin: Health Research Board, p.12; p.14.

[63] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.3.

[64] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.13.

[65] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.13; p.14; p.45; p.47.

[66] Dillon, L. & O'Brien, M. (2001). 'Drug-Related Infectious Diseases', *A Collection of Papers on Drug Issues in Ireland.* Moran, R., Dillon, L., O'Brien, M., Mayock, P., & Farrell, E. with Pike, B., Dublin: Health Research Board; Drug Misuse Research Division (2002). *Drugnet Ireland*, Issue 6. Dublin: Health Research Board, p.4; Drug Misuse Research Division (2003). *Drugnet Ireland*, Issue 9. Dublin: Health Research Board, p.10; Drug Misuse Research Division (2004). *Drugnet Ireland*, Issue 10. Dublin: Health Research Board, p.9; p.10; p.15; Drug Misuse Research Division (2004). *Drugnet Ireland*, Issue 11. Dublin: Health Research Board, pp.8-10; Drug Misuse Research Division (2004). *Drugnet Ireland*, Issue 12. Dublin: Health Research Board, p.9; p.12; p.24; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 13. Dublin: Health Research Board, p.11; pp.12-13; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 14. Dublin: Health Research Board, p.3; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 15. Dublin: Health Research Board, p.6; Drug Misuse Research Division (2005). *Drugnet Ireland*, Issue 16. Dublin: Health Research Board, pp.10-11; Drug Misuse Research Division (2006). *Drugnet Ireland*, Issue 17. Dublin: Health Research Board, p.15; Drug Misuse Research Division (2006). *Drugnet Ireland*, Issue 19. Dublin: Health Research Board, p.22; p.24; Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 21. Dublin: Health Research Board, p.13; Alcohol and Drug Research Unit (2007). *Drugnet Ireland*, Issue 23. Dublin: Health Research Board, p.15; p.18.

[67] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.13.

[68] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.13; p.14.

[69] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.93.

[70] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.13; p.14; p.36; p.81.

[71] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, pp.82-83.

[72] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.34; p.48; p.64; p.68.

[73] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.78; pp.89-90.

[74] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.75; p.93.

[75] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.16.

[76] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.15.

[77] Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board, p.20.

[78] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services.* Dublin: Health Research Board, p.2.

[79] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services.* Dublin: Health Research Board, pp.v-vi; pp.2-3.

[80] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.vii; p.40; p.42; p.54; p.64.

[81] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.iv; pp.71-72.

[82] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.ii; p.72.

[83] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.41-42.

[84] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.ii; p.54.

[85] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.iii; p.51; p.53.

[86] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.64.

[87] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.78.

[88] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.vii, p.64; p.78; p.79.

[89] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.2.

[90] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.35.

[91] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.78-79.

[92] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.17.

[93] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.17; p.39.

[94] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.17; p.24; p.77.

[95] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.24.

[96] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.17; p.25; p.26; p.28.

[97] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.26.

[98] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.23.; p.28; p.45; p.46; p.77.

[99] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.23.

[100] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.77.

[101] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.18.

[102] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.30.

[103] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, pp.30-31; p.32.

[104] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.18; p.24; pp.34-35.

[105] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.34.

[106] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.77.

[107] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.18; p.29; p.34.

[108] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.18; p.61.

[109] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.35; p.36.

[110] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.35; p.36.

[111] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.35; p.36.

[112] McGarry, P. (November 1st, 2007). 'Alcohol consumption increases 17%', Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1101/1193444293021.html

McGarry, P. (November 1st, 2007). 'Doubling in hospital bed days to treat illness linked to alcohol', Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1101/1193444293015.html

Editorial (November 1st, 2007). 'Binge drinking' Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/opinion/2007/1101/1193444281581.html

Editorial (November 1st, 2007). 'Irish three times more likely to binge-drink', Retrieved 01.11.2007 from: http://archives.tcm.ie/irishexaminer/2007/11/01/story46793.asp

Editorial (November 1st, 2007). 'Drink-related deaths have doubled in 10 years', Retrieved 01.11.2007from:
http://archives.tcm.ie/irishexaminer/2007/11/01/story46776.asp

O'Halloran, M. (November 2nd, 2007). 'Cowen concern at abuse of alcohol', Retrieved 02.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1102/1193444383971.html

Waters, J (November 5th, 2007). 'Inebriated nation needs help', Retrieved 05.11.2007 from:
http://www.ireland.com/newspaper/opinion/2007/1105/1193444563765.html

Editorial (November 5th, 2007). 'Call for Irish alcohol strategy', Retrieved 05.11.2007 from:
http://www.irishmedicalnews.ie/articles.asp?Category=news&ArticleID=19791

Judge, T. (November 6th, 2007). 'Getting a grip on our drink problems', Retrieved 06.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1106/1194222679534.html

Ryan, S. (November 9th, 2007). 'Government alcohol policies ignored and often contradictory', Retrieved 09.11.2007from:
Source: http://www.imt.ie/news/2007/11/government_alcohol_policies_ig.html

McGarry, P. (November 13th, 2007). 'Education not effective in limiting alcohol abuse', Retrieved 13.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1113/1194550197031.html

McDonagh, M. (November 13th, 2007). 'Call for limits on alcohol advertising', Retrieved 13.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1113/1194550189427.html

Mulvey, C. (November 19th, 2007). 'Irish ranked 3rd biggest drinkers', Retrieved 19.11.2007 from:
http://www.ireland.com/newspaper/breaking/2007/1119/breaking26.html

Knowles, R. (November 20th, 2007). 'HSE calls for more tax on alcohol', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1120/1195251510546.html

Brennan, M. & O'Regan, E. (November 20th, 2007). 'Consumer chief rejects HSE call for 10pc hike in drink duty', Retrieved 20.11.2007 from:
http://www.independent.ie/national-news/consumer-chief-rejects-hse-call-for-10pc-hike-in-drink-duty-1223565.html

Editorial (November 20th, 2007). 'Health authorities urge 10% hike in tax on alcohol', Retrieved 20.11.2007 from:
http://archives.tcm.ie/irishexaminer/2007/11/20/story48351.asp

Houston, M. (November 27th, 2007). 'Alcohol is major factor in youth suicides – study', Retrieved 27.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682394007.html

Slattery, L. (November 27th, 2007). 'A taxing issue?', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682389884.html

Slattery, L. (November 27th, 2007). 'The economist's view', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682389888.html

Hennessy, M. (December 7th, 2007). 'Lenihan set to ban sales of below-cost alcohol', Retrieved 07.12.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1207/1196839063486.html

Bracken, A. (December 23rd, 2007). 'Cocaine is in the headlines but alcohol is our No.1 killer', Retrieved 23.12.2007 from:
http://www.tribune.ie/article.tvt?_scope=Tribune/News/Home%20News&id=81549&SUBCAT=Tribune/News&SUBCATNAME=News

Coulter, C. (January 8th, 2008). 'Think tank to tackle alcohol problem', Retrieved 08.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0108/1199313619907.html

Woulfe, J. (January 9th, 2008). 'Radical proposals to target underage drinking', Retrieved 09.01.2008 from: http://archives.tcm.ie/irishexaminer/2008/01/09/story52156.asp

McGreevy, R. (January 10th, 2008). 'Group to consider raising legal age for alcohol', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0110/1199313758982.html

Wilde, J. (January 10th, 2008). 'State must play central role in public health', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/opinion/2008/0110/1199313758988.html

Hogan, L. (January 10th, 2008). 'Get-tough campaign to tackle the binge drinkers', Retrieved 10.01.2008 from:
http://www.independent.ie/national-news/gettough-campaign-to-tackle-the-binge-drinkers-1261942.html

Editorial (January 10th, 2008). 'Combatting our biggest social ill', Retrieved 10.01.2008 from:
http://www.independent.ie/opinion/editorial/combatting-our-biggest-social-ill-1261872.html

Editorial (January 10th, 2008). 'Action on Health', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/opinion/2008/0111/1199917849639.html

Andersen, A. (January 15th, 2008). 'Controlling the drink-link factor', Retrieved 15.01.2008 from:
http://www.ireland.com/newspaper/health/2008/0115/1200260464414.html

Slattery, L. (January 31st, 2008). 'Rise in tax on alcohol 'a better means' of cutting consumption', Retrieved 31.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0131/1201501795567.html

Baker, N. (February 6th, 2008). 'Teenage 'test buyers' to target off-licenses', Retrieved 06.02.2008 from:
http://www.irishexaminer.com/archives/2008/0206/ireland/teenage-test-buyers-to-target-off-licences-54575.html

McGreevy, R. (February 6th, 2008). 'Call for under-18s to be sent to buy drink in 'sting' move', Retrieved 06.02.2008 from:
Source: http://www.ireland.com/newspaper/ireland/2008/0206/1201903564466.html

Cullen, P. (February 6th, 2008). 'Alcohol 'credits' card for young people proposed', Retrieved 06.02.2008 from:
Source: http://www.ireland.com/newspaper/ireland/2008/0206/1201903564464.html

Cullen, P. (February 12th, 2008). 'The taxing issue of alcohol', Retrieved 12.02.2008 from:
http://www.ireland.com/newspaper/health/2008/0212/1202509695196.html

[113] Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services*. Dublin: Health Research Board, p.vii, p.64; p.78; p.79.

[114] Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board, p.34; p.77.

Chapter 7: Researching Harm Reduction: The NACD

The timeframe being documented in this study was marked by a great deal of change in drug policy generally. One of main areas in which a significant degree of transition occurred, when compared with early periods of policy making, was the level of Government backed research being carried out. During the years being looked at here research on drug policy and treatment issues took on an increased role within drug policy and the level of funding made available for such work improved. This took place in line with the more favourable economic circumstances, colloquially referred to as the 'Celtic Tiger' years, which Ireland found itself in at this time. Accordingly, an increased pace of statutory funded research projects on drug issues were supported and carried out over this period. At the same time, the type of research work being completed became more refined and sophisticated it terms of the output being produced as a strong indigenous knowledge base on drug issues developed. One of the key players in the generation and dissemination of a significant portion of this new statutory funded research was the National Advisory Committee on Drugs (NACD). This part of the thesis looks at some of the work of the NACD during these years, the extent to which they supported the development of treatment and harm reduction in it, and some of the ways in which their work developed over time.

The present chapter is comprised of five sections. The first part of the chapter is concerned with the background and role of the Committee. Following this the second section explores work carried out by the NACD on needle and syringe exchanges programmes (NSPs) and considers their backing for this treatment option at different points in the time studied. The third portion of the chapter looks at the nature of different pieces of work on cocaine use by the Committee and discusses the emergence of key changes over time. After this the chapter moves to a consideration of the NACD's work on dual diagnosis and its role in the development of mental health policy. Subsequently, the chapter discusses an evaluation of the Committee's structure and performance. This is followed by an overall conclusion.

The Creation and Role of the Committee

The years under analysis witnessed an unprecedented increase in the level of official actions aimed at tackling drug use and improving the treatment options available to drug users. A wide range of changes occurred at different levels of the Governmental response to drug problems in this respect. These ranged from changes in the type of policies that were formulated and how they were implemented to the structures that were designed to deliver them on the ground. Consequently, one of the key areas where a significant level of change took place was the field of drug research. Specifically, during the timeframe under analysis there was an increased amount of funding allocated to drug research projects. This section of the chapter explores the background of the National Advisory Committee on Drugs (NACD).

Reflecting trends in drug policy internationally, the Irish Government's decision to establish a body for advisory purposes in the area of drug policy was not unusual. Many countries have a structure that functions more or less along the same lines as the NACD. For example, in the UK the Advisory Council on the Misuse of Drugs (ACMD) provides the government with policy relevant advice. There is, however, an important difference between the operational status of the Irish body and a structure such as the ACMD. While the ACMD is a statutory body, the Irish structure was created on a non-statutory basis. One of the main benefits of the NACD being established on a non-statutory basis at the time of their inception was that it allowed them to become operational straight away. As a result they avoided having to wait until legislation could be passed to put them on a statutory footing. Consequently, they were able to start their work straight away and in their first progress report in 2003 they showcased the rapid pace at which they had completed 6 projects and initiated another 19.[1]

In order to understand the way in which the NACD came into being it is necessary for us to consider the work of the Interim Advisory Committee on Drugs (IACD). The 15th of July 1999 saw the Minister in charge of the drugs brief at the time, Chris Flood, announce the Interim Committee's creation.[2] After meeting eight times and receiving a range of submissions from key stakeholders, including the NDST, the IACD presented the Cabinet Committee on Social Inclusion (CCSI) with its findings and recommendations in February 2000.[3] The CCSI is one of the key structures in Irish drugs

policy that we discussed in chapter four. It is chaired by the Taoiseach and facilitates the merging of drug policy and social inclusion policy. Hierarchically, the CCSI sits at the top of the drug policy structural chain of command.

The Interim Committee was set a range of tasks in its terms of reference. These included the need to consider the structure and composition of the new Advisory Committee, how existing resources in the drugs policy area could be most effectively utilised, and to design an initial three-year programme of work for the body.[4] Regarding the Committee's work schedule, the submission from the NDST played a key role in helping them to define what type of research would be carried out.[5] At a number of points in their report the Interim Committee placed importance on the need to encourage agencies involved in the drugs area, particularly those in receipt of statutory funding, to collect and report data and to do so in accordance with best practice standards.[6] In addition, the IACD asserted that it would be beneficial to all those involved in the drugs area if a central clearing house for information and research on drug issues was established.[7] This ultimately led to the creation of the National Documentation Centre on Drug Use (NDC), which was housed within the HRB as a result of their drug section having been appointed as its custodian.

In May 2000 the IACD's efforts came to fruition when the Minister for Tourism, Sport and Recreation made a formal request to the Government to establish the NACD and to appoint the HRB as being in charge of the NDC.[8] Consequently, in July 2000 the Committee was formally established under the auspices of the Department of Tourism, Sport and Recreation, where it would remain until June 2002 when the Department of Community Rural and Gaeltacht Affairs became responsible for it.[9] At this time the NACD was allocated a budget of 3.8 million Euros to cover its triennial work schedule.[10] We can garner a sense of the Committee's success in completing its work to a standard that the Government, or more specifically the CCSI, was satisfied with from the extension of their terms of reference. Specifically, the NACD's lifespan was initially extended by one year ending in July 2004 and then increased for a further four years to match the running time of the National Drugs Strategy up to 2008.[11]

Looking back across the Committee's activities since its inception it is clear that the individuals involved were committed to their work and productive. For example, by

July 2001 they had held 10 ordinary meetings, their subcommittees had convened meetings, and three research projects had been commissioned.[12] The sustained efforts of the Committee are evident from the fact that by 2003 they held 30 meetings in total, all of which were well attended by the members, thus ensuring that the NACD was not merely functional 'on paper'.[13] By 2006 the Committee was holding meetings every six weeks with a summer recess in July and August.[14] The members each sat on two subcommittees, as well as playing a role in the research tendering process and being part of the Research Advisory Groups (RAGs) for individual projects.[15] This activity resulted in the members on average giving the equivalent of 24 days each year to the Committee's work.[16]

In a semi-structured interview the Chairman of the Committee asserted that those involved were determined that the new body would not be the type of policy structure that was merely set up and only to then slowly fade away.[17] Rather, the members of the NACD were committed to the process of carrying out research and delivering advice for the long haul and ensuring that the Committee survived as a structure.[18] In this respect, the individual members became involved in the control and delivery of the research process, as seen in the role on RAGs for example, in order to ensure that the research product they were delivering was of as good a quality as it could have been.[19] The Chairman highlighted that this was crucial while they established themselves initially to the research consuming community as a credible research body.[20]

The IACD set out a range of research tasks for the NACD to complete revolving around the commissioning of new research and the analysis of existing studies. The Committee was to focus on prevalence, treatment, the consequences of drug use, prevention, as well as early warning and emerging trends.[21] Their work was designed as being explicitly aimed at informing policy.[22] While the ADRU's work aimed to inform policy, this was not the result of a defined operating agenda approved by the Government in the way that the Committee's was. Consequently, the view yielded from our analysis of their work throughout this chapter highlights the policy-relevant nature of their output.

The IACD stated that the new Committee would play an important role in terms of providing policy makers with relevant research data and advice on courses of action to deal with the issues raised.[23] This was a point that was affirmed by the NACD in their annual reports and business plans.[24] In this sense, one of the key functions of the

Committee was to carry out research at the request of the Government and provide any advice that was needed on particular issues.[25] For example, the Committee's report on the pharmacotherapy Buprenorphine was the result of a request from Minister of State with responsibility for the drugs strategy.[26] Similarly, the NACD carried out work on creating a Drug Trends Monitoring System (DTMS) as a result of a direct request from Government.[27] In addition, 2005 saw the Committee respond to a request from Government to update their research on cocaine use in Ireland.[28]

Like the ADRU there are also examples where the Committee has responded to aspects of *Building on Experience*, and can accordingly be seen as having its research agenda partially defined by the national drugs strategy. A prominent example of this process in action can be seen from the different studies on vulnerable groups – homeless, Travellers, prostitutes, early school leavers – that the Committee had carried out or was initiating during the period under study in response to drug strategy action 98.[29] Similarly, their review of harm reduction treatments and their seminar on quality standards in addiction treatments were both asserted to be responses to actions 50 and 100 in the drugs strategy respectively.[30] In addition, their longitudinal study of treatment outcomes, known as ROSIE was presented as being a response to action 99 of the drugs strategy.[31] The following section of the chapter explores the Committee's work on needle and syringe exchange programmes (NSPs) completed during the period being studied.

Researching Needle and Syringe Exchanges

During the time studied the NACD conducted a range of different studies on various aspects of the approaches to drug treatment that fall within the general category of practices referred to as harm reduction strategies. Of prime importance to the focus of this study on the development specific parts of the treatment system, as well as our concerns in the present section, are two studies that the Committee carried out in 2004 and 2008.[32] These pieces of work were concerned with the role of needle and syringe exchange programmes (NSPs). The completion of these research projects at different points in the middle and near the end of the period being examined affords us a view of the way the

NACD's work on this issue progressed over time and their support for it as a treatment option.

Launched in May 2004 *A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature* was the first report by a Government-backed research body exploring the nature of such treatment issues.[33] While the report itself was concerned with harm reduction generally, it devoted a specific section to exploring the issue of NSPs and as we will see below looked at issues related to them throughout its analysis.[34] It was clear that the report was designed to be an aid to policy makers and those developing services. In this sense, the document began with a forward from the Minister of State with responsibility for the drugs strategy at the time Noel Ahern which noted:

> "The research and analysis provided by the NACD is particularly helpful to the policy development process and also to developing best practice in service delivery."[35]

The Minister's sentiment was supported and reiterated by the Committee themselves in their conclusion to the study.[36] Specifically they felt the prefabricated compendium of research knowledge that they had put together offered itself as a useful tool for the development of drug services. In this respect, the Committee's perspective on the role of the report was reflective of the search-route sub-type of the problem solving model of the research / policy interface discussed in chapter one. Essentially, they were attempting to provide those concerned with exploring the issue from a policy or service development point of view with a comprehensive knowledge base from an indigenous source. This was a view of their agenda that the Chairman of the NACD agreed with in a semi-structured interview.[37]

At a number of points in the Committee's study it was possible to detect a clear level of support for harm reduction in general and particularly in relation to its ability to reduce, if not stop, the spread of blood borne viruses (BBVs). The Committee pointed out that the beneficial effects of harm reduction practices were being achieved without any additional drug use arising from them, highlighting that these practices did not exacerbate existing or initiate new substance use.[38] Their support for the role of harm reduction as a core element of drug treatment could be gauged from their comments on its accessibility.

Throughout the study it was made explicitly clear that the limited opening hours of many services coupled with poor geographical coverage was a problem that needed to be addressed.[39] These generally supportive points showed that the Committee was in favour of harm reduction practices being used in drug treatment. This could also be seen from the way the report repeatedly legitimated the use of NSPs via its asserted primary focus with examining methods for reducing the sharing of drug using paraphernalia.[40]

Over the course of the study whenever the Committee's focus rested on the use of NSPs there was a strong sense of consistency in their presentation of the details of different studies and on the back of this data the beneficial utility of such programmes.[41] Given that NSPs were operational in Ireland long before the Committee came into being there is perhaps more of a sense of their backing for such measures to be gained from taking a look at their stance on the fine tuning of such services. In this respect, a key issue warranting attention since the advent of HCV at the end of the 1980s has been the need to try and get IDUs to stop sharing any injecting paraphernalia. This is a point that the study emphasised a number of times. It was asserted that service providers needed to be exchanging all drug preparation materials – spoons, filters, swabs, water – as all of these items were efficient mechanisms for the transmission of HCV.[42] In addition and more clearly we can see the backing that was being given for NSPs from the way in which the report broached the issue of establishing them at community level via the utilisation of pharmacies. In discussing the level of provision available they stated:

> "Where it is not viable for Health Boards to provide exchange services or extended opening hours, initiatives such as vending machines and dispensing through community pharmacies should be considered."[43]

The Committee made this point after having detailed the positive findings of a number of studies on the use of such systems for the distribution of needles and syringes.[44] This essentially built a strong case for their argument and displayed their support for the intervention in question.

The NACD's report discussed the development of NSPs in a range of different countries internationally and noted that they had been recoded as having achieved a reduction in HIV transmission rates between IDUs in Switzerland.[45] The extent of the

Committee's backing for the use of NSPs can be seen from the support they expressed for their use in other settings and some of the more controversial aspects of their development as a form of treatment. Chief among these were the document's focus on NSPs in prisons and its discussion of safe injecting facilities (SIFs) an additional and more controversial extension of how NSPs are delivered. On the former issue the Committee noted,

> "International research indicates that the introduction of relevant harm reduction programmes in prison, such as equipment exchange, can help reduce HIV and HCV transmission rates, without a subsequent increase in the rate of illicit drug consumption."[46]

They also supported this point by reiterating in their overall conclusions that the establishment of NSPs was not linked to increases in drug use and that needle sharing was a key factor in disease transmission in Irish prisons.[47]

On the issue of SIFs they reviewed evidence from a number of different countries to explore the topic.[48] Again, reflective of the process of hierarchical diffusion discussed in chapter one, as in the case of NSPs themselves at an earlier stage, their analysis noted how a range of countries had operational SIFs and how others were planning such interventions.[49] These included Australia, Germany, Spain, the Netherlands, and Switzerland in the former group, with Portugal and Luxembourg in the latter.[50] Ultimately, the Committee gave what can be seen as guarded support for the role that such an intervention might play in Irish drug treatment on the basis that NSPs alone were not enough to eliminate the sharing of materials used in the preparation of drugs for injection.[51]

The end of the Committee's report was marked by an overall conclusions section rather than a specific set of recommendations on the issues discussed.[52] As we will see below, this was to stand in direct contrast to their later work on the same topic. At this stage in the period studied it was evident that the NACD had come out clearly in favour of the utilisation of NSPs as a core feature of drug treatment services. This was evident from the supportive manner in which they had been discussed and framed throughout their 2004 report as discussed above.[53] In this respect, the document ended without

putting forward specific actions to be taken or directive advice.[54] Instead the approach adopted was to offer critical guidance on the thrust of the state of play in international research more so than what should be done next in a very solid way.[55] At the same time, these distilled summaries of the research reviewed were interspersed with comments noting the existence of certain problems among Irish IDUs and gaps in service provision.[56] While this was done in a subtle and non-directive manner, the way in which the report both attempted to influence policy and reflected the NACD's support for NSP was evident from these tactfully presented closing remarks.[57]

The Chairman of the NACD felt that the difference between the approach taken with the end of their reports at these points – the later one having specific actions – was due to the developmental phase at which the Committee was at.[58] By this he meant that at that point, around 2004 or so, they were still proving themselves as a legitimate research entity to both policy makers and the wider research utilising community.[59] In this sense, he felt that at this stage they were quite focused on producing research, namely as there was such a small indigenous knowledge base to begin with.[60] After this point had been sufficiently reached, they then started to progress their advisory role to a greater extent, as we shall see below in their later work on the same subject.[61]

December 2008 saw the Committee release their second piece of work dealing with the topic of NSPs during the period under study. Unlike its 2004 predecessor *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs* was solely focused on the topic and not harm reduction generally. As its subtitle implies, the work was co-authored with the National Drugs Strategy Team (NDST). The report had its origins in a Ministerial request from September 2007. At that time the then Minister of State with responsibility for the National Drugs Strategy, Pat Carey, asked for work to be done on the issue in response to issues raised by the Voluntary Drug Sector.[62] According to the Chairman of the NACD the Committee was already engaged in work on BBVs and NSPs around this time and essentially discovering that the NDST wished to do a similar project led them to join forces for the production of the research.[63] This was for a number of reasons including the hope of having a greater impact on policy.[64] The report itself allows us to see the way

in which the NACD's support for NSPs as a feature of drug treatment was maintained over the period under study and the way in which their work changed.

Reflecting the more in-depth coverage of the issue that their 2008 report presented and the progression in level of sophistication in the Committee's work over the period studied, NSPs were discussed in relation to three main sections. These consisted of issues related to BBVs and IDU, the operation of NSPs, and NSP services in Ireland.[65] In exploring the nature of BBV health problems among IDUs in Ireland the more refined character that the Committee's work had taken on when compared with its 2004 review of the same subject was apparent.[66] In this respect they noted a range of key data highlighting both the successes that had been achieved through the deployment of NSPs in Ireland in combating HIV as well as other information that underlined the need for expansion of the services. In the former sense, they drew attention to Department of Health and Children (DoHC) and national Virus Reference Laboratory figures for the period from 1982 to 1995.[67] They noted how these figures had suggested that NSPs had helped reduce HIV rates among IDUs as while 60 percent were positive during the years 1982 to 1985, this had decreased to 17.7 percent by 1997.[68]

In the latter sense, in terms of supporting the scaling-up of NSP services, the Committee described a range of factors related to the way in which services had been more successful in their current form at tackling HIV than HCV among IDUs. Chief among these was their stating on the one hand that recent studies showed that one in ten IDUs was HIV positive.[69] While on the other they pointed out that seven out of ten IDUs in drug treatment had tested positive for HCV.[70] They went on to discuss a range of issues related to the severity of the problems posed by HCV infection. These included the development of sever health problems by roughly 80 percent of those infected, as well as its highly resilient nature and ease of transmission through a variety of injecting paraphernalia.[71] Both strands of their discussion in this respect show us the thorough nature of their work on the issue and the way in which they had started their report by legitimating the case for the expansion of NSPs. This was a process which essentially reflected their own support for the further development of the services in question. Further evidence of this was visible from the outset of the document when the Committee asserted that its recommendations were geared towards achieving a better level of NSP

provision and in the process tackling BBVs.[72] Such an approach marked a much more direct and engaging style than the one taken in their earlier work on the topic.

In discussing the operation of NSPs, the report went on to offer a highly comprehensive picture of the different modes of delivery and their effectiveness by reviewing research that underlined their support for the use and expansion of such services.[73] The Committee set out a range of points that revealed the success NSPs had achieved in combating HIV. Chief among these was their noting that the benefits of NSPs as a HIV prevention tool were clearly recognised and international research had displayed those attending exchanges had lower rates of infection than non-attendees.[74] The report went on to note the way in which NSPs had been shown to reduce the amount of used needles in circulation, as well as the fact that those who attend exchanges are less likely to share their injecting equipment.[75] In addition, it also drew attention to the way in which NSPs functioned as an important means of referring IDUs onto other drug treatment services.[76] The Committee added further strength to their build-up of evidence supporting the existing use of NSPs by referring to the way in which the WHO's 2004 evaluation of NSPs for HIV prevention had strongly supported the intervention.[77]

While the Committee's report noted how HIV had been successfully combated by NSPs, it also explored how they were less successful against HCV and in the process made a strong case while reviewing research evidence for the further expansion and diversification of services.[78] Specifically, they drew attention to the fact that internationally there were high rates of HCV among IDUs in countries were there were both NSPs in operation and low levels of HIV.[79] This was largely seen as a result of the ease with which the virus was spread and its predating the opening of NSPs.[80] In this respect the Committee discussed a number of issues in the research evidence essentially setting out a case of the expansion and diversification of existent NSPs.

For example, while they underlined the beneficial aspects of fixed site or clinic based NSPs, they noted a key draw back for users was their limited opening hours.[81] Following on from this they pointed out that having NSPs in close proximity to IDUs increased the likelihood that they would be utilised and as a result a diversity of NSP modalities, such as pharmacies, vending machines and mobile units, needed to be adopted.[82] In developing their discussion the Committee drew attention to the

EMCDDA's discussion of community based pharmacy NSP (CPNSP).[83] While citing its operating in eleven EU counties, they also focused on the manner in which this NSP modality accrued benefits in terms of opening hours and increased levels of needle exchanges taking place.[84] Similarly, in exploring different operational strategies for delivering NSPs, the document drew attention to the fact that at that stage ten EU countries were running exchanges via vending machines.[85] The Committee highlighted that research evidence had supported CPNSPs and mobile NSPs, as well as showing how such multi-site units and vending machines were able to make contact with IDUs that were not engaged by other types of NSPs.[86]

An additional location in which the report drew attention to the use of NSPs was in prisons as a result of the heightened BBV risks from IDU in such settings.[87] In this context it showed how a study looking at a number of evaluations of prison NSPs had found them to have generally favourable outcomes.[88] In their exploration of research issues the Committee also noted from an Irish study how IDUs were still engaged in sharing other paraphernalia.[89] Consequently, one of the other formats for the delivery of NSP that the report reviewed was its provision via secondary NSP or peer-based outreach.[90] This was seen as being effective in reaching IDUs who were homeless, allowing services to cover a wide geographical area without incurring a high financial cost, as well as trying to initiate change in the social rituals of IDUs linked to drug use.[91]

The Committee's exploration of the different modes of operation and effectiveness for the delivery of NSP represented a detailed showcase of research knowledge in the area that underlined the manner in which their work had become more sophisticated over time. It also drew attention to their support for both the existing use of NSPs as a core part of the drug treatment system and their backing for their expansion. Specifically, they had built a strong case for the further development of services by marshalling together a range of evidence that legitimated the use of diverse NSP modalities. In the process of doing so the Committee's actions can be seen as adding to a process of hierarchical diffusion through their advisory capacity via the strong case they were making for the use of, for example, CPNSP and more secondary NSP.

When it explored the nature of NSPs services in Ireland the report presented a detailed overview of the state of play regarding their provision. This was set out in terms

of the type of modalities being utilised and the geographical regions within which they were available.[92] In the former sense, they noted how the majority of NSPs available were of the fixed site type, while there were some mobile units and outreach provision as well.[93] They also discussed how there was still no CPNSP, which the 2001 drugs strategy had called for a pilot of in action 63, due to a range of issues including organisational issues with pharmacists.[94] Similarly, they pointed out that there were no NSP vending machines or prison services available in the State.[95] It was significant and a reflection of the Committee's more policy assertive approach and supportive of NSPs use in the treatment system that these issues were highlighted on the back of their discussion of evidence essentially supporting their introduction.

Regarding the availability of NSPs the Committee displayed their accessibility at the time by Regional Drugs Task Force (RDTFs) area, incorporating the Local Drugs Task Forces (LDTFs) within these regions. Overall they noted that NSPs were operational in thirteen LDTFs and four RDTFs.[96] While the specifics of NSP provision in the DTF areas during the period studied is explored in chapter eight, for our concerns in the present section it is sufficient to note that the report presented a highly inclusive picture of the services in operation.[97] During their review of the adequacy of these services the Committee made a number of points that highlighted both their desire to see services expanded and their strong support for the utilisation of NSPs.

In particular they drew attention to the fact that while *Building on Experience* had sought an expansion of the service, most provision still remained within LDTF areas.[98] Reflecting a switch from their reporting style and tone in their earlier work on the subject, this was seen as being 'inadequate'.[99] In further commenting on services, they highlighted that the four RDTFs that had NSPs were ones that were based within LDTF areas within those regions.[100] Most critically, they asserted that out of the LDTFs that had NSPs in operation, none were necessarily adequate enough as a result of the coverage and opening times being provided.[101] Directly following this point they drew attention to research by the UK National Treatment Agency (NTA), that underlined the way in which utilising a mix of NSP modalities such as CPNSP and outreach as well as its traditional format would provide a greater coverage.[102] As before, the way in which this was raised is reflective of how the Committee's actions can be seen as contributing to a process of

hierarchical diffusion by legitimating the utilisation of additional options to policy makers.

Drawing the document to a close the Committee ended their 2008 work on NSPs with a section of recommendations that represented a distinct break with the more non-directive approach taken in their previous paper on the topic.[103] In this sense, the last pages of the report consisted of a series of detailed actions that built on the evidence and service information discussed earlier on.[104] Reflecting the assertive and confident position being taken by the Committee, the recommendations established what areas needed to be adjusted and named the specific actors that should take responsibility for handling the detail of the modifications needed.[105] For example, their recommendations called for the HSE and LDTFs and RDTFs to directly scale-up the level of NSP services being provided and ensure that these were offering the full range of injecting paraphernalia as well as exchanging needles.[106] Similarly, they also requested the HSE and the DTFs to provide a diversity of NSP modalities, including fixed site centre-based exchanges, outreach NSP, and the piloting of CPNSP, secondary NSP and vending machines.[107]

Ultimately, the NACD's second piece of research on the issue of NSPs can be seen as having solidified their support for the use of the intervention as a core element of the treatment system over the course of the period studied. It also reflected a clear progression in their work towards a more sophisticated style of policy-influencing research production. In this sense, it can be seen as contributing to a process of hierarchical diffusion via its discussion of research supporting the utilisation of different NSP modalities while at the same time drawing attention to the gaps that these specific tools could fill in the Irish system.[108]

This section of the chapter has discussed the principal work carried out by the NACD during the time analysed on the topic of NSPs. During these years the Committee completed two landmark reports, the first being a more generalised look at harm reduction issues, but which gave extensive consideration to NSPs, and the latter a significant NSP-specific report providing in-depth coverage of the area. While both studies were characterised by a high level of research quality there was distinct change in aspects of the approach taken by the Committee over time. The core attribute from the concerns of this chapter of the thesis that the documents did share was they indicated the

NACD's backing for the utilisation of NSPs as a legitimate feature of the drug treatment system. Further, it was evident in both reports, particularly the latter work, that this was an area of the system that they wished to see expanded and developed. In this sense, this area of research was reflective of their overall backing for harm reduction as an approach to drug treatment during these years. On another level the two reports differed in their engagement with the substance of the issues at stake. While the initial work was typified by a more guiding and navigating style of advisory work, the latter report was more firm and policy assertive in its assessment of evidence, services and delivery of recommendations building on them. Ultimately, these distinctions can be seen as representative of a sophisticated progression in the Committee's work over time. As we will see in the following section, which explores the NACD's work on cocaine use, it is possible to see a similar transition in their style of research in other areas over the timeframe studied.

Cocaine Use as a Research & Policy Issue

Over the course of the period being analysed the NACD undertook a range of diverse studies that did much to illuminate previously obscured aspects of substance use in Ireland. One of the key areas that they explored in this respect was the issue of cocaine use. During these years the Committee completed two different research projects looking into the area of cocaine use, shortly after their inception in 2003 and another near the end of the time examined here in 2007. Together both studies allow us to observe the way in which the NACD developed new areas of policy-relevant research and utilised its output to express support for aspects of harm reduction. They also help us to see the manner in which the nature of their research can be seen as having undergone a process of modification over time.

Released in April 2003, the Committee's report *An Overview of Cocaine Use in Ireland* was a good example of the type of quick-fire literature review based research that they could do. In the absence of there being much significant indigenous research on the use of cocaine the Committee's study was intended to helped policy makers orientate themselves to, and get a grasp of, the emerging cocaine problem. The Chairman of the

NACD felt that their work on cocaine had been successful in its purpose in this respect.[109] Reflecting some of the principles of rapid assessment research, the study made effective use of existing data rather than setting out to conduct its own empirical work. This was a critical factor in their being able to complete the project in a few months.

In this respect, the Committee drew on data from a range of pre-existing studies that were either specifically focused on drug use or had included it as a feature of the work. This allowed them to construct a thorough picture of cocaine use. As well as utilising the first all Ireland prevalence survey they presented data from the European School Survey Project on Alcohol and Other Drugs (ESPAD), the Survey of Lifestyle, Attitudes and Nutrition in Ireland (SLAN), and the Irish Health Behaviour in School-aged Children survey (HBSC).[110] This allowed them to provide as detailed a picture as they could of how widely the drug was being used. The Committee also drew on Garda statistics on the volume of seizures occurring.[111] In addition, they explored laboratory data on the level of increases in positive urine tests for cocaine use among those in receipt of drug treatment, as well as data on drug treatment numbers.[112] The information they had from the drug treatment system at that stage showed that only 1 percent of those in treatment cited cocaine as their main drug.[113] In addition, the document drew on other published surveys of drug users, anecdotal evidence and an earlier exploratory study by the ADRU, representing a complex mixture of data sources that functioned to provide a full picture of the topic being explored.[114]

The Committee's report made extensive use of data from the ADRU's NDTRS. They used this information in an effective manner that showed the rise of cocaine use in Ireland.[115] Specifically, they noted the slowly increasing way in which a rising proportion of all and new treatment contacts were starting to cite cocaine as their main problem drug as well as their second problem drug of use.[116] In this sense, for the year 2000 they highlighted that 67.9 percent of those who reported it as a primary drug of use snorted it, with 17.9 injecting it, while 47.5 percent of those reporting it as a secondary drug of use were injecting it.[117] Consequently, we can see the way in which the report drew attention to the harm reduction issues surround IDU and cocaine consumption for policy makers by reiterating the ADRU data.

The Committee's use of the ADRU's work, specifically the NDTRS, is generally reflective of the way in which the enlightenment model of the research / policy interface discussed in chapter one operates over time. Namely, it shows how research on a topic stacks up over extended periods of time, in this case treatment data on cocaine use, but may not necessarily be influential in triggering policy action or decision making on resource allocation at the time it was generated.[118] Then at a later date, such as in or around the time the Committee came to complete its initial work on cocaine use, this same data becomes reactivated and reutilised in a new study looking at the same area. This presents the research information with a chance to contribute towards a cumulative impact on policy, essentially as the stacking effect of the enlightenment model continues over time. Accordingly, a synergy across the streams of analytic work on subjects such as cocaine, for example, by both the ADRU and the NACD during the time can be seen.

The Committee's report provided an overview of the main treatment methods being used to deal with cocaine use.[119] During the course of this review they drew on a range of international research literature to explore the utility of these options.[120] In this respect one of the key points that they raised was that unlike methadone maintenance treatment (MMT) for heroin use, there was no tried and tested pharmacotherapy for cocaine use.[121] They did highlight that success had been reported in the international research literature with the use of Buprenorphine and Disulfiram.[122] They noted from the UK National Treatment Outcome Study (NTORS) that while those heroin users using crack at entry had decreased use at follow-up, others had initiated use, underlining the seriousness of secondary drug use involving cocaine among this population.[123] Outside of the realm of pharmacotherapies the Committee drew attention to the relative success that different forms of counselling had been shown to have in treating cocaine use.[124] In this sense, they asserted that both individual and group counselling for dependence had been shown to be beneficial, with cognitive behavioural forms well supported by research evidence in the USA.[125]

The Committee also noted how longitudinal research from the USA had shown that different forms of treatment had an impact on cocaine use and crime.[126] Specifically, they pointed out that both long-term residential treatment as well as outpatient drug free treatment helped to reduce crime provide a good return on the money invested in it.[127] In

building strong support for the development of treatment for cocaine use they went on to discuss how long-term residential treatment worked best for those with the most complex problems with outpatient care performing better for those with less serve dependencies.[128] In this context they asserted that when the right form of treatment is matched to the client reductions in use of up to 85 percent have been achieved.[129] In this respect, we can see the way in which the Committee was actively building a picture that was encouraging the further development of treatment systems. Similarly, they went on to underline the need for harm reduction messages to be targeted at users.[130] They stressed that harm reduction approaches to cocaine use have been shown not to lead to an increase in drug use, a point which draws attention to their backing of these interventions within the treatment system.[131]

Ultimately, the Committee's review of current practices at the time in the treatment of cocaine can be regarded as presenting policy makers with an efficient and clear view of where they could move to next in terms of responding to the issue of cocaine use. In this sense, it offered its knowledge in a trimmed down and non-directive manner. The manner in which the Committee utilised the international research evidence to construct its report and present a snapshot of the state of treatment options for cocaine users can be seen as reflective of the process of hierarchical diffusion discussed in chapter one.[132] In this sense, they utilised their research as a means of presenting policy makers with a relatively unambiguous view of how effective treatment responses were being delivered elsewhere. By extension this action highlighted the way the system should be progressed in Ireland to react to cocaine use. As a result, this type of prompting action via the assembly and discussion of best practice on treatment can be seen as adding to a process of hierarchical diffusion in terms of modifying the system in responding to cocaine use.

In the absence of any overarching study synoptically covering all aspects of cocaine use the Committee's report represented a valuable resource for policy makers in orientating themselves to the drug's arrival in Ireland. In addition, the Committee displayed its skills in getting to grips with the main issues and producing a document at a fairly rapid pace. In bring their report to a close, the Committee took the decision to opt for a 'findings and implications' piece as its ultimate section.[133] Consequently, the report

was marked by the absence of any specific recommendations of a solid or persuasive type.[134] Nonetheless, the report had expressed its backing for the development of treatment to meet the needs of cocaine users throughout its discussion and had additionally shown its backing for harm reduction in the process. At the same time, its closing statements were permeated by a number of critical non-directive but policy influencing comments on the challenges ahead.[135] For example, they noted the relatively low numbers at that stage in treatment for use of the drug, the risks linked to injecting and snorting, as well as the challenge of altering the treatment system to accommodate these users.[136]

One of the most important aspects of any strand of research on drug issues is the extent to which a particular study can be replicated at a future date if the issue in question is still of policy relevance at that time. This allows a revised view of the situation to be obtained. Within this context, one of the styles of research projects that efficiently lends itself to such duplication are studies that are primarily based on collating existing data in the process of a general literature review of an area. Consequently, a prime example of this process occurring within the Committee's research schedule was their completion of a second project on cocaine use in March 2007.

One of the key functions that *An Overview of Cocaine Use in Ireland: II* performed was to present policy makers with a clear update on the situation.[137] In this sense, the Committee can be seen as having made a continued contribution to work on the general area of cocaine use with its output over the period studied through their strategic decision to revisit and revitalise the knowledge base on the issue. One of the implications of this course of action, referring back to the models of the research / policy interface from chapter one, is that, their decision was broadly reflective of the process encapsulated within the enlightenment model. Namely, the strategy to continue building up research data from both international and indigenous sources into a honed text geared towards policy makers can be regarded as furthering the stacking process whereby no one piece of research has an impact on its own.[138] In essence, such action aids the way in which the ideas and approaches arising from research come to have an effect on policy making and the design of treatment options.

The data presented by the NACD gave a comprehensive picture of cocaine use and functioned to show policy makers the manner in which patterns of cocaine use had evolved over time. As such, it provided a critical time-lapsed snapshot of the way in which events had metamorphosed in the years between their reports. The Committee mirrored the process adopted in the earlier study and utilised a range of pre-existing material. As before, they incorporated ADRU and other survey data, which essentially showed that cocaine was now a stable feature of drug use in Ireland and that it had slightly increased over the four year interval.[139] The report made clear that the drug was at that point being used by young people across all the social classes.[140] Reflecting the more refined nature of their analysis of the situation they drew attention to contextual factors surrounding cocaine's use by noting the increased incidence of polydrug use involving cocaine and alcohol.[141] This was, essentially, showing that simultaneous use of both drugs had, by 2007, more or less become a normalised feature of many recreational drug users' patterns of substance use.[142] In addition, they also stressed that cocaine use was also at that time a consistent feature of the range of drugs being used by problematic drug users.[143]

Reflecting the process of diffusion internationally, a point evident throughout their review, the Committee noted that the majority of information on the treatment of cocaine use came from the USA.[144] In exploring the evidence base, the range of different treatments available for cocaine use they were still faced with the same problem they had encountered when completing their first report on the topic. Namely, there had been no significant advancement towards the creation of a pharmacotherapy treatment solution comparable to the use of MMT in the treatment of heroin use.[145] This was a point that the report underlined from the outset of its discussion of the international evidence.[146] In this respect, the Committee pointed out that Disulfiram had been shown to reduce usage, but there were still no fully endorsed medications for cocaine treatment.[147] While other medications such as Dopamine agonists and anti-convulsants had been used, more trials were needed.[148] The absence of a clear solution capable of attracting and retaining users into treatment complicated the Committee's task of trying to provide advice on what action could be taken by policy makers. Nonetheless, the document gave a thorough consideration to the nature of the different avenues of treatment that could be chosen.[149]

Building support for the utilisation of different approaches to the treatment of cocaine use, the Committee noted from the US Drug Abuse Treatment Outcome Study (DATOS) that it had been shown that use of the substance was treatable.[150] Among the key approaches that the report found to be beneficial were a number of cognitive behavioural strategies.[151] Primary among these was Cognitive Behavioural Therapy (CBT) coupled with Contingency Management (CM) to aid completion of treatment programmes and the prevention of dropout, while Brief Motivational Interviewing (BMI) had also been shown to be successful.[152] In addition the Committee pointed out the links between cocaine use and risky injecting and sex practises and their related HIV risks.[153] Within this context they discussed how different forms of harm reduction had been successful in reducing both cocaine use and HIV among particular groups of users.[154] These health gains had been achieved through the use of brief interventions and a combination of MMT, CBT and CM respectively.[155]

While the review of treatment options and evidence contained in the Committee's second report on cocaine use can be seen as progressing on the 2003 document of the subject, it did reiterate some of the same points made in the earlier work. This can be regarding as has having a policy influencing function on a number of levels. In one sense, it shows the continuing relevance of the options being discussed. More critically, however, it is reflective of the strategy of persistence in the presentation of a position on a course of action. In this case, the range of best practices in treatments for cocaine that the Committee was prepared to give its backing to by drawing policy makers' attention to in their reports was reiterated. In a semi-structured interview the Chairman of the NACD confirmed that he very much saw the process of influencing policy in this way.[156] In essence, he conceived of it as a long-term strategy involving the Committee holding to their position on a topic such as what to do about treating cocaine use.[157] Overtime through a mixture of the quality of their research and their perseverance the position taken would being to influence the policy process.[158] In this context, the element of reinforcement created by the Committee across its reports can be viewed as a highly tactical strategy. It functioned to both reinvigorate the lifespan of the earlier research and add critical weight and stacking signification to the latter report as the extent to which supporting evidence had continued to mount was emphasised. The area of cocaine policy

development was a sphere within which the Chairman felt that the NACD's work had been successful in influencing the policy process during the years studied.[159]

As well as presenting an overview of the state of the art in treatments for cocaine the report provided a comprehensive insight into the current practices that were being deployed by in the Irish system to respond to cocaine use.[160] In this respect, they noted from a survey they had undertaken that the main approach being used by Irish treatment centres was a medication-free one involving CBT, motivational interviewing and brief interventions.[161] Additionally, the report pointed out that the NDST had at the request of the Department of Community Rural and Gaeltacht Affairs (DCRGA), *inter alia*, set up four treatment interventions.[162] They underlined that this had been done in the aftermath of their first research on cocaine use and increased calls for action on the issue from a range of groups.[163] The projects initiated were designed to work with different cohorts of users such as those engaged in IDU, snorting, polydrug use and female users.[164] They also noted how five LDTF projects had been brought online to provide a service to cocaine users.[165] In this respect, the document can be seen as providing policy makers with a dynamic dual purpose facility for exploring what potential steps to take next in evolving the policy and treatment responses. Essentially, the report facilitated both a consideration of international best practices in the treatment of cocaine, while at the same time offering a current view of what had been adopted from this array of options within the Irish system at that point. Thus functioned to highlight what was left to be analysed by policy makers for either expansion or inclusion within the system.

The Committee's second report on cocaine use ended with a 'summary and recommendations' section.[166] This part of the document started by noting how all available indicators revealed that the use of the drug was increasing.[167] It then moved to present a series of thirteen detailed individual recommendations addressing what action might be taken.[168] Among the key issues they focused on was the need for the establishment of more projects targeted directly at cocaine users in areas with noted high levels of use.[169] In this sense, we can see the way in which the Committee was keen to emphasise the need to develop this aspect of the treatment system and by extension its support for evolving provision generally.[170] Similarly, another of their core recommendations highlighted that 63 percent of cocaine users in treatment were injectors

and as a result there should be an expansion of NSPs to address the issue.[171] This again shows us the way in which the Committee used its research to further the development of harm reduction services during the period studied and their backing for them across their research output. Consequently, these concluding remarks, which named the policy actors responsible for carrying them out, gave the document a far more authoritative policy-assertive tone than their earlier project.[172] This was accentuated by the expanded and thorough nature of the study as a whole when compared with the previous report on the same topic.

This part of the chapter has looked at the most significant pieces of work carried out by the NACD concerned with the issue of cocaine use within the timeframe studied here. In the main this strand of their work consisted of two key research studies based on the idea of utilising a range of pre-existing data and international research evidence.[173] These were used to formulate a detailed and technical overview of events regarding, *inter alia*, the consumption and treatment of the drug at a rapid pace to assist policy makers in reacting to the issue. In this sense, the latter report, arriving in 2007, was essentially a carefully calculated restatement and expansion of the topics broached and discussed in the initial document in 2003. This can be seen as having functioned to further the stacking process of the research in question in a manner that is generally reflective of the enlightenment model of the research policy / interface. It allowed the information to become revitalised and placed back on the policy making table again while being coupled with new research. In essence, this contributed towards the development of an overall cumulative impact of the ideas and approaches arising from the research. This can also be seen as adding to the overall weight of the evidence behind the thrust of what the Committee was saying. Consequently, as NACD's Chairman pointed out in an interview, their approach to the policy process was one of persistence and adhering to a position over time through its reports and the comments made on the back of them in policy sessions.[174]

While both reports supported the need to expand treatment and expressed support for harm reduction approaches to service development, a visible change in the style of advisory remarks made over time is clearly visible. While the early work was typified by a more generalised set of policy remarks in wrapping up its analysis, the second study

was characterised by a harder hitting tone.[175] This was represented by its inclusion of thirteen specific recommendations allocating responsibility to those concerned with the aspects of policy being discussed.[176] Similarly these points were built-up to with a punchy section asking 'Should we be concerned?', essentially stressing the interlocking levels of harm from cocaine use.[177] Overall, the Committee's work on the area of cocaine use shows us another angle from which discernable change in their research output towards a more sophisticated policy active style can be seen that built on their concern with developing the treatment system.

Drug Use and Mental Health Policy

Over the years being looked at in this study the Committee carried out a range of research projects that were well placed and timed to feed into policy making on different events. One area of critical importance to which the NACD turned its attention in this respect was the subject of mental health policy. Their decision to explore this issue early in their research schedule coincided with critical events. Principally, their analysis of this topic occurred at a time when, both internationally and in Ireland, Governments and treatment providers were starting to get to grips with this issue. Specifically, this was happening in terms of how the area should be dealt with in the provision of services and who exactly was responsible for the area. Consequently, the Committee's work on the subject allows us to consider some of the other types of research output they produced during the period and the way in which it was received at a time of transition in this policy area generally.

Launched in November 2004 the NACD's report *Mental Health and Addiction Services in the Management of Dual Diagnosis in Ireland* was a major examination of the area. In this respect, their research emerged during the most critical review of mental health services in Ireland since the mid 1980s when the policy document *The Psychiatric Services: Planning for the Future* was launched. The Committee's document was ideally timed to coincide with the work of the Expert Group on Mental Health (EGMH). This group, which met 23 times, had been established in August 2003 and concluded its undertakings in 2005 on the landmark policy document *A Vision for Change*, which was published in January 2006.[178]

The study was an accomplished piece of work characterised by a good use of several research methodologies and a thorough exploration of the pertinent issues. Principally, it consisted of a literature review, an open forum with practitioners working with dual diagnosis clients, and a survey aimed at exploring how the condition was being managed, which in turn led to the undertaking of semi-structured interviews with 10 percent of respondents.[179] The project was of key importance as it added another piece to the jigsaw of drug use in Ireland by virtue of its being the only detailed indigenous study of the topic. In this sense, it is one of a number of studies where the Committee broke new ground with its work. It essentially pulled together a diverse range of data sources to create a view of dual diagnosis that encapsulated the main issues concerning the conjunction of mental health and addiction services for policy makers.

The report made a number of important overarching points throughout its examination of the area. For example, the Committee drew attention to the need for the creation of guidelines on the management of dual diagnosis as a result of their being no national policy on how this aspect of drug treatment should be operated.[180] Crucially, the document set out some of the main ways in which dual diagnosis could be seen as functioning to increase both the complexity of drug related harms and as a consequence the nature of the response needed from service providers.[181] In this respect, the Committee discussed via international research how there was an increased risk of HIV infection among this group of drug users.[182] Accordingly, we can see the way in which the NACD was focused on harm reduction issues throughout the different strands of research that it was completing during this time. The report placed the difficulties facing practitioners in perspective by noting how a Cochrane review had concluded that no one approach appeared to be demonstrably more effective than any other, thus there being no single path to follow.[183]

Reflecting the complexity of service provision in the area the research drew attention to and provided a clear discussion of the three main types of models or frameworks used to deliver services to individuals with dual diagnosis.[184] In this sense, they noted that the integrated model, which provides a seamless transition from one service to another, generally emerged from the international literature as being the best. Reflecting the reality of the difference between neat theoretical models and the actual

operation of treatment services they showed that most practitioners were using a mixture of the serial and parallel models to treat clients.[185] The former framework involved clients going from one service to another in a linear manner, with the latter model having clients being treated by both services at the same time.[186] In addition to its utilisation of international research evidence in its literature review, the Committee's discussion of the different models of approaches to treatment displayed the way in which they were presenting policy makers with a detailed toolkit. This can be seen as potentially helping in the choosing and modelling of options as a result of the one-source rapid grounding it functioned to provide on the full spectrum of issues concerned. It is another area where the NACD's research actions can be seen as approximating to an attempt to initiate the process of diffusion generally.

Displaying the realistic and thorough nature of the Committee's analysis of the dynamics involved in co-administering drug and mental health treatments the study set out a range of critical comments highlighting some of the problematic features of existent operations that could be altered. In this respect the report observed how service users were not being involved in the development and modification of treatment delivery by those tasked with forging policy.[187] Similarly, they asserted that assessment for the condition needed to be made a part of clinical assessment in drug and psychiatric services, as this was not the case at the time.[188] Most significantly, the Committee went on to note that Irish social policy had not acknowledged or provided for this cohort of patients.[189] Among the problems they saw as arising from this were that some aspects of service policy were actually the opposite of what effective practice should be, such as the separation of drug and mental healthcare services when provision should be combined.[190]

The Committee went on to convey that the existent nature of service provision was not client-friendly and resulted in individuals being passed between different services as well as being subjected to exclusions as a result of having dual diagnosis.[191] For example, their survey revealed that those working in psychiatric services did not look favourably at the use of methadone. As a result of this it was not surprising that the research also showed that those working in addiction services found it very difficult to get patients who were on MMT into a mental health service.[192] This was exacerbated by the fact that the policies the Committee was able to uncover in some agencies were

typically only treating one aspect of dual diagnosis. They were never focused on dealing with the full condition, and the services provided were not being coordinated in a properly structured manner in any of the health boards.[193]

One of the key contexts within which the events of the present study took place was a shift in the organisation of drug treatment that saw a move away from a near total reliance on centralised services. Chiefly, a more sophisticated mix emerged which drew on the role of general practitioners and community level treatment to a significant extent. This topic is explored in detail in chapter nine. For our purposes in this portion of the thesis it is sufficient to note that studies such as the Committee's mental health project were taking place within this overall modification to the way services were structured and delivered. Consequently, while the main thrust of this change occurred prior to the Committee's inception, such research can be regarded as having an important role to play in the ongoing development of the transition from centralised treatment to community level care. As a result, a point made throughout the Committee's study on dual diagnosis was its consistent focus on the fact that GPs had an important role to play in the treatment and management of this condition.[194]

The final portion of the Committee's dual diagnosis study consisted of a piece concerned with 'Conclusions and implications for practice'.[195] At this point the main contours of the international experiences discussed in relation to managing dual diagnosis were reiterated, as well the fact that rates here were uncertain, but could be as high as 43 percent of those accessing services.[196] The Committee then set out seven paragraphs commenting on what needed to be changed, essentially highlighting the main themes addressed in the study.[197] They noted the need for a national policy, for services to be aware of the issue, for more focus to be placed on it in practitioner education, the need to use treatment models that had been shown to be effective, and to generate epidemiological data. In addition they pointed to the need to consider establishing national treatment guidelines and that their report and others like it be used in a process of dissemination aimed at raising overall awareness of the issue.[198]

While not naming the actors responsible for carrying them out, the report's recommendations were delivered in an assertive manner that specified what needed to be done in the case of each issue focused on.[199] The directly engaging stance taken can be

seen from the way the document called outright for policy to take account of the condition,

> "Dual diagnosis needs to be recognised and addressed in national policy, particularly in relation to mental health, drugs and alcohol."[200]

Specifically, it went on to assert that a degree of intersection between these areas should exist.[201] This style of policy guidance was also particularly evident in their remarks on the development of service models.[202] Collectively their closing remarks were carefully designed to aid those digesting the research to cut to the core of what action might most profitably be taken for developing the treatment system to deal with the issue.

Despite the quality and policy engaging nature of the Committee's research on dual diagnosis it had a limited impact on the formulation of the 2006 mental health policy.[203] Throughout the course of the EGMH's document there was only a limited reference to the NACD and its study on dual diagnosis. In its focus on the Committee *A Vision for Change* noted that:

> "The NACD (National Advisory Committee on Drugs) commissioned a report on the dual diagnosis issue. They advocated much closer collaboration between addiction programmes and general mental health services in order to improve outcomes for individuals with dual diagnosis."[204]

Consequently, it seemed that the Committee's very detailed and nuanced study, replete with honed policy relevant recommendations, was not fully engaged with by the EGMH. This is of course not to say that individual members of the EGMH and its subcommittees may have held views to the contrary regarding the research, rather it is to assert that those in charge of the policy group made an active decision not to utilise it. This is a scenario that reveals the difficulties a body in NACD's position can be faced with at times in playing a part in the policy process.

In considering some of the reasons why the Committee's report was not drawn upon by the EGMH it is helpful to return to the 'political model' of the research / policy interface from chapter one. This view holds that research will be used if it fits the current agenda of the politicians, however if it does not it will simply will not be used.[205] This does not imply that there is anything substandard with the work itself; rather it merely indicates that it is of sync with the agenda being pursed.[206] While the members of the

EGMH were not politicians their role in the policy process makes the political model just as applicable. In this sense, a key aspect of the mental health policy's discussion of dual diagnosis was that it did much to remove responsibility for addiction from the remit of mental health services and argued that it should not be their place to fund such services.[207] Rather, the report stated, only those with individuals with both addiction and mental health problem should be dealt with by community mental health services.[208] A clear line of demarcation on the basis of funding, as opposed to resource sharing in an SMI-era style, was an undertone present in the report at this point.[209] It is interesting to note that the two annual reviews of the implementation of the new mental health policy that were released in 2007 and 2008 had no references to dual diagnosis.[210]

In a semi-structured interview the Chairman of the NACD discussed the way in which the Committee's dual diagnosis study was not utilised by the EGMH and offered a number of explanations as to why this type of situation occurred generally in the policy process.[211] He agreed that it was frustrating that the research had not been used at the time in the construction of *A Vision for Change* as it was a well timed and themed report for the work being undertaken.[212] One reason he saw that can impede the development of change in the way services are delivered across policy areas in general in this context was that bar events occurring in the midst of a period crisis, such as the emergence of HIV and IDU, it can be hard it initiate and maintain the momentum for change.[213] At another level he felt that an additional problem hindering the effective filtering of research into the policy process was aspects of the system itself.[214] In this respect, he was referring to the ability of the system to absorb research properly.[215] Specifically, he felt the difficulties some policy makers face effectively understanding and making use of research stopped it having a role.[216] This was seen as a consequence of there being both a limited element of policy analytic training and/or experience in the background of some individuals, as well as a general limited amount of specific policy analysts within Government assigned to digesting and incorporating scientific data into policy.[217] While this was the case, he did agree that it is possible the research may yet come to have an impact in the future.[218] This is broadly reflective of the way in which research can be seen as stacking up and having a collective impact over time via the ideas and approaches engendered by it as set out in the enlightenment model of the research / policy interface.

This portion of the chapter has explored work undertaken by the Committee focused on the area of mental health during the years under study. Specifically, it looked at their study *Mental Health and Addiction Services in the Management of Dual Diagnosis in Ireland.* The report presented a detailed view of the areas of concern facing policy makers in the management of mental health and addictions services. In this sense, it highlighted the need for national policy to take account of dual diagnosis and create guidelines for its management, the increased risk of HIV infection among this group, and the different models of service provision being used internationally.[219] In this respect, the report functioned to provide policy makers with a key means of grounding themselves in the core options being utilised in the modelling of treatment systems to respond to dual diagnosis internationally. Similarly, the research underlined the nature of the key problems in the delivery of services for those with dual diagnosis that could be altered in an Irish context.[220]

Yet while the study itself was an accomplished piece of work, typified by a strong research design and report, as well as a set of policy-relevant recommendations, it had a minimal impact on mental health policy at the time of its release. In particular, the document was not utilised by the EGMH in their formulation of the new mental health policy *A Vision for Change*, which was underway when the Committee made its report available. This was a result of a number of factors. Among these were the EGMH wishing to maintain a sense of demarcation between addiction and mental health services.[221] Additionally, a general problem facing the Committee's work at various stages, such as this, was there being insufficient policy analytic capacity within the system to absorb all of the available research available at a given time when a new policy is being formulated.[222] Also, the absence of a strong sense of crisis linked directly to dual diagnosis functioned to limit the extent to which change was perceived to be need and as a result research was seen as of high importance at that point in policy formulation.[223] This granted the work in question may, in line with the cumulative stacking effect of the enlightenment model of the research / policy interface, come to have an impact at a later date. In the final section of the chapter we will look at an evaluation of the Committee during the time studied and consider some of the positive and negative aspects of their work.

Structure and Performance

While the period being studied was marked by an increase in the pace and diversity of indigenous drug policy and treatment research projects being undertaken, it was also characterised by a general utilisation of management science approaches to policy work. The continued presence of the strategic management initiative (SMI) era norms, which we discussed in chapter four, was evident when the decision was taken to subject the Committee's work and operations to an evaluation. Consequently, between February and May 2004 the management consultants Talbot Associates carried out a review of the NACD's operations for the Department of Community Rural and Gaeltacht Affairs (DCRGA).[224] An extensive assessment process was initiated by the consultants. They met with the NACD's Chairperson, its Director, the Chairs of all five subcommittees, a range of individuals on the Committee representing different sectoral groups, as well as other external stakeholders.[225] This portion of the chapter discusses some of the findings of the evaluation and considers their implications.

In the first section of the chapter we saw how the individual members of the NACD displayed their commitment to their work through their frequent meetings at the general, sub-committee, and research advisory group levels in bringing an extensive portfolio of diverse research projects to completion. The merit of this hard work was given a prominent place in the Talbot Associates' evaluation. At the outset of their overall conclusions and recommendations in relation to the Committee's future they stated that,

> "In overall terms, the conclusion of the Review is that the NACD should continue in its present form. It is effective, it meets a very real need and it provides the Government with excellent value for money."[226]

In this sense we can see the way in which the consultants were supportive of the manner in which the Committee had progressed its agenda and ultimately saw it as delivering a key service to Government with its research projects.

We can gain a sense of the extent to which the Government was satisfied with the evaluation's findings and its general satisfaction with the NACD's work from their extension of the Committee's lifespan to match that of *Building on Experience*. This was

clearly called for in the fourth recommendation that the consultant's made.[227] They stated,

> "The NACD should continue in its present structure and with its current Terms of Reference for a further period, that period to coincide with the life of the National Drugs Strategy 2001-2008." [228]

Similarly, the report's main recommendation also consisted of a call for the Committee to be maintained in their function as one of the key information providers on drug issues.[229] Additionally, the consultants felt that there was no need to alter the way in which the NACD was established and to put it on a statutory footing.[230]

The evaluation supported the Committee's research agenda when it asserted that their having filled a range of different gaps in Irish drug policy research was the right course of action to have been taken during these years.[231] Later when considering their objectives and work programme they stated that the NACD had, *inter alia*,

> "Undertaken a heavy programme of commissioned research against a background of inadequate research capacity in Ireland."[232]

The report consistently noted the cost-effectiveness of the Committee's work, how it broke new ground and helped to use the capacity of other agencies and groups.[233] Yet, the consultants also asserted that the Committee would be strengthened, and as a result more useful to the Government, if its internal human resources were increased and its research schedule streamlined.[234]

One of the defining features of the Committee's output during the period studied was its diverse nature spanning a wide range of different areas. In their evaluation the consultants focused on this issue and asserted that the initial programme of work had been too multi-faceted for the NACD to manage within its first three-year plan.[235] This was seen as a result of the Committee at that stage not having had its internal resources fully developed and that in many of the areas being looked at there had been little, if any, research undertaken before.[236] This is a situation that highlights the dual edged nature of the Committee's work. For example, while they were breaking new ground with many of their projects, the time consuming nature of this work made their task difficult while they themselves were still a structure in formation. This combination of positive and negative

traits in their work reflects the difficulties that a new body operating in a policy area with a dearth of pre-existing information is faced with.

The Talbot Associates' evaluation drew attention to a range of process-orientated and structural problems in the way the Committee was going about its research tasks at this stage. They pointed out that their work programme needed to be altered. In effect, they called for a reduction in the number of new projects so that more emphasis could be placed on considering the implications of research and conveying this information to policy makers.[237] The report emphasised the need to alter the Committee's work schedule by asserting that in most countries where such advisory bodies are used there was a lot less primary research being undertaken by them.[238] This was however seen as a result of the fact that elsewhere a more established research capability existed in the market.[239]

As referred to earlier in this chapter, the Chairman of the NACD asserted that in the initial phase of its lifespan the Committee was geared towards the commissioning and completion of new projects at the same time as developing its advisory role.[240] The main reason for this being that there was a need to create a knowledge base on these areas and that the NACD felt it had to properly establish itself as a credible research body in the minds of those who would subsequently be using the work.[241] In this sense those concerned were heavily involved in the research process to guarantee the quality of the product emerging.[242] It was felt that prior to being able to move into a position where they could focus more on their advisory role, they had to first fill these gaps in knowledge and prove themselves as being a capable research producing entity.[243] Accordingly, it is important to note that it was at this juncture in their growth as a research body that the Talbot Associates' evaluation took place. Essentially, the NACD were still in the middle of this period of their development phase or rather moving out of the first phase and into the second around this time.

The evaluation was critical of the efficiency with which the Committee had been bringing projects to completion.[244] Their main concern was that an overly time consuming process had been adopted and was slowing down the turn around of research.[245] In this sense they stated,

> "While the Committee has been properly anxious to ensure outputs reach a high standard, the processes in place for the commissioning, review and publication of research outputs appear to have been unnecessarily time consuming."[246]

At the same time the consultants pointed out that the NACD had to become involved in several studies to make them ready for publication and that this was a consequence of the limited private research market and its capacity in Ireland.[247]

The Chairman of the Committee also commented on this issue in a semi-structured interview.[248] He felt that when they started their work as a body they were quite surprised at the lack of capacity in the private research market in Ireland and in the universities geared towards carrying out the research they wanted to commission.[249] One of the main consequences of this was that they had to work with some of the firms that were awarded tenders to ensure that the projects were being completed properly.[250] Again, the main reason behind this being that at this stage the Committee was very much focused on completing as high a quality research product as possible.[251] They wanted these materials to prove themselves to policy makers and research consumers so that their advice would be seen and accepted as credible.[252]

In evaluating the NACD's structure and operations, the consultants also drew attention to some problems with the way the Committee's design was impacting on its work schedule. Specifically, they identified the need to expand the Committee's core staff and how the lack of internal research capacity had affected the pace of their research output.[253] In particular, they noted how a significant amount of the Committee members' time had been taken up with administrative tasks. The consultants pointed out that the Committee members should not really have been doing this work, apart from the fact that they did not have adequate internal staff numbers to perform these tasks.[254] The evaluation also went on to state that many of the individuals serving on the Committee found the volume of work needed prior to their meetings to be very demanding.[255]

The consultants' report asserted that even when the NACD was operating with its full complement of internal staff this was still not enough to meet the demands of their research activities.[256] They noted that the pressures caused by this lack of capacity impacted upon the senior members of the Committee far more than the others and that this was clearly detracting from their ability to tend to more important matters.[257] In this

context, they asserted that many of those on the Committee felt that there was a clear need for their internal staff numbers to be increased to both meet the challenging administrative demands of their activities and to make the NACD less exposed to the underdeveloped nature of the private social research market in Ireland.[258] This was a view that Talbot Associates supported when they asserted that the Committee's internal research capacity needed to be expanded.[259]

The Chairman of the NACD commented on these issues in a semi-structured interview.[260] He noted that while the evaluation of the work had called for their internal resources to be expanded to meet the needs of their work programme this had not been favourably responded to by policy makers at the time.[261] As a consequence, he asserted that the Committee had to come up with different ways to try and help itself to meet the demands of its schedule.[262] One of the key strategies that he felt that they successfully adopted in this respect was the employment of external researchers on short-term contracts to work on individual studies.[263] He felt however, that the absence of an additional internal research officer restricted their ability to carry out their core work and respond to short-term projects at the same time, in terms of having sufficient flexibility in their work schedule.[264]

This part of the chapter has discussed some of the findings from a key evaluation of the Committee's work. The review in question was undertaken midway through their lifespan and several years before the end of the period studied here. At this time the Committee was moving from developing its advisory role and knowledge base through filling gaps in research into a phase where it was more fully engaging with its advisory function having firmly established itself as a credible research entity. In overall terms the Talbot Associates' review found the Committee to be an effective body and recommended that it be continued. In this context, the report stated that the NACD had adopted the right approach with their research agenda during their early years of existence, in that, they had cost-effectively and efficiently filled many gaps in knowledge.

However, the consultants also asserted that the Committee's internal human resources needed to be increased. Among the key reasons for this was the wide ranging nature of their work programme during these years and the demands it placed on the members of the NACD, as well as the lack of pre-existing research in these areas. The

Consultant's felt that the research process adopted by the Committee had at times become too lengthy, though it was accepted that this was a result of the under developed research market. The Committee's Chairman pointed out that this factor required them to sometimes become involved in projects to ensure the quality of the final product.[265] Despite the problems identified with its structure and operations at the time it was carried out the Talbot Associates' review was supportive of the Committee and what it had achieved with the resources it had been allocated. The following section presents the overall conclusion to the chapter.

Conclusion

This part of the thesis has looked at some of the increased amount of Government funded research on drug issues that was carried out during the years studied. In this context it focused on the output of the NACD and the degree to which they backed the development of treatment and in particular harm reduction, as well as changes in their work over time. Within the timeframe analysed here the Committee completed a diverse set of research projects on different aspects of drug use. This work functioned to help build the knowledge base on drug issues in Ireland as a result of its frequently breaking new ground and drawing together a wide array of data sources into single policy-relevant reports.

Their work on NSPs was supportive of this harm reduction strategy's role within the treatment system and became more sophisticated over time. One of the key changes to occur in this sense was the move from an early style of guidance-orientated advisory work to a more policy-assertive position in their later work. A similar pattern was also present in their engagement with cocaine use, in that, their studies on the subject became more refined over time, expressed support for harm reduction approaches to treatment and moved towards a more engaging style of policy advisory work. While the same traits were also present in the NACD's work on dual diagnosis, the study did not have a discernable impact on the formulation of the 2006 mental health policy at the time of its release despite its quality and policy relevance. This is a factor which highlights the difficulties a body in the Committee's position faces in having its work effectively utilised in the short-term. An evaluation of the NACD around this time, while they were still developing their advisory role and commissioning a lot of studies, found that they were an effective body and recommended that they be continued. It was also supportive of their decision to fill gaps in research as having been the right one, while it did note that they needed more internal resources and a more streamlined approach to managing studies. However this latter factor was a result of the need for quality and the underdeveloped research market in Ireland open to the Committee, which required them to become quite involved in some projects.

Despite the existence of problems with their structure and operation during the time studied the NACD achieved a great deal with its research agenda. For example, they

completed a number of studies that further developed the overall picture of drug use available for the purposes of policy making during the time studied. The work that they carried out was consistently of a high degree of quality and became more sophisticated and refined over time, particularly in terms of its engagement with and expression of the Committee's advisory role. That some of its work was not used in the short term was a factor beyond the Committee's control, however, it may come to have an impact in the future. Their research can be seen as having contributed to an enlightenment process broadly in line with the model discussed in chapter one as a result of its stacking of data on key issues that may have future influence on policy. In essence, this can be seen as adding to the cumulative impact of the ideas and approaches arising from the research. This characteristic can be found in much of their work and is evident in the research on NSPs, cocaine and dual diagnosis. In addition their research actions in these reports can be seen as contributing to a process of hierarchical diffusion by placing sets of options on the discussion table for policy makers through the lucid discussion of international best practice in different areas of treatment. The following chapter is concerned with the way in which the development of NSPs have been impacted by some of the unanticipated and unintentional consequences linked to the new policy structures established after 1996.

[1] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.5; p.23; NACD (2003). *Progress Report*. Dublin: NACD, p.6.

[2] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.8.

[3] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.9; Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report*. Dublin: Department of Community, Rural and Gaeltacht Affairs, p.4.

[4] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, pp.3-4; p.7.

[5] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.17.

[6] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.4; p.6.

[7] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.4; p.6; p.15.

[8] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report*. Dublin: Department of Community, Rural and Gaeltacht Affairs, p.5.

[9] NACD (2003). *Progress Report*. Dublin: NACD, p.7.

[10] NACD (2003). *Progress Report*. Dublin: NACD, p.7.

[11] NACD (2005). *Business Plan 2005 – 2008*. Dublin: NACD, p.4; Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report*. Dublin: Department of Community, Rural and Gaeltacht Affairs, p.5.

[12] NACD (2003). *Progress Report*. Dublin: NACD, p.6.

[13] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report*. Dublin: Department of Community, Rural and Gaeltacht Affairs, p.8

[14] NACD (2007). *Annual Report 2006*. Dublin: NACD, p.9.

[15] NACD (2003). *Progress Report*. Dublin: NACD, p.5.

[16] NACD (2007). *Annual Report 2006*. Dublin: NACD, p.6

[17] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[18] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[19] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[20] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[21] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.17.

[22] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.5; NACD (2003). *Progress Report*. Dublin: NACD, p.8; NACD (2007). *Annual Report 2006*. Dublin: NACD, inside cover – no pagination.

[23] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.3; p.5; p.22.

[24] NACD (2003). *Progress Report*. Dublin: NACD, p.7; NACD (2006). *Progress Report August 2003 – December 2005*. Dublin: NACD, from inside cover – no pagination; NACD (2007). *Annual Report 2006*. Dublin: NACD, from inside cover – no pagination; p.21.

[25] Interim Advisory Committee on Drugs (2000). *Report of the Interim Advisory Committee on Drugs*. Dublin: Author, p.5.

[26] NACD (2003). *Progress Report*. Dublin: NACD, p.13; p.24.

[27] NACD (2005). *Business Plan 2005 – 2008*. Dublin: NACD, p.4.

[28] NACD (2007). *Annual Report 2006*. Dublin: NACD, p.16.

[29] NACD (2003). *Progress Report*. Dublin: NACD, p.12; p.13; p.30; NACD (2007). *Annual Report 2006*. Dublin: NACD, p.15; p.16.

[30] NACD (2003). *Progress Report*. Dublin: NACD, p.13; 18.

[31] NACD (2005). *Business Plan 2005 – 2008*. Dublin: NACD, p.4.

[32] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A Review of Harm Reduction Approaches in Ireland and Evidence from the*

International Literature. Dublin: NACD; Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD.

[33] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature*. Dublin: NACD.

[34] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature*. Dublin: NACD, pp.20-22.

[35] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.3.

[36] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.65.

[37] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[38] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.4; p.21; p.36; p.67.

[39] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.4; p.7; p.26; p.37; p.51; p.53; p.65.

[40] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.4; p.7; p.8; p.20; p.21; p.32; p.33; p.34; p.35; p.36; p.37; p.44; p.46; p.47; p.50; p.65; p.66.

[41] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.20; p.21; p.32; p.36; p.37; pp.46-47; p.66.

[42] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature*. Dublin: NACD, p.8; p.33; p.35; p.44; p.47; p.50; p.65.

[43] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.52.

[44] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.4; pp.20-21.

[45] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.21.

[46] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.9.

[47] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.66; p.67.

[48] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.23-26.

[49] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.23.

[50] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.23.

[51] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.26.

[52] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.65-67.

[53] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, p.9; p.20; p.21; p.32; p.36; p.37; pp.46-47; p.52; p.66.

[54] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.65-67.

[55] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.65-67.

[56] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.65-67.

[57] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: NACD, pp.65-67.

[58] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[59] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[60] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[61] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[62] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD, p.5.

[63] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[64] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[65] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD, pp.7-36.

[66] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD, pp.7-13.

[67] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, p.6.

[68] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.6.

[69] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.7.

[70] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.6.

[71] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.9; 10.

[72] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.6.

[73] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.14-22.

[74] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.17.

[75] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.14.

[76] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, p.19.

[77] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.21.

[78] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.17-18.

[79] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.18.

[80] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.18.

[81] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.15.

[82] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.15.

[83] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.15.

[84] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.15.

[85] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, p.16.

[86] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.20.

[87] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.16.

[88] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.20.

[89] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.18.

[90] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.20.

[91] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.20; p.21.

[92] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.24-30.

[93] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.24.

[94] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, p.24.

[95] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.24; p.25.

[96] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[97] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.26-30.

[98] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.35.

[99] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.35.

[100] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[101] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[102] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[103] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, pp.37-40.

[104] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.7-35.

[105] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.37-40.

[106] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.37.

[107] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.37-38.

[108] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, pp.14-30.

[109] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[110] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.6; p.10.

[111] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.6; p.12.

[112] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.6; p.13.

[113] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.6; p.13.

[114] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, pp.6-7l; pp.16-18.

[115] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, pp.13-15.

[116] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.13.

[117] NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD, p.13.

[118] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[119] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.7; pp.20-21.

[120] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, pp.20-21.

[121] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.20.

[122] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.20.

[123] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.20.

[124] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.20.

[125] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.20.

[126] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[127] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[128] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[129] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[130] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[131] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.21.

[132] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[133] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.22.

[134] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.22.

[135] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.22.

[136] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.22.

[137] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD.

[138] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[139] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.10; p.11; p.14; p.23; pp.28-29; p.31; pp.32-33; p.39; p.45; p.47; pp.50-51.

[140] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.7; p.10; p.46.

[141] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.14; pp.33-34; p.43; p.46.

[142] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.14; p.43; p.46.

[143] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.33; p.43.

[144] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52.; p.52-54.

[145] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52.

[146] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52.

[147] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52.

[148] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52.

[149] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.52-53.

[150] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.53.

[151] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.53.

[152] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.53.

[153] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.54.

[154] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.54.

[155] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.54.

[156] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[157] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[158] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[159] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[160] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.54-58.

[161] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.54-55.

[162] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.55-56.

[163] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.55-56.

[164] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.56.

[165] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.56.

[166] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.59-64.

[167] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.59.

[168] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.63-64.

[169] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.63.

[170] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.63.

[171] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, p.63.

[172] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.63-64.

[173] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD; Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD.

[174] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[175] NACD (2003). *An Overview of Cocaine Use in Ireland.* Dublin: NACD, p.22; Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.63-64.

[176] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.63-64.

[177] Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II.* Dublin: NACD, pp.63-60.

[178] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, p.7.

[179] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.19; pp.22-51; pp.52-60; pp.61-84; p.62.

[180] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.9; p.11; p.13; p.41; p.90.

[181] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.27; pp.28-30.

[182] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.30.

[183] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.44.

[184] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, pp.42-43; pp.50-51.

[185] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.59.

[186] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.59.

[187] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.30.

[188] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.36.

[189] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.41.

[190] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.56.

[191] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.57.

[192] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.70.

[193] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.66; p.73.

[194] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.p.12; p.43; p.56; pp.79-80; p.91.

[195] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, pp.91-93.

[196] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.91.

[197] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, pp.92-93.

[198] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, pp.92-93.

[199] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, pp.92-93.

[200] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.92.

[201] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.92.

[202] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.92.

[203] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[204] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, p.147.

[205] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.36-37.

[206] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.36-37.

[207] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, pp.146-147.

[208] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, p.146.

[209] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, p.146.

[210] IMG (2007). *A Vision for change: Report if the Expert Group on Mental Health Policy – First report on implementation 1st February 2006 to 31st January 2007*. Dublin: DoHC.

IMG (2007). *A Vision for change: Report if the Expert Group on Mental Health Policy – Second report on implementation 1st February 2007 to 31st January 2008*. Dublin: DoHC.

[211] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[212] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[213] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[214] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[215] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[216] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[217] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[218] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[219] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.9; p.11; p.13; p.30.; p.41; pp.42-43; pp.50-51. p.90.

[220] MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD, p.30; p.36; p.41; p.56; p.57; p.70; p.66; p.73.

[221] EGMH (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Department of Health and Children, p.146.

[222] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[223] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[224] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.1.

[225] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.17.

[226] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.2

[227] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.41.

[228] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.41.

[229] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.40.

[230] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.41.

[231] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.41.

[232] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.43.

[233] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.17; p.23; p.31; p.39; p.40; p.44; p.45.

[234] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.45.

[235] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.17.

[236] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.17.

[237] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.31.

[238] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.39.

[239] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.39.

[240] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[241] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[242] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[243] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[244] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.23.

[245] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.23.

[246] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.23.

[247] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.23.

[248] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[249] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[250] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[251] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[252] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[253] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.18.

[254] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, pp.18-19.

[255] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.19; pp.41-42.

[256] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.19.

[257] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.42.

[258] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.19.

[259] Talbot Associates (2004). *Review of work of National Advisory Committee on Drugs (NACD) Final Report.* Dublin: Department of Community, Rural and Gaeltacht Affairs, p.2; p.43.

[260] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[261] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[262] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[263] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[264] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[265] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

Chapter 8: Policy & Operational Structures

The start of the period under study was marked by a time of transition in Irish drug policy on a number of levels. A shift in the extent to which the statutory response to the drugs problem was being perceived by those in the communities most impacted by heroin use from being inadequate towards moving in the right direction began to occur. Similarly, a more harmonious working relationship between the different sectors involved in delivering drug treatment services to users began to emerge. Integral to and in the midst of this change was the work of the 1996 Ministerial Task Force on Measures to Reduce the Demand for Drugs. This Task Force functioned to put in place a range of new policy and coordination structures that facilitated much of the change that occurred throughout the period analysed. At the same time as these structural innovations and inter-sectoral collaborations were taking place problems with blood borne viruses (BBV) linked to injecting drug use (IDU) persisted. This chapter of the thesis is concerned with some of the different operational aspects of the new structures put in place during these years and looks at some of the ways they developed over this time.

This chapter consists of four main sections. Section one outlines the main policy structures that were created after 1996 and explores some of their positive and negative features. Sections two and three focus in more detail on the role of the new local and regional level structures and their coordination and policy link-in mechanisms through a discussion of the National Drugs Strategy Team and the Local and Regional Drugs Task Forces. The impact of other structures within the drugs policy machinery and the influence of politics and power relations are considered. The fourth portion of the chapter takes a look at the relationship between the Drugs Task Forces and the development of needle and syringe exchange programmes (NSPs) over the course of the period under analysis. Sections two, three and four are about the Drugs Task Forces in general. However, the bulk of the focus is on the Local rather than the Regional Drugs Task Forces as a result of the latter only having come into existence relatively late in the period under analysis, in 2005, while the former had been up and running since 1997. This portion of the chapter is followed by an overall conclusion.

Innovation in Drug Policy

The start of the period under study witnessed a hitherto unprecedented level of policy action aimed at tackling the problems linked to injecting drug use in Ireland. One of the defining features that marked the efforts of the Ministerial Taskforce on Measures to Reduce the Demand for Drugs (MTMRDD), or Task Force, apart from the work of its predecessors was the sophistication of the structural response it both designed and successfully implemented. The Governments that followed in the years after these initiatives had been put in place sought to capitalise on the successes of the model already up and running. This gave rise to a situation where a core set of structures were allowed to remain intact for a sustained period of time, transcending the lifespan of the Government that initiated their work. Below I discuss the Cabinet Committee on Social Inclusion, the Interdepartmental Group on Drugs, the Minister of State with Responsibility for the National Drugs Strategy, the Drugs Strategy Unit, the National Drugs Strategy Team, and the Local and Regional Drugs Task Forces. The latter three bodies are greatly expanded upon in section two which is specifically devoted to analysing their work.

The Cabinet Committee on Social Inclusion (CCSI) is located at the top of the drugs policy infrastructural chain of command. Reflecting its hierarchical importance within the structures operating during the period being analysed it was chaired by the Taoiseach. The CCSI was originally known as the Cabinet Drugs Committee, but its name and remit were modified by the new Fianna Fail/Progressive Democrats Government in July 1997 to facilitate better policy development in the interlinked or 'cross-cutting' areas of social exclusion and drug use.[1] In this respect, the CCSI can be regarded as building on the role of the early Drugs Committee and it essentially considers all policy and organisational issues linked to the drugs strategy and gives overall leadership to the process.[2] A range of Government Ministers sit on the CCSI with the Taoiseach. These include the Tánaiste, the Minister of State with Responsibility for the National Drugs Strategy, the Minister for Finance, the Minister for the Environment and Local Government, the Minister for Community and Family Affairs, the Minister for Justice, Equality, and Law Reform, and the Minister for Education and Science.[3]

An important, though lesser known and somewhat obscure policy making group beneath the CCSI in the reporting hierarchy, is the Senior Officials Group on Social Inclusion (SOGSI). This group is chaired by the Department of the Taoiseach and notably is one of the two structures, like the CCSI, that is limited to statutory sector members only. All of the other drug policy structures having members from the community and voluntary sectors as well as representatives from other agencies in some instances such as in the case of the IDG where the Chair of the NACD was also made a member. The SOGSI is essentially an Inter-Departmental Group of high-level civil servants. It is concerned with all aspects of social inclusion policy and is charged with keeping the CCSI abreast of current developments in the various interlinked or cross-cutting policy areas and strategies that fall within this overall area, of which drugs policy is one.

Situated directly below the CCSI in the drugs policy hierarchy is the Interdepartmental Group on Drugs (IDG). It is made up of civil servants at the Assistant Secretary level from the different Departments that are part of the CCSI and is chaired by the Minister of State with responsibility for the national drugs strategy who reports to the CCSI.[4] Significantly, the IDG also includes representatives from the community and voluntary sector. In terms of functionality the IDG can best be regarded, at least theoretically, as a bridge between the NDST and the CCSI, with the original intention being that it perform a policy filtration function for the CCSI before passing matters back up to it. In this sense its terms of reference require it to advise the Cabinet Committee on important matters related to the drugs strategy and ensure all Departments and agencies help to resolve strategy implementation problems.[5] It does this though its work with the National Drug Strategy Team (NDST) in the form of joint meetings. The IDG endorses both DTFs plans and is responsible for monitoring their implementation and evaluation on an ongoing basis. The group was made also responsible for the strategically important job of analysing the NDST's work load and the level of support that it needed to undertake its role.[6]

Alongside the CCSI and the IDG, the NDST was part of the structures originally established by the Task Force in 1996 that was retained by subsequent Governments. Theoretically the Team acts as a conduit for policy information from lower level structures to travel to the IDG and essentially performs the same policy filtration function

that the IDG does for the CCSI. The NDST's composition reflects the principles of partnership working as its members include civil servants seconded from the Departments involved in delivering the strategy on a part-time basis and one member each from the community and voluntary sectors.[7] As indicated above the Team functions as a bridge between the upper level drug policy structures and the Local and Regional Drugs Task Forces (L/RDTFs). In this respect, most of its energies are devoted to working with the DTFs to ensure that their plans are delivered properly and that the Departments and agencies involved are cooperating and playing the roles required of them.[8] It is responsible for reviewing the DTFs' work on an ongoing basis and for monitoring the need for their presence in urban areas with significant heroin problems.[9] In working with the DTFs each member of the NDST is designated as a 'liaison person' for one LDTF and no more than two RDTFs.[10] The Team produces operational guidelines for the DTFs and evaluates the strategies they produce as well as making recommendations on them to the IDG that have an impact on the level of funding they receive.[11] The NDST is also charged with locating and considering policy issues and acting as a conduit for policy flows from the DTFs to the upper lever structures through its meetings with the IDG.[12]

The LDTFs were created as a response to the problem of heroin use in urban areas in 1996 by the Task Force and they commenced operations in 1997 after preparing their first round of action plans.[13] The Task Forces represented a dynamic response to the need to respond to the drug problem and to do so by marshalling together the statutory, community, and voluntary sectors, as well as the local communities into one structure designed to function as a partnership.[14] The LDTFs' strategies, which focused mainly on the areas of supply reduction, education and prevention, and treatment and rehabilitation, were intended to strategically address gaps in existing service provision in their areas.[15] After the success of the local model had been confirmed and the need for a more targeted response to the drug problems emerging throughout the country in the Twenty First Century the Task Force design was replicated and extended in the form of the RDTFs by the 2001 national drugs strategy, though the 10 RDTFs only commenced operations proper in 2005. While the NDST developed the operational guidelines for the LDTFs in 1999 and the RDTFs in 2002 their core contents are essentially the same. Accordingly, I discuss them conjointly below.

In order to help the Task Forces progress the implementation of their plans their membership includes statutory representatives. These civil servants are supposed to be of a suitably senior level within their own Department or agency to be able to influence or to be able to have clear access to other individuals who can.[16] They are seen as acting as conduit for information from their organisation to the LDTF and vice versa in the development of policy and services.[17] Each Task Force has a voluntary Chairperson who is charged with facilitating meetings and getting the members to work well together, as well as helping the LDTF to formulate polices and abide by these.[18] The LDTF Coordinators are employed directly by the Health Services Executive (HSE) and their duties include helping to develop appropriate evaluation mechanisms for DTF projects, profiling existing and planned services in the area, and reviewing and adjusting the DTF plans.[19] The community and voluntary sector LDTF members function to both infuse the structure with their benefit of their local experience and understanding of drug issues as well as being a representative of the local community or voluntary sector in the particular area.[20] Community representatives are typically individuals who have been active on drug issues in their local areas and have experience of dealing with the issues, while voluntary members are those who work for drug treatment agencies based in the LDTF areas.[21]

As is the case in most countries a lead Ministry has been designated as having responsibility for the drugs brief in Ireland. During the period under study the practice of assigning a Department to coordinate the drugs strategy commenced at the turn of the Century with the Department of Tourism Sport and Recreation (DTSR) being the first to hold the job. For the majority of the timeframe studied here the Department of Community Rural and Gaeltacht Affairs (DCRGA) was responsible for overall coordination of drugs policy. Within the Department the Drugs Strategy Unit (DSU) was the key section dealing with all matters related to the handling of this policy area. The DSU's role requires it to coordinate the overall implementation of the national drugs strategy. In this sense it provides key supports such as progress reports to a number of the other structures, such as the CCSI, the SOGSI, the IDG, the MOS for the national drugs strategy and liaises with the NDST.[22]

At the mid and end points of the national drugs strategy the Government brought in PA Consulting to undertake an overall evaluation, which included examining the way

in which its structures had been performing. In 2004 the consultants reported positively that progress had been made in all of the drugs strategy's actions in the area of coordination. In particular, they noted that measures to reinforce the functioning of the IDG, the NDST, and the LDTFs – the RDTFs were only being established at this time – were being implemented.[23] In the build up to the formulation of a new drugs policy the same consultants noted in another evaluation four years later that the coordination structures played an important role in creating the success of the strategy.[24] They saw the LDTFs as having helped to deliver services into communities and aiding inter-agency working. In addition they felt that the NDST, DSU and IDG had been important as dedicated structures in delivering what was a complex cross-cutting policy.[25]

These same evaluations, and some of the other ones carried out by the same firm during the period under study for the Government, also showed that there were a range of problems with the structures being used and that these negative aspects overtook the positives in some instances. An earlier evaluation not long after the launch of the 2001 strategy found that there was a lack of clarity in the reporting relationships between the different structures.[26] At the end of *Building on Experience's* lifetime another evaluation asserted as one of its key findings that the structures were hindering the development of the strategy as a result of problems with the way they were working and it called for more effective ones to be developed.[27] Among the issues it raised were need for better lines of accountability and management, the capacity to develop policy, the ability to deliver services and the role played by evaluation.[28] Below I consider some of the key implications from these reports in relation to the main drug policy structures discussed above.

The IDG is positioned as one of the most strategically important bodies among the policy structures as it effectively acts as a bridge between the local and upper level statutory sector-only structures. However, the evaluations from 2004, and 2008 found faults in the IDG's operations that resulted in the consultants stating, "The IDG has not fulfilled its role and proposed reconstituting and revising its membership to strengthen it."[29] These problems can generally be seen as arising from one overarching issue with two aspects to it, namely the issue of attendance at IDG meetings. Firstly, the IDG's ability to act as a link between the purely operational (DTFs), mixed policy and

operational (NDST – and later, the DSU), and policy arms (CCSI, SOGSI) of the strategy was based on its being comprised of civil servants at Assistant Sectary level. The Group was chaired by the MOS for the drugs strategy to ensure that there would be appropriate attendance.[30] However, the practice that emerged over the years was that the Assistant Sectaries stopped attending the IDG meetings altogether or greatly reduced their presence.[31]

A second aspect of the problems created by the non-attendance of senior civil servants at IDG meetings has been the blurring of the respective roles of the Group and the NDST. As for the most part only NDST members were present all IDG meetings were by default joint IDG/NDST meetings.[32] It was originally intended to have both IDG only meetings and joint NDST/IDG meetings, but the former were not taking place.[33] As a result the Group's ability to play a leadership role was undermined. This functioned to damage the overall system to the extent that there was no longer, according to the consultants, a structure properly focused on highlighting problems, priorities, and examining performance.[34] As a result of the absence of the civil servants with decision making power, or direct access to those with it, the IDG became more of a forum for exchanging information than taking policy decisions. The 2004 evaluation commented that, "...the IDG is perceived as a critical 'blockage' in the decision-making system".[35]

This point was confirmed by the Chairman of the NACD in a semi-structured interview. He outlined the process of trying to convey research findings and what the NACD would like to see happen as a result of them to the IDG as repetitive.[36] By this he asserted that one had to be prepared to be involved for the long haul and to keep reiterating findings and asking what was being done to follow up on them meeting after meeting with the IDG for anything to start happening.[37] This is both generally reflective of the slow way in which research has an impact in the enlightenment model of the research/policy interface and the fact that there were few, if any on some occasions, Assistant Secretaries there to listen to and act upon the research. Similarly, the community sector representative on the IDG, Fergus McCabe, also commented in a semi-structured interview that he would ask at IDG meetings who was in attendance from Assistant Secretary level and that there would be apologies made for the non-attendance to the Minister chairing.[38] He felt that the non-attendance was clearly linked to the

perceived power of the MOS for the drugs strategy and when the civil servants felt this was weak, attendance was particularly low.[39]

The Chairman of the NACD felt that part of the decline in IDG's policy function was due to the SOGSI having taking more of an active role in drugs policy after the IDG had been 'opened-up' to non statutory members.[40] This was partially supported by the community sector representative.[41] He felt there had been more structures, such as the DSU, now getting involved in policy work, thus diluting the role and importance of the IDG by default within the system in as much as it could be to do with a power grab by SOGSI alone.[42] It was his opinion that when drugs policy was operating without an official strategy per se, prior to 2001, and there were fewer structures things worked clearer and faster and there was more of a political will to drive the process.[43] This view is supported by an earlier evaluation from 1998, which asserted that after the early years of the drugs initiative, that is, the establishment of the DTFs, the operation, roles and responsibilities of both the IDG and the NDST were clear. However, after this period they became confused, particularly in relation to wider drugs strategy issues.[44]

Like the IDG, the NDST is one of the most important structures within the overall drugs policy system as it both deals with the local level structures (DTFs) and interacts with the higher-level parts of the system on a continuous basis (IDG, CCSI). This allows it to serve as a conduit for information flows in both directions. However, like the IDG problems have been found by a number of evaluations with the way in which the Team has functioned. One of the key issues has been the extent to which the operational aspects of its work – managing and running the activities of the DTFs – have overburdened the NDST and reduced its ability to work on others areas, such as its policy role. As noted above the Team is required to locate and consider policy issues and act as a channel for policy information to flow in both directions from higher to lower level structures.[45]

The issue of NDST's workload and its impact on their performance has been focused on by a number of evaluations over the years. An evaluation carried out several months after *Building on Experience* was launched noted the NDST's role had been significantly expanded as it was now expected to be responsible for both the LDTFs and the RDTFs.[46] A review of the LDTFs carried out the following year for the Team reiterated this view and found that the NDST needed additional staff as a result of the

burden its operational duties were placing upon it.[47] It asserted that provision of this support would allow them to pursue policy work.[48] The evaluation carried out as part of the mid-term review of the drugs strategy asserted that after a review of the Team's supports its resources were expanded to include a fulltime coordinator, an independent chairman, and more core staff. They concluded that, "This has allowed the Team to devote more time to strategic and policy issues."[49]

The improvements from the additional staff did not appear to be lasting in terms of restoring the NDST's ability to engage in its policy work. In 2008 another evaluation by the same consultants noted that the focus of the NDST's work was still overly operational and that its roles were unbalanced as a result of the number of DTFs and the volume of projects being managed.[50] In stating almost the opposite of their comments four years earlier they concluded, "The current structures have become overly operational with insufficient focus on policy and strategy development."[51]

These issues were explored in a semi-structured interview with Fergus McCabe, who had been the community sector representative on the Team for eight years.[52] He felt that there were a number of reasons behind the subordination of the NDST's policy role to its operational functions with the DTF's projects.[53] The departure of some of the original Team members and their replacement by others who were perceived as closer to the civil service was seen as part of the reason why the NDST had taken on more of a micro management role in project affairs.[54] This was due to the fact that these Team members probably felt they had to take on this work in terms of an obligation coupled with the fact that some agencies were not fulfilling their roles in accordance with the 1999 handbook and as they had agreed to.[55] Beyond this it was felt that there had also been an element of intentionality on the Government's part in not reacting to the evaluations pointing out the NDST's overburdened state as a result of there being somewhat of a systemic shock to the new structures after their activation.[56] By this it was meant that the highly dynamic structures that arose out of the 1996 Task Force report proved to be a step too radical and somewhat out of sync with both the civil service and the Government, neither of whom were all of a sudden entirely happy with the prospect of too much policy work being carried out by the NDST.[57] As a result they allowed it to

remain heavily involved in operational affairs so it could not become too involved in policy work.[58]

An additional perspective as to why the NDST's policy role had not been properly achieved can be found in the some of the evaluations. The 2004 PA report suggested that there had been a sense of confusion in terms of defining the respective roles of the NDST and the DSU. Principally, they felt that the DSU's role as the main Department responsible for the drugs brief had been understated regarding the development of policy as a result of its being designated as having a coordinating responsibility, while the NDST's policy role had been somewhat overstated.[59] A later report by PA from 2008 noted that the NDST was having difficulties in getting its priorities to be reflected in DTF action plans. This was seen as making part of its policy task, to see that national priorities are reflected at the local level and that local concerns are considered at the national level, rather difficult.[60]

When the DSU was first evaluated by PA in 2001 a negative assessment of its policy role capabilities was given. The consultants asserted, "The DSU is under-resourced and therefore not able to function as effectively as it might. The Unit spends most of its time 'fire-fighting', with little or no time to develop a more considered, strategic view of issues as they emerge."[61] In one sense this shows why the NDST was still at least expected to be playing more of a policy role than it perhaps should have, in that, the DSU as an emergent and pressurised structure was still grounding itself. Consequently, it appears that part of the problem behind the NDST not fulfilling its policy role satisfactorily was due to the coexistence of two structures – the Team and the DSU – within the system with similar, overlapping, and not clearly differentiated purposes. This itself can be regarded as an unanticipated and unintentional consequence of the development of a set of new and highly dynamic structures in a relatively short period of time. It simply lead to role confusion and poor resource utilisation in terms of task delegation regarding policy development – particularly from the point of view of infusing policy with the lessons learned from the operational arms of the structures.

The appointment of a dedicated Minister of State (MOS) with responsibility for the drugs strategy represented the creation of another important and potentially dynamic tool within the policy system. However, like the other key parts of the policy machinery

the evaluations carried out during the period studied found problems with the MOS's functionality. The 2008 PA report found that, "The Minister of State has overall political responsibility for the NDS but no authority to ensure implementation of NDS actions across all pillars."[62] Consequently the main operational difficulties for the MOS and the NDS are that the organisations delivering the strategy are directly answerable to their own Department's Accounting Officer and Minister for matters of expenditure and actions, rather than to the MOS.[63] This chain of command underlines the manner in which the MOS cannot compel implementation of specific NDS actions. This appears, in part, to be the unintentional consequence of creating another additional structure, sitting within an already highly complex network of inter-Departmental and inter-agency relationships in the management of drugs policy. It would seem that sufficient thought was not given as to how the post's ability to drive implementation would realistically fit with these pre-existing and highly complex arrangements spanning several Departments and their budgets.

While the area of drugs policy was one of the first areas of social policy to have many of the principles of the SMI applied to it, a number of the evaluations carried out have pointed to ways in which the structures have not matched up to these expectations. An early evaluation from 1998 by PA Consulting found that there were problems with the participation of statutory representatives on the LDTFs. Specifically, the quality of their input was variable and was dependent upon the personal interest of the delegated individual and the backing they got from their organisation.[64] While many statutory representatives were performing well, others were not participating properly, were not at the appropriate level of seniority within their organisation or on occasion from the right part of the body.[65] Others were simply not attending DTF meetings or the sub-committee meetings.[66] In 2001 PA found that some statutory representatives were still having problems allocating the required 2.5 days per week of their time to LDTF work over their other responsibilities.[67] This was a situation which reflected the fact that LDTF work had still not been written into the statutory representatives work role as a core aspect of their job description. A later review from 2002 asserted that the level of involvement required of statutory representatives was not fully understood by their respective agencies in some cases.[68] This assessment stressed that as the statutory representatives' contribution to the

LDTFs was not always recognised as a core part of their work, it should be included in their job description.[69]

This part of the chapter has discussed the new policy structures that were brought online from the start of the period studied onwards and has explored their operation and some of the problems that arose for them. Specifically, it looked at the role of the Cabinet Committee on Social Inclusion, the Interdepartmental Group on Drugs, the Minister of State with Responsibility for the National Drugs Strategy, the Drugs Strategy Unit, the National Drugs Strategy Team, and the Local and Regional Drugs Task Forces. The structures created after 1996, both as a whole and as individual units, represented a dynamic new way of organising the statutory response to the drugs problem. The relative success of the new policy and operational mechanisms created at this time was evident from the backing they received in different evaluations and their being maintained in existence by different Governments throughout the period studied. However, there were also a range of problems with the new structures and these were also revealed by the same sets of evaluations discussed here.

The drugs area was, as we have seen in chapter four, one of the first areas of social policy to have the SMI's principles applied to it in terms of defining new structures and operating procedures. Consequently, it was not unusual that problems arose from the attempt to institutionalise and bed-down this new innovative way of working. Advancement in social policy as in any field often comes at a cost, and in the case of drugs policy the structures had many problems that could not have been foreseen or easily worked out. The new approach to managing the area of drug policy through a range of structures that were based on the SMI idea of cross-cutting management was somewhat out of sync with the operational norms of the Government Departments that were being drafted into them. Many of the problems can be regarded as unanticipated and unintentional consequences that arose from the drug policy structures as a result of their being slightly ahead of their time and the attendant difficulties for Government in managing several new structures and knowing how to best utilise them. In the following section I consider the impact of some of the structural problems that have arisen in relation to the NDST, LDTFS and the RDTFs.

From Protests to Participation

One of the most significant changes that occurred within the period being studied was the extent to which the social tensions and community unrest surrounding drug issues, discussed in chapter four, declined after the launch of the Ministerial Task Force in 1996. This is not to say that there were no episodes of tension or that there was not a sense of disillusionment with some of the processes and structures involved in delivering drug policy by those in various sectors over time. Nonetheless, it is clear that for the majority of the timeframe studied here the Government was able to generate and maintain a successful multi-sector collaboration in delivering the drugs strategy. The present section further explores the structural solutions that were specifically devised to overcome the sense of dissatisfaction local communities had with the response to drug problems and the sense of mistrust between the community and voluntary sectors and the statutory sector towards forming effective collaborative relationships.

The disruptive and intense presence of large-scale anti-drug protest marches in 1996 and their distinct dwindling and marked absence over the remainder of the period under analysis is indicative of the extent to which a successful long term structural response was effectively orchestrated by policy makers. It shows the extent to which many activists within local communities became part of the official response to drug problems through their participation in the new structures. This represented a dynamic scenario in which complex power relations were formed. Central to understanding why the need for this change arose, how it was put into place, and subsequently maintained is Antonio Gramsci's idea of hegemony as it allows us to effectively illuminate the dynamics at play in the social partnership-styled new LDTF structures.[70] One of the elements in the operation of hegemony is the idea of a 'hegemonic alliance'.[71] Hegemony itself can concisely be conceived of as the rule of one group by another. Importantly, however, this leadership occurs with the consent of the led.[72] A hegemonic alliance is one of the key tools in creating and maintaining hegemony.[73] It involves the group that intends to lead, in our case the Government, offering those it wants to exercise power over (*inter alia*, local activists from different sectors involved in LDTFs) some inducement to give their consent to be led.[74]

Such a process can more or less be seen in the way DTFs were designed so that their membership could accommodate a range of actors from all of the main stakeholder groups. As a result they were offered a place on a structure that was hooked into the overall policy hierarchy and decision-making network. This essentially functioned to incorporate individuals who were and would potentially be involved in various forms of activism, campaigning, and political lobbying. This view was confirmed in a semi-structured interview with Fergus McCabe, the community sector representative on the NDST for 8 years.[75] He asserted that it was an unusual atmosphere at first for the statutory sector to be sitting down with people such as himself who had up to that point been viewed as a source of antagonism as a result of their campaigning activities.[76] To identify the presence of such a strategy is, of course, not to assert the existence of some grand conspiracy theory. Rather, it is to show how one of the multiple rationales intermingling in the creation and operation of such structures is to reduce dissent and antipathy from politically active lobbying groups.

While such structures create opportunities for actors to achieve goals they also function in other ways to incorporate individuals into wider systems of accepted action that can place limitations on their abilities to realise sector-specific agendas. This is a point that was touched on by Tony Geoghegan, the CEO of Merchants Quay Ireland, at the Vital Connections conference held for the Task Forces in 2005. He stated,

> "Ironically enough, what has, I think, contributed to the complacency, and has undermined the success of LDTF's has been its success in some regard. The success of the partnership approach in pulling people into the process, has added to the complacency, by dampening down the criticisms. Traditionally the community and voluntary sector were the critical voice, being engaged in partnership has made this harder to maintain."[77]

The conundrum that advocacy groups find themselves in when offered access to such policy structures can be seen as reminiscent of what has been one of the most critical ongoing debates in contemporary sociological theory, the agency versus structure dichotomy.[78] A helpful tool for framing this theoretical problematic in relation to the DTFs can be found in Anthony Giddens' structuration theory. His tactic to overcome this

division is to assert that it is in fact a *duality* of structure and agency.[79] In this respect, actors are *both* enabled *and* constrained (rather than *either/or*) by social structures.[80]

It is this duality of structure – linking back to Gramsci – that allows a hegemonic alliance to remain a viable means of achieving goals for both those being led and those alleged to be doing the leading. Essentially, all parties in the hegemony are simultaneously subject to some degree of enablement and constraint in achieving their different agendas as a result of remaining within the structure. Given time and the achievement of a certain number of successes such hegemonic structures (DTFs) start to become the only ontological reference frame within which viable action can be conceived of as taking place by advocacy groups. This in turn can be regarded as functioning to solidify the means by which hegemony is created and maintained. In an Irish context this has been carried out through the medium of the social partnership processes and on a micro level through the abovementioned drug strategy structures of the DTFs and the NDST and more recently the IDG.

Some of the evaluations of the LDTFs reveal the extent to which there was a need for such structures to overcome the mistrust between the different sectors and the Government and the importance that the creation of a lasting hegemony represented to policy makers. In their 2002 review of the LDTFs the NDST noted the circumstances that produced the need for hegemony:

> "It will be recalled that the LDTFs were set up against a background of a spiralling drug problem. There was considerable discontent in the affected communities at the perceived inability of the statutory sector to respond adequately to the situation and, in some instances, individuals were even resorting to extra legal activities in an ultimately futile attempt to deliver some response."[81]

Similar comments are found elsewhere in the documentation relating to the LDTFs and their operations.[82] This highlights the importance that was placed on establishing structures that conveyed in a clear way to local communities that the drugs problem was being dealt with and that their participation was welcome and required. As a result of this focus, a large part of Government's energies was on getting and keeping them up and running rather than being overly concerned with the quality or structured homogeneity of their output during their first years of existence.[83]

In this respect it is possible to detect the importance that LDTFs represented to policy makers, in terms of maintaining hegemony, from a range of documentary evidence. For example, we can note this function in the subtext to the introduction of the LDTFs operational booklet by the Minister in charge of the drugs brief at the time Chris Flood. He stated,

> "Since their inception in 1997, the Task Forces have achieved a significant number of successes, but not least in reducing the feelings of isolation and frustration previously experienced by many community and voluntary organisations working at the coalface of the drug problem. These organisations now feel that they are part of a co-ordinated and effective response to drug misuse in their areas".[84]

The role of the LDTFs in reducing feelings of isolation and mistrust is a theme that is present in several of the evaluations of their operations and this itself is indicative of the importance of the Task Forces' functionality in this respect.[85]

Later in the same operational booklet during a discussion of supports for the LDTFs we can also see an example of how the Task Forces' role positioned them to be the key mechanism for generating and maintaining community support for the drugs strategy and Government action:

> "Community representatives have an important role in providing information to and consulting with local communities in relation to drugs issues, as well as re-assuring them that the Task Force is operating on the basis of genuine partnership".[86]

The sentiment implicit in such statements conveys the clear role that the LDTFs were seen as playing in legitimating the Government's actions to local communities and attempting to restore their faith in the official response to the drug problem. This same rationale was also present in the decision to add locally elected 'public representatives' to the LDTFs after they had been initially set up as a further means of gaining local support for their work.[87] Specifically, they were seen as being able to,

> "...assist the Task Forces in overcoming misapprehensions and fears around the provision of drug programmes and services in their areas."[88]

In this respect, the 2002 review of the LDTFs by the NDST found that the Task Forces had both 'energised communities' and 'restored confidence' in the way the drugs problem was being dealt with.[89]

In exploring the role of the DTFs in generating and maintaining support for the statutory response to the drug problem it becomes evident that successive Governments have made substantial commitments to sustain the hegemony or partnership in place. One of the most visible forms that this level of investment has taken is the fiscal resources that have been allocated to DTF projects over the years. Initially an outlay of £10 million Irish pounds was provided to support the first round of LDTF action plans in 1997 and this allowed some 200 different measures in the areas of education, prevention, treatment and rehabilitation, and supply reduction to be funded.[90] A further £15 million Irish pounds was added to cover the LDTFs second round of action plans during the period from 2000-2001.[91] From 1997 to July 2004 round 1 and 2 of the LDTF's action plans were awarded €84 million in order to support measures.[92] Between 1997 and 2005 €120 million in funding overall was given to the LDTFs to help implement measures responding to drug use.[93] A similar funding scenario unfolded for the RDTFs since their inception. In 2005 after the 10 RDTF action plans were subject to assessment and then approved €5 million was allocated to them initially.[94] The overall level of funding awarded to the RDTFs to develop their action plans was subsequently increased to €14.2 million the following year.[95] This financial resource had allowed to the Task Forces to build their project numbers steadily, with 22 started in 2005 and an additional 71 initiated in 2006.[96]

A major consequence of the sustained Government fiscal support for the LDTFs as a result of a political desire to maintain hegemony and gain lasting support for its actions was that the Task Forces achieved a range of notable successes in their work. Successive evaluations noted the positive impact that the DTFs had in a number of ways on the drugs situation at the local level. For example, the 1998 PA evaluation found that they had enabled previously strained inter-sectoral collaborations to take place and that the early projects it examined were working successfully highlighting the benefits of a community based approach to tackling to drug issues.[97] In its 2002 review of the Task Forces the NDST asserted that they had implemented a range of new projects under the four pillars of the national drugs strategy and that these had significantly helped to

improve the services available for drug users in local areas.[98] The NDST also noted the success that the LDTFs had achieved in convincing communities that the statutory sector was now taking the drugs problem seriously.[99]

Reviews of the Task Forces work carried out slightly later in the period being studied also found the LDTFs to have achieved a wide range of successes in their work. An evaluation by Goodbody Economic Consultants in 2006 reported that there was a good fit between the type of projects being delivered by Task Forces and the drugs strategy's objectives, and that these measures were both cost effective and generally supported by research evidence and international experience.[100] In particular, the review credited the LDTFs with playing a key role in helping to expand the availability of MMT at the local level and developing other harm reduction services as well as delivering multiple services from the same settings.[101] It also noted that nearly all of the measures in rounds 1 and 2 of the LDTFs' strategic plans had been put into action, with only 10.8 percent and 4.4 percent from rounds 1 and 2 respectively not being initiated.[102] An evaluation of LDTF funded projects from 2008 crucially found that the services,

> "...provide an open and welcoming door for individuals with a wide range of needs who may otherwise not access more formal provision."[103]

This review went on to assert that the treatment projects being funded played a vital role as a result of their ability to fill gaps in statutory service provision.[104] It concluded that overall the projects in general – across all pillars – were well established in their areas and operating at a decent standard.[105]

This section of the chapter has discussed the response implemented by policy makers to overcome the widespread dissatisfaction with their handling of the drugs problem in the communities most affected by it at the start of the time studied. Principally, this took the form of establishing a hegemonic alliance with local communities, and the community and voluntary sectors in the establishment of the Local Drugs Task Forces and later the Regional Drugs Task Forces to convey and display that serious action was being taken. This approach was highly successful and remained in place as a form of partnership working for the duration of the period studied, though there was a return of feelings of dissatisfaction and distrust with the statutory sector towards the end of the study. This aside, DTFs achieved a range of positive outcomes in their

work, such as improving services locally and changing local attitudes towards them, facilitating inter-sectoral working, and making communities feel that the problem of drug use was being dealt with. The following section focuses on the way in which the Government acted to keep the hegemony that it had put in place intact in the long term by the approach it chose to endorse towards the running and management of the DTFs.

Maintaining Hegemony

One of the main consequences arising out of the consistent desire by Governments to involve the different sectors in a hegemonic alliance via the DTFs was that they adopted a number of management tactics that had important impacts upon the DTFs work. Deploying such strategies was critical to the relationship's survival, particularly when we reconsider the dissatisfaction with the statutory response to the drugs problem at the start of the period studied, as discussed in chapter four. Chief among the methods utilised by policy makers to ensure the survival of the working relationships enshrined in the new drug policy structures was the adoption of a form of management that can be regarded as 'loose control'. By this it is meant that in overseeing the operation of the DTFs through the CCSI, IDG, and NDST policy makers consistently opted to err on the side of affording them as much latitude as possible in terms of the extent to which they were expected to follow rigid monitoring and management guidelines in, for example, running projects. However, the application of this form of management by policy makers can be seen in many other aspects of the LDTFs' work. The rationale behind this approach was simply to ensure that the different sectors would not become alienated as time progressed by the necessary bureaucratic elements of the DTF programme and all of the consequences that being hooked into a relationship with the statutory sector entailed in the long term.

In considering how 'loose control' as a strategy can be distinctly identified it is helpful to set it alongside an SMI-era management science tool that we discussed initially in chapter seven in relation to the NACD – 'the logic of quick wins'. This approach places importance on building solidarity and cohesion amongst the members of new structures over and above their attention to precisely following operational rules and

regulations so they may achieve some early successes in their work. Over time the fine detail of operational process is then placed centre stage and refined. We have already seen the background of hostility and animosity against which the LDTFs where initially introduced and the PA evaluation from 1998 noted the hurried pace with which the Task Forces were activated to show action was taking place on the ground.[106] This was essential from the Government's point of view if the negative sentiment that had built up within communities impacted by heroin use was to be reversed. In this sense policy makers made use of the logic of quick wins by having the LDTFs prepare their initial plans as rapidly as possible so that work could get under way and the structures could take shape.[107] There is however a key point of demarcation between the logic of quick wins and loose control as distinctive strategies in the case of the LDTFs. Namely, the former tactic was extended to such an extent that it became the operating norm by which the Task Forces were managed on a continuous basis rather than a short-term new-structure-energizing method and it was kept in place for the duration of the period studied. In the following paragraphs I explore the presence of this policy of loose control through the findings of some of the main evaluations of the LDTFs work.

Among the main ways in which we can see the presence of loose control in the operation of the LDTFs by policy makers is in the issue of monitoring criteria in different aspects of the Task Forces work. An evaluation by PA Consulting in 2008 highlighted the way in which the LDTFs were not being subjected to the same forms of monitoring that other structures and bodies involved with the statutory sector could expect to be. For example, it noted that there was a,

> "...need to focus on more measurable outputs and outcomes to assess their effectiveness."[108]

This same concern with the way in which the LDTFs' effectiveness was being monitored was also expressed by Horwath Consulting in 2008 during the course of an extensive LDTF-wide review of project funding.[109] The PA report went on to assert that the financial reporting arrangements between the individual L and R DTFs and the Department in charge of the drugs brief, as well as the reporting arrangements between individual projects and their financers in the statutory sector lacked clarity.[110] In the case of the latter the consultants stated,

> "There are c.600 projects but many of them operate on a semi-autonomous basis with underdeveloped governance arrangements and connections to national priorities. ...The accountability arrangements for projects are unclear with little connection between the source of the funding and accountability"[111]

This is indicative of the way in which policy makers continued to pursue a strategy of loose control in relation to the operation of the LDTFs exceeding that which could reasonably be accounted for under the rationale of the logic of quick wins.

An evaluation of Task Force expenditure by Goodbody Economic Consultants in 2006 raised many of these same concerns in relation to the monitoring of the LDTFs. It called for the introduction of standardised monitoring templates for projects, the creation of clear monitoring and evaluation responsibilities for mainstreamed projects, and the introduction of a system of performance indicators to improve overall efficiency.[112] The review found that mainstreamed projects were not being subjected to any evaluation or monitoring by the LDTFs or the statutory agency funding them and that the findings of evaluations undertaken in relation to the projects appeared not to have been followed up on or distributed to projects.[113] They noted,

> "However, no mechanism appears to have been put in place to ensure that such projects, or their funding agencies, followed up on the proposals made by the evaluators."[114]

This is a point which highlights the loose control that was being operated by policy makers.

The presence of a policy of loose control in how policy makers opted to handle the management of the DTFs can be traced back to the start of the period studied. The 1998 PA evaluation reported that there was no evaluation framework for the new structures in place and that the nature of their introduction, according to Government officers, had militated against the creation of performance indicators and monitoring mechanisms, out of fear for alienating those involved.[115] The consultants went on to assert that there was confusion between the funding agencies, the LDTFs and the NDST as to who was responsible for monitoring and evaluating projects.[116] Chiefly, the funding agencies were hesitant to rely on the LDTFs to monitor the projects directly, as was envisaged by NDST and supported by the consultants ultimately, but something that,

reflecting the dynamic nature of the structures, represented a break with normal statutory sector procedure.[117] The initial pressure to try and monitor LDTF projects was compounded by NDST's own operating difficulties upon its inception as it was left with no administrative support for the first seven months of its life.[118] Ultimately the LDTFs retained responsibility for monitoring projects during the period studied.[119]

A review of Task Force work from 2002 by the NDST also highlighted the way in which a loose form of control was applied to the operation of the initiative. In relation to project implementation it noted,

> "...the LDTFs currently do not have a mechanism for monitoring the implementation of their plans, although implementation of projects from the second round has commenced."[120]

In this respect, we can see that the lack of monitoring criteria was not hindering the development of the programme in terms of continuing Government support for it in the long term in a fiscal sense. Particularly, as this situation pertained to the second wave of action plans rather than the initial more time pressurised first round.

Another way we can see the presence of a strategy of loose control having been consistently adopted by policy makers via the drugs strategy structures in relation to the LDTFs is in relation to problematic aspects of project management. A range of concerns were raised by evaluations of the Task Forces' work about the way in which projects were being run. For example, the 2008 Horwath evaluation found that there was an inconsistency across LDTF projects in their approach to monitoring and evaluating their operations and that this needed to be countered by the introduction of a standardised, but flexible, methodology.[121] Similarly, it was also noted that while some projects were engaged in actively planning and managing their activities others were not setting aside the appropriate time for such strategic tasks.[122] In addition projects were not analysing and developing their relationships with other services in order to develop the referral process for clients.[123] The consultants also found that there was a degree of duplication among the smaller projects in the areas of treatment and rehabilitation, alongside the existence of a tendency for some projects to be primarily focused on providing employment and with the clients' needs being a secondary concern.[124]

The 2006 Goodbody evaluation also found problems with the management of LDTF projects and linked these to the fact that the individuals in charge often came from the community and voluntary sector and therefore had strong links with the community but were not adequately skilled to run a project.[125] As a result there were problems with planning, monitoring, and overall management that were highlighted in evaluations of mainstreaming projects.[126] The 2000 PRC evaluation found that there were a number of problems with the way projects had been planned from the outset. These included a reliance on anecdotal evidence, rather than proper data, in gathering initial information on the nature of the drugs problem in the area, and an overuse of informal rather than proper research methods to carry out needs assessments.[127] It also noted that projects had not made a clear link between their objectives and the services that they had subsequently chosen to provide, and that a large number of project managers were not able to estimate their target groups.[128] These points show the way in which a form of loose control was operated by policy makers over the LDTF projects. Overall these points from the different evaluations act as snapshots that reveal how a form of loose control was maintained on the LDTF projects throughout the period under study and not just at the start of it. This was done to maintain the cross-sectoral hegemonic alliance that the Task Forces represented.

While policy makers pursued a form of lose control in their operation of the LDTFs there were other factors at play in how the Task Forces came to be managed over the period studied. One of these can be seen as issues related to the newness of the structures and managing them. In essence, after the Task Force's launch in 1996 of a set of highly dynamic new structures represented a challenging situation for policy makers as much as it also represented new scenarios for the exercise of control. A useful snapshot of events near the middle of the period analysed can be found in the NDST's review of the LDTFs from 2002, as it offers us a number of insights into the way in which the freshness of the LDTFs had still to be fully grappled with by the statutory sector that was managing them.

Throughout their analysis of the LDTFs the NDST noted a range of ways in which the aspects of the Task Forces' work or structure needed to be refined in order to

better facilitate the structure's overall operation and interaction with the wider drugs policy machinery and Government Departments. As the Team put it,

> "...the setting up of "cross-cutting" teams, such as the LDTFs, is a relatively new departure and we are still very much on a learning curve as to their capabilities and effectiveness."[129]

They went on to note a range of issues that highlighted fact that the Task Forces were still being shaped and proving to be complex to manage. For example, they were still discussing the need for implementation plans, detailed role descriptions for agency representatives, and where responsibility lay for training coordinators.[130] Similarly, issues of cross-LDTF management were not fully worked out as they were commenting on the variability with which the role of the chairperson could be interpreted from the handbook and the fact that the coordinators were not working together in a structured way.[131]

This part of the chapter has shown that one of the main ways in which policy makers were able to maintain this hegemonic alliance for such a long period of time was by operating a form of loose control in the management of the DTFs. This amounted to, for example, allowing them leeway in terms of the type and depth of monitoring and evaluation activities that they had to engage in at different levels throughout the time studied, so as to avoid alienating the different sectoral participants. This form of loose control had a range of impacts on the DTFs' work in positive, negative, direct and indirect ways. In the final section of this chapter we will look at the development of NSPs by the DTFs during the time studied.

Needle & Syringe Exchange Programmes

The period under analysis was characterised by an unprecedented level of cooperation between the statutory and community and voluntary sectors in the development and delivery of drug policy and services. The structures put in place to both coordinate the local and regional bodies and to organise and give shape and meaning to these groups in the form of the Drugs Task Forces (DTFs) were central to the facilitation of this collaborative alliance. The LDTFs were, as we saw in chapter four, originally set up in the communities most affected by heroin use by the Ministerial Task Force in 1996. This

portion of the chapter examines the extent to which needle and syringe exchange programmes (NSPs) were advocated and developed by the DTFs as a result of the persistence of blood borne viruses (BBVs) among IDUs over the course of the period studied. This is done by first taking a look at the 'state of play' regarding NSP provision over the course of the period studied though a number of evaluations and reports so that a clear picture of NSP availability can be created. Subsequently, our analysis shifts to a discussion of the extent to which NSPs were featured in the action plans and strategies of the DTFs.

A 1996 evaluation of the EHB's drug services provided a positive overall assessment of the treatment system. In particular, the consultants were impressed with the size of the treatment network, its rapid growth, and the number of options it contained, including MMT, NSP, and outreach (OR).[132] In discussing the impact of treatment the consultants made an observation, which indirectly served to account for why certain parts of the system were being advanced over others at this time,

> "It is clear that the problem of HIV and AIDS among the injecting drug using population was the initial priority for responding to drug problems within the Irish and in particular within the Dublin setting. This type of HIV generated response occurred in most EU member states and the policy imperative has moved to a broader concern about all aspects of drug misuse with a particular concern about the links between drug misuse and crime, and community safety and community well being."[133]

A consequence of this was that drug policy's scope, or at least the crisis focus that it had when the conjunction of HIV and IDU was driving events initially, had been reduced and widened out to incorporate other policy concerns. These were comments that were reiterated by the consultants in their 2000 evaluation of the EHB's drug services.[134] In one sense, they offer a partial insight into why, as we will see below, NSP provision remained static throughout the period studied.

The evaluation made a number of interesting points about the provision of NSP services in the EHB. Reflecting the persistence of BBVs at the start of the time studied, the consultants stated,

> "The estimate of HIV infection rates among new presenters to services is about 8% but hepatitis C figures are reported between 50-70%".[135]

The report later noted that the establishment of a NSP network had been a positive development but one that need to be built upon,

> "Given the HIV and drug situation in Dublin we were impressed with the establishment of and provision of a network of needle exchange programmes across the city. Overall we feel that that there is a need for a review of the needle exchange facilities with a view to further expansion in provision."[136]

In this sense, we can see how in 1996 there were still high rates of BBVs among IDUs and the NSP network was in need of further development.

On the whole the 2000 evaluation of the EHB's drugs services mirrored the positive findings of its predecessor, however its discussion of NSPs showed that this area of the treatment system had not been developed in the same way as MMT, for example, had. In framing the progress made on NSPs in the time between the two evaluations the consultants stated that,

> "Virtually all of the key recommendations from the previous report have been implemented with the exception of two things. There has been limited progress in the implementation of a comprehensive needle exchange programme. There has been limited links between the DRUGS/AIDS service and other related services such as alcohol treatment services."[137]

The consultants' remarks showed that only a small amount of change in the NSP network had occurred during the years that had elapsed. The topic of NSP expansion was not subject to discussion in the EHB's reviews of its drugs services from the interval between the two evaluations.[138]

In offering an appraisal of the NSP network as it stood at the turn of the Century the consultants described a system which was at odds to the MMT network that they outlined in the same report and that we will explore in chapter nine. They asserted,

> "The needle exchange provision within Dublin is patchy and not very comprehensive. It is understandable that there is substantial sensitivity and community resistance to such services. However the limited amount of facilities

for the safe disposal of used injecting equipment is an environmental hazard that should be directly addressed."[139]

This displays the way in which the NSP network was not scaled up in terms of its geographical coverage, on a par with the scale up in MMT treatment, in the intervening years between the evaluations.

One of the key ways in which NSPs have been provided to IDUs in the absence of a scale-up in fixed site, that is, clinic-based NSPs, is through outreach (OR) based back packing NSPs. The consultants commented on this development stating that,

> "It is also noteworthy that outreach workers provide a range of syringe exchange services. In the absence of other provision this service is critical to the current geographic spread of needle exchange provision." [140]

While fixed site NSPs were not expanded up to this time those from the different sectors providing drug treatment utilised OR NSP as a sophisticated way of expanding and buttressing the existent level of service provision.

The NACD's 2008 report on NSPs, which we initially looked at in chapter seven, represented a more complex view of NSP provision than the EHB evaluations. As a result of its more detailed focus it showed how events had come to be characterised by continuity and change. In the main the most significant development to have occurred since the middle of the period studied was the work being done by the DTFs and the services they were providing. At the same time as this, however, there remained a problem, nationally, with the overall development and roll out of the NSP network. In these respects the Committee remarked,

> "The review of the current provision of needle exchange in Ireland clearly highlights the fact that despite the identification of service needs and the inclusion of specific actions in the NDS on development of services, provision is still largely concentrated in local drug task force areas with inadequate coverage at a national level despite the evidence of drug misuse throughout Ireland..."[141]

These comments show us the way in which the situation regarding the overall expansion of the NSP network had not developed to provide a more comprehensive level of service after the 1996 and 2000 EHB evaluations.

The NACD's report provided a detailed look at the level of action being taking on NSPs in LDTF areas. Table 1 has been reproduced from the Committee's report and it gives a break down of NSP by modality and DTF area, though the data is reported by RDTF area as opposed to L and R DTF individually. The Committee noted that 11 LDTFs had NSPs (Dun Laoghaire/Rathdown, Clondalkin, Finglas/Cabra, Blanchardstown, South Inner City, Ballyfermot, Ballymun, North Inner City, Bray, Dublin North East, and Tallaght).[142] They found that two of the remaining three LDTFs, Dublin 12 and Canal Communities, had together with the HSE collaborated on a harm reduction project involving NSP, while Cork LDTF had no NSP at all.[143]

Table 1[144] - National Availability of Needle Exchange Services by RDTF Area

East Coast RDTF: Dun Laoghaire, Rathdown and Wicklow	**3 fixed-site needle exchanges:** Operation hours range from one to five hours, one day per week in each fixed site.
	2 specialist needle exchange for sex workers (fixed-site & mobile).
	4 areas covered by outreach services through either mobile units or home visits each area is serviced for four to five hours, one day per week.
South West RDTF: South Dublin City, South Dublin, Kildare and West Wicklow	**9 fixed site needle exchanges:** Operation hours range from one to three hours, one/two days per week. Merchants Quay Ireland operates a fixed site exchange Monday to Friday, 10:00-16:30.
	1 mobile Unit: Monday to Friday one hour a day.
	1 specialist needle exchange for homeless people: Simon Homeless Hostel.
	Home visits or 'backpacking' service is available by appointment in Kildare and West Wicklow.
Northern RDTF: North Dublin City and Fingal	**8 fixed site** exchanges most are operated in community health centres for two hours per week. In Blanchardstown one service operates in two locations from Monday to Friday, for between eight to eleven hours.
	1 specialist service for sex workers operates one evening a week.
	I specialist needle exchange for homeless people: Clancy Hostel.
Mid Western RDTF: Clare, Limerick and North Tipperary	**1 fixed site needle exchange** in Limerick City one day per week, for two hours.
	Outreach services through backpacking in public places & home visits available throughout the region, no fixed day or time.

Table 1[145] continued - National Availability of Needle Exchange Services by RDTF Area

Western RDTF: Galway, Mayo and Roscommon	**No service available:** The HSE is in the process of developing a mobile unit that will operate for half a day in each county.
North Eastern RDTF: East Cavan, Louth, Meath & Monaghan	**No service available:** In the process of developing mobile unit.
Midlands RDTF: Laois, Longford, Offaly and Westmeath	**No service available:** Awaiting approval for mobile unit.
South East RDTF: Carlow, Kilkenny, South Tipperary, Waterford &Wexford	**No service available:** Discussing development of services.
Southern RDTF: Cork and Kerry	**No services available.**
North West RDTF: Donegal, Leitrim, Sligo and West Cavan	**No service available:** HSE and RDTF investigating need.

While there were a range of NSP modalities operating in 11 of the countries 14 LDTFs, the NACD asserted that this was not in and of itself reflective of a satisfactory level of NSP coverage in these areas. They asserted,

> "At a local drug task force level, i.e. those areas with the most concentrated opiate usage and evidence of growing cocaine usage, the fact that 13 provide needle exchanges in no way indicates adequate coverage within these areas. It is important that sterile injecting equipment is available at the right place, at the right time. None of these areas provides 24-hour access to sterile injecting equipment, and none provides weekend coverage."[146]

In this respect, we can see that even though the majority, but not all, of the LDTF areas had NSPs of one sort or another in operation during the period studied, the level of coverage provided was still in need of further scaling-up.

The Committee's report found that there were also problems with the level of NSP provision in the country's 10 RDTF areas during the period studied. In the main this came down to the fact that more than half of the RDTFs had not developed NSPs. The NACD asserted,

> "The fact remains that needle exchange programmes are currently provided in only four of the ten Regional Drug Task Force Areas and these are concentrated in the LDTF geographical areas. Within the six RDTF areas with no needle exchange coverage, only three are in the process of developing such services (Western RDTF, North Eastern RDTF, and Midlands RDTF). Of some concern is the fact that only one of these areas (Western RDTF) proposes to implement a fixed-site or centre-based exchange..."[147]

The difficulty surrounding the level of stasis that NSP service development had entered into in these areas was underlined by the Committee when they noted the fact that all of the RDTF areas, according to all available data indicators, had some level of IDUs.[148]

One point that emerges clearly from the three reports we have used here to look at NSP development is that there was not a great deal of change in this service during the period studied. As a treatment option NSP pre-existed the period being analysed by a number of years having first being introduced by the EHB in 1989. Consequently one of the main ways in which NSPs changed was that they were subjected to a certain amount of expansion. However, as the snapshots from 1996, 2000, and 2008 have shown, NSPs as a treatment option, by and large, remained static and somewhat underdeveloped within the overall treatment system.

We can see the extent to which the examination of NSP provision can be considered within the remit of the DTFs from a number of different sources. Particularly in terms of the way in which the DTFs were designed to fill gaps in existent service provision under the themes or pillars of the drugs strategy and as well as their being ideally positioned, strategically speaking, to do so. The Eastern Health Board noted how the DTFs were envisaged as placing a lot of importance on treatment in their 1997 service plan,

> "The Cabinet Sub committee on Drugs [now CCSI] which is chaired by the Taoiseach also decided that local drugs task forces should be encouraged to make the expansion of treatment services a priority in developing local plans."[149]

This shows us how the gap-filling function of the DTFs was seen as a core part of their work in developing the drug treatment infrastructure in local communities from the time of their creation.

The NDST's LDTF operational manual from 1999 emphasised how a core part of the LDTFs' objectives was to coordinate services in their areas and aim to address any gaps that existed in those programmes available to drug users.[150] In discussing how revised LDTF drug strategies should be developed the guidelines made a number of comments on drug treatment. Specifically, they saw the Task Forces as profiling the area's services and then assessing what gaps or specific needs of drug users needed to be addressed by an additional service.[151] The idea behind this approach being, that a continuum of treatment options would be created as a result of gaps being addressed, with new DTF services buttressing and supporting existing, but overburdened services, as well as offering new services.[152] The role of the LDTFs of addressing gaps in service provision and their ability to initiate new services was confirmed by the NDST's 2002 review of the Task Forces.[153] Similarly, the Team's 2005 annual report noted the way in which the LDTFs had been mandated to address gaps in service provision through their action plans that reflected the thematic areas of the drugs strategy.[154]

While the DTFs only had a partial role to play in the overall development and provision of NSPs within the drug treatment system it was a key role nonetheless, particularly in terms of buttressing and supporting statutory services and filling gaps where they existed. This is all the more so when we remember that the Task Forces were initially established in the areas most drastically impacted by heroin IDU at the start of the period studied here. Accordingly, we will now look at the extent to which the different strategies and action plans of the DTFs dealt with the issue of developing existing and new NSPs in their areas in light of the reason for their inception and the persistence of BBVs.

The NACD's report on NSP provision provided us with a very clear picture of the level of service being offered to drug users in DTF areas and how this had, when compared with the EHB evaluations, over the period studied not developed that much. When we look into the DTF plans themselves, first the L then the R DTFs, we can see that there are no clear homogenous trends in the way that they dealt with the subject of NSPs. Rather there is a varied approach to the issue and it is in exploring the ways in which they have dealt with the topic that we can gauge the impression that they as Task Forces sought to give on the issue in their policy statements.

The strategies and actions plans of the LDTFs offer us an insight into the Task forces' engagement with NSPs as an aspect of harm reduction by allowing us to look at the developmental process partially behind the stasis in NSP expansion identified by the NACD. For example, we can see that many LDTFs had discussions of NSPs in their action plans.[155] In some cases this would involve a sophisticated consideration of their operation, though this was the exception rather that the rule.[156] Sometimes NSPs would merely be noted and not discussed any further in terms of expanding or developing the service or considering the capacity or suitability of existent services in realistic operational level detail.[157] Yet on some occasions the need to grow the local NSP was raised and explored, however, this was uncommon and not the norm.[158]

At times LDTFs have raised wider issues related to the diversification of NSPs through the utilisation of diverse modalities such as OR NSP and community based NSP (CPNSP).[159] Other Task Forces have made calls for extended opening hours in their plans, as well as displaying the way in which they were buttressing and supporting statutory NSP provision.[160] However, all of these aspects of LDTF plans were relatively isolated amongst the LDTF strategies as a collective whole, and as such represented exceptions. Many plans and other documents contained no discussion of NSPs.[161] Others provided data that highlighted the need for NSPs, but did not discuss putting them in place or the processes of buttressing and supporting the statutory services to fill gaps in provision.[162] Overall the impression that the LDTFs' action plans gave off on NSP development, in the Goffman sense, mirrored that reflected in the NACD's analysis of NSP provision in LDTF areas, in that, it was underdeveloped for the needs of users.[163]

The NACD's 2008 report on NSPs noted that only four of the RDTFs had NSPs in operation, and that three of these had LDTFs within their boundaries, indicating that the RDTFs had not been successful in contributing to the development – along with other sectors – of NSPs.[164] Like the work of the LDTFs the Regional Task Forces' action plans allow us to see the extent to which they focused on the development of NSPs as an issue within their operations and planning. In this respect, more than half of the RDTFs had some form of discussion of NSPs in their regional strategies and action plans, ranging from the more general in nature to passing references.[165] In some cases this included a direct call for the development of NSPs in the particular region.[166] Task Forces also drew

attention to the limited nature of services in their areas in some instances.[167] While other discussions remained at the level of indirect references or did not move into the realm of realistic action-oriented planning.[168] Like the LDTFs, there were also a number of cases where Regional Task Forces provided no discussion of NSPs.[169] Following the same pattern as the LDTFs, the Regional Task Forces action plans consolidated the picture that NACD's 2008 NSP report had given of their role in NSP development, in that, their strategies had on the whole not contributed to the development of NSPs during the time studied.

In this section we have seen that there has been a consistent call for NSPs to be developed further from a number of sources and also that the DTFs did not develop this aspect of drug treatment in their action plans to a great extent. One of the reasons for this can be partially traced back to the inception of the DTFs. In section two we noted how at the time there was pressure on the Government to deliver a credible response to the drugs problem in order to restore the faith of both local communities and the community and voluntary sectors in its ability to work towards solving the issues. Critical to this was the statutory sector's ability to set the LDTFs up fast. In a semi-structured interview, Fergus McCabe, who was the community sector representative on the NDST from its inception until 2005, asserted that at that time the issue of harm reduction was complex.[170] By this he elaborated that while the NDST was pro-harm reduction and pro-NSP, they were not in a position to approach the establishment of the LDTFs with a prescriptive set of instructions on what should be included in each LDTF plan as regards the area's NSP needs.[171]

This situation was somewhat at odds with the fact that the LDTFs were established in the areas most impacted by heroin IDU. However, he explained that the concern was that if the NDST was to impose its will on the LDTFs at this stage it would have risked breaking apart what was in reality a very fragile sectoral alliance of groups not that trusting of each other.[172] As a result the stance that was taken was to essentially say, as the people that were on the LDTFs from each area were the local experts if they wanted to focus on prevention and education then that's what they were to be allowed to run with, but the Team would also try to get them to work in some harm reduction issues

too.[173] This offers us an insight into part of the reason behind variability between DTFs in terms of the extent to which they engaged with NSP.

The impact of consistent loose control by policy makers on the management of the DTFs over the period studied can also be seen as partially affecting the development of NSPs. It unintentionally functioned to leave the issue of NSPs submerged in the DTFs' other work and subject to a degree of cross-DTF variation. This is an issue that was no doubt not helped by NSPs' controversial and costly – in the economic sense of implementation – nature. The way in which the NDST had itself been left over exposed to the operational aspects of managing the DTFs for the duration of the period studied impacted upon its ability to deal with issues such as NSPs in a cross-DTF way. Fergus McCabe felt that the Team had been a victim of excessive micro-management.[174] By this he explained that their intense focus on the operational aspects of the DTFs was a case of the urgent driving out the important in the running of the drugs initiative in the wider sense.[175] In this respect, we can see how issues such as the cross-DTF role of developing NSPs and NDST's part in this became submerged in the myriad of other operational issues to be dealt with as a result of the approach taken to running the DTFs.

At the same time another structural factor unintentionally functioned to add to the static nature of NSPs' policy development, that is, the presence of a certain degree of role confusion for policy creation. After the new strategy had been launched in 2001 another structure located at a comparable point within the policy hierarchy as the NDST, with a similar-enough set of functions (mixed operational and policy development), but with a poorly differentiated role was created in the form of the DSU. As a result, their part within the overall responsibility for developing and driving policy on issues such as NSP became lost and submerged to a certain extent in the role confusion between them, with neither the DSU or the NDST having really taking the lead. The role confusion between these two structures, which we first discussed in section one, was noted by the 2004 PA consulting evaluation of the drugs strategy, as was the problems the DSU initially had with its policy role when first evaluated by PA in 2001.[176] This situation itself can be regarded as an unanticipated and unintentional consequence of the introduction of too many dynamic policy structures in a relatively short period of time, without a full enough consideration being given to the overlap and demarcation points between them. As such,

in one sense the development of NSPs partially became a hostage to overcrowded structural innovation within the drug policy system.

This part of the chapter has looked at the development of needle and syringe exchange programmes (NSPs) by the Drug Task Forces (DTFs) over the course of the period studied as a result of their originally being established in the areas most affected by heroin use. Specifically, it has discussed the development of NSPs throughout the period studied by looking at a number of key reports that have focused on this aspect of the treatment system, as well as the way in which the DTFs engaged with the issue in their strategies. NSPs as a core feature of the treatment system pre-existed the period under study by a number of years. During the timeframe analysed here their development largely remained static as the key reports from 1996, 2000 and 2008 have shown. This resulted in the network's coverage not being particularly scaled up over these years. The majority of LDTFs had NSPs operating during this time, though their coverage and opening times remained in need of expansion, while a minority of RDTFs had NSPs up and running.[177] The area of NSP development was subject to variation within DTF plans in the manner that it was dealt with, resulting in an uneven engagement with the issue overall in a cross-DTF sense. A range of reasons fed into the creation of this situation. These included the unanticipated and unintentional consequences of the form of loose control applied by policy makers and by extension the NDST at different stages over the period in the management of the DTFs that caused NSPs to become submerged in DTF work. The following section presents the overall conclusions from the chapter.

Conclusion

This chapter of the thesis has looked at some of the operational features of the new structures that were brought online after 1996 and has considered certain consequences from the way they developed during the period studied. Specifically, it discussed the role of the Cabinet Committee on Social Inclusion, the Interdepartmental Group on Drugs, the Minister of State with Responsibility for the National Drugs Strategy, the Drugs Strategy Unit, the National Drugs Strategy Team, and the Local and Regional Drugs Task Forces. The different policy and coordination structures that were brought online at this time represented a new and innovative way of managing and delivering drug policy and services. These structures received a positive endorsement in a number of key evaluations and were kept in place by successive Governments throughout the timeframe analysed. However, these new structures, which were based on the SMI cross-cutting approach to the management of policy issues, were found to have a range of problems when evaluated. This granted many of the areas of concern in relation to their operation were a result of a mix their newness, their dynamic nature, and the related challenges for Government in managing a number of new structures simultaneously. As such these problems can be seen as unanticipated and unintentional consequences of the attempt to advance the delivery of policy that characterised the structures collectively.

As part of the new structural solutions initiated at the start of the years being looked at the Government utilised the creation of the Local Drugs Task Forces (LDTFs) to create a hegemonic alliance with the communities most affected by drug use and the community and voluntary sectors. This strategy was aimed, *inter alia*, at displaying that real action was happening and proved effective and was left in place and functioned as a form of partnership working throughout the period examined, though dissatisfaction with the processes and structures was present. This inter-sectoral alliance enabled a range of positive outcomes such as the improvement of local treatment services, altering local attitudes to services, showing communities that drug issues were being tackled and getting the different sectors to effectively work together. Integral to the Government's successful maintenance of this alliance over the course of the period studied was a form of loose control in their operation of the DTFs. This involved a form of scaled back control essentially allowing them leeway in terms of issues such as monitoring and

evaluation on different aspects of their work during the period studied so as to minimise potential alienation among the different sectoral partners involved. This had a range of positive and negative impacts on their work.

The unanticipated and unintentional consequences from the complexities of managing several new and innovative policy structures introduced in a relatively short time after 1996, coupled with the need to maintain hegemony had an unexpected impact on the development of NSPs by the DTFs. The loose control utilised by policy makers and the NDST in the management of the DTFs unintentionally functioned to cause NSPs to become submerged in the Task Force's work. As a core part of the treatment system NSPs pre-existed the period under study by several years and their development remained largely static during the time looked at. A majority of LDTFs had NSP services active in their area in this timeframe, however less than half of the RDTFs had NSPs in operation during these years.[178] In dealing with the topic of NSP development in their plans and strategies, the issue was given a variable treatment by the DTFs, ultimately leading to an uneven cross-DTF engagement with the matter.

[1] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.8.

[2] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.7.

[3] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.8.

[4] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.8; PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2.* Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3; National Drugs Strategy Team (2006). *Annual report for 2006.* Dublin: NDST, p.19.

[5] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2.* Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3.

[6] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2.* Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3.

[7] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem.* Dublin: Department of Tourism, Sport, and Recreation, p.50.

[8] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.18.

[9] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.18.

[10] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.19.

[11] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.18.

[12] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.18.

[13] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem.* Dublin: Department of Tourism, Sport, and Recreation, p.4.

[14] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem.* Dublin: Department of Tourism, Sport, and Recreation, p.4.

[15] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem.* Dublin: Department of Tourism, Sport, and Recreation, p.4.

[16] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.13; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, p.9.

[17] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.19; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, pp.9-10.

[18] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.17; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, p.9.

[19] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.24; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, pp.16-17.

[20] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.20; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, pp.10-11.

[21] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.21; National Drugs Strategy Team (2002). *Establishment of the Regional Drugs Task Forces: Guidelines*. Dublin: NDST, pp.10-11.

[22] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.2; PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, pp.3.1-3.2.

[23] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.10.

[24] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.79.

[25] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.79.

[26] PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, p.ii.

[27] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.69; p.77; p.104.

[28] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.77; p.104.

[29] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.65.

[30] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3; PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.75.

[31] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3; pp.6-7; Chapter 7, p.13.

[32] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.3; pp.6-7; Chapter 7, p.13.

[33] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, pp.6-7.

[34] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, pp.6-7.

[35] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, pp.6-7.

[36] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[37] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[38] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[39] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[40] Semi-structured interview with Dr Desmond Corrigan, Chairman, NACD, 03.03.2009.

[41] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[42] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[43] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[44] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, pp.15-16; p.19.

[45] National Drugs Strategy Team (2005). *Annual Report for 2005.* Dublin. NDST, p.18.

[46] PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, p.i.

[47] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team.* Unpublished, p.12; pp.39-40; p.43.

[48] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team.* Unpublished, pp.39-40.

[49] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2.* Dublin: PA Consulting Group, Unpublished, Chapter 6, p.6.

[50] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August).* Unpublished, p.73.

[51] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August).* Unpublished, p.76.

[52] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[53] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[54] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[55] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[56] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[57] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[58] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[59] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, Chapter 6, p.6.

[60] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.73.

[61] PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, p.ii.

[62] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.70.

[63] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.70.

[64] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, pp.12-13.

[65] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, p.13.

[66] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, p.13.

[67] PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, p.ii.

[68] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, pp.11-12.

[69] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p35; 43.

[70] Simon, R. (1982). *Gramsci's Political Thought: An Introduction*. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[71] There are many good works available that attempt to refine Gramsci's output in the famous prison notebooks into a clear theoretical formation. In this sense, I am drawing on the interpretation of the theory of hegemony as expressed by the British economist Roger Simon. This text on Gramsci's political thought is widely regarded as one of the most clear, accessible and accurate treatments of his work:

Simon, R. (1982). *Gramsci's Political Thought: An Introduction*. London: Laurence and Wisheart, pp.22-24; pp. 38-41.

[72] Simon, R. (1982). *Gramsci's Political Thought: An Introduction*. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[73] Simon, R. (1982). *Gramsci's Political Thought: An Introduction*. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[74] Simon, R. (1982). *Gramsci's Political Thought: An Introduction*. London: Laurence and Wisheart, pp.22-23; pp.38-41.

[75] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[76] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[77] Finglas/Cabra LDTF (2006). *Vital connections Local Drugs Task Forces – Leading the response – Conference report*. Dublin: Finglas/Cabra LDTF, p.10.

[78] Cuff, E.C., Sharrock, W.W., & Francis, D.W. (1998). *Perspectives in Sociology*. Fourth Edition. London: Routledge, p.317.

[79] Cuff, E.C., Sharrock, W.W., & Francis, D.W. (1998). *Perspectives in Sociology*. Fourth Edition. London: Routledge, p.318.

[80] Cuff, E.C., Sharrock, W.W., & Francis, D.W. (1998). *Perspectives in Sociology*. Fourth Edition. London: Routledge, p.312; p.318.

[81] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.6.

[82] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.9; p.11; p.25; PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, pp.23-24; NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.2.

[83] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009; PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, p.iii; p.10; pp.23-24; National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.11; p.25.

[84] NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.2.

[85] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, p.ii; pp.23-24; NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.26; Policy Research Centre (2000). *Evaluation of Local Drug Task Forces Projects: Experiences and Perceptions of Planning and Implementation*, Dublin: NCI, p.95; Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, pp.37-38; p.47; p.70.

[86] NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.26.

[87] NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.15.

[88] NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.22.

[89] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.9; p.13.

[90] NDST (1999*). Local Drug Task Forces: A Local Response to the Drug Problem*. Dublin: Department of Tourism, Sports and Recreation, p.4.

[91] NDST (1999). *Local Drug Task Forces: A Local Response to the Drug Problem.* Dublin: Department of Tourism, Sports and Recreation, p.5; p.34.

[92] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.15.

[93] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.i.

[94] National Drugs Strategy Team (2005). *Annual Report for 2005*. Dublin: National Drugs Strategy Team, p.7.

[95] National Drugs Strategy Team (2006). *Annual Report for 2006*. Dublin: National Drugs Strategy Team, p.3.

[96] National Drugs Strategy Team (2006). *Annual Report for 2006*. Dublin: National Drugs Strategy Team, p.15.

[97] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished, p.ii; p.iv.

[98] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.7; p.9; p.10; p.13; p.14.

[99] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.7; p.13.

[100] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.i; pii.

[101] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.i; pp.37-39; p.47; p.49.

[102] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.25.

[103] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.4.

[104] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.47.

[105] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.90.

[106] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.ii; p.iii; p.10; p.23.

[107] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.ii; p.iii; p.23.

[108] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August).* Unpublished, p.65.

[109] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.19; p.35; p.74; p.89; pp.90-91.

[110] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August).* Unpublished, p.71; p.75.

[111] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August).* Unpublished, p.75.

[112] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.ii; pp51-52.

[113] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.53.

[114] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.71.

[115] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.ii; p.iv.

[116] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, pp.17-18.

[117] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, pp.17-18.

[118] PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report.* Unpublished, p.21.

[119] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.89.

[120] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, pp.14-15; p.17.

[121] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.36.

[122] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, pp.36-37.

[123] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.39.

[124] Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished, p.81.

[125] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.50.

[126] Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants, p.50.

[127] Policy Research Centre (2000). *Evaluation of Local Drug Task Forces Projects: Experiences and Perceptions of Planning and Implementation*, Dublin: NCI, pp.90-91.

[128] Policy Research Centre (2000). *Evaluation of Local Drug Task Forces Projects: Experiences and Perceptions of Planning and Implementation*, Dublin: NCI, pp.91-92.

[129] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.6.

[130] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.6; pp.20-21; p.35.

[131] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.25; p.38.

[132] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.2.

[133] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.7.

[134] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.1.

[135] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.7.

[136] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.15.

[137] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.7.

[138] EHB (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00A.M.*, Dublin, p.5; EHB (1997). *Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*, Dublin, EHB, p.10.

[139] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, pp.13-14.

[140] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p14.

[141] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.35.

[142] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.27.

[143] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.27.

[144] Table 1 has been reproduced from Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.28.

[145] Table 1 has been reproduced from Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.28.

[146] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[147] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

[148] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.35.

[149] Eastern Health Board (1997). *Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Service*, Dublin, EHB, p.1.

[150] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.4; p.9.

[151] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.38.

[152] National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation, p.39; p.40.

[153] National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished, p.14; p.20.

[154] National Drugs Strategy Team (2005). *Annual Report for 2005*. Dublin: National Drugs Strategy Team, p.10.

[155] Clondalkin LDTF (1997). *Clondalkin LDTF Local Development Plan May 1997 to 1999*. Dublin: Clondalkin LDTF, p.36; Dun Laoghaire Rathdown LDTF (1997). *Second*

Report. Dublin: Dun Laoghaire Rathdown LDTF, p.p.50-57; Finglas/Cabra LDTF (2001). *Finglas/Cabra LDTF Strategic Plan 2001*. Dublin: Finglas/Cabra LDTF, p.18; Blanchardstown LDTF (2004). *Towards A Comprehensive Drug Treatment Service in Blanchardstown*. Dublin: Blanchardstown LDTF, p.11; Tallaght LDTF (2000). *Review of 1997 Service Development Plan & Formulation of New Service Development Plan – Final Report*. Dublin: Tallaght LDTF, p.59; p.74; p. 75; Tallaght LDTF (2008). *Strategic Plan 2008-2013*. Dublin: Tallaght LDTF, p.25; p.40; South Inner City LDTF (2008). *Strategic Plan 2008 to 2012*. Dublin: South Inner City LDTF, p.29; pp.35-6; p.47.

[156] Blanchardstown LDTF (2001). *Blanchardstown Drugs Task Force Action Plan 2001-2005*. Dublin: Blanchardstown, pp.42-45.

[157] South Inner City LDTF (1997). *Recreating Hope – South Inner City LDTF Service Development Plan*. Dublin: South Inner City LDTF, p.28; Dublin North East LDTF (1997*). Dublin North East LDTF Service Development Plan*. Dublin: Dublin North East LDTF, p.71 of PDF/p.5 (pagination is handwritten on original scan) Kilemore report; Ballymun LDTF (1997). *Ballymun LDTF Interim Service Development Plan*. Dublin: Ballymun LDTF, p.32; Ballymun LDTF (2000). *Ballymun LDTF Revised Action Plan 2000*. Dublin: Ballymun LDTF, pp.11-12; Ballyfermot LDTF (1997). *Ballyfermot Drugs Task Force Progress Report 1997 to 1999*. Dublin: Ballyfermot LDTF, p.4; Ballyfermot LDTF (2000). *Ballyfermot Drugs Task Force Strategic plan 2000-2001*. Dublin: Ballyfermot LDTF, p.26; Canal Communities LDTF (2000). *Canal Communities LDTF Service Development Plan*. Dublin: Canal Communities LDTF, p.55; North Inner City LDTF (2001). *North Inner City LDTF Strategic Plan 2001 Phase Two of a Programme for Action*. Dublin: North Inner City LDTF, p.16; p.41;

[158] Blanchardstown LDTF (2001). *Blanchardstown Drugs Task Force Action Plan 2001-2005*. Dublin: Blanchardstown, pp.39-40.

[159] Dun Laoghaire Rathdown LDTF (1997). *Second Report*. Dublin: Dun Laoghaire Rathdown LDTF, p.p.50-57; ISIS Research Group (1999). Towards a Drugs Service Development Plan for Bray – Report for the Bray Drugs Working Group. Dublin: Bray Drugs Working Group, p.4; Ballyfermot LDTF (2000). *Ballyfermot Drugs Task Force Strategic plan 2000-2001*. Dublin: Ballyfermot LDTF, p.28; Bray LDTF (2001). *Bray LDTF First Report*. Dublin: Bray LDTF, p.50; Finglas/Cabra LDTF (2001). *Finglas/Cabra LDTF Strategic Plan 2001*. Dublin: Finglas/Cabra LDTF, p. 27; Blanchardstown LDTF (2004). *Towards A Comprehensive Drug Treatment Service in Blanchardstown*. Dublin: Blanchardstown LDTF, p.11.

[160] Finglas/Cabra LDTF (2001). *Finglas/Cabra LDTF Strategic Plan 2001*. Dublin: Finglas/Cabra LDTF, p.7; p.8; Blanchardstown LDTF (2001). *Blanchardstown Drugs Task Force Action Plan 2001-2005*. Dublin: Blanchardstown, pp.39-40; North Inner City LDTF (2001). *North Inner City LDTF Strategic Plan 2001 Phase Two of a Programme for Action*. Dublin: North Inner City LDTF, p.16.

[161] Dublin North East LDTF (1997). Dublin North East LDTF Service Development Plan. Dublin: Dublin North East LDTF, p.40 of PDF/p.10 of Darnale report; P.59 of PDF/p.4 of report; South Inner City LDTF (1997). *Recreating Hope – South Inner City LDTF Service Development Plan.* Dublin: South Inner City LDTF, pp.52-59; South Inner City LDTF (2008). *Strategic Plan 2008-2012.* Dublin: South Inner City LDTF, p.29; pp.35-36; Ballyfermot LDTF (1997). *Ballyfermot Drugs Task Force Progress Report 1997 to 1999.* Dublin: Ballyfermot LDTF, pp.15-16; Cork LDTF (1997). *Cork LDTF Strategic Plan.* Cork: Cork LDTF, pp.28-31; Tallaght LDTF (1997). Tallaght LDTF Service Development Plan. Dublin: Tallaght LDTF, pp.22-29; Tallaght LDTF (2000). *Review of 1997 Service Development Plan & Formulation of New service Development Plan.* Dublin: Tallaght LDTF, p.19; p.20; Clondalkin LDTF (2000). *Clondalkin Drug Task Force Action Plan 2000-2001.* Dublin: Clondalkin LDTF, pp.23-24; Ballymun LDTF (2000). *Ballymun LDTF Revised Action Plan.* Dublin: Ballymun LDTF, pp.27-30; pp.37-39; Canal Communities LDTF (2000). *Canal Communities LDTF Service Development Plan.* Dublin: Canal Communities LDTF, p.70; p.98; p.99.

[162] Clondalkin LDTF (1997). *Clondalkin LDTF Local Development Plan May 1997 to 1999.* Dublin: Clondalkin LDTF, p.68.

[163] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD, p.36; Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life.* London: Penguin, pp.14-18.

[164] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD, p.26.

[165] East Coast Area RDTF (2005). *East Coast Area RDTF Action Plan 2005-2008.* Dublin: East Coast Area RDTF, p.10; Mid-Western RDTF (2005). *Mid-Western RDTF Action Plan 2005.* Limerick: Mid-Western RDTF, p.13; p.29; North Eastern RDTF (2005). *North Eastern RDTF Regional Drugs Strategy 2005-2008.* Meath: North Eastern RDTF, p.24; South Western RDTF (2005). *South Western RDTF Strategy Document.* Dublin: South Western RDTF, p.25; Western RDTF (2005). *Shared Solutions – First Strategic Plan of the Western RDTF.* Galway: Western RDTF, pp.59-66; South Eastern RDTF (2005). South Eastern RDTF Strategic Plan 2005 – 2008. Waterford: South Eastern RDTF, p.46 .

[166] North Eastern RDTF (2005). *North Eastern RDTF Regional Drugs Strategy 2005-2008.* Meath: North Eastern RDTF, p.32; South Western RDTF (2005). *South Western RDTF Strategy Document.* Dublin: South Western RDTF, p.43; p.45; p.46; p.50.

[167] East Coast Area RDTF (2005). *East Coast Area RDTF Action Plan 2005-2008.* Dublin: East Coast Area RDTF, p.44; South Western RDTF (2005). *South Western RDTF Strategy Document.* Dublin: South Western RDTF, p.25; p.36; Western RDTF (2005). *Shared Solutions – First Strategic Plan of the Western RDTF.* Galway: Western RDTF, p.49.

[168] North Dublin City & County RDTF (2005). Strategic Plan 2005 – 2008. Dublin: North Dublin City & County RDTF, p.12; South Eastern RDTF (2005). *South Eastern RDTF Strategic Plan 2005 – 2008.* Waterford: South Eastern RDTF, p.54; p.56; *Mid-Western RDTF Action Plan 2005.* Limerick: Mid-Western RDTF, p.29.

[169] Southern RDTF (2005). *Strategic Plan 2005 – 2008 & Action Plan 2005 – 2007.* Cork: Southern RDTF, p.32; p.84; pp.86-87; Midland RDTF (2006). *Midland RDTF Action Plan 2006 – 2008.* Laois: Midland RDTF, p.28; p.42; North Western RDTF (2005). *North Western RDTF Strategic Plan 2005 – 2008.* Sligo: North Western RDTF, pp.22-37; South Eastern RDTF (2005). *South Eastern RDTF Strategic Plan 2005 – 2008.* Waterford: South Eastern RDTF, p.48; p.78.

[170] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[171] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[172] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[173] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[174] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[175] Semi-structured interview with Fergus McCabe, Community Sector Representative on the IDG, 06.04.2009.

[176] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2.* Dublin: PA Consulting Group, Unpublished, Chapter 6, p.6; PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished, p.ii.

[177] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the*

National Drugs Strategy Team and the National Advisory Committee on Drugs. Dublin: NACD, p.36.

[178] Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs*. Dublin: NACD, p.36.

Chapter 9: The Social Organisation of Drug Treatment

The period under study was defined by a profusion of official actions in drug policy on a number of fronts. These ranged from the creation of different strategies to the establishment and funding of research bodies. One of the most important areas within which a range of fundamental changes occurred during the years being examined here was the sphere of drug treatment. Throughout the 1990s and after the turn of the century a significant amount of alteration occurred in the way drug treatment services were made available. Specifically, the design and delivery of methadone maintenance treatment (MMT) underwent a number of key transitions that had a considerable impact on the nature of the service and its users. Chief among these were the opening of new clinics and the increased involvement of General Practitioners (GPs) and Community Pharmacists (CPs) in the system, enabling its extension into the community setting. The present chapter is not concerned with a technical examination of the efficacy of MMT or its success as a treatment modality. Rather, as this chapter's title indicates, which is derived from the name of Prior's work *The Social Organization of Mental Illness*, our focus is to explore a shift in how treatment was made available to more people through modifications to its delivery mechanisms.[1]

This part of the thesis consists of four sections. The chapter begins by exploring the relationship between drug policy and the development of methadone maintenance treatment (MMT) during the timeframe under study. The second part of the chapter takes a look at the way in which the delivery and operation of MMT changed over the period studied. Following this, the third section considers some of the consequences and challenges that emerged as a result of the modifications to the treatment system arising from the development of MMT. The fourth portion of the chapter is concerned with the extension of MMT beyond the community setting and into the prison system and looks at the way in which this service changed over time. This section is followed by an overall conclusion. Throughout the chapter we will be able to gain a sense of the type of interaction occurring during this time between research and policy from looking at the organisation of drug treatment and the role that research played at key points of change.

Drug Policy and Methadone

A number of significant developments have occurred within drug policy generally during the time being analysed in this study. Chief among these were the move towards a more managerial SMI-era form of policy making and a shift in the organisation of drug treatment towards the expansion of methadone maintenance treatment (MMT) into the community setting. The change in policy making was also marked by an increased pace of policy action, in that, the years being looked at here witnessed an unprecedented pace of official developments. At the same time as these movements on the policy front, a major alteration to the structural operation of the drug treatment system was brought in, bedded-down, and then significantly expanded. This section of the chapter seeks to explore the nature of the connection between these two general developments in drug policy. Specifically, it discusses the extent to which the expansion of MMT was driven by drug policy during the period in question. This is done by looking at the different drug strategies that were launched during the timeframe and the work of a number of special groups involved in the development of the MMT protocol.

While MMT was available in Ireland from the 1960s onwards on a small scale, it was not until the launch of the 1991 *Government Strategy to Prevent Drug Misuse* that support for its development and expansion was given a strong backing. Accordingly, in order to consider the degree to which the progressive build-up of MMT services during the years 1996 to 2008 was driven by drug policy it is first necessary to look at some of the events slightly before that timeframe. This allows us to effectively distil and separate the momentum built-up by early policy work from that generated by later strategies launched during the years specifically under study. This is necessary, given that MMT was a pre-existing treatment option that pre-dated the period being studied and was expanded rather than initiated during that time.

Launched in the years following the emergence of the HIV and IDU crisis, the 1991 drugs strategy, as discussed in chapter four, represented the first formalised national drug strategy *per se* that an Irish Government had put in place. Reflecting the extent to which HIV was starting to influence drug policy the strategy focused on the links between drug use and the virus.[2] In this respect it noted how epidemiological data had

revealed that IDU was the main way in which the virus was being transmitted and that Dublin's inner city was the area worst affected by the increase in infections.[3]

While the 1991 drugs strategy's focus on HIV marked a new tone in drug policy, its concern with how drug treatment should respond to the challenge posed by the virus marked an equally important policy development. At a number of points the strategy expressed support for and concern with the role and progression of community-based drug treatment as implemented by general practitioners (GPs).[4] In particular, it noted how at the time GPs based in local communities were faced with a range of problems that were negatively affecting their treatment of drug users.[5] In stating that HIV prevention must involve drug policy, the strategy asserted that the responses needed must be community-based and, *inter alia*, involve the use of MMT.[6] In setting out what this entailed, the strategy went on to describe the contours of what would later come to be the defining feature of MMT that was drastically expanded under later strategies and the 1998 protocol. In essence, it described a situation that reflected the increasingly important role that the GP was to take on in the management of drug users in the community. The strategy asserted that those entering treatment should be initially assessed by a specialist and then transferred back to a GP for ongoing treatment.[7]

The 1991 strategy focused on the increased role of developing demand reduction policies internationally and the recognition of this and the call to develop such policies at the 1990 Dublin EC summit.[8] Consequently, it was not surprising that policy makers sought to follow suit with their international counterparts in the expansion of MMT as a response to HIV. This is a situation which is generally reflective of both the search route sub-type of the problem-solving model and the enlightenment model of the research / policy interface that we discussed in chapter one. It shows how policy makers looked to international research and the experience of other countries during the onset of the HIV crisis to find a response. It also reflects how they were influenced by and sought to adopt the ideas and approaches that had proven to be the most common and successful way of responding. This view of developments generally was supported by Jimmy Duggan, a Principal Officer in the DoHC who had been centrally involved in developments related to the scale-up in MMT during the years studied and, *inter alia*, the NACD, NDST and the development of the 2001 drugs strategy.[9] This is also indicative of the way in which

at this stage a 'threshold of awareness' in support had been reached for the use of MMT as a result of HIV. Accordingly the treatment had begun to diffuse internationally to such an extent that it became the logical option for policy makers to expand and mainstream the modality in Ireland.

In the years that followed the 1991 strategy it was clear that a new threshold of support for the development MMT services had been reached. This was evident from the policy action taking place within the Department of Health (DoHC) (Later renamed the Department of Health and Children) on developing MMT. While at a later stage individual Departments came to have responsibility for the drugs brief and the drug strategy, the DoHC has always had responsibility for the development of drug treatment policy within drug policy as an overall area. The Department's work on MMT offer us an insight into the way in which action was taking place in the early 1990s to progress this treatment modality and the role of drug policy as driving force in this process.

The most significant piece of work initiated by the DoHC in the wake of the 1991 drugs strategy was the creation in 1993 of the Expert Group on a Protocol for the Prescribing of Methadone (EGPPM). One of the principal forces leading to the Groups inception was the work of the National AIDS Strategy Committee (NASC), which we discussed in chapter five. Specifically, the NASC's 1992 report had backed the utilisation of MMT in locally based satellite clinics and the formulation of treatment protocols for the standardisation and control of treatment delivery.[10] As a result of this endorsement the Minister for Health set up the Expert Group to develop such protocols.[11] This situation reflects the extent to which both the development of MMT and the change in the organisation of drug treatment were being driven by drug policy and the degree to which this process had already started prior to the period being studied.

Reporting in March of 1993 the Expert Group produced a landmark document on the delivery of MMT that functioned to lay out key parts of the blueprint adopted by the working group that later designed the 1998 MMT protocol.[12] In this respect, among the key features of the system that the Expert Group outlined were the provision of a treatment card to each person receiving MMT and that the card should be held by the pharmacist providing methadone until the treatment is finished.[13] Their report also called for the Drug Treatment Centre Board (DTCB) to be placed in charged of maintaining a

central list, known as 'the Central Treatment List (CTL)', of all patients on MMT.[14] Significantly, the Expert Group set out their opposition to licensing doctors to treat drug users as a result of it functioning to inhibit GPs from participating.[15] Rather, they supported the adoption of a system of registration for GPs being contracted to deliver MMT to drug users.[16] The report also stressed that while satellite clinics were to be used by GPs for treatment purposes, the Expert Group wanted to see doctors using their own practices to administer MMT.[17] This allows us to see the way in which there was a strong build-up from the policy side towards creating the momentum that would eventually lead to the creation of a system of MMT marked by significant GP involvement and the engineering of shift in the organisation of the location of treatment.

The DoHC was centrally involved in the development of the 1998 MMT protocol and 1997 saw it create the Methadone Treatment Services Review Group (MTSRG) or Review Group to work on standardising delivery of the treatment. The Group was tasked with advising the Minister for Health on the nature of the arrangements in place for the treatment of heroin users.[18] This consisted of looking at the role of GPs and CPs in treating them, the links between GPs, CPs, and treatment centres, and to design a set of treatment protocols.[19] Reflecting both the pre-existing nature of MMT as a treatment option and the sophisticated work that had been carried out in 1993 by the earlier Expert Group established by the DoHC, the 1998 protocol adopted many of the earlier documents designs as well as adding its own.[20] Among the key conclusions and recommendations reached in their report were that the 1993 protocol should be used as the template to develop treatment services and that MMT should be made available on a national basis under the protocol.[21] In addition the Review Group stressed the importance of the involvement of GPs to the operation of the MMT protocol and gave its support to the system for their participation designed and set out by the Irish College of General Practitioners (ICGP).[22]

January 1998 saw the Review Group's report published, which was subsequently distributed to all GPs and CPs in the country, and led to the creation of the Methadone Prescribing Implementation Committee (MPIC) to oversee its recommendations.[23] On the back of the report the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, the operation of which is explored in more detailed in the third

section of the chapter, entered into force in July 1998.[24] This design and adoption of the 1998 MMT protocol allows us to see another instance of how drug policy was continuing to drive methadone policy during the period being studied as a result of its building on the policy work done outside of this timeframe. It also allows us to observe the way in which drug policy was effectively engineering a change in the social organization of drug treatment by extending it into the community setting by standardising GP and CP involvement. Interestingly, this burst of significant structural activity in the design of the treatment system was occurring at a time when there was very little indigenous Irish drug policy or treatment research being conducted. It also happened prior to the two national research bodies, the ADRU and NACD, which were the focus of chapters six and seven respectively, carrying out much of their own work, the latter only being founded in 2002.

During the time under analysis a number of key changes had an impact on the organisation of drug treatment. Among these was the increased number of locally based treatment clinics being brought online, and this is looked at in the next section. In addition, the adoption of the 1998 protocol functioned to add hitherto unavailable capacity to the system and allowed its extension into the community setting via the use of the primary care network. In this sense, the protocol helped set the stage for the progressive expansion of community based drug treatment throughout the period under study. This was initiated by the instruments' strong support for the involvement of GPs and CPs in the delivery of MMT, and for this provision to take place in local communities.[25] It essentially built on the ground work done since 1993 by the Expert Group as a result of the policy drive to respond to the HIV crisis.

We have already seen how there was a pre-existing level of support for the use and development of MMT within Irish drug policy prior to 1996 from our discussion of the 1991 drugs strategy and the initial work on the methadone protocol. Yet throughout the period studied the drug strategies that were launched were characterised by a common trait: a consistent level of support for MMT and its progressive extension into the community setting.[26] With the arrival in 1996 of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (MTFMRDD) or Task Force, this trend of supporting the expansion of MMT both continued and intensified.

The Task Force's initial report from 1996, which we discussed in chapter four, was significant on a number of fronts. Crucially, in terms of our concerns in the present section, it displayed a detailed and strong level of endorsement for furthering the growth of MMT.[27] In particular the Task Force stressed that all those who wanted to avail of treatment should be able to do so and supported in taking this step.[28] In this respect, at several points in their report they identified the existent level of MMT service provision and waiting lists as a key issue that needed to be dealt with in evolving the treatment system and dealing with the drug problem.[29] In legitimating their stance on raising the level of funding being channelled into the development of MMT provision the Task Force drew on the evaluation of the Eastern Health Board's (EHB) drug services from 1996, which we discussed in chapter eight.[30] They noted how the evaluation had shown, via an exploration of two American econometric studies, how MMT emerged positively in terms of achieving a larger return than the initial amount of money invested as a result of the savings from crime reduction.[31] This is a point that shows us the influence that international research was having on the Task Force's work and one that highlights the way in which support for and the use of such treatments diffuses internationally. Jimmy Duggan was supportive of this view of research utilisation and impact as he felt there was a dearth of indigenous research on the areas being looked at when the drug treatment system was in its formative years.[32] This resulted in policy markers looking at and being influenced by events internationally in research and policy.[33]

The Task Force's concern with the level of drug treatment provision allows us to see the momentum that was being generated by drug policy at the time and how it was altering the organisation of drug treatment. Specifically, the report was consistently supportive of extending community based drug treatment on a number of fronts. Backing was given to the use of diverse modalities for the delivery of MMT, such as a mobile clinic serving parts of Dublin's inner city.[34] The need to increase the numbers of GPs and CPs participating in the delivery of MMT at the local level was expressed in the report.[35]

The Task Force also focused on the work of the EHB's drug services and their plans for expansion.[36] In this respect, they noted how they had met with members of the EHB in order to explore their plans for service development as a result of the drug problem being at its worst in Dublin.[37] It was recommended that the Health Board

continue to grow its services, focusing specifically on expanding locally based treatment provision, and making a strong effort to involve and consult local communities in order to overcome opposition to treatment centre location plans.[38] Significantly, the Task Force strongly expressed that the EHB should aim to eliminate its waiting lists for treatment during 1997.[39] The extent to which drug policy was driving action on the ground in this respect can be seen from the EHB's drugs service review a year later in 1997. In their report the Board noted how as a result of the Task Force's work how it had been asked by the DoHC to examine how it could utilise an extra 5 million Irish Punts on top of its usual funds to end treatment waiting lists.[40]

The structural shift in the organisation of drug treatment that had been amplified and accelerated by the Task Force's work was continued during the period under study when the next major drug policy was launched in 2001. *Building on Experience*, which has been explored in, *inter alia*, chapter four, followed suit with the work of its predecessor in terms of the level of support it expressed for the development of MMT.[41] One of the ways in which this can be seen at a number of points in the document was from their showcasing of the growth in numbers on MMT from 1354 in 1995 to 5032 in 2000.[42] In a similar way, the strategy pointed out several times that the number of treatment sites in the EHB had grown from 21 in 1997 to 55 in 2001.[43] Reflecting this theme in the 2001 policy, one of key performance indicators in the area of treatment and a specific action, number 45, aimed to expand treatment places to 6000 in 2001 or 6,500 before the end of 2002.[44] In this respect, it too represented a further episode in the trend of Irish drug policy clearly driving the expansion of MMT policy during the timeframe explored.

Later in the period studied the level of backing expressed for the utilisation and expansion of MMT in the 2001 strategy was reiterated when the policy was the subject of both a separate progress report and a mid-term review.[45] The success that drug policy achieved in driving the expansion of MMT during this time can be noted from a 2008 PA evaluation of the strategy. It noted that the numbers on MMT had grown from 4,963 in 2001 to 7,269 at the end of 2006 and 8,537 by the end of 2007, representing a 72 percent increase overall.[46]

Like the 1996 drugs strategy, *Building on Experience* strongly supported the development of MMT into the community setting and as a result represented another instance where drug policy was actively engineering the organisation of drug treatment in the years analysed.[47] One of the key ways this was evident in the 2001 policy was its clear support for the expanded participation of GPs and CPs that had occurred since the introduction of the MMT protocol in 1998.[48] In particular, the document asserted the importance of increasing this service and the critical role of primary care in helping to reduce the pressure being place on secondary care services and made this the focus of one of its core actions.[49] Reflecting this level of concern with actively trying to develop the level of community based treatment and the expansion of MMT in general the 2001 strategy focused on the issue of waiting lists and access to treatment a number of times.[50] Specifically, it noted the way in which waiting times had remained a persistent problem for those seeking treatment, but that the EHB – then renamed to the Eastern Regional Health Authority (ERHA) – was actively working to reduce and eventually end the waiting lists.[51] This goal was made the subject of one of the strategy's actions, where access to treatment was to be made available within one month after assessment and its development was analysed in the policy's progress report and mid-term review.[52]

In carrying out its work in researching and formulating *Building on Experience* the Review Group charged with drafting the policy conducted an extensive review of different national drug policies.[53] They noted,

> "The Review Group also looked at national drug policies in the Netherlands, Portugal, England, Scotland, Spain, Sweden, Australia and Switzerland as broadly representative of the spectrum of recent national strategic responses."[54]

Primarily aimed at exploring the current best practices in these countries in relation to the utilisation of a range of harm reduction measures, including MMT and NSPs, this part of the Group's work is reflective of the 'search route' sub-type of the problem-solving model of the research policy interface that was discussed in chapter one. In particular, it shows the way in which policy makers in the course of their deliberations on the contours of a new strategy actively examine the approaches being pursued by their international counterparts.

This view was supported by Jimmy Duggan, who had also been a member of the National Drugs Strategy Review Sub-Group (NDSRSG) that helped the Inter-Departmental Group on Drugs (IDG) complete the review.[55] He felt that at this time, as had previously been the case during his years in the drugs area, a range of information sources were consulted and searched out.[56] These included the policies and treatment systems of other countries, as well as the work of international bodies such UN agencies and EU bodies such as the EMCDDA and the PG.[57] Policy makers were effectively hooked into these international information networks and utilised them to help in the process of searching for information on what courses of action to take.[58] This situation reflects the way in which different policies and treatment options diffuse international from one country to another, particularly when a 'threshold of awareness' in support has been reached for a specific modality such as MMT or some other new option.

This situation is also indicative of the extent to which international research and different national drug policies were influencing Irish policy more so than any indigenous drug policy research at the time. As previously stated, at this stage the two national research bodies – the ADRU and the NACD – had not completed much of their work on policy or research issues, with the latter not yet founded at this stage. This view of the type of research that was having an impact on policy – international versus national – was supported by Jimmy Duggan.[59] He felt that there was a limited amount of indigenous research on the treatment issues being looked at, as had been the case early around the time of the 1996 Task Force report.[60] The impact of international research on the work of the Review Group was also evident later in the strategy when the issue of MMT's suitability as a treatment modality was discussed in the context of it having been questioned in the public consultation process.[61] In offering a strong defence of the drug the strategy cited a meta-analysis from the international research journal *Addiction* in arguing that it was the most widely used form of substitution therapy.[62]

This section of the chapter has focused on the relationship between drug policy and MMT. It has shown that while MMT was a treatment option that pre-existed the period studied, work on scaling-up the development of MMT and its extension into the community setting also commenced outside of the timeframe under analysis. This development occurred prior to the arrival of the first managerial national drugs strategies

in 1996 and 2001. It also happened before any significant indigenous drug policy research had started to be undertaken, with the ADRU only commencing its work in 1989 and the NACD in 2002, and international research on MMT played more of a decisive role during the formative years of the system's early development in this respect.[63] Throughout the period studied, however, the ongoing development and significant expansion of MMT into the community setting has clearly been driven by the drug policies launched in 1996 and 2001. These strategies can be seen as having driven events and built a critical momentum that sustained the level of action and support behind the structural expansion of the system that led to a shift in the organisation of drug treatment during this time from a purely centralised service to one based on community care. The following section of the chapter explores the development of the move towards community care in detail and the role of the EHB in helping to bring it about.

The Delivery of Methadone Maintenance Treatment

During the period under study a range of significant changes in the manner that drug treatment was being provided were developed and expanded to dramatically enhance the capabilities of statutory services. Chief among these systemic alterations were the expansion of the number of drug treatment clinics, the recruitment of increasing numbers of General Practitioners (GPs) and Community Pharmacists (CPs) to become involved in administering MMT, and critically the development of the MMT protocol. Taken together these events culminated in both the emergence of a modernised drug treatment system and a shift in the organisation of how care was provided to drug users. In essence these changes marked the move from a full-scale reliance on centralised clinic treatment to mixed community based GP and clinic based treatment. This part of the chapter explores the central role of the Eastern Health Board (EHB) in the development of these services during the period under study. In addition, it also considers the operational contours of the system for delivering MMT that was formalised in the 1998 MMT protocol.

The origins and development of the role of the EHB (later renamed the Eastern Regional Health Authority, then the Health Service Executive Eastern Area) and the other

Health Boards in the delivery of drug treatment can be traced back to drug policy. Specifically, the 1991 *Government Strategy to Prevent Drug Misuse* felt that the resources available to the Boards made them the logical choice for the management of such services.[64] In this respect, the policy stated,

> "...the Government have decided that the provision, co-ordination and funding of treatment programmes for drug misusers should be the responsibility of the Health Boards."[65]

The work of the MTFMRDD or Task Force followed the tone set by the 1991 Strategy and their 1996 report strongly reaffirmed the central role of the Health Boards and in particular the EHB in building-up the capacity of the drug treatment system.[66] In this sense, the Task Force can be seen as central to the increased activity of the EHB in the drugs area as a result of the diverse measures it called for action on.[67] These ranged from the expansion of MMT delivery via the increased use of GPs and CPs, as well as increased utilisation of mobile treatment units, making locally-based services as accessible as possible so as to attract all potential treatment presenters, and the removal of waiting lists.[68] These concerns were also focused on the following year in the Task Force's second report when it considered the EHB's progress in reducing waiting lists and consulting with communities in the course of expanding services.[69] This reflects the extent to which drug policy was shaping a change in the organisation of drug treatment towards community care.

In setting out its designs for the EHB the Task Force was, in part, acting on the comments of the 1996 evaluation of the Board's drugs services, which had strongly backed the emerging move into the primary care setting as the correct long-term plan – but one that needed to be supported.[70] The consultants' report endorsed the work of the EHB to date in modernising its drug services and managing their transition into the community setting.[71] In particular, they were impressed with the general development of MMT services and the use of clinics for delivering them and the Board's work in overcoming community opposition and fears regarding their development.[72] However, the evaluation also stressed the need for the EHB to now utilise all means available to it to continue its expansion of services into the community setting. To this end, the

increased use of mobile dispensing centres, the creation of new clinics, and expanding the throughput of existing clinics were recommended by the consultants.[73]

In reacting to the work of the consultants and later the Task Force, as well as the policy impetus that had been generating action since the early 1990s, the EHB was engaged in a range of activities designed to modernise its drug services and expand service capacity. The extent to which the Board was altering its treatment structures and the impact this had upon the organisation of drug treatment can be culled from some of their annual reviews of their drugs services. This is especially the case at the start of the period when the initial thrust of the work was occurring and there was a large gap to be closed in service provision that was not there in later years.

Throughout the early years of the period under study it is evident from the EHB's plans and work that it was actively trying to scale-up drug treatment provision and that this activity was altering the organisation of service provision. In their 1996 service development plans for 1996 the Board was focused on trying to significantly increase the numbers in MMT through a mixture of further GP involvement, more treatment centres in local communities, and bringing online a mobile clinic.[74] In addition they were working to make available the full range of services in areas where they were not, such as the South Inner City.[75] A major part of the EHB's build-up in treatment provision at the time involved their efforts to actively introduce a seven-day MMT service into community drug centres.[76] This was successfully done and continued from 1996 onwards, as was the Board's goal of expanding the numbers on MMT in general.[77]

A key component of the EHB's strategy for the successful expansion of its services was the strategic development of locally-based clinics and further increasing the capacity of existing treatment centres. Principally, these new 'satellite clinics' were based in suburban areas with severe drug problems, providing a range of services including MMT.[78] This allowed users to receive treatment in their own area and was a major part of facilitating a move away from a dependence on centralised clinic based services, which involved users having to travel for treatment. The Board's 1997's service plan was indicative of the extent to which they were altering the nature of how drug treatment was organised with the number of satellite clinics they were opening or planning on developing, as well as the expansion to existing treatment centres.[79] In essence, their

plans encompassed an extremely wide geographical spread of areas. As the table below shows, the EHB was engaged in an incremental build-up of its community-based treatment clinics during the early years of the timeframe studied. It is clear that the rate of clinic establishment greatly increased in the aftermath of the 1996 Task Force report and the increased funding that this brought to drug treatment. As a result, the pace at which the shift in the organisation of drug treatment that had been slowly occurring since the early 1990s increased in the run up to the formulation of the MMT protocol in 1998 which in turn added to this overall process.

Table 2: EHB treatment centres opened between 1988-1998

1988 – 1 centre

1992 – 3 centres

1994 – 4 centres

1995 – 6 centres

1996 – 13 centres

1997 – 23 centres

1998 – 42 centres[80]

In addition its expansion of clinics, the EHB also worked to increase the number of GPs and CPs involved in the delivery of MMT, as well as trying to diversify the modalities it used to deliver treatment. Prior to the inception of the MMT protocol in 1998 and the subsequent expansion and nationalisation of MMT the Board was progressively building-up the level of GP participation in this form of service provision. By 1997 they reported that the number of GPs rose from 15 at the start of 1996 to 58 at the end of that year.[81] The Board noted that this number had again rose to 97 GPs in 1999.[82] A similar rate of growth in service development occurred with the EHB's efforts to attract more CPs into the delivery of MMT during the years leading up to the 1998 protocol. In this sense, the number of participating pharmacists rose from 3 at the start of 1996 to 39 at the end of that year.[83] By 1999 the Board noted a significant rise in the level of CP involvement, with the numbers haven grown to 145 altogether.[84]

As well as the EHB's work in developing the main aspects of the treatment system – expanded clinics, GP and CP involvement – and helping to engineer a shift in

the organisation of drug treatment in the process, the Board also utilised other modalities to deliver treatment. Chief among these was the launch in September 1996 of a mobile clinic for the deliver of MMT and NSP.[85] Primarily aimed at still using clients, it provided users with access to low dose MMT.[86] The service was slowly developed by the Board over a number of years and in the process allowed them to added important levels of extra capacity.[87] Operating at a limited number of locations, the clinic was aimed at the inner city and operated on a seven day basis and was important as both a low-threshold and ad-hoc extra capacity element of the Board's services during these years.[88]

When the EHB's drug services were reviewed again at the turn of the century the extent of the Board's efforts to develop its treatment infrastructure and the impact that this activity was having on the organisation of the system was evident. In particular the consultants were impressed with the way in which the expansion of the MMT service into the community setting had taken place and the large number of users, some 4,000 in 1999, availing of treatment.[89] In assessing the rate of change and the task of achieving it, the report made it clear that the Board had been highly successfully on a number of fronts. The evaluators felt the EHB had worked well with local communities in order to overcome the problems that can be encountered when drug treatment networks are trying to be expanded, particularly the location of new clinics.[90] Similarly, they saw the Board as having effectively dealt with the assimilation of a large number of MMT clients into their services as a result of the implementation of the 1998 MMT protocol when many were transferred out of private practice.[91] In this respect, the report noted how a network of pharmacy coordinators had been put in place by the EHB to manage the pharmacists involved in delivering MMT and was, alongside the protocol, another important aspect in the standardisation of the drug treatment system.[92] Similarly, the consultants were satisfied with the nature of GP involvement in the delivery of MMT, finding it to have been both well planned and reflective of innovation in the manner that care was provided.[93]

The consultants also drew attention to the way in which the pace of the Board's programme of clinic expansion and its impact on drug treatment's organisation had been driven by drug policy when they noted that this had been made possible as a result of the more significant finances allocated to the EHB. They asserted,

> "Thus the services have expanded from three locations to over 50 locations in the space of five years. Over the past decade the budget for the service has increased more than 10 fold."[94]

This shows us the progressive level of investment that was made in scaling-up the service during the time studied, but as the table above showing the number of clinics opened reveals, this expansion occurred from a low starting point.

In this part of the chapter we have looked at the role played by the EHB during the early years of the period under study in the development of the drug treatment system. At this time the Board's activities were being driven by drug policy, initially by the 1991 drugs strategy and later the 1996 Task Force's work to expand their treatment infrastructure. This lead to the Board becoming involved in the restructuring of how services were socially organised through their progressive build-up of locally based clinics and the increased involvement of GPs and CPs in the delivery of MMT in advance of the 1998 MMT protocol's introduction. The Boards work at this time was crucial in facilitating the shift away from a dependence on centralised drug treatment services towards community based treatment. The following section looks at the main features of the way in which MMT has been operated and considers some of the problems that have been encountered in the process of developing the system.

The Limits of Expansion

Within the timeframe being analysed the design and delivery of the drug treatment system underwent extensive change, moving from being a centralised system to one based on the principle of community care. An integral part of facilitating the transformation of how the delivery of drug treatment was socially organised was played by GPs and CPs and their increased participation in MMT. The greater role that they began to play in the system, as well as the range of new clinics opened, helped the statutory services to treat a larger number of drug users than ever before. Yet while these events represented the more successful aspects of the dynamic changes in drug treatment that were driven by drug policy, there were setbacks in the expansion of MMT as well. This part of the chapter explores the operational details of the way MMT has been

provided through the protocol. It then moves on to examine some of the problems that have arisen since the development of MMT and the barriers that were encountered in attempts to further increase the size of the service.

While the use of MMT as a treatment option and policy moves towards scaling-up its role in the drug treatment system both pre-dated the time under study, they greatly increased from 1996 onwards. Among the key developments in this respect was the launch in January 1998 of the Methadone Treatment Services Review Group (MTSRG) or Review Group's report, which supported the protocol designed by the 1993 Expert Group on a Protocol for the Prescribing of Methadone. Subsequently, in the July of 1998 the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations came into operation. The effect of the new regulations was considerable, as it represented the culmination of the policy and structural organisation work that had been taking place since the early 1990s to try and standardise and expand the delivery of MMT into the community setting.

Prior to the establishment of the MMT protocol there were a range of problems with the provision of methadone services, despite the ongoing efforts of policy makers and the EHB to develop its delivery. Among the principal reasons for establishment of the protocol was that prior to 1998 there was a limited number of GPs involved in the prescribing of MMT.[95] As a result, large numbers of drug users were attending the practices of these GPs in order to avail of treatment.[96] This led to a situation with two negative consequences, mainly, the areas where the surgeries were sited became a hub for drug users and drug users had to travel far from their own local area to avail of treatment.[97] The involvement of increasing amounts of GPs and the nationalisation of MMT through the protocol essentially put an end to both of these problems.

One of the other significant issues that the protocol helped to tackle was the diversion of methadone supplies. Prior to its enactment there was concern with the illegal supply of medication from a small number of GPs who were engaged in bad prescribing practices, largely as a result of a lack of training in the area of drug treatment.[98] With the advent of the protocol the issues of double-scripting and diversion were more or less bought to an end. This was a result of the provision of proper training for GPs, the

adoption of clear prescribing guidelines, special prescription forms, identification cards for drug users receiving treatment, a central treatment list.[99]

The guidelines adopted in 1998 bought a new level of sophistication to the provision of MMT, as they allowed the creation of a clear template for the standardisation of how each stage of the treatment was to be delivered and controlled. Of critical importance within the development of how this process was to work was the decision by the Review Group to back the Irish College of General Practitioners (ICGP) report that detailed how GPs should participate in the scheme.[100] The centre piece of the ICGP report, and one of the defining features of how the MMT treatment system would come to operate for the remainder of the period under study after its inception, was the creation of two tiers of GPs to operate the protocol.[101] While there were 56 GPs involved in MMT in December 1996, by the same month in 2003 the number had risen to 205.[102] This is a point which highlights both the success of the system in expanding the delivery of MMT into the community setting and as a result of this, altering the organisation of drug treatment further away from a reliance on centralised clinic based treatment.

The more numerous of the two types of GPs operating under the protocol scheme are referred to as level 1 GPs. These doctors are unable to directly initiate drug users onto MMT themselves and as a result take all of their patients from either a HSE (formerly Health Boards) clinic or a level 2 GP.[103] All of the drug users that these GPs receive into their practices are already stabilised on MMT.[104] In order to start treating patients under the protocol GPs must complete an ICGP training course and keep informed of relevant updates.[105] The ICGP ensures that the participating GP is subject to ongoing evaluation.[106] The upper limit on the number of patients that a level 1 GP can treat is set at 15.[107]

The main distinction between the different categories of doctors involved in the protocol is centred on the number of patients they are allowed to treat and the amount of experience that they have in the area. Level 2 GPs have had a greater degree of training in working with drug users than their level 1 counterparts.[108] This involves undertaking an extensive course organised by the ICGP and the HSE.[109] As a result of their greater experience and extent of knowledge in the area these GPs are entitled to initiate treatment for patients.[110] Level 2 GPs are allowed to treat 35 drug users in their surgeries, or if there

are two level 2 GPs working together, a total of 50 patients can be treated.[111] A national GP coordinator assists the HSE in working with GPs and dealing with a variety of issues related to the operation of MMT, as well as recruiting more GPs into the system.[112]

Integral to the successful operation of the protocol system and in turn the engineering of the change in the organisation of drug treatment was the participation of CPs in the delivery of MMT in the community setting. The extent to which pharmacists became involved and helped to alter the nature of how drug treatment was delivered can be seen from the fact that there were 42 CPs involved in MMT in December 1996 and 295 participating the protocol in December 2003.[113] Through the Community Pharmacy Contractor Agreement the HSE engages pharmacies to dispense methadone so that patients on MMT can receive treatment in their local areas.[114] The medication is only available to individuals who have a current treatment card, which is given to them by the Central Treatment List (CTL) onto which all drug users receiving MMT are recorded.[115] Pharmacists providing the patient's methadone keep the treatment card for the duration of the dispensing period or unless the treatment is ended for some other reason or the card expires.[116] Each CP involved in the scheme receives training on the operation of the system from the GP coordinator or liaison pharmacist.[117]

The adoption of the 1998 MMT protocol represented the culmination of the drug policy drive to expand methadone treatment and further alter the organisation of drug treatment services by extending them into the community setting since the early 1990s. Throughout the period being analysed there was a concerted effort to increase the number of GPs involved in the treatment of drug users with methadone. However, despite the progress made in this regard problems existed in relation to the rate at which they were joining the scheme. By the time the 2001 drugs strategy was undergoing its mid-term review process in 2004 concern with the level of GP involvement in the methadone protocol had began to be raised. In both the main review and an evaluation undertaken by PA Consulting for the Steering Group overseeing the process the issue of poor levels of GP involvement was brought up.[118] Both reports made the point that the nationalisation of the MMT protocol was being adversely impacted by the fact that there were insufficient numbers of GPs to make the treatment available to drug users, particularly outside of the Dublin area.[119]

One of the critical problems that the mid-term evaluation of the drugs strategy identified in relation to rural GPs was that there was an inadequate number qualified to initiate MMT for patients.[120] When the Methadone Prescribing Implementation Committee (MPIC) or Implementation Committee set up to review the protocol in 2002 by the DoHC reported in 2005 they reiterated this concern regarding the involvement of rural GPs.[121] They noted how the rural submissions they had received highlighted the problem of drawing adequate numbers of GPs into the protocol at both levels, but that there were particular problems with getting level 2 GPs.[122] When PA Consulting completed their 2008 evaluation of the drugs strategy they found that the issue of inadequate amounts of level 2 GPs becoming active within the system had not been resolved.[123] In this sense, they asserted that one of the reasons inhibiting the amount of treatment initiating GPs within the system from building-up was that it had proven uneasy to get doctors to undergo the necessary training.[124] Consequently, while the expansion of MMT and the corresponding change in the organisation of services was greatly increased by both the number of new clinics and the increase in GPs delivering the treatment, it is clear this progressive expansion was not an entirely smooth process.

In the same way there were issues with GPs' participation in the MMT system, there were ongoing problems with the involvement of pharmacists in the methadone protocol during the period studied. The mid-term review of the drugs strategy noted that there had been trouble around the country in involving CPs in the system when it was reviewing progress under action 56 of the strategy, designed to increase CP and GP participation.[125] Similarly the Implementation Committee outlined a corresponding set of concerns regarding the involvement of CPs in their 2005 report.[126] In particular, they saw the dual issues of unsatisfactory levels of pharmacist recruitment and already participating CPs not taking onboard the maximum number of patients that they could under the protocol, as serious hindrances to the expansion of the system.[127] In this respect, we can see some of the ongoing challenges and complexities that the generally successful expansion of and shift in the organisation of drug treatment underwent during the time being examined.

One of the main consequences of the ongoing problems with the expansion of the MMT system with GPs and CPs was that access to treatment was hindered for some

users. This resulted in the need for waiting lists as a result of capacity problems in terms of the number of patients that could be treated. At the time of the mid-term review of the drugs strategy PA Consulting noted that the extent to which the MMT system had grown during the period studied when they asserted that there were 7,281 places available on the treatment at the end of October 2004.[128] Yet they also expressed concern with the continued presence of waiting lists stating,

> "Waiting times have improved but in some areas they still way off achieving the one month target set in the Strategy."[129]

When the consultants came to evaluate *Building on Experience* again in 2008 they noted that HSE data at the time listed the number as waiting to access to MMT as 418, with the main reason for the delay outside of Dublin being the shortage of level 2 GPs.[130]

While the problems with the ongoing recruitment of GPs and CPs functioned to slow down rather than halt the MMT system's expansion into the community setting, a range of concerns with their impact were evident in PA Consulting's 2008 evaluation.[131] Its was clear from a number of points the consultants raised that the protocol's ability to further increase the capacity of the system to deliver MMT to greater numbers of drug users was approaching or already had reached its limit of expansion.[132] In this respect, their report pointed out that there was a need to consider the adoption of alternative methods for the delivery of MMT.[133] In offering a means of relieving the congestion that had been reached in the expansion of the MMT system, the consultants asserted that a nursing-led model of treatment should be adopted.[134] At the same time as this, they also called for voluntary bodies to be allowed to directly employ GPs to provide MMT.[135] In addition, the evaluation stated that more experienced GPs should be allowed to treat larger numbers of MMT patients.[136] It is clear that the changes in drug treatment brought about by the involvement of GPs and CPs and the opening of local clinics made MMT more widely available than ever before during the period studied. However, the natural limits of these means of expansion appeared to have been reached by the end of the timeframe. Despite this, a fundamental shift in the organisation of drug treatment had taken place within these years and was facilitated by these delivery mechanisms.

This section of the chapter has explored a number of different aspects of MMT's development during the period studied. It began by looking at the advent of the

methadone protocol as one of the critical events in the evolving nature of the service. In this respect, the 1998 guidelines brought a new level of sophistication and standardisation to the delivery of MMT and facilitated both the recruitment of increased numbers of GPs and CPs to make the service available and as a result the nationalisation of MMT. The progress achieved in altering the nature of the drug treatment system during this time, was however, not without its setbacks. Towards the end of the period studied the maximum expansion point to which the system could be taken via GPs and CPs was being reached. Among the key difficulties was the lack of level 2 treatment initiating GPs being recruited, especially in rural areas. Such issues aside, the methods used to increase the availability of MMT in the years analysed were overall successful in extending the treatment into the community setting and in the process changing the nature of the organisation of treatment. The final section of the chapter looks at the development of MMT beyond the community setting and into the prison system and how this service changed over time. This part of the chapter is followed by an overall conclusion.

Methadone & the Prison System

The most significant shift in the organisation of the drug treatment system in the period examined in this study was the move from whole-scale reliance on centralised clinics to the backing of community-based treatment for drug users. This diversification of treatment settings for expanding the numbers receiving MMT was driven by drug policy and enabled by the work of the EHB, the number of new clinics established, the increased participation of GPs and CPs, and the 1998 protocol. Beyond the community setting the prison system plays a key role in delivering healthcare to drug users. The present section of the chapter is not concerned with the wider dimensions of prison healthcare policy or prison policy itself in a general sense. Rather, our focus in this section is on the development of MMT within the prison system during the time studied, as a result of its representing part of the overall methadone treatment system. This is done by looking at the level of support that was expressed for the build-up of methadone services over time and their gradual refinement.

At the start of the period being analysed there was a minimal level of drug treatment services available in the prison system and 1996 represented a turning point when change began to occur.[137] During this year Mountjoy prison in Dublin brought in a programme of counselling and detoxification for drug users, as well as opening a drug free section of the prison in the Training Unit.[138] The low base from which treatment services were being operated within the prisons system can be seen from the fact that while these programmes were themselves successful, their largest obstacle was consistently identified as strained operational resources.[139] 1999 witnessed the start of significant change in the way drug services were to be provided in prisons when a strategy on, *inter alia*, treatment was formulated by the Department of Justice Equality and Law Reform (DJELR) and the EHB.[140] Of core importance from our concerns in the present section, was the plan's backing of allowing drug users already on MMT in the community to remain on the treatment when committed to prison.[141] Following the strategy's completion and further exploratory discussions between the DJELR and the IPS, the Steering Group on Prison Based Drug Treatment (SGPBDT), or Steering Group, was established to work on the implementation and refinement of the draft strategy.[142]

The Steering Group's report contained a critical analysis on the nature of drug treatment service provision within the prison system that marked a key point in prison policy's discussion of such issues. Their work noted the importance of a partnership in stopping and treating drug use and highlighted the central role that the IPS had to play in this process.[143] In particular the Steering Group stressed the need to involve and work with other departments, the community and the families of prisoners, as well as community and voluntary sector groups.[144] Through expanding on this issue and outlining one of their most significant conclusions from our perspective in the present chapter, the document expressed strong support for increasing the level of equivalence of care and the level of throughcare available.[145] They noted,

> "...the Prisons Service must replicate in prison to the maximum extent feasible the level of medical and other supports available in the community outside."[146]

This point was reiterated in the report's outline of what system-wide policy should be.[147]

In a similar way, the Steering Group saw the use of throughcare connections to community drug treatment programmes as integral to the proper operation of the IPS's

services.[148] Building on the work of the DJELR and the EHB, their recommendations called for the drug users already availing of treatment prior to incarceration to be allowed to remain on it upon committal.[149] In discussing methadone initiation policy for prisoners who were not on the treatment prior to entering jail, they went on to assert that those on long sentences or who were HIV positive should be able to avail of MMT.[150] In this respect, the Steering Group's discussion of these issues allows us to see the strong backing that they gave to the utilisation of MMT within the prison system.

Further expression of support by the Steering Group for both the provision of drug treatment in prison and development in how it was to be delivered arose in their comments on the role of nurses. In this respect, they noted that the IPS was starting to increasingly employ registered nurses, with Cloverhill prison being a case in point at that time, as it had 15 among its staff.[151] They saw this as a positive development as a result of the role that these healthcare workers had to play in the delivery of drug treatment services for drug users.[152] As the PA Consulting evaluation in 2008 noted, the model that subsequently developed throughout the IPS was a nursing-led model of drug treatment.[153]

The recommendations that the Steering Group made in their report in July 2000 was endorsed in October by Government.[154] Reflecting the immediate impact of the report, December of the same year saw a landmark development in the provision of MMT in prisons when those drug users already on the treatment prior to committal were allowed to remain on methadone when incarcerated.[155] During that month 184 inmates in 5 prisons in Dublin were availing of MMT.[156] This brought an effective end to the practice of terminating treatment for users who had been on community drug programmes upon entering prison.[157] It represented the start of a trend in the progressive scale-up of MMT during the time studied as a result of both the Steering Group's work and the general policy push since the early 1990s towards the increased utilisation of methadone outside of centralised clinic settings. However, as these figures show, this change was occurring from a low level of provision within the prison system. As such, this initial shift in prison policy towards the increased use of MMT marked a critical move towards the further alteration of the organisation of the drug treatment system alongside the role of new clinics and GPs and CPs. Like developments in the community

setting at the same time and before them, these changes were starting to occur at a time when there was little indigenous drug policy and treatment research being conducted.[158]

November 1999 saw another major development in the change that was occurring in the approach towards drug treatment in prisons when the Group charged with Reviewing the Structure and Organisation of Prison Health Care Services (GRSOPHCS), or Services Group, was established. The Minister for Justice gave them a wide ranging remit requiring them to consider, *inter alia*, the operational nature of healthcare services within prisons.[159] This effectively required them to look at issues related to the nature of drug treatment. In this respect, the Services Group strongly noted the problems with drug use that had persisted within the prison system and the unsatisfactory nature of the treatment response that had been brought to bear upon it prior to 1996 and later with the work of the Steering Group.[160] Specifically, they drew attention to the fact that their work was being undertaken against a background of consistently poor levels of funding being allocated to prison healthcare services, but that there were now changes in prison drug treatment taking place.[161] They saw the extension of MMT for prisoners already availing of it in the community into Cloverhill and Mountjoy prisons as a positive example of this change.[162]

The Services Group's report expressed support for the need to engage in partnership working in order to effectively develop services in prisons. They felt that the DJELR, the IPS, the DoHC and the Health Boards, should all be working collaboratively in the provision and development of prison healthcare.[163] This was subsequently stated as one of the report's key recommendations.[164] The backing that the Services Group gave to the utilisation of partnership working allows us to see the extent to which international policy and research was having an influence on their work. In discussing the nature of the type of change and working style they wanted to see in action, the Services Group made reference to work undertaken in the UK by the H.M. Prison Service in England and Wales and the National Health Service.[165] The report in question had called for the instigation of service development to be commenced between the two bodies in prisons.[166] This is a situation which is reflective of the search route sub-type of the problem-solving model of the research / policy interface discussed in chapter one. Jimmy Duggan, who had also been a member of the Services Group, supported this view of

events.[167] Mirroring research utilisation developments in drug policy generally around this time, such as in the scale-up of MMT, there was little indigenous research on the issues being looked at.[168] As a result international research and the policy work of other countries played an important role in the development of policy.[169]

In a similar manner, when their report came to consider the issue of blood borne virus prevention in prisons it was clear that the Services Group had been influenced by international work, rather than national research at this time.[170] In strongly supporting the introduction of disinfectant tablets into prisons for IDUs they again made reference to the work of the H.M. Prisons Service in England and Wales and their report on their report on the utilisation of this harm reduction strategy.[171] In addition, while discounting the introduction of NSPs at the time for Irish prisons, the Steering Group noted how a European conference at the time had shown that their use was developing in European prisons.[172] This again displays relevance of the search route sub-type of the problem-solving model of the research / policy interface in terms of characterising the way in which the Steering Group was utilising international policy information to shape its deliberations.[173]

Like the Steering Group before them, the Services Group also stated their support for the development of both equivalence of care and throughcare services in prisons and addressed a range of issues that, while not stopping MMT's expansion, were not aiding its development. In setting out how they wanted services to progress in their core recommendations, the Services Group asserted that they gave their backing to the idea of equivalence of care between the community and the custodial settings.[174] Similarly, they also stated that as part of their recommendations that coordinated arrangements should be put in place to provide aftercare for prisoners.[175] While the report had noted the change in policy to allow those on MMT to remain on the treatment after entering prison, the Services Group drew attention to an ongoing problem with the further development of the service.[176] Principally, they highlighted the fact that there were still unresolved issues with placing prisoners initiated on MMT within prison on treatment places in the community after their release.[177] This was as a result of the IPS being unable to receive a guarantee from the health authorities that prisoners would be offered a place.[178]

A 2007 IPS annual report noted that the issue of post-release placement guarantees had not been resolved during the period studied.[179] However, it was one that hindered rather than halted the development and expansion of MMT services in prisons, as the same Service annual report also stated,

> "The IPS was the second highest provider nationally of new treatment contacts and Cloverhill Prison continues to demonstrate the highest clinical activity in this area."[180]

This is a point which highlights the way in which the provision of MMT within the prison service has grown throughout the time studied despite the persistence of problems with the system as whole. It reveals the way in which the organisation of drug treatment was additionally altered by the changes in the IPS as well as the changes taking place in the community sector in the delivery of methadone.

The extent to which the IPS was actively building up its drug treatment services during the years being examined can be seen from the changes that took place in the provision of MMT within the system. Specifically, in the years following the reports by the Steering Group and the Services Group, there was an upward change in the availability of methadone within prisons. For example, in 2001 there were 300 inmates availing of methadone.[181] Several years later in 2004 the numbers receiving methadone annually had risen significantly to 1,309.[182] Subsequently, the IPS reported that 1,564 prisoners were given the treatment in 2005, 1,579 in 2006, and 1,840 in 2007.[183] In 2006 the IPS reported that 162 prisoners received methadone for the first time while in jail, which made the Service one of the State's biggest treatment initiators.[184] By 2007 the number of such individuals receiving methadone for the first time while in prison had risen to 185.[185] This series of progressive increases in the IPS's delivery of methadone to prisoners shows us the extent to which their provision of the service was developed over time. It also displays the manner in which the Prisons Service was, alongside its counterparts in the community setting, functioning to alter the organisation of drug treatment by expanding the availability of locations in which it could be delivered.

The extent to which the provision of drug treatment was actively being scaled-up over time by the IPS can also be seen from a number of other developments related to the delivery of MMT within prisons. One of the main innovations that the Service developed

to provide treatment to drug users was the adoption of a nursing-led model of care, which as PA Consulting's noted in 2008 was the main method being deployed in delivering MMT in prisons.[186] It is clear that the Service was engaged in trying to enhance its capabilities in this area of healthcare during the time analysed. For example, their Assistant Training Officer (Drug Treatment) having worked with community drug centres in order to better understand the training undertaken by their staff so that prison nurses could avail of the same level and standards of drug treatment training.[187] 2004 saw the introduction of a pilot project in Wheatfield prison in Dublin, where two nurses were tasked with the delivery of drug services as their main duties, which was satisfactorily appraised by the drug treatment specialist for the location.[188] Towards the end of the period, in 2007, the IPS announced plans to continue to expand the number of nurse officers it had in order to better facilitate drug treatment.[189]

Other initiatives undertaken by the IPS also show us the extent to which it was building MMT provision and contributing to the further alteration of the organisation of drug treatment. For example, in 2003 a pilot programme was underway between Mountjoy prison in Dublin and the then Northern Area Health Board aimed at initiating drug users onto MMT in prison where appropriate if they met the entry criteria applying in the Health Board area for commencement.[190] The following year, in 2004, the IPS created an auditing system to help provide a better level of structure and coordination of the release and throughcare of prisoners between prisons and community clinics.[191] Further moves towards the facilitation of smoother throughcare transitions came in 2005 when the IPS and the HSE were jointly awarded a contract for the supply of methadone, essentially allowing for a more seamless treatment setting switch for relevant patients.[192]

The extent to which the IPS had progressively scaled-up its provision of MMT services over the period studied can be seen from their 2005 annual report. They noted,

> "Currently the Irish Prison Service is treating 42.8% more patients than the largest drug treatment facility in Ireland and is one of the highest recipients of new patients into treatment, second only to the HSE South Western Area."[193]

In this respect, we can see the extent to which the prison environment was being utilised to deliver drug treatment during the time studied, and how this increased role of the IPS as service provider had developed since work of the Steering Group. The fundamental

shift from the low level of MMT in prisons prior to the work of the Steering Group to increasing levels of provision after the turn of the century was also noted by PA Consulting. In their 2008 Evaluation of *Building on Experience* they pointed out that the Prisons Service had now become the largest MMT centre in Ireland, and that it had deployed a nursing-led model to deliver the treatment.[194] In this respect we can see another way, as distinct from the opening of clinics and the involvement of GPs and CPs, that the organisation of drug treatment was altered during the period under study.

Indicating the way in which the IPS was actively working to develop healthcare services in prisons, the period studied saw them produce two sets of general prison health care standards in 2004 and 2006, with the latter essentially restating and updating aspects of the former. Reflecting the extent to which MMT had become a more common treatment within the prison system and the IPS's approach to developing the service for patients, both sets of healthcare standards offered a detailed discussion of the nature of how methadone was to be provided. In this respect the guidelines set out the manner in which criteria for continuation of MMT for prisoners who were on the treatment prior to committal were to be applied, as well as the grounds for those undergoing it for the first time.[195] The guidelines also plotted out the manner in which new arrivals to prison with drug problems were to be assessed and treated by healthcare staff.[196] Critically, the IPS's guidelines were framed so as to be applicable in a system wide manner. Consequently, we can see the way in which they were attempting to standardise the nature of treatment services throughout the prison service by creating a template from which individual institutions could work from.

Additional restatement of the IPS's approach to treating drug came in 2008 with the launch of their *Drug Treatment Clinical Guidelines*. While the guidelines covered a range of general drug treatment issues, they allow us to see how MMT services were still being kept in focus at the end of the time studied. In general terms the policy as a whole represented a rigorous attempt on the IPS's part to move towards a more standardised approach to the application of drug treatment practices within the prison system and in this sense it set out it detail a number of operational procedures. Among these were the grounds under which those categories of patients regarded as being treatment priorities could be initiated onto MMT.[197] Building on its early work and providing a more

comprehensive compendium of material on working methadone, the policy elaborated the nature of the toxicological screening elements linked to MMT and the need for continuous contact with the CTL.[198] Further aspects of the approach towards working with MMT that the IPS wished to see standardised were later set out when they went on to discuss the way in which the drug was ordered, dispensed to patients, and the nature of its administration and record keeping matters.[199] As a result, we can see the way in which the IPS was actively try to homogenise the way in which MMT was being delivered through the prison service during the time studied.

In setting out their MMT guidelines the IPS noted that they had derived these from the *European Methadone Guidelines*, an extensive set of operational strategies based on international research on the utilisation of MMT.[200] This was the case in both the development of their Health Care and Drug Treatment guidelines in 2004, 2006 and 2008.[201] Similarly, in their Drug Treatment guidelines the IPS drew on the Maudlsey Protocol and Prescribing Guidelines when constructing its own Lofexidine and alcohol detoxification and withdrawal guidelines.[202] This allows us to see the way in which international policy and research, rather than national research was being used in the formulation of the IPS's MMT policy. It reflects the way in which research information diffuses internationally from one country to another, and is indicative of the enlightenment model of the research / policy interface. Specifically, it shows how the IPS was influenced by pre-existing ideas and approaches that had built-up when formulating its own policy when the time came for it to do so as result of the expanded numbers of MMT patients it was then processing through its prisons.

In 2006 the IPS launched its first official prison drugs policy in the form of 2006's *Keeping Drugs Out of Prisons*, and its discussion of treatment issues allows us to see how the Service's support for their development continued to evolve over the period. The strategy was generally supportive of drug treatment and acknowledged the greater numbers entering the system already on MMT and desiring to remain on the treatment during their time in prison prior to returning to the community.[203] In this respect, the policy asserted that the IPS saw its aims as being the provision of treatment and throughcare for those with drug problems.[204] The strategy went on to assert that each prison should make available a range of treatment options, including, *inter alia*,

methadone detoxification, maintenance, and reduction programmes.[205] In supporting the development of its increasing MMT services at this time and drug services generally, the document went on to voice strong backing for the development of throughcare.[206] Specifically, it asserted that the IPS would try to provide continuity of care for drug users and called for the strengthening and streamlining of the work practices of all the agencies involved with the Service in developing the process.[207]

This section of the chapter has looked at the development of MMT outside of the community setting and into the prison system during the time studied and the way in which the service changed over these years. Prior to the time examined and up to the work of the Steering Group and its impact in 2000 methadone services and drug treatment generally within prisons was underdeveloped and set against persistent drug problems within prisons. After this time change began to occur on the treatment front, which like developments in the community setting, was being driven by the general policy push at this time towards the expansion methadone's utilisation. From the turn of the century to the end of the period studied the IPS scaled-up the level of access to methadone within the prison system, to the point where it became one of the country's largest providers of the treatment. Central to this build-up was the decision to allow those entering prison already on MMT to remain on the treatment while incarcerated. In the course of instigating this change, the Service developed refined its system for working with methadone through drawing on international guidelines and adopted a nursing-led model of care for its delivery. Through this process of change the IPS, like locally based treatment clinics, GPs and CPs, contributed to a shift in the organisation of where drug treatment was made available during the time studied. Specifically, this involved a move away from centralised clinic based treatment as the main access setting for drug users.

Conclusion

The present chapter of the thesis has explored some of the main changes that occurred in the area of drug treatment during the years under study. Specifically, it has reviewed the way in which the design and delivery of MMT underwent a series of fundamental changes during this timeframe that resulted in a shift in the organisation of how drug treatment was delivered. The ultimate effect of these alterations was a system marked by a sophisticated level of localised treatment provision, as well as in prisons, that had moved away from a sole reliance on a centralised clinic-based model. A number of factors were central to this occurrence. Primary among these was the policy push towards the increased use of MMT and its expansion into the community setting that had been developing since the early 1990s, which had gained momentum during the time studied. This policy work in turn led to the creation of locally based clinics and the further involvement of GPs and CPs in the delivery of MMT to drug users in their local area, which was expanded after the 1998 protocol's introduction. In addition, mirroring community based services and essentially starting from a low level of provision, methadone treatment within the prison system developed from the year 2000 on to make the treatment more widely available. Near the end of the period while the alteration of the system had been achieved and greater numbers were in treatment in a wider variety of settings than ever before, the natural expansion limits of the system under the protocol had been reached. Among the main factors inhibiting the further growth of the treatment system's progression in this respect were on going problems with GP and CP recruitment, particularly with Level 2 treatment initiating GPs and in rural areas.

Throughout the development of the MMT system and the shift in the organisation that its new delivery mechanisms ushered in, international rather than national research played a key role in its development.[208] A number of factors fed into the development of this situation. Prior to and at the start of the period being studied when the scale-up of the MMT treatment system was being developed by policy makers the drug treatment system was still in its formative phase. During these years those planning out the system were responding to the conjunction of the public health issues of HIV and IDU. At the same time there was little indigenous drug policy or treatment research being carried out. Both of the country's research bodies were more active in the latter part of the period studied,

with the NACD only being founded in 2002 and the ADRU not really completing much non-epidemiological work prior to this time. Essentially the bulk of their work took place after the treatment system's contours had been set; though it is clear ADRU's epidemiological work had an impact in other ways as seen in chapter four on the location of LDTFs. This is a situation which shows us the manner in which research information diffuses internationally. In essence, when faced with the need to respond to HIV by expanding the treatment system policy makers looked to the international policy and research settings for guidance. As a consequence, this action is broadly reflective of both the search route sub-type of the problem-solving and the enlightenment models of the research / policy interface discussed in chapter one. It represents the former, in that, channels of information and the treatment systems and policies of other countries were explored in the development of Irish policy. At the same time it is indicative of the latter model as a result of policy makers being influenced by pre-existing ideas and approaches that had cumulatively arisen. In this case, the ideas and approaches stimulated by the stock of policies supporting the use of MMT and the research evidence backing it. At this stage, from the early 1990s to the middle of the period studied, a 'threshold of awareness' in support of the utilisation of MMT had been reached internationally. The following chapter contains the overall conclusion from the thesis.

[1] Prior, L. (1993). *The Social Organization of Mental Illness*. London: Sage.

[2] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.17.

[3] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.17.

[4] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.17; p.19; p.20; p.21; p.22.

[5] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.17.

[6] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.17.

[7] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.19.

[8] *Government Strategy to Prevent Drug Misuse*. (1991). Dublin: Department of Health, p.14.

[9] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[10] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, pp.67-68.

[11] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.68.

[12] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.47; p.51; p.63.

[13] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, pp.74-75; pp.75-76; p.82.

[14] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.76.

[15] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.78.

[16] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.79.

[17] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.73.

[18] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.45.

[19] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.45.

[20] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.47; p.51; p.63.

[21] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.51; p.63.

[22] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.52; p.63.

[23] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.2.

[24] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.3.

[25] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, pp.6-7; p.9; p.11; p.54; p.55; p.63.

[26] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.11; p.12; p.16; p.31; p.33; p.34; p.41; p.64; Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.38; p.39; p.57; p.94; p.95; p.100; p.101; p.110; p.116; p.117.

[27] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.11; p.12; p.16; p.31; p.33; p.34; p.41; p.64.

[28] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.11.

[29] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, pp.11-12; p.16; p.34; p.41.

[30] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.34.

[31] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.34.

[32] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[33] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[34] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.16; p.41.

[35] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.16; p.41.

[36] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.31.

[37] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.31.

[38] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.16; 41.

[39] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach, p.16; 41.

[40] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.1.

[41] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.38; p.39; p.57; p.94; p.95; p.100; p.101; p.110; p.116; p.117.

[42] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.38; p.94.

[43] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.57; p.94.

[44] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.110; p.116.

[45] Department of Community, Rural and Gaeltacht Affairs (2004b). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office, p.iii; p.15; p. p.33; p.34; Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34.

[46] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.37.

[47] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.38; p.94; p.95; p.100; p.117.

[48] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.95.

[49] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.100; p.117.

[50] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.57; p.100; p.116.

[51] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.57; p.100.

[52] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.116; Department of Community, Rural and Gaeltacht Affairs (2004b). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office, p.33; Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34; p.38.

[53] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, pp.70-79.

[54] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.70.

[55] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[56] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[57] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[58] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[59] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[60] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[61] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.101.

[62] Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office, p.101.

[63] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[64] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.19.

[65] *Government Strategy to Prevent Drug Misuse.* (1991). Dublin: Department of Health, p.19.

[66] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.16; p.41.

[67] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.16; p.41.

[68] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, p.16.

[69] Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997). *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* Dublin: Department of Taoiseach, pp.25-26.

[70] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.3; p.13.

[71] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.2; p.12.

[72] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.2; p.3; p.12; p.17.

[73] Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB, p.3; p.13.

[74] Eastern Health Board (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00 A.M.* Dublin: EHB, p.1; p.2; p.3.

[75] Eastern Health Board (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00 A.M.* Dublin: EHB, p.3.

[76] Eastern Health Board (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00 A.M.* Dublin: EHB, p.3.

[77] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.5; p.7.

[78] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, pp.3-4.

[79] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.13; p.14.

[80] Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.15.

[81] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.5.

[82] Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.14.

[83] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.6.

[84] Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.14.

[85] Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.16.

[86] Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.16.

[87] Eastern Health Board (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00 A.M.* Dublin: EHB, p.2; Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.14.

[88] Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*. Dublin: Eastern Health Board, p.14; Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999*. Dublin: EHB, p.16.

[89] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.2.

[90] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.2; p.6.

[91] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.6.

[92] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.6; p.14.

[93] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.9.

[94] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.2.

[95] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.6; pp.23-24.

[96] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.6; pp.23-24.

[97] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.6; pp.23-24.

[98] Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB, p.9.

[99] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9; p.10; p.11;

[100] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9; p.53.

[101] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9; p.10.

[102] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[103] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[104] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[105] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[106] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[107] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.9.

[108] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.10.

[109] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.10.

[110] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.10.

[111] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.10.

[112] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.23.

[113] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.11.

[114] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.11.

[115] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.11.

[116] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.11.

[117] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.11.

[118] Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34; PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, chapter 4, p.16.

[119] Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34; PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, chapter 4, p.16.

[120] Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34.

[121] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.2; p.16.

[122] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.16.

[123] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42.

[124] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42.

[125] Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office, p.34.

[126] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.17; p.23.

[127] Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office, p.25.

[128] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, chapter 4, p.12.

[129] PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished, chapter 4, p.12.

[130] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, pp.43-44.

[131] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42; p.57; p.121.

[132] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42; p.57; p.121.

[133] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42; p.121.

[134] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42; p.121.

[135] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42; p.121.

[136] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.42.

[137] Irish Prison Service (2000). Report of the Steering Group on Prison Based Drug Treatment Services. Dublin: Irish Prison Service, p.2; Irish Prison Service (2001a). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[138] Irish Prison Service (2000). Report of the Steering Group on Prison Based Drug Treatment Services. Dublin: Irish Prison Service, p.2; Irish Prison Service (2001a). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[139] Irish Prison Service (2000). Report of the Steering Group on Prison Based Drug Treatment Services. Dublin: Irish Prison Service, p.2; Irish Prison Service (2001a). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[140] Irish Prison Service (2001a). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[141] Irish Prison Service (2001a). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[142] Irish Prison Service (2000). Report of the Steering Group on Prison Based Drug Treatment Services. Dublin: Irish Prison Service, p.2; Irish Prison Service (2001). Report of the Group to Review the Structure and Organisation of Prison Health Care Services. Dublin: Irish Prison Service, p.45.

[143] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.2; p.3.

[144] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.2; p.3.

[145] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, pp.2-3; p.10; p.26

[146] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.2.

[147] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.10.

[148] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.10.

[149] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.10.

[150] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.10.

[151] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.3.

[152] Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service, p.3.

[153] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.46.

[154] Irish Prison Service (2000). *Irish Prison Service Report 1999 –2000*. Dublin: Irish Prison Service, p.16.

[155] Irish Prison Service (2000). *Irish Prison Service Report 1999 –2000*. Dublin: Irish Prison Service, p.17.

[156] Irish Prison Service (2000). *Irish Prison Service Report 1999 –2000*. Dublin: Irish Prison Service, p.17.

[157] Irish Prison Service (2000). *Irish Prison Service Report 1999 –2000*. Dublin: Irish Prison Service, p.17.

[158] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[159] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.13.

[160] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.14; p.45.

[161] Irish Prison Service (2001). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.14; p.45.

[162] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.45.

[163] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.17.

[164] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.1.

[165] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.17.

[166] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.17.

[167] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[168] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[169] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[170] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.46.

[171] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.46.

[172] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.46.

[173] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[174] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.9.

[175] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, p.9.

[176] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, pp.45-46.

[177] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, pp.45-46.

[178] Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service, pp.45-46.

[179] Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service, p.23.

[180] Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service, p.23.

[181] Irish Prison Service (2001b). *Irish Prison Service Annual Report 2001*. Dublin: Irish Prison Service, p.30.

[182] Irish Prison Service (2004a). *Irish Prison Service Annual Report 2004*. Dublin: Irish Prison Service, p.34.

[183] Irish Prison Service (2005). *Irish Prison Service Annual Report 2005*. Dublin: Irish Prison Service, p.28; Irish Prison Service (2006). *Irish Prison Service Annual Report 2006*. Dublin: Irish Prison Service, p.29; Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service, p.23.

[184] Irish Prison Service (2006). *Irish Prison Service Annual Report 2006*. Dublin: Irish Prison Service, p.29.

[185] Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service, p.23.

[186] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.46.

[187] Irish Prison Service (2002). *Irish Prison Service Annual Report 2002*. Dublin: Irish Prison Service, p.35.

[188] Irish Prison Service (2004a). *Irish Prison Service Annual Report 2004*. Dublin: Irish Prison Service, pp.33-34.

[189] Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service, p.22.

[190] Irish Prison Service (2003). *Irish Prison Service Annual Report 2003*. Dublin: Irish Prison Service, p.29.

[191] Irish Prison Service (2004a). *Irish Prison Service Annual Report 2004*. Dublin: Irish Prison Service, pp.25-26.

[192] Irish Prison Service (2005). *Irish Prison Service Annual Report 2005*. Dublin: Irish Prison Service, p.31.

[193] Irish Prison Service (2005). *Irish Prison Service Annual Report 2005*. Dublin: Irish Prison Service, p.28.

[194] PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished, p.46.

[195] Irish Prison Service (2004b). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.28; pp.35-36. Irish Prison Service (2006a). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.35; pp.36-37.

[196] Irish Prison Service (2004b). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.35; Irish Prison Service (2006a). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.36.

[197] Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, p.29.

[198] Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, p.30; pp.31-33.

[199] Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, pp.34-35.

[200] Irish Prison Service (2004b). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.28; pp.68-85; Irish Prison Service (2006a). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.35; p.77-96; Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, p.6.

[201] Irish Prison Service (2004b). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.28; pp.68-85; Irish Prison Service (2006a). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service, p.35; p.77-96; Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, pp.6-28.

[202] Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service, pp.44-49; pp.51-58.

[203] Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service, p.10.

[204] Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service, p.10.

[205] Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service, p.12.

[206] Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service, p.13.

[207] Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service, p.13.

[208] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

Chapter 10:

An Elusive Nexus: Drug Policy, Harm Reduction, & Research

This study has explored some of the main changes that occurred in Irish drug policy between the years 1996 and 2008. In this respect, it falls within the small number of studies that analyse specific periods of Irish drug policy from a documentary perspective, such as the body of work carried out by Butler on different aspects of this general area.[1] Specifically, it has sought to make a contribution to knowledge by providing a documentary analysis through a range of written records of various developments in drug policy from 1996 to 2008. During this timeframe there was a great deal of Government action designed to respond to illicit drug use and provide healthcare to injecting drug users (IDUs). However, there has been a minimal level of documentary based analysis of this policy action.

Consequently, this study's central aim was to provide a documentary analysis of the contemporary history of Irish drug policy, focusing on some of the main developments in policy, the drug treatment system, and the role of research in these changes. In achieving this overall aim the thesis had a number of interconnecting sub-aims. In the first instance it sought to describe certain aspects of the international drug policy context within which the events happening in Ireland took place. Secondly, it endeavoured to explore some of the key features of drug policy in Ireland in the years being looked at. Thirdly, the thesis set out to provide an account of the work of indigenous research bodies in operation during this period. Fourthly, the study looked at changes in the case of two specific features of the drug treatment system between 1996 and 2008.

This chapter of the thesis presents the overall findings from the research and draws the study as a whole to a close. It is comprised of five sections and starts by discussing the research methods that were used to undertake the project. Following this, the chapter moves on to set out and explore the main findings from the study as a whole in three different, but interrelated and overlapping sections. These portions of the chapter look at the international context, the national environment and the interaction between

policy, harm reduction and research. After this portion of the chapter some considerations for further research related to the present study and its subject matter are considered.

The Research Process

A qualitative research approach was adopted to achieve the aims of the study. The main research method drawn upon was documentary analysis of different records. This reflected and was driven by the project's overarching aim to create a contemporary history account of some of the main developments in Irish drug policy. Additionally, qualitative interviewing was employed to carry out the research. In this respect, a small amount of semi-structured, or what are sometimes referred to as 'focused', interviews were carried out. This research design was broadly based on the approach traditionally taken in policy studies with similar goals, such as the different works by Butler and Duke, for example.[2] This section outlines the methods used, presents some reflections on their utilisation and considers some of the limitations of the study.

A number of reasons lay behind the decision to utilise documentary analysis as the principal research method to complete the study. Certain features of the period in question set it apart from earlier phases of Irish drug policy. Among these was the significant increase in the level of official Government action being taken to respond to drug use. This included, *inter alia*, the emergence of a large amount of Government-backed research and a range of changes linked to the development of the drug treatment system. Another important characteristic of this chapter in Irish drug policy was its being marked by the creation of a vast amount of documentary material on all of the processes and developments taking place. However, while this build up of data had been occurring there had, at the same time, been a very limited amount of analysis of it. The existence of this situation – a prolific and well-documented era in policy action – fed into the study's seeking to make a contribution to knowledge by using documentary analysis of different records to build a contemporary history account of different developments in policy between 1996 and 2008.

Documentary analysis allowed the range and detail of the developments being looked at to be efficiently and clearly dealt with. In this sense, the application of this

method facilitated the organisation and examination of the materials arising from events in a coherent manner. For example, the use of documentary analysis involved a series of interrelated steps to complete the project. These included the creation of a sampling frame for the selection of documents, the acquisition of the materials, and the analysis procedure, which, as outlined in chapter two, involved two distinct phases – identification and analysis, and organisation and analysis. Together these different aspects of the documentary analysis method functioned to work on the research topic and allowed it to be approached, examined and completed in a systematic and effective way. This was necessary as a result of the large volume of information being handled and the type of research aims that the study had.

At times the processes involved drew attention to the nature of this research method in terms of its use in the present and future studies. For example, the issues of time and choice were of key importance. Given the particular focus and questions of such a project, the application of documentary analysis represented a significant and long-term undertaking. While it maximised comprehensiveness and clarity, it is a tool that had to be carefully applied within the parameters of the research. One of the main reasons behind this relates to a consequence of present day information generation practices. In essence, vast amounts of multiple genres and categories of what may be profitably selected as data are available as a result of digitization and electronic publishing. These factors feed into and impact upon the issues of designing a sampling frame, acquiring the materials, and conducting the analysis of them. In an age where there is perhaps more information than knowledge, sharply defined research aims are needed to make the application of documentary analysis a beneficial method, least it lose its focus in the exponentially increasing array of information. Knowing clearly what you want to know, why you need to know it, as well as its relative value for the completion of the project is critical when navigating different defined and potential streams of information.

Time is an issue that looms large in undertaking a sizeable documentary analysis. While much information can be accessed easily as a result of its being freely available, at other times it can be difficult to obtain if its access is restricted. In applying documentary analysis this is a factor that needs to be planned out in tandem with the construction of a sampling frame if the selection criteria arrived at is to be realistically achievable. In the

present study, this was a core factor that involved carefully weighing up the feasibility of the data needed to animate the various dimensions of the project. One of the benefits of electronic documentation is that it lends itself to a greater ease of analysis. Such documents can be utilised and dissected in more dynamic and rapid ways than hard copy materials. At the same time, certain key pieces of information are not available in such formats and exist only in traditional forms of publishing. Being aware of the state within which the information need actually resides was important in this research so that issues of access and analysis could be economically balanced. Such concerns warrant careful consideration where a documentary analysis extends into multiple genres and different periods of time.

The analysis of documentary sources is an area of the overall documentary method that requires a clear approach. Once obtained documentary materials pose a particular challenge. Namely, while one is presented with the means to gather detailed knowledge on issues, the scale of the data that needs to be handled in order to acquire it can be extensive. In this sense, a key point within this approach is the adoption of a systematic means of analysis, such as that outlined in chapter two. This allows a standardised approach to be followed when the materials are examined. In turn, this facilitates the creation of a lucid and rigorous scrutiny of the topic under study, both within and between its different strands and themes. The devising and executing of such an approach was integral to this study's undertaking and completion. Without implementing such a means of working, the documentary method threatens to become laborious in the extreme, as well as becoming incoherent and losing its focus.

Qualitative interviewing was draw upon in conjunction with documentary analysis in this study for a range of reasons. Chiefly, this included the need to gather information to close gaps that emerged in the documentary records, collecting new information, while also exploring key findings from the study. While I was able to access an extensive amount of documentation on the themes that I was researching, at certain points there were breaks in the records that I had assembled. At these stages, conducting semi-structured interviews with key policy actors that had played a role in the developments being looked at afforded me a dynamic way of closing gaps that had arisen. Holding these interviews also facilitated the gathering of fresh information and additional details

linked to issues being focused on, which subsequently helped to further the overall analysis being generated. At these sessions, I was also presented with a chance to test out and explore a range of key propositions arising from my research with some of the main players that had taken part in the events. This was an important means of getting in-depth reactions and feedback that functioned to support, question, and modify critical points.

In order to maintain a high degree of flexibility while conducting interviews, in terms of the way issues are covered and responded to, it was decided that semi-structured interviews represented the best means of generating and keeping the discussion both dynamic and focused.[3] This mode of interviewing allowed me to enter each session with a list of questions honed to draw upon the particular experiences of and parts played by individual respondents.[4] This contributed towards triangulation among the interviews, as well as between them and documentary analysis, as a result of its facilitating me being able to ask respondents different questions linked to their roles in the same developments.[5]

While using qualitative interviewing to complete this piece of research a number considerations arose about its use in the present study and in general. In this sense, its use was impacted by the interrelated issues of respondent selection and the time needed to conduct the sessions. When choosing respondents, as in the analysis of documents, it is necessary to clear about what it is that you wish to find out and which individual can help you acquire this data. This involves being precise in the identification of potential interviewees and narrowing choices down. The idea being to separate the people from whom you are likely to be able to meet with and obtain worthwhile material, from those that might prove more difficult to access and less able or inclined to explore issues with you. In this study, these concerns were of great importance in planning out and undertaking the work.

The selection of respondents was a complicated process characterised by a need to keep the decisions made under review while the documentary analysis was being completed. It had to be balanced against the pace with which the documentary analysis was progressing as it was dependent upon it to reveal and review – in light of subsequent analysis – who should be approached in the end. At the outset certain respondents appeared to be logical choices in terms of what they would be able to contribute.

However, later, as the study progressed, some of these individuals emerged as less central to particular events or process than had been originally thought. While at the same time others remained strong possibilities as the work being undertaken supported their status as key players. In this sense, while a respondent may have been clearly identified at a particular point, the nature of the themes to be explored with them might not have been fully defined at that same time. Consequently, deciding when to approach and interview policy actors was dependent upon the range of issues and developments within which they had been involved being fully explored. Engaging with them prior to this point would have been premature and impacted upon the full spectrum of concerns that could have been discussed.

As a result of the depth with which the documentary materials allowed me to probe, the range of actors involved was quite wide because of the different thematic concerns of the study. It was important to step back from the micro detail of certain events and establish who were the key players involved not just in one event or process but those who had played a part consistently in a range of developments. In essence, those policy actors who repeatedly surfaced in the ebb and flow of change and who occupied roles that indicated they were important players in these situations. While all policy actors have interesting and valid contributions to make if interviewed, it was those that had multiple high-level engagements with the events being examined that were the primary focus in this study.

As a result of the need to strike a balance between the two methods being used, in terms of their interrelationship and the time needed to let both feed into each other, the contact period was a key concern. Making contact with respondents was thus a strategic waiting game. As outlined in chapter two, all respondents received a letter requesting their participation in the study. While some replied quite fast to the letter, others took longer to make contact. In some cases my attempts at contact failed to generate a response from the individuals concerned. Given the possibilities around the way in which a particular respondent might react to being contacted, it was necessary to try and make sure that enough space was left for me to be able to meet with them and have time to let the information acquired influence and fuse with the documentary analysis. Ultimately,

this was an aspect of the method that did not greatly impact upon the completion of the work or development of insights from the interviews.

Irrespective of the methods chosen to undertake and complete research, there are always certain limitations arising from their use. This is an issue that warrants careful consideration at the outset of a project so that the right research tools can be selected to complete the work. The research strategies decided upon influence how information is collected, as well as the sorts of issues that the data generated can deal with. This study was primarily a documentary analysis of a range of different developments in Irish drug policy. However, it also involved the use of qualitative interviews at different points as outlined above. As a result of this, the project employed triangulation between these approaches.[6] The type of research questions addressed in this study through its main aim and sub-aims directed the nature of this approach, that is, the division of labour or split between the methods being used.

While this methodological configuration was suited to achieving the goals of the present study as they stand, it would have created difficulties and imposed restrictions on the way in which other research questions could have been handled. For example, such limitations would have prohibited fully exploring the nature of how policy networks operate. A different research strategy would have to be adopted to engage with such a topic and the sorts of questions that could be posed in addressing it. This would require an alternative balance or relationship being struck between the two research methods. Essentially, a far greater use of qualitative interviewing would be needed. The method drawn upon in the present piece of work would have also had an influence on the type of conclusions that could be arrived at in such a project. In this respect, the particular design used here would not be favourable if an attempt was being made to generate grounded theory about policy making, as could be the case in a different study. A more extensive use of qualitative interviewing would be required in this respect. The following part of the chapter is the first of three interrelated and overlapping sections that present a discussion of different aspects of the main findings from the study. Specifically, it focuses on the international environment of the period studied.

The International Context

At the start of the thesis a number of models and concepts for helping to frame and discuss aspects of the documentary history being presented were looked at. Principally, these included the knowledge-driven model, the problem-solving model – with its two subtypes the purposeful commissioning and search routes – the interactive model, the political model, the tactical model, and the enlightenment model. Of equal concern were the concepts of critical mass, threshold of awareness, and hierarchical diffusion. Also of importance was the interaction between epidemic disease and policy diffusion. Specifically, the present study looked at the way in which drug policy and aspects of the treatment system changed as a result of the emergence of the links between HIV and IDU.

In this research, the concepts that came closest to reflecting the nature of the developments being looked at were the search route sub-type of the problem-solving model, the enlightenment model, the idea of 'threshold of awareness', and the process of diffusion generally and hierarchical diffusion. Consequently, a key feature of these models is that they are all what can be referred to as 'ideal types'.[7] In this sense, developments can be regarded as broadly approximating to, as opposed to stringently mirroring, the hypothetical projections on the nature of the interface between research and policy that they attempt to account for. When tested against the messy nature of reality's flow, the neat ordered world of theoretical abstractions typically reveals an important point. Namely, each theory or concept can be useful to account for aspects of occurrences – the how and why of their transpiring – but none can provide a picture that is fully realistic on its own. A key conclusion in this study is that there is little to be gained from trying to find one model or concept that can account for the complex developments being looked at. Rather, a better perspective on the way in which events transpired is to be found at the intersection between a number of these analytic tools, each offering their own insights to reveal part of the overall picture.

Events in Ireland can be seen as mirroring the global situation occurring whereby drug policy markers were reacting to and altering strategy to respond to HIV and IDU. The manner in which this occurred can be seen as broadly representing a temporally compressed cycle of the enlightenment model of the relationship between research and

policy in terms of the speed with which new approaches gained enhanced credence and operational viability. There was a reduced time-lag between research and other information on treatment issues having cumulatively stacked-up and the ideas and approaches arising from it having an impact upon policy. Consequently, pre-existing treatment options such as MMT were expanded over time and others such as NSPs were brought on stream. In line with the idea of hierarchal diffusion, this process occurred in a largely circuitous manner due to varying involvements on the part of those involved in developing policy and treatment in forums and information networks at the EU and international levels.[8]

Those charged with progressing a response to the public health problems of IDU and HIV became aware of international developments in a variety of ways. Among the channels of information that those involved in such work became exposed to discussions, research and data on treatment, as explored in chapters three and five, were the work of EU and UN bodies and institutions.[9] Similarly, the policy experiences of their EU and international counterparts also shaped their views on the developing nature of how to respond to IDU and HIV.[10] Accordingly, it is difficult to associate the experience of any one country, or research body for that matter, with having a fundamental influence in this process of diffusion more so than the role of others involved.[11] In essence, the general threshold of awareness being reached on, or build-up of support for, these treatments and their institution as norms in policy was more important than spatial proximity as a behaviour changing factor in the greater scheme of long-term treatment system alteration.

The Irish drug treatment system was influenced by international research as a result of policy makers responding to the crisis presented by the conjunction of HIV and IDU from the mid 1980s onwards. This resulted in a situation where those responsible for finding and implementing the solutions needed to create an adequate public health response looked for and were influenced by information from a range of different sources. These included international research on treatment issues and the experience of other countries' systems and policies.[12] During the formative years of the treatment system there was a limited amount of indigenous research for policy makers to utilise.[13] This information gathering activity was generally reflective of the search route sub-type of the problem-solving model of the research policy / interface.[14]

Internationally, the time studied witnessed a continued strengthening and development of harm reduction's role as a norm within drug policy. The work of the two main bodies operating internationally in the area of drug control, the UN and EU, continued to express support for the treatment options encompassed within harm reduction during the years discussed. Harm reduction evolved as norm within international drug policy and became a legitimate core element of strategy and treatment, particularly in the EU, reflecting the slightly more focused and unambiguous nature of its stance on the topic compared with the UN.[15] While elements of the UN system's engagement with harm reduction can be seen as reflective of tension with this orientation to drug treatment, this has not hindered their backing for, and the continued rise of, harm reduction as an endorsed component of policy on the whole.[16] In this sense, much of the work completed by key UN bodies, like that of the EU's agencies and bodies, has reflected this backing for harm reduction. This has been an ongoing process that has overarched the elements of dynamic tension and political jostling that form a part of the surface policy arena in which new norms take shape and embed in an ongoing manner. In essence, contention and controversy have not inhibited harm reduction from being increasingly legitimated and established.

In much the same way that different tensions and currents of opinion have not impacted the progress of harm reduction, the international drug control system has also not inhibited this approach to drug treatment's continued rise. Regardless of whether one looks at the UN drug conventions or some of the different legal studies aimed at considering the way these laws can be interpreted by both the UN and EU the same conclusion arises.[17] Namely, the different harm reduction practices can generally be seen as permissible under international law. This is a result of the way in which the UN drug conventions have been written in a style that is sufficiently vague and ambiguous to allow different parties to reach different conclusions on their meaning.[18] Such a quality is a consequence of the need for such laws to be forward-looking and contain enough accommodation so that parties with different legal systems and policies can be equally accommodated.[19] In this sense, a key point on the permissibility of harm reduction approaches has been the way in which 'medical and scientific purposes' have remained unelaborated and are not defined in either the conventions or their official

commentaries.[20] This has essentially facilitated different parties being able to draw different conclusions in line with their position on the topic.[21] In turn this has allowed harm reduction to continue to develop internationally as a result of its growth as a norm through the continued adoption of such approaches in national contexts. This is an important part of the macro context within which the period of Irish drug policy being looked at here has developed.

Adding to this situation, the actions of key EU bodies can be seen as contributing towards the extent to which harm reduction develops as a norm and in particular the degree to which EU countries, such as Ireland, are exposed to and influenced by such ideas in an ongoing way. In a manner that is broadly in line with the enlightenment model of the research / policy interface, the actions of the EMCDDA and the PG can be seen performing an 'enlightenment function' with the EU. Specifically, both bodies, as well as EU policy work generally, can be viewed as having been largely supportive of harm reduction as an approach to drug treatment. This is something that has been present in the different streams of policy-relevant work that they have produced. This knowledge has the potential to feed, in a circuitous manner, into the way norms are shaped through the utilization of the ideas and approaches arising from research that have stacked up to the point where a 'threshold of awareness' in support of them has been reached.

At the same time Irish policy on drug issues clearly moved in a similar direction and can broadly be seen as endorsing harm reduction's role in drug treatment. We have observed this throughout the study in the level of backing expressed for such approaches to treatment in a variety of ways and developments. Primarily these have included the consistent support expressed for such treatments in policies and strategies, the type of issues selected for analysis by Government-backed research bodies and the nature of the core treatment options institutionalised over time. The advent of the SMI and drug policy's subsequent incorporation into different areas of social policy and healthcare policy generally played a role in this process. Ultimately, these events reflect the way in which norms in Irish drug policy on the issue of harm reduction's legitimacy as a core part of policy mirrored and were influenced by those shaping-up internationally during the same timeframe. This set of interrelated developments was driven by the crisis presented by HIV and IDU and the pressure to respond to the manifestation of these

problems in local communities. The following section of the chapter focuses in more detail on the national environment.

The National Context

The impact of the SMI and the policy norms associated with it, such as the more managerial and rational approach to the overall content, style and tone of the policies and structures launched was considerable. One of the key ways in which the SMI style of policy making can be seen as having a defining effect on the period studied was in terms of its ability to accelerate the pace, sophistication, and success of the level of action occurring. This was evident in the nature of the policy, treatment and research responses that emerged during this time and was particularly marked when compared with earlier periods of drug policy and attendant activity. For example, the type of drug policies and the structures and arrangements that existed in the 1970s and 1980s were relatively unsophisticated and a reflection of the newness of drug problems in Irish society and social policy. However, from the mid 1990s onwards the way in which drug issues were framed and responded to in terms of policy and structures, was characterized by an increased level of complexity. This can be seen as reaching its height with the drug polices and structures launched and refined in 1996 and 2001. The conjunction of several contextual factors – the SMI, the rise of harm reduction as an element of policy, the HIV and IDU crisis – was significant during these years.

As part of the new structural responses that were created, the LDTFs can be seen as having been utilised to build a hegemonic alliance between the Government and the local communities that were most impacted by drug use as well as the community and voluntary sectors.[22] This strategy was aimed, *inter alia*, at decreasing the feelings of mistrust and dissatisfaction that existed at the start of the period studied towards the statutory response to drugs by showing that real action was taking place. It was successful and was kept in place as a form of partnership working for the duration of the period studied and facilitated a range of positive developments in areas such as treatment services and inter-sectoral working.

Many aspects of the DTFs, as well as the NDST and more recently the IDG, and the role they have played are reflective of Gramsci's idea of hegemony.[23] Succinctly stated, hegemony can be regarded as the rule of one group by another.[24] However, this leadership involves the consent of those being led.[25] One of the main means of achieving and maintaining hegemony is through the construction of a hegemonic alliance.[26] This involves the group that aims to lead (i.e. the Government) giving some incentive (such as the ability to achieve some sectoral goals) to those they want to lead (*inter alia*, local activists from different sectors involved in DTFs) so that their consent may be acquired.[27] This process can be seen as being present in how the DTFs were constructed in a manner capable of accommodating members of all the key stakeholder groups. It can also be regarded as being present in the composition of the NDST and later the IDG after it had been 'opened-up'. Essentially, those involved were given a place at the decision making table within the overall policy and decision making hierarchy. As a result, individuals taking part in different types of activism, campaigning, and political lobbying were incorporated, thus empowering them in some ways, while also placing restrictions on their actions in other ways. As noted in chapter eight, concern at the consequences of this process have been expressed by members of the sectors involved.[28] The survival of the DTFs throughout the period does, however, represent the success of the overall approach, the benefits for those involved and the difficulty of leaving and working outside such a process once it has become embedded as the established approach.

Some of the most visible signs of frustration with the statutory response to drug issues that were present at the start of the period studied had significantly abated over the course of the years looked at. In a sense, the protest marches that defined the years in and around the emergence of a more effective response by the Government were no longer a prominent feature of drug issues in Ireland. In this sense, while the problems behind such highly visible tensions were not fully resolved by the statutory actions taken, they became submerged as result of the new approach being taken and its success in managing conflict.[29] This can be seen as a hallmark of the SMI-era style of policy making.[30] In essence, the amelioration of problems being achieved through, *inter alia*, paying attention to and accommodating the sectors concerned.

SMI-era policies and structures were also successful in containing and concealing conflict in and between the different sectors and groups with opposing views and interests involved in the drug policy process.[31] This function fed into its ability to develop a more effective response to the drugs problem over the period. This can be seen from the way in which the new structures contained sufficient room for the accommodation of those who were more disposed to one approach to drug treatment than another. Such facilitation allowed a broad alliance of positions to have their needs successfully met within the structures for the duration of the time studied. This was sustained and aided by the increased amounts of revenue available for all aspects for the drugs strategy during these years as a result of the wider economic boom that Ireland had been experiencing. As such, the development of the DTFs, where sides both in favour of and not disposed towards harm reduction, were successfully integrated into a dynamic new structure was a prime example of this process in action. Consequently, the imagery of an apparent consensus that had been arrived at masks an important fact. Chiefly, points of contention had been resolved to an extent, through their removal from the forefront of the discussion agenda. This again represents the way in which the SMI-era approach to drug policy was effective at circumventing conflict while not necessarily fully solving the issues behind it.[32] The style of making and operating policy essentially facilitated the progression of the statutory response, helping it avoid being stalled on areas of divergence among participants.

Equally, the SMI-era policies, as well as the continuing presence of HIV linked to IDU and international support for harm reduction's role in drug treatment, allowed politically difficult topics to be dealt with in a way that did much to step over the sharper contours of their subject matters.[33] In this sense, these factors were integral to setting a context in which the scale-up of the MMT system and the use of NSPs could be framed and presented as acceptable courses of action. This facilitated their discussion in rational medical terms backed-up by scientific evidence in line with what was taking place elsewhere in the world to respond to the same problems. In one sense, the discordant chaos of competing perspectives was harnessed into a type of equilibrium, characterized and reinforced by the rational managerial action approach of the SMI and its ability to submerge, as much as resolve, conflicts.

In much the same way, the policy and discussion environment created by the SMI-era drug polices also helped to legitimate the funding for an unprecedented level of indigenous Government backed research on a range of drug-related issues. This was partially facilitated by a mixture of their functioning to tone and present the need for such for work in rational terms. It essentially shifted the context of their utility away from the ground of groups in favour of or opposed to the funding of research on such areas. Rather, it relocated the consideration of information generation to the setting of accepted and normalised international 'best practice', in essence, keeping pace with what was being done by administrations elsewhere as part of policy and monitoring developments.

In this sense, the SMI-era approach to drug policy, research, and the structures it gave rise to, allow us to see how aspects of the official response to drug issues can be used to create and manage particular impressions of what is being done. In both the international and national arenas, policy makers are keen to build a positive picture of their actions. This is a situation that can be seen as reflective of and involving aspects of Goffman's idea of impression management from his dramaturgical analogy of social interaction.[34] In their interactions with other policy makers in international forums and bodies, those charged with responding to drug use face pressures to appear in sync with best practice.[35]

Consequently, this is a factor that has influenced the adoption of harm reduction practices in Ireland. Specifically, policy makers have been involved in a range of forums dealing with drug issues, such as the Pompidou Group, or where drug issues arise, as is the case with the British-Irish Council and the Presidency of the European Union. Their engagements in this respect have placed pressure on them to appear in line with policy and treatment norms that have generally been supportive of harm reduction. Equally, in showing those most impacted by drug problems that an effective response was being deployed at the national level, the Irish Government has been eager to create a favourable impression of its actions. This was particularly evident at the start of the period studied when a high degree of tension and dissatisfaction surrounded the way drug issues had been handled.

In this sense, policy makers set out to influence the responsive treatment that others gave to their actions.[36] However, the mid 1990s was a period when their ability to

control the impression being given and that which was being given off by their actions was curtailed.[37] Specifically, it was hindered by the animosity felt towards the statutory sector and the fact that the new aspects of the approach to dealing with drug problems that was emerging had not yet begun to have a strong effect, both on the problem and of how those impacted by it perceived the actions taken. As discussed in chapter five, this was evident during the course of the seminar and citizens' hearing held as part of the 1996 Irish presidency of the European Union. Specifically, it was visible from the negative reactions that emerged when policy makers were attempting to control the responsive treatment of their actions and create a favourable impression.[38] While dissatisfaction with and tensions surrounding the official response to drug problems have never fully been resolved or disappeared throughout the time analysed, they were reduced and removed from the forefront of discussion. In this sense, the way in which the response to drug issues was perceived was successfully managed by policy makers, largely through the type of policies, activities and structures that emerged from the SMI-era of policy making.[39]

In many ways the period reviewed appears to be predominately marked by an air of consensus on many issues. While this is the case, a more accurate view of events is found in the idea that this consensus, both the perceived and real aspects of it, was built on and contained conflict. In this sense, some of the key factors that came together to influence the way in which policy developed – the rise of harm reduction as a norm internationally, the emergence of the SMI, the HIV/IDU crisis – functioned simultaneously to facilitate the way in which events transpired. If one or more of these elements had have been absent from the mix of contextual factors that defined the time in question, then the conflicts being submerged by them as a whole would not have been effectively contained. Rather, they would have impacted in a more pronounced way on the progression of services and the creation of indigenous research. Consequently, the struggles between different sectors and the Government, among the sectors themselves, as well as the general public's view of 'what should be done', were channeled and contained by the unique contextual features of the time in question. In other words, while events in retrospect can appear to be undefined by conflict, they are in fact infused with and reflective of it.

In light of the presence of the submerged conflicts discussed above the political model of the research / policy interface offers us an interesting view of developments during the time studied. The period in question was characterized by the forward momentum that harm reduction as approach achieved within Irish drug policy. The build up to and the facilitation of harm reduction's progression into a core aspect of treatment and care through the drug policies launched and the structures created over this time represented a significant political feat. In essence, it involved making what was unpalatable and risky from a political point of view, something that could be supported and developed. This can be seen as a move by some of the key aspects of treatment, such as MMT, from the controversial to the conventional, though not in absolute terms.

The rebranding, that is, the redefining of its image, which harm reduction underwent within the years analysed was significant. Many of the different dimensions of the drug policy arena had to be engaged with in a strategic way to facilitate this. For example, groups with differing views on the subject had to be carefully facilitated within the new structures and have their stances reflected in policy. Similarly, the communities where services were being opened and developed, as well as the public in a more general sense, had to be shown that 'the right course of action' was being taken. In this respect, the gravity of the task achieved, whereby harm reduction was successfully legitimated as a core feature of policy, is clear.

Consequently, those charged with formulating a response to drug problems were not keen to overly encourage or facilitate anything that brought into question the nature of the response devised. This can be seen as including research that drastically opened-out the basis for these interventions or particular operational aspects of their utilization. In essence, with the difficult to achieve and highly effective response to the drug problem that the new strategies and structures typified in place, politicians were not enthusiastic about continually deconstructing and re-orientating the approach being taken. This is a situation that can be seen as generally reflective of aspects of the political model of the research policy interface. In particular, it is indicative of the way in which policy makers can be quite discriminating in relation to the research that they are sympathetic to and incorporate into their actions.[40] The idea being that research that fits with pre-existing agendas is utilized and functions as a form of 'weaponry' against opposing viewpoints in

the policy process.[41] The following section focuses in more detail on the interaction between policy, harm reduction and research

Drug Policy, Harm Reduction & Research

In the latter part of the period studied when the economic situation in Ireland had improved and increased Government funding was allocated to drug initiatives, a more detailed body of indigenous research work started to emerge with the arrival of the NACD. At the same time the ADRU continued and expanded its research output and role as the EMCDDA's REITOX link in Ireland. In the midst of these developments, the treatment system continued to witness an increased level of service provision, with greater numbers entering MMT than ever before via a more diverse range of treatment settings beyond centralised clinics. Throughout the period NSPs continued to be made available in local communities, though it was subject to only minor scale-up and was static for much of the time. The collective implication of these developments is that despite the many structural, operational and strategic problems that were encountered during the time examined, overall the nature of the response to drug use developed, rather than diminished, in its level of complexity and sophistication.

One of the defining features of drug policy and the treatment system during the time being looked at was the move towards the expression of support for and the utilisation of harm reduction strategies. The change in Irish policy norms that occurred in the 1990s was a reflection of the way in which policy makers here had adopted the norms emerging within the EU and internationally that were supportive of such approaches to drug treatment. This situation saw the Government take the decision to give its backing to the expanded use of MMT and NSPs and was accordingly indicative of the role of policy diffusion generally and the process of hierarchical diffusion. In essence, the treatment options that were expanded were the ones that were being rolled out internationally to tackle the crisis of HIV and IDU. In this sense, a key consequence of the managerial turn in Irish drug policy – SMI-era strategies and structures – as well as the normalization of harm reduction internationally, was that these approaches underwent a shift, to a certain

extent, from the controversial to the conventional. However, it is important to realize that this is something that did not happen in absolute terms.

While the two key aspects of the treatment system that the study looked at in chapters eight and nine, NSPs and MMT, shared a similarity in that their instigation as options both pre-existed the timeframe explored, there were key differences between their development. Chief among these were the way in which the two treatments changed over time. Throughout the period studied NSPs were not subject to any major form of expansion and their service delivery was never significantly scaled-up after their initial wave of development and refinement. On the other hand, MMT was progressively built-up and rolled-out as a treatment option over the period studied. In this respect, we saw the way in which its development by drug policy had ultimately resulted in a shift in the organisation of drug treatment away from centralised clinics towards community based treatment as well as its wider availability in prisons. The changes in the organisaiton of drug treatment show us the way in which harm reduction had become a core part of policy and was being seen as a legitimate aspect of healthcare to a far greater extent than it had been previously. In this sense, wider availability of treatments and their being placed in local areas despite a certain level of ongoing opposition, is reflective of the way such approaches had, to a certain degree, been successfully rebranded from being controversial to conventional.

Part of the reason for the different paths that the development of NSP and MMT took during these years can be traced back to the role of policy and structures. As seen in chapter four, Irish drug policy underwent a series of changes during the years analysed here, particularly when compared with the early history of responses to drug use. As previously noted, a significant marker in this process was the advent of the SMI and its instigation of a more managerial approach to policy making. This essentially coincided with and helped to further usher in the already occurring changes that had been driven by policy since the early 1990s towards harm reduction.

The new style of drug policy that emerged and developed during the period in the work of the 1996 Task Force and later 2001's *Building on Experience* was certainly in sync with both treatment options, as seen throughout the thesis. However, the increased sophistication that marked the style of the managerial turn in Irish drug policy proved no

hindrance to MMT's development, but the opposite could be said for NSPs. While MMT was continuously expanded, NSPs were not developed in a similar manner. Part of the reason for this was their being caught up in the policy and operational structural overload that emerged during the period studied.

After the 2001 drugs strategy was launched the DSU was created. This gave rise to a situation where there were two structures – the DSU and the NDST – that were located at similar points in the policy hierarchy. They both had comparable functions (mixed operational and policy development), but their roles were inadequately differentiated. As a result of this role confusion neither body really took the lead in terms of their part within the overall responsibility for the development and driving of policy on NSPs. This can be seen as impacting the way NSPs evolved. Equally, the form of loose control – discussed in chapter eight – adopted by policy makers and the NDST in the management of the DTFs to ensure their survival can be regarded as effecting the development of NSPs. It contributed to NSPs becoming submerged in the work of the DTFs and subject to a degree of cross-DTF variation. Also, as a result of the NDST overburdened by the operational aspects of the LDTFs' work, NSPs can be seen as having become an area of treatment that was not progressed over the period for a variety of reasons. These factors can be regarded as some of the unanticipated and unintentional consequences of there being too many innovative structures brought online in or around the same time and the challenges and complexities that they represented for Government in terms of management and utilisation for Government.

A range of factors can be regarded as feeding into the way in which the treatment system developed in certain directions and not in others, that is, why other harm reduction practices apart from MMT and NSPs did not figure in its evolution during this time. The expansion of the treatment system to accommodate more diverse forms of harm reduction, as well as and the development of indigenous research focused in-depth on these issues, was impacted by the way these treatments had evolved internationally at this time. In this sense, while MMT and NSPs were strongly developed and normalized forms of treatment, characterized by being extensively researched and widely implemented internationally, heroin assisted treatment (HAT) and safe injecting facilities (SIFs), for example, were not.

While treatments such as HAT and SIFs were gaining ground during this time and continuing to be the subject of research as well as increased implementation internationally, neither was at the point of normalization that MMT or NSPs were. Consequently, a threshold of awareness in support for either option had not neen reached.[42] In this sense, not enough legitimating support for their usage had built up to encourage or facilitate politicians in smaller and less powerful countries like Ireland adopting them.[43] This is a point that is generally reflective of how the process of hierarchical diffusion had not begun in relation to certain aspects of harm reduction as a result of their utility and orthodoxy still being under scrutiny.[44] Essentially, the transition from experimentation to policy backed long-term implementation as part of treatment systems, had not happened to a wide enough an extent on these aspects of harm reduction to facilitate a policy push towards their use in Ireland.

Additionally, the extent to which politicians were prepared to engage with expanding harm reduction into more controversial areas had diminished as a result how the sense of crisis surrounding HIV/IDU had diminished in comparison to when it first emerged as a policy issue. This was a result of the degree to which medicine and research had impacted upon the illness.[45] Essentially, it had moved from being a 'death sentence' to being a 'chronic illness' capable of 'management', as the title of a retrospective account by the World Health Organization put it in 2006.[46]

The still evolving nature of HAT and SIFs was not strong enough to provide the type of backing that would make researching and calling for trialing of such modalities a feasible option for either the NACD to take to politicians or them to fund. This is a factor that can be seen as impacting upon to the development of harm reduction practices within the treatment system during the period studied. In essence, the dynamics of the NACD's situation, the natural desire for politicians to avoid controversy, and the lack of a threshold of awareness being reached on HAT and SIFs functioned to make detailed research on them and their possible use untenable. During this period, the NACD had to adopt a carefully calculated style in its policy advisory work in order to ensure its continued survival.

Consequently, this contextual pressure partially functioned to make certain topics more sensitive than others. While issues such as HAT and SIFs were dealt with as part of

wider projects on harm reduction, it would have been more complicated and risky to produce full-length studies debating the merits of such treatments or calling for their trialing.[47] Underlining such issues in a prominent way while they were still highly controversial internationally would have been unlikely to trigger policy action and may have served to undermine the NACD's position and clout politically. The Committee's approach to its advisory work allowed them to ensure their survival and can be seen as a shrewd tactic as a result of its affording them future occasions for dealing these issues.

However, one of the unanticipated and unintentional consequences of this approach is that it helped to create a research/policy context in which harm reduction issues beyond the more normalized treatments (MMT, NSPs) were essentially off the political agenda. This was a result of their being no desire on the part of politicians to engage with more controversial aspects of harm reduction. While at the same time, they were not being presented with any impetus to do so, as a result of their being no national research evaluating or pushing these issues as key topics in their own right for consideration and trialing. As a result of the treatment options already in place having been expanded, a comprehensive drug treatment system that was more or less dealing with the issues around IDU and BBVs existed. Consequently, there was no further political desire to broaden out the array of harm reduction interventions within the treatment spectrum beyond the relatively conventional into the realm of the controversial.

One of the defining features of the period studied, however, was the scale-up in the provision of drug treatment, particularly into the community setting, while the same timeframe saw an unprecedented level of indigenous research being carried out. Yet, the years examined here witnessed a level of disconnect between the initial development of the drug treatment system and Government backed indigenous research. Collectively, the work of the ADRU and NACD was unable to have an impact on shaping the defining features of the treatment system as a result of the time at which it was commenced. This was essentially a function of the fact that the main aspects of drug treatment had been configured and were predefined in advance of either research body coming online with its streams of work. In this sense, the period is marked by a paradox to an extent. Essentially, while increased money was allocated to indigenous drug policy and treatment research, the critical moment in which it could have had a defining effect on the design of

the system had already passed as its key features were already set. However, the extensive range of research created by both bodies may be seen to play important roles in policy in the future.

The enlightenment model of the research / policy interface allows us to effectively consider the way in which the implications of the ADRU and NACD's research could have an extended time-lagged influence beyond its immediate launch and the time studied here. Central to this model is the idea that no one research study will have a fundamental influence on its own.[48] Rather, as work is done and accumulates on a particular topic or set of issues, the ideas engendered by research start to filter through into the realm of policy making.[49] In this respect, the Committee's 2003 and 2006 studies on cocaine, and its 2004 and 2008 work on NSPs, and the Unit's work on BBVs, for example, may come to have future impacts on policy. This work can be seen as feeding into the overall enlightenment process occurring, whereby research internationally stacks up and the ideas and approaches arising from it have an impact in a cumulative way.[50]

The work completed by the two Government-backed research bodies can be seen as having potential future impacts in other ways beyond the collective non-associative impact of the enlightenment model. For example, the build-up of research knowledge that these two bodies started during the time period studied on different issues can be seen as functioning as a pre-existing indigenous research resource on critical drug issues for policy makers. One of the significant aspects of the presence of this information and the function it serves and may come to have in the realm of policy making is that it was precisely this type of research base that was absent at the start of the period studied. Accordingly, at points where a decision was taken to deal with or react to the topics covered by such research, the works in question may then take on a valuable orientating and grounding role. They may function as crucial indigenous 'state of play' benchmarks in terms of the modifying and expansion of interventions.

Collectively, key aspects of the way both the ADRU and NACD changed over time allow us to see some important features of the national research environment. In particular the evolution of their work reveals the way in which Irish policy went from having practically no indigenous research input, to a situation where it had a diverse and high quality level of national research. The ADRU and the NACD both adopted their own

styles of engagement with policy makers through the information the produced. The more EU influenced Unit largely adopted a subtle style of policy discussion, characterized by underlying areas of concern without spelling out the details of change needed. At other times in different streams of their work the ADRU employed a more engaging and policy assertive mode, visible from their setting out options for change in addition to creating a detailed view of developments and highlighting points of concern. The work of the NACD, on the other hand, can be seen as moving from an early phase characterized by a guidance-orientated style of advisory work to one that was later reflective of a more policy-assertive position in their projects. The output of both bodies can broadly be seen as having been supportive of the development of drug treatment and harm reduction.

Consequently, it is clear that the timeframe looked at saw the continued rise of research as a supported aspect of the official approach to dealing with drug issues and that the work being done developed over this period. Yet it is also evident from the way in which the research bodies' output evolved and the style taken in either advising on issues or drawing attention to them that limits were in place. Such restrictions impacted upon the type of commentaries that could be produced, the subject matters they covered and the potential effect they were able to have. In this sense, the area of producing policy relevant information can be seen as a politically sensitive task. It involves a balancing act between highlighting issues of concern and areas for action, without drawing organizational criticism that could prove detrimental to a body's long-term survival.

The tactical model of the research / policy interface offers us a critical view of the way in which some of the Government funded research completed during this time can be seen as being 'used'.[51] For example, the work being completed by the NACD during these years can be seen as helping to deflect criticism of the approaches that had been adopted within drug policy and treatment. Specifically, the ongoing research on different aspects of harm reduction that was being undertaken, as well as their work in other areas, helped construct an image that the current way of dealing with drug problems was being kept under review and closely monitored in general. This can be seen as functioning to placate different groups interested in the drugs area. It presented those calling for more and diverse forms of treatment with a statement that other options were being examined and considered. Similarly, it gave those opposed to existing approaches and responses a

declaration that issues were being looked at. This can be considered as effectively taking the pressure off the options and strategies in place by showing that they were not necessarily permanent, but that alteration had to be held off till other avenues had been explored.

These features of their work can be regarded as broadly reflective of the tactical model's view that research can be a bargaining chip or played as a card by politicians to fend off criticism of ongoing actions or the need to formulate new responses to a particular issue.[52] It shows how research can be used to keep things at bay, maintain the status quo and delay change.[53] This is reflective of the way in which the funding of research and its presence in the policy process can be seen as a double-edged sword. On the one had it can be aimed at seeking out new data, ideas and approaches to help monitor and modify a response, yet it can also be utilized to create the impression that such action is taking place for a variety of reasons.[54] Such a view shows us how developments can be seen as having many sides simultaneously.

The present research has allowed us to see a number of key points about the nature of the interface between research and policy. Chief among these is the fact that this point of intersection is more than just a hypothetical projection or analytic model of how events connect and unfold. Rather it is a real nexus within which the two elements of research and policy interact. However, it is a convergence zone that can be characterized as being more amorphous than it is clearly defined in terms of its structure and character. As a nexus, it is far too complex and shifting – from time to time, place to place, situation to situation – to fit with any neat models of how it operates. It is something that, as a result of its involving multiple issues moving in different directions and influenced by a range of factors at the same time, cannot be seen as being one way or another in a definitive sense. Accordingly, while models of the research / policy interface can help us to reveal aspects of the way in which such an intersection develops and operates, individually none of them can be seen as capable of accounting for or encompassing its dynamics within their schemas.

Consequently, the use of a number of models used concurrently to explore issues, as in this study, offers a clearer and more rigorous perspective on the nexus where research and policy meet. This can be seen from the abovementioned research paradox

that marked the period; while increasing amounts of indigenous research were being funded and was improving in terms of its quality, the time in which it could have had a defining effect on the treatment system had passed as a result of its no longer being a structure in formation when the work was being undertaken. Here a range of models and other concepts can be seen as each partially accounting for events and helping to contribute to and construct a better picture in the round.

In the case of this research paradox, the concept of threshold of awareness, the enlightenment model, and the search route subtype of the problem-solving model, can be seen as broadly reflective of events as the system was being developed. While the nature of the response to HIV and IDU was developing in Ireland a threshold of awareness had been reached on the use of MMT and NSPs. Around this time, as a result of the cumulative build up of policy and research support for harm reduction, the ideas and approaches engendered by research started to filter quite strongly into Irish policy to respond to HIV and IDU. As a result of this process and while it was ongoing, policy makers began to search out more specific information on how best to evolve what they had in place and what additionally needed to be brought online.

Equally, the political and tactical models can help partially account for the nature of the treatment system's shape after its defining features had been set and the emergence of an influence paradox in relation to indigenous research. One of the core features of the response that was brought to bear on HIV and IDU was its being a relatively risky enterprise from a political point of view given the way harm reduction and aspects of it were perceived by some. In this sense, politicians can be seen as having gone quite far in pushing the boundaries of what they could expect to justify and allow to bed down slowly. In this sense, the research system was 'locked down' and elements for inclusion beyond the normalized (but still contentious) elements of harm reduction were off the agenda. As a result, research on the more controversial aspects of harm reduction was not being given the same chance to mould the evolution of the treatment spectrum that work covering MMT and NSPs were. At the same time, and specifically as a result of this 'closed door' approach to the shape of the treatment system, there was little scope for the indigenous work that started to be completed later to have a significant impact. Yet, this national research – reflecting aspects of the tactical model – also fitted in important ways

with the SMI-era ethos and the managerial approach to drug policy. It allowed the impression of an approach to policy and treatment typified by perpetual review to be created, deflecting attention away from the way in which actual movement and modification in terms of expanding the spectrum was not being taken.

The facilitation of research / policy interactions, or the generation and sustaining of such a nexus, is constantly dependent upon and intrinsically linked to a range of contextual factors. These both shape the way it exists and stands at a particular point, as well as the elements within research and policy coming to the fore within it, as well as the ones that may come to take precedence in the future. During the time under scrutiny here a range of these key factors were identified and discussed. Chief among these were the HIV and IDU crisis, the rise of harm reduction as an element of policy, and the SMI. Further, it was the contextual conjunction of these factors during this period that had a determining role on the nature of the interface between research and policy. If any of these elements had have been absent from the mix of contextual components and/or others been present, then developments could have moved in a different direction to that which they did.

This study shows us that Irish drug policy is comprised of a range of different traits simultaneously, revealing the way in which its development has been far from black and white. For example, it can be seen as innovative and dynamic in certain aspects, while at the same time it can be regarded as lacking in progression and restricted in other ways. During the period studied the nature of the policy and treatment system responses to drug use evolved and developed. A more multifaceted and sophisticated approach emerged, as seen in the types of structural solutions devised to deliver policy and expand treatment. The core elements of the treatment system were based on the ideas and approaches that had grown internationally to represent best practice the area of drug treatment.

Yet at the same time, the nature of the Irish drug policy arena placed limitations on the character of the response materializing. This is particularly evident in terms of the drug treatment spectrum. While existing approaches, such as MMT and NSPs were refined and expanded during the period studied, the nature of the improved and dynamic manner of the way in which they were employed as part of drug treatment highlighted the

existence of a clear boundary. Namely, the parameters within which movement and experimentation could take place were quite rigidly set by politically acceptable standards of what constituted treatment tool utilization. The array of options to be deployed in response to IDU and BBVs failed to move beyond the longstanding methods whose merits had become increasingly free from highly controversial and detrimental scrutiny. Further, this factor can be regarded as indicating the way in which policy will continue to progress in the short to medium term, that is, characterized by a lack of forays into areas of harm reduction beyond MMT and NSPs. Consequently, the Irish treatment system cannot be regarded as a sphere in which innovations that research limits and forge new boundaries in care take place. Rather, it is dependent upon developments internationally in order to initiate new responses and modify existing ones. It is a system that follows and learns, rather than leads and teaches, on issues of drug treatment. The next part of the chapter, which brings it to a close, looks at some considerations for further research.

Further Research

The present study has focused on the period from 1996 to 2008 in Irish drug policy. While this period represented the most prolific phase of policy action in the response to drug use in Ireland, the events occurring directly after it from 2008 onwards will have an important bearing on what transpired. Specifically, later developments will shed new and further light on the occurrences from this time and reveal the way in which the themes identified in this study continued to evolve in relation to changing global and national circumstances. The evolving nature of the context within policy, research, and treatment are made is something that cannot be fully accounted for with any snapshot of events. In this sense, a further study completed at a later date could deepen our understanding not only of this phase of Irish drug policy, but of how it relates to the unfolding developments that take place and collectively form the next period of policy making.

Consequently, another study looking at an equally long period of policy making could be carried out. This could use end of *Building on Experience* and the lifespan of the next national drugs strategy or some defining events after its completion as its main parameters. In such a study a different approach to the one adopted here could be utilised.

The models of the research / policy interface drawn upon here cannot fully account for the nature of developments that were looked at. This is largely a consequence of the complexity of the situations and events analysed. In this respect, the models utilised functioned well as a set, allowing a range of different aspects of the occurrences studied to be examined. This granted, more or different models and concepts could employed to explore the topics at hand in a future study. Alongside adopting a wider set of models, a future study looking at and asking different sorts of questions could also seek to make a wider use of qualitative interviews. Such an approach would help to generate grounded theory about policy making.

[1] Butler, S. (1991). 'Drug problems and drug policies in Ireland: A quarter of a century reviewed, *Administration*, Vol.39, No.3, pp.210-33; Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration; Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324; Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', in O'Mahony, P. (ed.). *Criminal Justice in Ireland.* Dublin: Institute of Public Administration; Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422; Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, pp.125-144.

[2] Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland.* Dublin: Institute of Public Administration; Duke, K. (2003). *Drugs, Prisons and Policy-Making.* Basingstoke: Palgrave Macmillan.

[3] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.53; Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press, p.227.

[4] Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press, p.227.

[5] Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods.* London: Butterworth & Co. Ltd., pp.307-8; Ball, S.J. (1994). Political interviews and the politics of interviewing', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press, p.97.

[6] Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, p.42; Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods.* London: Butterworth & Co. Ltd., pp.307-308.

[7] Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24.

[8] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[9] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[10] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[11] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[12] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[13] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[14] Semi-structured interview Jimmy Duggan, Principal Officer, DoHC, 23.10.2009.

[15] Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526; Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[16] Transnational Institute (2005). 'Drugs and Democracy'. Retrieved January 23 2006: http://www.tni.org/detail_page.phtml?&publish=Y&int02=&pub_niv=&workgroup=&text06=&text03=&keywords=&lang=&text00=&text10=drugsreform-docs_unharmred&menu=11d

[17] UN (1971). *Convention on Psychotropic Substances, 1972*. Geneva: UN. Retrieved January 23 2006 from: http://www.incb.org/pdf/e/conv/convention_1971_en.pdf; UN (1972). *Single Convention on Narcotic Drugs, 1961, As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961*. Geneva: UN. Retrieved January 23 2006 from: http://www.incb.org/pdf/e/conv/convention_1961_en.pdf; Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group.; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5).

[18] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[19] Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, p.330.

[20] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group, p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm*

Reduction Approaches – Prepared by the Legal Affairs Section UNDCP. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4.

[21] Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group; p.3; p.4; p.8; UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5), p.4.

[22] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[23] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[24] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[25] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[26] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[27] Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart, pp.22-24; pp.38-41.

[28] Finglas/Cabra LDTF (2006). *Vital connections Local Drugs Task Forces – Leading the response – Conference report*. Dublin: Finglas/Cabra LDTF, p.10.

[29] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, p.141.

[30] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, p.141.

[31] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, p.141.

[32] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, p.141.

[33] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, p.141.

[34] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, p.231.

[35] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.109-117.

[36] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-15.

[37] Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin, pp.14-18.

[38] The Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin.* Dublin: Department of Justice, pp.22-24; p.69.

[39] Butler, S. (2007). Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on, *Administration*, Vol.55, No.3, pp.141.

[40] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[41] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.36.

[42] Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead.* Strasbourg: Council of Europe Publishing, p.57.

[43] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[44] Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., p.114.

[45] Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.302.

[46] Matic, S., Lazarus, J.V., & Donoghoe, M.C. (eds.). (2006). *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management*. Copenhagen: World Health Organization European Regional Office; Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge, p.302.

[47] Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature*. Dublin: NACD.

[48] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[49] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, pp.37-38; Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, p.24; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[50] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.38; Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, p.279.

[51] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[52] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[53] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

[54] Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin, p.37.

Appendix one: Finalised annotation key, thematically grouped and numeric-bibliographically tagged

- The following annotation key relates to the ninth chapter of thesis, The Social Organisation of Drug Treatment.
- Some identifier codes do not have number-bibliographic tagging as these issues may have discarded or merged with other themes

Part 1: Drug Policy and MMT:

BMP: Background MMT protocol
(05 EG p.1; 2; 3; 4) (98 EG p.7; 8; 9; 10; 13; 14) (EHB AR 96 p.3) (EHB 97 AR p.6) (FAR 00 p.5)

OMP: Origins MMT protocol
(98 EG p.8; 10; 14) (93 EG p.15; 16; 17; 18; 19)

DPDMP: Drug policy driving methadone policy
(05 EG p.5) (98 EG p.8) (93 EG p.15) (C&AG p.5; p.8) ('91 p.2; 3; 4) ('96 NDS p.8) (EHB 97 AR p.4)

SM: Support for methadone
(93 EG p.16; 19) (C&AG p.5; 8) ('91 p.2) ('96 NDS p.6; 7; 8; 9; 10) ('01 NDS p.15; 19; 20)

SET: Support for expansion of treatment
(C&AG p.5; 8) ('96 NDS p.7; 8; 9; 10) ('97 NDS p.11; 12) ('01 NDS p.15; 16; 19; 20; 21; 22) (NDS MTR p.22; 23)

HIVDMP: HIV driving methadone policy
('91 p.2; 3)

HIVDDP: HIV driving drug policy

BBVDDP: BBV driving drug policy
(96 NDS p.6)

PHE CBT: Protocol helped expand community based treatment
(05 EG p.2; 4; 6) (98 EG p.10; 11; 14) (C&AG p.6)

SCBDT: Support for community based treatment
(98 EG p.7; 8; 10) (93 EG p.16; 17) ('91 p.3; 4) ('96 NDS p.8; 10) ('97 NDS p.11; 12) ('01 NDS p.15; 16; 19; 20; 22)

SRGP: Support for role of GPs
('91 p.2; 3; 4; 5) ('96 NDS p.10) ('97 NDS p.12) ('01 NDS p.19; 20; 22) (NDS MTR p.22; 24) (NDS PR p.25; 26)

RIPRD: Role of international research policy & diffusion
('91 p.1) ('96 NDS p.8; p.10) ('97 NDS p.12)

SDMM: Support for diversity of methadone modalities
(C&AG p.6) ('96 NDS p.8; p.10) ('97 NDS p.12)

ISM: Indirect support for methadone
('91 p.1; 2)

CWWL: Concern with waiting lists
('96 NDS p.6; 7; 8; 9; 10) ('97 NDS p.11) ('01 NDS p.15; 16; 19; 21; 22) (NDS MTR p.23; 24) (NDS PR p.25; 26)

FDTIP: Focus on drug treatment in prison
('97 NDS p.13) ('01 NDS p.16; 20; 21) (FAR 00 p.4) (PA 08 p.10; 20)

FDUIP: Focus on drug use in prison
('01 NDS p.14) (NDS MTR p.24) (BUN '96 p.7)

FDBCPT: Focus on divergence between community & prison treatment
('97 NDS p.11; 12; 13) ('01 NDS p.16; 20)

FCCMIPIP: Focus on continuity of care & MMT initiation problems in prisons
(NDS MTR p.2; 3) (PA 08

CFEDTIP: Call for expansion of drug treatment in prison
('01 NDS p.20; p.21) (NDS MTR p.23; 24) (PA 08 p.10)

SFPPDP: Support for progress in prison drug policy
(NDS MTR p.23) (NDS PR p.25; 26) (PA 08 p.10)

URIPP: Use of research in prison policy
('01 NDS p.14)

PMTO: Pre-existence of MMT as a treatment option
(EHB 99 AR p.9)

ITNDS: Importance of treatment in NDS
(PA 08 p.16)

Part 2: The Delivery of MMT:

OREHB: Origins of the role of the EHB
('91 NDS p.3) ('96 NDS p.8; 10) ('97 NDS p.11) (EHB 99 AR p.9)

C2DMD: Call to diversify MMT delivery
(BUN '96 p.2)

EHBADMS: EHB actively developing MMT services
(98 EG p.9) (EHB 96 AR p.1; 2; 3; 4) (EHB '97 AR p.5; 6; 7) (EHB 99 AR p.9) (BUN 96 p.1; 3; 5; 6; 8)

EHBEMC: EHB expanding MMT clinics
(EHB 96 AR p.1) (EHB 97 AR p.7) (EHB AR p.9; 10) (FAR 00 p.1; 2; 3)

EHBEMTGP: EHB expanding MMT through GPs
(EHB 96 AR p.1) (EHB 97 AR p.5) (EHB 99 AR p.8) (BUN 96 p.2; p.5) (FAR 00 p.4)

EHBEMTCP: EHB expanding MMT through CP
(EHB 97 AR p.6) (EHB 99 AR p.8) (BUN 96 p.6) (FAR 00 p.9; 10)

EHBUDMDMS: EHB using different methods to develop MMT services
(EHB 96 AR p.1; 4) (EHB 97 AR p.5; 7) (EHB 99 AR p.9) (EHB POL 98 p.10) (FAR 00 p.3)

PWMPP: Problems with methadone prior to protocol
(05 EG p.2; 6) (93 EG p.17) (FAR 00 p.5)

IMPTS: Impact of methadone protocol on treatment services
(FAR 00 p.3)

SMWTS: Significance of MMT within the treatment system
(PA 08 p.18)

MR: Methadone regulations

ODMP: Operational details of methadone protocol
(05 EG p.2; 3; 4; 5) (98 EG p.10; 11; 12; 13) (C&AG p.4; 6)

SCIODT: Slow change in organisation of drug treatment
(FAR 00 p.5; 6)

Part 3: The Limits of Expansion:

ESPGPI: Early signs of problems with GP involvement in MMT

PWRGP&P: problems with rural GPs & pharmacists

PGL2GPS: Problems getting level 2 GPs
(PA 08 p.19)

PRRCP: Problems recruiting rural pharmacists
(05 EG p.5; 6) (C&AG p.6) (NDS MTR p.22) (PA 04 p.22)

PWWL: Problems with waiting lists
(C&AG p.8) (FAR 00 p.7) (PA 04 p.21) (PA 08 p.19; 20)

LCCMT: Lack of continuity of care in MMT
(05 EG p.5; 6) (98 EG p.7)

PWTTO: Problems with tracking treatment outcomes
(C&AG p.4)

CRMP: Call for review of methadone protocol
(PA 08 p.10; 19; 21)

Part 4 Methadone and the Prison System:

PDPB: Prison drug policy background
(SGPBDT p.1; 3) (01 S&O p.1; 2; 4; 5) (04 HCS p.1; 5; 6) (07 HCS p.1) (00 AR p.1; 2) (02 AR p.3; 4) (03 AR p.5) (04 AR p.7) (05 AR p.9) (07 AR p.15) (IPS DP 03 p.5)

ADIP: Acknowledgment of drug use in prisons
(SGPBDT p.2) (01 S&O p.2; 4) (IPS DP 03 p.5)

SDTP: Support for drug treatment in prisons
(SGPBDT p.3; 4; 5; 6; 7) (07 HCS p.1) (00 AR p.1) (01 AR p.2) (02 AR p.3) (03 AR p.5) (07 AR p.13; 14; 15)

CLDIPDS: clear development in prison drug services

DMP: Development of MMT policy

SMMT: Support for MMT
(SGPBDT p.1; 2; 6; 7) (04 HCS p.5; 7; 9) (01 AR p.2) (02 AR p.3) (03 AR p.5) (04 AR p.7) (05 AR p.9) (06 AR p.11; 12) (07 AR p.13; 14; 15)

MPIP: Methadone provision in prisons
(C&AG p.2; 8; 9; 10; 11) (PA 08 p.20) (04 HCS p.7) (07 HCS p.2) (00 AR p.1; 2) (01 AR p.2) (05 AR p.9) (DTCP p.1; 7; 27)

MIP: Methadone initiation policy
(C7AG p.10; 11) (SGPBDT p.5) (01 S&O p.5) (04 HCS p.5) (07 HCS p.1; 2) (00 AR p.1; 2) (01 AR p.2) (03 AR p.5)

SFCMOC: Support for continuity of methadone on committals
(SGPBDT p.5; p.7) (04 HCS p.5) (07 HCS p.1; 2) (00 AR p.1)

SFE: Support for equivalence of care
(SGPBDT p.1; 5) (01 S&O p.1; 2) (04 HCS p.1; 5) (07 HCS p.1) (01 AR p.2) (DTCP p.1)

SFT: Support for through care
(C&AG p.9) (SGPBDT p.1; 2; 5; 7) (01 S&O p.1) (04 HCS p.1; 2) (02 AR p.4) (04 AR p.7) (05 AR p.10) (07 AR p.15) (IDSDP 06 p.1; 2; 3) (IPS DP 03 p.5; 7; 8; 9; 10) (DTCP p.28)

SPW: Support for partnership working
(C&AG p.9) (SGPBDT p.1; 2; 7) (01 S&O p.1; 2; 3) (07 AR p.13) (IPS DP 06 p.3) (IPS DP 03 p.5; 11) (DTCP p.1)

PWCMPR: Problems with continuing methadone post-release
(C&AG p.10; 11) (01 S&O p.5) (04 HCS p.5) (07 AR p.14)

PWPPS: Problems with prison pharmacy services
(SGPBDT p.3) (01 S&O p.3; 4)

DNLDT: development of nursing-led drug treatment
(SGPBDT p.2) (02 AR p.3) (04 AR p.7) (07 AR p.13; 15)

DOG: Development of overdose guidelines
(07 HCS p.3) (IPS DP 03 p.9) (DTCP p.8; 18)

DODG: Development of detox guidelines
(DTCP p.11; 12; 13; 14)

DOAG: Development of alcohol guidelines
(DTCP p.19; 20; 22; 23; 24)

DOCG: Development of cocaine guidelines
(DTCP p.24)

DOBBVG: Development of BBV guidelines
(04 HCS p.2; 3; 4)

DPCS: development of prison counseling service
(C&AG p.8; 9; 10)

SBBVP: Support for BBV prevention
(SGPBDT p.5) (01 S&O p.1; 5) (04 HCS p.3) 9IPS DP 03 p.9; 11)

SPDTS: Sophisticated progression in drug treatment standards
(07 HCS p.6; 7) (03 AR p.5) (04 AR p.7) (05 AR p.10) (DTCP p.1; 2; 3; 5; 7; 27; 28)

ATSDTPS: Actively trying to standardize drug treatment in the prison system
(04 HCS p.1) (07 HCS p.1; 2) (IPS DP 06 p.2; 4) (IPS DP 03 p.7) (DTCP p.1; 2; 3; 5; 7; 8; 10; 12; 13; 14; 18; 19; 20; 21; 22; 23; 24; 28)

IR&D: International research and diffusion
(01 S&O p.2; 3; 5) (04 HCS p.5; 9) (07 HCS p.1; 5) (IPS DP 03 p.5; 11) (DTCP p.1; 11; 12; 13; 14; 19; 20; 21; 22; 23;24)

AGNOM: Acknowledgment of greater numbers on methadone
(IPS DP 06 p.1)

Appendix Two: Respondents Consent Form

I, the undersigned, have had the nature of Eoghan Quigley's PhD research explained to me and I am happy to be interviewed and have this interview taped for transcription.

I agree that Eoghan Quigley can quote from the transcript of this interview (in his thesis and in any other publication which results from this) and that he can attribute quotations to me by name. ☐

I agree that Eoghan Quigley can quote from the transcript of this interview (in his thesis and in any other publication which follows this) and that he can attribute quotations to me by name, only if he checks each individual quotation with me in advance of such attribution. ☐

I agree that Eoghan Quigley can quote from the transcript of this interview (in his thesis and in any other publication which results from this), only if he disguises my identity in an agreed way. ☐

Appendix Three: Interview Schedules

Interview Schedule for Des Corrigan

(1) Could you talk about the way in which you think the NACD's research has an influence on policy making?

(Probe: IACD '00/NACD PR '03 & AR '06 & '07 etc. NACD as influencing policy)

FUQ How do you think the NACD's ability to influence policy has changed over time (or has it)?

FUQ Could you talk about the Committee's role as information provider to policy makers and the importance of this function?

Probe: Direct requests (Bup., cocaine, NDS A98 VG, DTMS)

FUQ: What structures and processes are in place to feed NACD research into the policy making process?

(2) How would you see the NACD's non-epidemiological research, such as work on harm reduction and NSPs having an impact on policy making?

Probe: stacking – slow permeation Vs rapid impact

(3) Over time the reports have become more directive in terms of recommendations such as the 2003 & 2007 cocaine studies and the 2004 & 2008 HR/NSP studies – could you talk about that?

Probe: more likely to influence policy if there is a clear, short, direct message? If reports have recommendations are they more likely to be paid attention to?

(4) Could you talk about the NACD's dual diagnosis study and the mental health strategy A vision for Change published in January 2006 – why the report did not get used in your view considering that it came out at an ideal time – November 2004 – while the EGMH was still undertaking its work?

(5) What would you see as some of the main problems that the NACD has encountered in completing its research projects?

(Probe: lack of good private sector firms – lack of internal NACD research capacity – structure of NACD as a problem)

Appendix Three: Interview Schedules

Interview Schedule for Des Corrigan (Continued)

(6) What are some of the factors that limit the impact of NACD research on policy making?

(7) The NACD has done a lot of work on HR generally, would you say a little about the topics it has chosen to research?

(8) The order in which the projects under NDS action 98 were carried out was interesting, could you talk about the decision to leave the NSP and prostitution studies until last?

(9) Could you talk about the findings of the 2004 TA review of NACD?

Is there anything else that you think I should have asked you?

Would it be ok for me to contact you by email in the near future if I need to clarify anything?

Appendix Three: Interview Schedules

Interview Schedule for Fergus McCabe

(1) The new structures that emerged out of the MTFMRDD helped to overcome the sense of dissatisfaction local communities had with the response to drug problems and the sense of mistrust between the community and voluntary sectors and the statutory sector towards forming effective collaborative relationships. Could you say a little about the effect of the new structures in this sense?

(2) Could you talk about your decision to resign from the NDST in December 2005, particularly it being motivated by a need to highlight the declining political support for the NDS?

(3) You had spoken in the media about the problems with the HSE taking a long time to appoint their representative to the NDST and the inadequate nature of funding being made available to the LDTFs as instanced by the 1m Euro that was initially made available under the ENF to be split between the 14 LDTFS could you say a little about those issues as being factors behind your decision to resign from the NDST?

(4) Prior to your resignation there had been growing dissatisfaction among many in the community and voluntary sectors with the NDS and the processes involved in running it. Would you see the Vital Connections conference that was held on the 3rd of October in 2005, and in particular the Taoiseach and Minister of State's appearances at it, as an attempt to try an turn the tide of negative sentiment then forming about the lack of political commitment to the NDS – if you like to create a favourable impression?

(5) At the Vital Connections conference Tony Geoghegan from MQI was one of the speakers and he made a comment that the that the very success of the LDTFs and the partnership process that their operation entailed had ironically functioned to inhibit and erode the critical faculties of the community and voluntary sectors and their ability to push for change. Could you talk about that impact on the LDTFs?

(6) Could you talk about the extent to which the NDST addressed the need for LDTFs to develop NSPs in their area – either new ones or buttressing existing ones – during your 8 years on the Team?

(7) Tony also asserted that the "while decisions are or appear to be made at the local level, the real decisions are ultimately made at the NDS level or beyond". He was implying that decision making on drugs policy was not at the local level of the LDTFs and the NDST and implying that the NDST's policy function – to convey policy relevant information up the structural hierarchy – was more of an ideological one for the sake of making the LDTF C&V representatives and the NDST appear credible rather than actually sharing decision making power with them via the NDST. What would your take on that be?

Appendix Three: Interview Schedules

Interview Schedule for Fergus McCabe (Continued)

(8) For most of its existence the NDST has been under a lot of pressure as a result of the extent to which it has been heavily involved in the operational aspects of the LDTFs and subsequently the RDTFs. This has restricted the Team's ability to develop its policy role, and this is a situation that policy makers have long been aware of. Could you talk about some of the reasons they might have let this situation persist? (SMI out of sync with civil service; new structures too radical & difficult to manage properly; not comfortable with others being involved in developing policy).

Probe: Do you think that the general 'newness' of the structures (CCSI – IDG – NDST – LDTFs – RDTFs) resulted in politicians being unsure of how to best utilize them and that this simply result in poor working habits that lasted?

Probe: Would it be the case that policy makers simply wanted to convey that a new era of cooperation was taking place but in reality did not really want the C&V sectors to have too much in put via the NDST and accordingly left the NDST overburdened with operational work so it could not become too involved in policy work?

Probe: Would it be a mixture of both of these situations – policy makers not being used to the new structures and new ways of making policy in a cooperative manner, as well as not wanting to give too much power or influence to the C&V sectors via the NDST?

(9) Could you talk about the policy making ability of the IDG, particularly since it took on community & voluntary sector representatives & the Chair of the NACD in relation to the SOGSI?

(Probe: i.e. They have essentially pulled IDG's policy function and transferred it to SOGSI)

(10) Are the officials at Assistant Sectary level on SOGSI the same individuals that are supposed to be attending the IDG?

(11) Do you think their non-attendance has anything to do with overlap and repetition between the areas of the two Groups?

(12) Do you think that the CCSI has intentionally sought to limit the policy input of the NDST and the LDTFs?

(13) When the LDTFs where being set up initially and during their first few years of operations it seemed more important to government to simply get them operationally and keep them going above and beyond what they were actually doing in their work and plans. What would your take on that be?

Appendix Three: Interview Schedules

Interview Schedule for Fergus McCabe

Is there anything else that you think I should have asked you?

Would it be ok for me to contact you by email in the near future if I need to clarify anything?

Appendix Three: Interview Schedules

Interview Schedule for Jimmy Duggan

The conjunction of IDU and HIV and the sense of crisis that this represented is often seen as the key factor in making MMT a useful tool that policy makers decided to incorporate into the response to the drug problem in Ireland – could you say a little about that?

The drug policies launched in 1996 and 2001 in the SMI era both backed the expansion of MMT and were successful in seeing this through. Could you say a bit about whether you think this style of policy – more managerial – was able to present politically difficult issues such as MMT and its expansion as being acceptable courses of action?

Would you see research internationally as opposed to indigenous Irish research as being important in the development of MMT in Ireland from the mid 1990s onwards?

(Probe: At this time there was no Government back research – no ADRU; no NACD)

How would you describe the process of trying to find out what was the best approach to take with the treatment system back then? Was it one of searching for the best option through international research and the treatment systems and policies of other EU countries?

Would you see the role played by MMT in the treatment systems of different countries internationally as an important factor in the development of support for MMT here among policy makers?

Could you talk a bit about the way in which you think Irish MMT policy has been influenced by drug treatment policy internationally?

Could you talk about the way in which the 1998 protocol altered the social organization of drug treatment?

Would you say a bit about the way in which MMT developed in the IPS?

(Probe: Now biggest MMT provider)

Could you say a bit about 1999 being a key year when change started to occur when the Steering Group on Prison Based Drug Treatment (SGPBDT) and the Group charged with Reviewing the Structure and Organisation of Prison Health Care Services (GRSOPHCS) November?

Would you see international research as having also played a role in the decision to expand MMT in prisons given that there was little indigenous research around at this time?

Appendix Three: Interview Schedules

Interview Schedule for Jimmy Duggan (Continued)

In discussing the nature of the type of change and working style they wanted to see in action, the Services Group made reference to work undertaken in the UK by the H.M. Prison Service in England and Wales and the National Health Service;

In strongly supporting the introduction of disinfectant tablets into prisons for IDUs they again made reference to the work of the H.M. Prisons Service in England and Wales and their report on their report on the utilisation of this harm reduction strategy

In addition, while discounting the introduction of NSPs at the time for Irish prisons, the Steering Group noted how a European conference at the time had shown that their use was developing in European prisons

Bibliography

Andersen, A. (January 15th, 2008). 'Controlling the drink-link factor', Retrieved 15.01.2008 from:
http://www.ireland.com/newspaper/health/2008/0115/1200260464414.html

Ahern, B. (2006). *Statement by the Taoiseach, Mr. Bertie Ahern, T.D. at the High Level Meeting on HIV/AIDS, United Nations, New York, 2 June 2006.* Retrieved 27.07.2006 from:
http://www.un.org/webcast/ga/aids/2006/statements/aids.06.06.02.ireland.eng.pdf

Ahern, B. (March 9th, 2008). 'Government can lead way on drink by responsibility lies with individual', Retrieved 09.03.2008 from:
http://www.independent.ie/national-news/government-can-lead-way-on-drink-but-responsibility-lies-with-individual-1311616.html

Alcohol and Drug Research Unit (2007a). *Drugnet Ireland*, Issue 21. Dublin: Health Research Board.

Alcohol and Drug Research Unit (2007b). *Drugnet Ireland*, Issue 23. Dublin: Health Research Board.

Atkinson, P. and A. Coffey (1997), 'Analysing documentary realities', in D. Silverman (ed.), *Qualitative Research: Theory, Method, And Practice*, London: Sage.

Bakalar, J.B. & Grinspoon, L. (1981). *Psychedelic Drugs Reconsidered.* New York: Basic Books.

Baker, N. (February 6th, 2008). 'Teenage 'test buyers' to target off-licenses', Retrieved 06.02.2008 from:
http://www.irishexaminer.com/archives/2008/0206/ireland/teenage-test-buyers-to-target-off-licences-54575.html

Ball, S.J. (1994). Political interviews and the politics of interviewing', in Walford, G. (ed.). *Researching the Powerful in Education.* London: UCL Press.

Ballyfermot LDTF (1997). *Ballyfermot Drugs Task Force Progress Report 1997 to 1999.* Dublin: Ballyfermot LDTF.

Ballyfermot LDTF (2000). *Ballyfermot Drugs Task Force Strategic plan 2000-2001.* Dublin: Ballyfermot LDTF.

Ballymun LDTF (1997) *Ballymun LDTF Interim Service Development Plan.* Dublin: Ballymun LDTF.

Ballymun LDTF (2000). *Ballymun LDTF Revised Action Plan 2000*. Dublin: Ballymun LDTF.

Banting, K. (1986). 'The social policy process', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin.

Berridge, V. (2001). 'Altered states: opium and tobacco compared', *Social Research*, Vol.68, No.3, pp.655-675.

Berridge, V. & Thom, B. (1996). 'Research and policy: what determines the relationship?', *Policy Studies*, Vol.17, No.1, pp.23-34.

Berridge, V. (1992). 'AIDS, drugs and history', *British Journal of Addiction*, Vol.87, No.3, PP.363-70.

Berridge, V. (1991). AIDS and British drug policy: history repeats itself?, in Whynes, D.K. & Bean, P.T. (eds.). *Policing and Prescribing: The British System of Drug Control*. London: Macmillan.

Blanchardstown LDTF (2001). *Blanchardstown Drugs Task Force Action Plan 2001-2005*. Dublin: Blanchardstown.

Blanchardstown LDTF (2004). *Towards A Comprehensive Drug Treatment Service in Blanchardstown*. Dublin: Blanchardstown LDTF.

Boseley, S. (January 11th, 2006). 'Psychiatrist calls for end to 30-year taboo over use of LSD as a medical treatment',
retrieved 11/01/06 from : http://www.guardian.co.uk/drugs/Story/0,2763,1683780,00.html

Bourdieu, P. (1990). *In Other Words: Essays Towards a Reflexive Sociology*. London: Polity Press.

Boyle, R. (1999). *CPMR Discussion paper 8: The Management of Cross-Cutting Issues*. Dublin: Institute of Public Administration.

Bracken, A. (December 23rd, 2007). 'Cocaine is in the headlines but alcohol is our No.1 killer', Retrieved 23.12.2007 from:
http://www.tribune.ie/article.tvt?_scope=Tribune/News/Home%20News&id=81549&SUBCAT=Tribune/News&SUBCATNAME=News

Bray LDTF (2001). *Bray LDTF First Report*. Dublin: Bray LDTF.

Brennan, M. & O'Regan, E. (November 20th, 2007). 'Consumer chief rejects HSE call for 10pc hike in drink duty', Retrieved 20.11.2007 from:
http://www.independent.ie/national-news/consumer-chief-rejects-hse-call-for-10pc-hike-in-drink-duty-1223565.html

British-Irish Council (2003). *British Irish Council Report 1999-2003*. Dublin: Department of Foreign Affairs / London: Department of Constitutional Affairs.

Bruun, K., Pan, L., & Rexed, I. (1975). *The Gentlemen's Club: International Control of Drugs and Alcohol*. Chicago: University of Chicago Press.

Bulmer, M. (1986). 'The policy process and the place in it of social research', in Bulmer, M. (ed.). *Social Science and Social Policy*. London: Allen & Unwin.

Butler, S. (1991). 'Drug problems and drug policies in Ireland: A quarter of a century reviewed', *Administration*, Vol.39, No.3, pp.210-33.

Butler, S. (2002). *Alcohol, Drugs and Health Promotion in Modern Ireland*. Dublin: Institute of Public Administration.

Butler, S. (2002b). 'The making if the methadone protocol: the Irish system?', *Drugs, Education, Prevention and Policy*, Vol.9, No.4, pp.311-324.

Butler, S. (2002c). 'A tale of two sectors: A critical analysis of the proposal to establish drug courts in the Republic of Ireland', O'Mahony, P. (ed.). *Criminal Justice in Ireland*. Dublin: Institute of Public Administration.

Butler, S. & Mayock, P. (2005). 'An Irish solution to an Irish problem': Harm reduction and ambiguity in the drug policy of the Republic of Ireland', *International Journal of Drug Policy*, Vol.16, No.6, pp.415-422.

Butler, S. (2007). 'Rabbitte revisited: The first report of the ministerial task for on the measure to reduce the demand for drugs – ten years on', *Administration*, Vol.55, No.3, pp.125-144.

Canal Communities LDTF (2000). *Canal Communities LDTF Service Development Plan*. Dublin: Canal Communities LDTF.

Clondalkin LDTF (1997). *Clondalkin LDTF Local Development Plan May 1997 to 1999*. Dublin: Clondalkin LDTF

Clondalkin LDTF (2000). *Clondalkin Drug Task Force Action Plan 2000-2001*. Dublin: Clondalkin LDTF.

Commission of the European Communities (23.06.1994). *COM (94) 234 Final: Communication from the Commission to the Council and the European Parliament on a European Union Action plan to Combat Drugs (1995-1999)*. Brussels: Commission of the European Communities.

Commission of the European Communities (23.5.2001). *COM (2001) 259 Final: Proposal for a Council Framework Decision on laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking.* Brussels: Commission of the European Communities.

Commission of the European Communities (08.06.2001). *COM (2001) 301 Final: Communication form the Commission to the Council and the European Parliament on the Implementation of the EU Action Plan on Drugs (2000 – 2004).* Brussels: Commission of the European Communities.

Commission of the European Communities (30.10.2001). 'Proposal for a Council Framework Decision on laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking', *Official Journal of the European Communities*, C 304, pp.172-175.

Commission of the European Communities (04.11.2002). COM (2002) 599 Final: *Communication form the Commission to the Council and thhe European Parliament on the Mid-term Evaluation of the EU Action Plan on Drugs (2000 – 2004).* Brussels: Commission of the European Communities.

Commission of the European Communities (12.11.2003). *COM (2003) 681 Final: Communication from the Commission to the European Parliament and the Council on Coordination on Drugs in the European Union.* Brussels: Commission of the European Communities.

Commission of the European Communities (11.11.2004). 'Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking', *Official Journal of the European Communities*, L 335, pp.8-11.

Cork LDTF (1997). *Cork LDTF Strategic Plan.* Cork: Cork LDTF.

Costa, A. (11 November, 2004). *Letter to Robert B. Charles, assistant secretary with the International Narcotics and Law Enforcement Affairs (INLEA) division at the US Department of State.* Retrieved January 23 2006 from:
http://www.tdpf.org.uk/LETCOSTA2004.pdf

Coulter, C. (January 8th, 2008). 'Think tank to tackle alcohol problem', Retrieved 08.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0108/1199313619907.html

Council of the European Union (12.02.1993). 'Council Regulation (EEC) No 302/93 of 8 February 1993 on the establishment of a European Monitoring Centre for Drugs and Drug Addiction', *Official Journal of the European Union*, Series (L) 036 Luxembourg: COE.

Council of the European Union (01.12.1999). *12555/3/99 REV 3 LIMITE CORDROGUE 64: European Union Drugs Strategy (2000 – 2004)*. Brussels: Council of the European Union.

Council of the European Union (2003). 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, Series (L) 165, Luxembourg: COE, pp.31-33.

Council of the European Union (19.12.2004). *14702/04 REV 1 CORDROGUE 76 ENFOPOL 167 SAN 178 RELEX 524 EU Drugs Strategy (2005 – 2012)*. Brussels: Council of the European Union.

Council of the European Union (8.7.2005). 'EU Drugs Action Plan (2005 – 2008)', *Official Journal of the European Communities*, (C) 168, Luxembourg: COE, pp.1-18.

Cox, G. & Robinson, J. (2008). *Needle Exchange Provision in Ireland: The Context, Current Levels of Service Provision and Recommendations. A Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs.* Dublin: NACD.

Cuff, E.C., Sharrock, W.W., & Francis, D.W. (1998). *Perspectives in Sociology*. Fourth Edition. London: Routledge.

Cullen, P. (February 6th, 2008). 'Alcohol 'credits' card for young people proposed', Retrieved 06.02.2008 from:
Source: http://www.ireland.com/newspaper/ireland/2008/0206/1201903564464.html

Cullen, P. (February 12th, 2008). 'The taxing issue of alcohol', Retrieved 12.02.2008 from:
http://www.ireland.com/newspaper/health/2008/0212/1202509695196.html

Denzin, N.K. (1970). *The Research Act in Sociology: A Theoretical Introduction to Sociological Methods*. London: Butterworth & Co. Ltd.

Department of Community, Rural and Gaeltacht Affairs (2004a). *National Drugs Strategy 2001 – 2008: Critical Implementation Path*. Dublin: Stationery Office.

Department of Community, Rural and Gaeltacht Affairs (2004b). *National Drugs Strategy 2001 – 2008: Progress Report*. Dublin: Stationery Office.

Department of Community, Rural and Gaeltacht Affairs (2004c). *Mid-Term Review of the National Drugs Strategy 2001 – 2008: Report of the Steering Group*. Dublin: Stationery Office.

Department of Community, Rural and Gaeltacht Affairs (2006). *Critical Implementation Path for New and Amended Actions in the National Drugs Strategy*. Dublin: Author.

Department of Community, Rural and Gaeltacht Affairs (2007). *Report of the Working Group on Drugs Rehabilitation*. Dublin: Stationery Office.

Department of Health and Children (2000). *The National Health Promotion Strategy 2000-2005*. Dublin: Stationery Office.

Department of Health and Children (2001). *Quality and Fairness: A Health System for You – Health Strategy*. Dublin: Stationery Office.

Department of Health and Children (2002). *Your Views about Health - Consultation report for the Health Strategy*. Dublin: Stationery Office.

Department of Health and Children (2004). *Review of the National Health Promotion Strategy 2004*. Dublin: Stationery Office.

Department of Health and Children (2005a). *Review of the Methadone treatment Protocol*. Dublin: Stationery Office.

Department of Health and Children (2005b). *Report of the Working Group on Treatment of Under 18 Year Olds Presenting to Treatment Services with Serious Drug Problems*. Dublin: Stationery Office.

Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.

Department of Social, Community and Family Affairs (2001). *National Action Plan Against Poverty and Social Exclusion 2001-2003*. Dublin: Stationery Office.

Department of Health, Social Services and Public Safety (2006). *New Strategic Direction for Alcohol and Drugs 2006-2011*. Belfast: Author.

Department of the Taoiseach (1996). *Partnership 2000*. Dublin: Stationery Office.

Department of the Taoiseach (1996b). *Delivering Better Government: Second Report of the Co-ordinating Group of Secretaries – A Programme of Change for the Irish Civil Service*. Dublin: Department of the Taoiseach.

Department of the Taoiseach (1998). *Action Programme for the Millennium*. Dublin: Author.

Department of the Taoiseach (1999). *Action Programme for the Millennium – As Reviewed by Fianna Fail and the Progressive Democrats in Government*. Dublin: Author.

Department of the Taoiseach (2000a). *Action Programme for the Millennium – Progress Report at the End of Year Three*. Dublin: Author.

Department of the Taoiseach (2000b). *Programme for Prosperity and Fairness*. Dublin: Stationery Office.

Department of the Taoiseach (2002a). *An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author.

Department of the Taoiseach (2002b). *Programme for Prosperity and Fairness – Progress Report 8*. Dublin: Stationery Office.

Department of the Taoiseach (2003a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author.

Department of the Taoiseach (2003b). *Sustaining Progress – Social Partnership Agreement 2003-2005*. Dublin: Stationery Office.

Department of the Taoiseach (2004a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author.

Department of the Taoiseach (2004b). *Sustaining Progress 2003-2005 – Progress Report on Special Initiatives*. Dublin: Stationery Office.

Department of the Taoiseach (2005a). *Progress Report on the Implementation of An Agreed Programme for Government between Fianna Fail and the Progressive Democrats*. Dublin: Author.

Department of the Taoiseach (2005b). *Sustaining Progress 2003-2005 – Final Report on Special Initiatives*. Dublin: Stationery Office

Department of the Taoiseach (2006). *Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015*. Dublin: Stationery Office.

Department of Tourism Sport and Recreation (2001). *Building on Experience: National Drugs Strategy 2001 – 2008*. Dublin: Stationery Office.

De Ruyver, B., Vermeulen, G., Vander Beken, T., Vander Laenen, F., & Geenens, K. (2002). *Multidisciplinary Drug Policies and the UN Drug Treaties*. Antwerpen: Maklu.

Dillon, L. (2001a). *Drug Use Among Prisoners: An Exploratory Study*. Dublin: Health Research Board

Dillon, L. & O'Brien, M. (2001b). 'Drug-Related Infectious Diseases', *A Collection of Papers on Drug Issues in Ireland*. Moran, R., Dillon, L., O'Brien, M., Mayock, P., & Farrell, E. with Pike, B., Dublin: Health Research Board.

Donnellan, E. (December 6th, 2007). 'Cigarettes to cost 30 cent more for packet of 20', retrieved 06.12.2007 from:
Source: http://www.ireland.com/newspaper/ireland/2007/1206/1196838986749.html

Downs, J. (December 14th, 2005). 'Member of drugs body resigns', Retrieved 09.03.2009 from:
http://www.irishtimes.com/newspaper/ireland/2005/1214/1134117170711.html

Drug Misuse Research Division (2000). *Drugnet Ireland*, Issue 2. Dublin: Health Research Board

Drug Misuse Research Division (2002). *Drugnet Ireland*, Issue 6. Dublin: Health Research Board.

Drug Misuse Research Division (2003a). *Drugnet Ireland*, Issue 7. Dublin: Health Research Board.

Drug Misuse Research Division (2003b). *Drugnet Ireland*, Issue 9. Dublin: Health Research Board.

Drug Misuse Research Division (2004a). *Drugnet Ireland*, Issue 10. Dublin: Health Research Board.

Drug Misuse Research Division (2004b). *Drugnet Ireland*, Issue 11. Dublin: Health Research Board.

Drug Misuse Research Division (2005a). *Drugnet Ireland*, Issue 13. Dublin: Health Research Board.

Drug Misuse Research Division (2005b). *Drugnet Ireland*, Issue 14. Dublin: Health Research Board.

Drug Misuse Research Division (2005c). *Drugnet Ireland*, Issue 15. Dublin: Health Research Board.

Drug Misuse Research Division (2005d). *Drugnet Ireland*, Issue 16. Dublin: Health Research Board.

Drug Misuse Research Division (2006a). *Drugnet Ireland*, Issue 17. Dublin: Health Research Board.

Drug Misuse Research Division (2006b). *Drugnet Ireland*, Issue 18. Dublin: Health Research Board.

Drug Misuse Research Division (2006c). *Drugnet Ireland*, Issue 19. Dublin: Health Research Board.

Dublin North East LDTF (1997). *Dublin North East LDTF Service Development Plan.* Dublin: Dublin North East LDTF.

Duff, P. (1998). *Final Report: A Study on the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System: Plan for the Implementation of the NDTRS in Prison and GP Services.* Dublin: Health Research Board.

Duke, K. (2003). *Drugs, Prisons and Policy-Making.* Basingstoke: Palgrave Macmillan.

Duke, K. (2002). 'Getting Beyond the Official Line: Reflections on Dilemmas of Access Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, Vol.31, No.1, pp.39-59.

Duke, K. (2001). 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice: The International Journal of Policy and Practice*, Vol.1, No.3, pp.277-300.

Dun Laoghaire Rathdown LDTF (1997). *Second Report.* Dublin: Dun Laoghaire Rathdown LDTF.

Dyck, E. (2005). 'Flashback: psychiatric experimentation with LSD in historical perspective', *Canadian Journal of Psychiatry*, Vol.50, No.7, pp.381-388.

East Coast Area RDTF (2005). *East Coast Area RDTF Action Plan 2005-2008.* Dublin: East Coast Area RDTF.

Eastern Health Board (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00 A.M.* Dublin: EHB.

Eastern Health Board (1997). *1997 Drugs Service/Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services.* Dublin: EHB.

Eastern Health Board (1999). *EHB Report on drug services in the EHB submitted by Mr. P. McLoughlin, CEO, to the Public Accounts Committee, February 1999.* Dublin: EHB.

ECOSOC (2004). *Commission on Narcotic Drugs Forty-seventh Session. Strengthening Strategies Regarding the Prevention of HIV/AIDS in the Context of Drug Abuse: Report of the Executive Director* (The UN reference for this document is: E/CN.7/2004/3).

Editorial (September 20th, 1996a). '1,000 march in anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0920/archive.96092000042.html

Editorial (September 24th, 1996b). 'Drugs protesters hold two marches', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0924/archive.96092400063.html

Editorial (October 11th, 1996c). '800 march over drugs in Dublin', retrieved from:
http://www.ireland.com/newspaper/ireland/1996/1011/archive.96101100032.html

Editorial (October 16th, 1996d). '300 in march against drugs', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1016/archive.96101600030.html

Editorial (October 30th, 1996e). '300 in city anti-drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1030/archive.96103000004.html

Editorial (November 8th, 1996f). 'Anti drug groups plan GPO protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1108/archive.96110800031.html

Editorial. (December 14th, 2005). 'Govt's drugs strategy 'inadequate'', Retrieved 09.03.2009 from:
http://www.breakingnews.ie/story/cwmhojaueygb/

Editorial (June 03, 2006a). "UN Aids wording frustrates Annan". London: BBC. Retrieved 17.08.2006 from: http://news.bbc.co.uk/1/hi/world/5039948.stm

Editorial (June 05, 2006b). "Telling it like it is". London: The Guardian. Retrieved 17.08.2006 from:
http://www.guardian.co.uk/aids/story/0,,1790529,00.html

Editorial (November 1st, 2007a). 'Binge drinking' Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/opinion/2007/1101/1193444281581.html

Editorial (November 1st, 2007b). 'Irish three times more likely to binge-drink', Retrieved 01.11.2007 from: http://archives.tcm.ie/irishexaminer/2007/11/01/story46793.asp

Editorial (November 1st, 2007c). 'Drink-related deaths have doubled in 10 years', Retrieved 01.11.2007from:
http://archives.tcm.ie/irishexaminer/2007/11/01/story46776.asp

Editorial (November 5th, 2007d). 'Call for Irish alcohol strategy', Retrieved 05.11.2007 from:
http://www.irishmedicalnews.ie/articles.asp?Category=news&ArticleID=19791

Editorial (November 20th, 2007e). 'Health authorities urge 10% hike in tax on alcohol', Retrieved 20.11.2007 from:
http://archives.tcm.ie/irishexaminer/2007/11/20/story48351.asp

Editorial (December 5th, 2007f). 'Cowen unveils stamp duty reform in budget', Retrieved 05.12.2007 from: http://www.ireland.com/newspaper/breaking/2007/1205/breaking2.htm

Editorial (January 10th, 2008a). 'Combating our biggest social ill', Retrieved 10.01.2008 from:
http://www.independent.ie/opinion/editorial/combatting-our-biggest-social-ill-1261872.html

Editorial (January 10th, 2008b). 'Action on Health', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/opinion/2008/0111/1199917849639.html

Edwards, G. (1993). Substance misuse and the uses of science, in Edwards, G., Strang, J. & Jaffe, J. (eds.). (1993). *Drugs, Alcohol and Tobacco: Making the Science and Policy Connections*. Oxford: Oxford University Press.

Edwards, G. (Ed.). (2002). *Addiction: Evolution of A Specialist Field.* Oxford: Blackwell Science/Addiction Press.

EHB (1996). *EHB Special Board Meeting – Drug Service – Review of 1995 and Development Plans for 1996 – Tuesday 2nd April, 1996 at 11:00A.M.*, Dublin.

EHB (1997). *Review of the 1996 Service Plan and the 1997 Service Plan for the AIDS/Drugs Services*, Dublin, EHB.

EMCDDA (1993). *Inventory of EC (Legal) Texts on Drugs*. Lisbon: EMCDDA.

EMCDDA (1997). *Drugnet Europe*, No.3. Lisbon: EMCDDA.

EMCDDA (1997). *Drugnet Europe – Special: Irish Presidency*, No.3. Lisbon: EMCDDA.

EMCDDA / PG (2000). *Scientific Report: Treatment Demand Indicator Standard Protocol 2.0*. Lisbon: EMCDDA.

EMCDDA (2002). *Strategies and Coordination in the Field of Drugs: A Descriptive Review*. Lisbon: EMCDDA.

EMCDDA (2004a). *A Short Briefing Paper: A European Perspective on Responding to Blood Borne Infections Among Injecting Drug Users*. Lisbon: EMCDDA.

EMCDDA (2004b). *Coordination of Drug Policy in the European Union 2000 – 2004.* Lisbon: EMCDDA

European Commission (2007). *Special Eurobarometer: European Social Reality.* Strasbourg: Author.

European Parliament & Council of the European Union (12.12.2006). 'Regulation (EC) No 1920/2006 of the European Parliament and of the Council of 12 December 2006 on the European Monitoring Centre for Drugs and Drug Addiction (recast)', *Official Journal of the European Union*, Series (L) 376/1 Luxembourg: COE.

Expert Group on Mental Health (2004a). *Speaking Your Mind: A Report on the Public Consultation Process*. Dublin: Department of Health and Children.

Expert Group on Mental Health (2004b). *What we Heard: A Report on the Service User Consultation Process*. Dublin: Department of Health and Children.

Farrell, M. & Bunning, E. (1996). *Review of Drugs Services in the Eastern Health Board Area 1996*. Dublin: EHB.

Farrell, M., Gerada, C., & Marsden, J. (2000). *External Review of Drug Services for "The Eastern Health Board"*, Dublin: EHB.

Fianna Fail (1997). *A Radical Approach to Drugs and Drug Related Crime: A Fianna Fail Position Paper – Preparing for the Millennium*. Dublin: Author.

Fianna Fail (2002). *A Lot Done. More to Do. Fianna Fail Manifesto 2002-2007*. Dublin: Author.

Finglas/Cabra LDTF (2001). *Finglas/Cabra LDTF Strategic Plan 2001*. Dublin: Finglas/Cabra LDTF.

Finglas/Cabra LDTF (2006). *Vital connections Local Drugs Task Forces – Leading the response – Conference report*. Dublin: Finglas/Cabra LDTF.

Gallagher, P. (September 19th, 1996). '300 march in Dublin inner city anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0919/archive.96091900018.html

Goodbody Economic Consultants (2006). *Expenditure Review of the Local Drugs task Forces*. Dublin: Goodbody Economic Consultants.

Goffman, E. (1956/1990). *The Presentation of Self in Everyday Life*. London: Penguin.

Goudsblom, J. (1986). 'Public health and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage.

Government Strategy to Prevent Drug Misuse. (1991). Dublin: Department of Health.

Hartnoll, R. (1994). *Drug treatment reporting systems and the first Treatment Demand Indicator: Definitive Protocol.* Strasbourg: Council of Europe Press.

Haughey, N. (August 23rd, 1996). 'Summerhill residents demand action', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0823/archive.96082300033.html

Health Research Board (1988). *Annual Report for 1987.* Dublin: Health Research Board.

Health Research Board (1989). *Annual Report and Accounts for 1988.* Dublin: Health Research Board.

Health Research Board (1990). *Annual Report and Accounts for 1989.* Dublin: Health Research Board.

Health Research Board (1991). *Annual Report and Accounts for 1990.* Dublin: Health Research Board.

Health Research Board (1992). *Annual Report and Accounts for 1991.* Dublin: Health Research Board.

Health Research Board (1993). *Annual Report and Accounts for 1992.* Dublin: Health Research Board.

Health Research Board (1994). *Annual Report and Accounts for 1993.* Dublin: Health Research Board.

Health Research Board (1996). *Annual Report and Accounts for 1995.* Dublin: Health Research Board.

Health Research Board (1997). *Annual Report and Accounts for 1996.* Dublin: Health Research Board.

Health Research Board (1998). *Annual Report and Accounts for 1997.* Dublin: Health Research Board.

Health Research Board (2003). *Annual Report and Accounts for 2001.* Dublin: Health Research Board.

Hennessy, M. (December 7th, 2007). 'Lenihan set to ban sales of below-cost alcohol', Retrieved 07.12.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1207/1196839063486.html

Hogan, L. (January 10th, 2008). 'Get-tough campaign to tackle the binge drinkers', Retrieved 10.01.2008 from:
http://www.independent.ie/national-news/gettough-campaign-to-tackle-the-binge-drinkers-1261942.html

Hope, A. (2007). *Alcohol Consumption in Ireland 1986-2006. Health Service Executive – Alcohol Implementation Group*. Dublin: HSE.

Horwath consulting Ireland & Matrix Knowledge Group (2008). *Evaluation of Local Drugs Task Force Funded Projects, 30th January 2008, Volume 1: Overall Evaluation Report Highlighting Key Themes from the Evaluation*, unpublished

Horgan, J. (2007). *An Overview of Cocaine Use in Ireland: II*. Dublin: NACD.

Houston, M. (November 27th, 2007). 'Alcohol is major factor in youth suicides – study', Retrieved 27.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682394007.html

Hughes, J. (2003). 'From Panacea to Pandemic: Tobacco-Use in the West', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage.

Humphreys, J. & O'Halloran, M. (June 20th, 2002). 'Protesters warn that progress in tackling drugs may be eroded', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/2002/0620/52028277HM6DRUGS.html

Hunt, N., Trace, M., & Bewley-Taylor, D. (2004). *Beckley Foundation Drug Policy Programme Report 4: Reducing Drug Related Harms to Health: An Overview of the Global Evidence*. London: Beckley Foundation Drug Policy Programme

INCB (2009). *Report of the International Narcotics Control Board for 2008*. New York: United Nations.

Irish Presidency and the European Commission (1996). *Combatting the Drugs Problem: A Seminar and Citizens' Hearing, 5-6th November 1996, Dublin Castle, Dublin*. Dublin: Department of Justice

Irish Prison Service (2000). *Report of the Steering Group on Prison Based Drug Treatment Services*. Dublin: Irish Prison Service.

Irish Prison Service (2001a). *Report of the Group to Review the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service.

Irish Prison Service (2001b). *Irish Prison Service Annual Report 2001*. Dublin: Irish Prison Service.

Irish Prison Service (2002). *Irish Prison Service Annual Report 2002*. Dublin: Irish Prison Service.

Irish Prison Service (2003). *Irish Prison Service Annual Report 2003*. Dublin: Irish Prison Service.

Irish Prison Service (2004a). *Irish Prison Service Annual Report 2004*. Dublin: Irish Prison Service.

Irish Prison Service (2004b). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service.

Irish Prison Service (2005). *Irish Prison Service Annual Report 2005*. Dublin: Irish Prison Service.

Irish Prison Service (2006a). *Irish Prison Service Health Care Standards*. Dublin: Irish Prison Service. Dublin: Irish Prison Service.

Irish Prison Service (2006b). *Keeping Drugs Out of Prisons*. Dublin: Irish Prison Service.

Irish Prison Service (2007). *Irish Prison Service Annual Report 2007*. Dublin: Irish Prison Service.

Irish Prison Service (2008). *Drug Treatment Clinical Policy*. Dublin: Irish Prison Service.

ISIS Research Group (1999). Towards a Drugs Service Development Plan for Bray – Report for the Bray Drugs Working Group. Dublin: Bray Drugs Working Group.

Judge, T. (November 6th, 2007). 'Getting a grip on our drink problems', Retrieved 06.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1106/1194222679534.html

Kelleher, T., Long, J., Kelly, F., & Sinclair, H. (2004). *Occasional Paper No. 14. Trends in Treated Problem Cannabis Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998-2002.* Dublin: Health Research Board.

Kelly, F., Lynn, E. & Long, J. (2005). *Occasional Paper No. 15. Treatment demand in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board.

Kelly, F., Long, J. & Lynn, E. (2005). *Occasional Paper No. 16. Trends in Treated Problem Drug Use in the Health Service Executive Eastern Region, 1998 to 2002.* Dublin: Health Research Board.

Kennedy, G. (June 27th, 1996). 'Stunned political leaders see killing as attack on democracy', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0627/archive.96062700039.html

Kilraine, J. (August 29th, 1996). 'Anti drugs protest group says other areas interested', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0829/archive.96082900017.html

Klingemann, H. & Klingemann, H.D. (1999). 'National Treatment Systems in Global Perspective', *European Addiction Research*, Vol.5, N.3., pp.109-117.

Knowles, R. (November 20th, 2007). 'HSE calls for more tax on alcohol', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1120/1195251510546.html

Krajewski, K. (1999). 'How flexible are the United Nations drug conventions?', *International Journal of Drug Policy*, Vol.10, No.4, pp.329-338.

Long, J., Jackson T., Kidd, M., Kelleher, T., & Sinclair, H. (2004a). *Occasional Paper No. 10.* Treatment Demand for Problem Alcohol Use in the South Eastern and Southern Health Board Areas, 2000-2002. Dublin: Health Research Board.

Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004b). *Occasional Paper No. 11. Treatment Demand in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board.

Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004c). *Occasional Paper No. 12. Trends in Treated Problem Drug Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board

Long, J., Kelleher, T., Kelly, F. & Sinclair, H. (2004d). *Occasional Paper No.13. Trends in Treated Problem Opiate Use in the Seven Health Board Areas Outside the Eastern Regional Health Authority, 1998 to 2002.* Dublin: Health Research Board.

Long, J., Lynn, E. & Kelly, F. (2005a). *Occasional Paper No. 17. Trends in Treated Problem Drug Use in Ireland, 1998 to 2002.* Dublin: Health Research Board.

Long, J., Lynn, E. & Keating J. (2005b). *Drug-related deaths in Ireland, 1990-2002. Overview 1.* Dublin: Health Research Board.

Long, J. (2006). *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005. Overview 4.* Dublin: Health Research Board.

Lowes, P.D. (1966). *The Genesis of International Narcotics Control.* Geneva: Librairie Droz.

MacGabhann, L., Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., & Philbin, M. (2004). *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland.* Dublin: NACD.

Maher, J. (August 3rd, 1996a). 'Protest at arrest of anti-drugs campaigner', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0803/archive.96080300011.html

Maher, J. (August 9th, 1996b). 'Drug protest in Clondalkin', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0809/archive.96080900058.html

Maher, J. (August 15th, 1996c). 'Protests at arrest of anti-drug activist', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0815/archive.96081500048.html

Maher, J. (September 27th, 1996d). 'Protest crowd mobs taxi carrying major Dublin drug dealer', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0927/archive.96092700022.html

Maher, J. (September 28th, 1996e). 'Anti drugs march highlights anger on failure to tackle city dealing', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/0928/archive.96092800031.html

Maher, J. (October 8th, 1996f). 'Alleged dealers are named at city anti drugs protest', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1008/archive.96100800013.html

Maher, J. (November 20th, 1996g). 'Anti-drug campaigners may boycott Garda', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1120/archive.96112000020.html

Maher, J. (November 22nd, 1996h). 'Anti drugs campaigners march against "Garda harassment"', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1122/archive.96112200058.html

Maher, J. (December 13th, 1996i). 'Anti drugs protesters besiege home', retrieved 23.03.2006 from:
http://www.ireland.com/newspaper/ireland/1996/1213/archive.96121300006.html

Maher, J. (May 29th, 1997). 'Rabbitte pledges new community projects', retrieved 12.03.2006 from:
http://www.ireland.com/newspaper/ireland/1997/0529/archive.97052900073.html

Matic, S., Lazarus, J.V., & Donoghoe, M.C. (eds.). (2006). *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management.* Copenhagen: World Health Organization European Regional Office.

McDonagh, M. (November 13th, 2007). 'Call for limits on alcohol advertising', Retrieved 13.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1113/1194550189427.html

McGarry, P. (November 1st, 2007a). 'Alcohol consumption increases 17%', Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1101/1193444293021.html

McGarry, P. (November 1st, 2007b). 'Doubling in hospital bed days to treat illness linked to alcohol', Retrieved 01.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1101/1193444293015.html

McGarry, P. (November 13th, 2007c). 'Education not effective in limiting alcohol abuse', Retrieved 13.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1113/1194550197031.html

McGarry, P. (March 7th, 2008). 'Alcohol a key factor in suicides, study finds', Retrieved 07.03.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0307/1204843531533.html

McGee, H. & Donnellan, E. (March 11th, 2008). 'Taoiseach hints at changes to restrict the sale of alcohol', Retrieved 11.03.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0311/1205104618161.html

McGreevy, R. (January 10th, 2008a). 'Group to consider raising legal age for alcohol', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0110/1199313758982.html

McGreevy, R. (February 6th, 2008b). 'Call for under-18s to be sent to buy drink in 'sting' move', Retrieved 06.02.2008 from:
Source: http://www.ireland.com/newspaper/ireland/2008/0206/1201903564466.html

McHugh, D.J. (1994). 'The Lord's will be done: interviewing the powerful in education', in Walford, G. (ed.). *Researching the Powerful in Education*. London: UCL Press.

Medical Research Council of Ireland (1986). *Annual Report for the Year Ended 31st December 1985*. Dublin: Medical Research Council of Ireland.

Medical Research Council of Ireland (1987). *Annual Report for the Year Ended 31st December 1986*. Dublin: Medical Research Council of Ireland.

Medico-Social Research Board (1985). *Annual Report 1984*. Dublin: Medico-Social Research Board.

Medico-Social Research Board (1986). *Annual Report 1985*. Dublin: Medico-Social Research Board.

Methadone Treatment Services Review Group (2005). *Review of the Methadone Treatment Protocol*. Dublin: DoHC.

Midland RDTF (2006). *Midland RDTF Action Plan 2006 – 2008*. Laois: Midland RDTF.

Mid-Western RDTF (2005). *Mid-Western RDTF Action Plan 2005*. Limerick: Mid-Western RDTF.

Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach.

Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997). *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Department of Taoiseach.

Moore, G., McCarthy, P., MacNeela, P., MacGabhann, Philbin, M., & Proudfoot, D. (2004). *A Review of Harm Reduction Approaches in Ireland and Evidence from the International Literature*. Dublin: NACD.

Mongan, D., Reynolds, S., Fanagan, S. & Long, J. (2007). *Health-related consequences of problem alcohol use. Overview 6* . Dublin: Health Research Board.

Moran, R. O'Brien, M. & Duff, P. (1997). *Treated Drug Misuse in Ireland - National Report 1996*. Dublin: Health Research Board.

Morahan, J. (May 27th, 2005). Drugs strategy row to be sorted soon, says Ahern', Retrieved 09.03.2009 from:
http://archives.tcm.ie/irishexaminer/2005/05/27/story359578241.asp

Mulvey, C. (November 19th, 2007). 'Irish ranked 3rd biggest drinkers', Retrieved 19.11.2007 from:
http://www.ireland.com/newspaper/breaking/2007/1119/breaking26.html

NACD (2003). *An Overview of Cocaine Use in Ireland*. Dublin: NACD.

Nadelmann, E. (1990). 'Global Prohibition Regimes: The Evolution of Norms in International Society', *International Organisation*, Vol.44, No. 4, pp.479-526.

National AIDS Strategy Committee (1992). *Reports and Recommendations of the Sub-Committees of the National Strategy Committee on: Care and management of Persons with HIV/AIDS; HIV/AIDS Surveillance (Interim Report); Education and Prevention Strategies; Measures to Avoid Discrimination Against Persons with HIV/AIDS – Adopted by the Main Committee on 13th April 1992*. Dublin: NASC.

National AIDS Strategy Committee (2000). *AIDS Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: Stationery Office.

National Anti Poverty Strategy – Sharing in Progress. (1997). Dublin: Stationery Office.

National Co-ordinating Committee on Drug Abuse (1986). *First Annual Report*. Dublin: Stationery Office.

National Drugs Strategy Team (1999). *Local Drugs Task Forces: A Local Response to the Drugs Problem*. Dublin: Department of Tourism, Sport, and Recreation.

National Drugs Strategy Team (2002). *Review of the Local Drugs Task Forces – Draft Report form the National Drugs Strategy Team*. Unpublished.

National Drugs Strategy Team (2005). *Annual Report for 2005*. Dublin. NDST.

National Drugs Strategy Team (2006). *Annual report for 2006*. Dublin: NDST.

North Dublin City & County RDTF (2005). Strategic Plan 2005 – 2008. Dublin: North Dublin City & County RDTF.

North Eastern RDTF (2005). *North Eastern RDTF Regional Drugs Strategy 2005-2008*. Meath: North Eastern RDTF.

North Inner City LDTF (2001). *North Inner City LDTF Strategic Plan 2001 Phase Two of a Programme for Action*. Dublin: North Inner City LDTF.

North Western RDTF (2005). *North Western RDTF Strategic Plan 2005 – 2008*. Sligo: North Western RDTF.

O'Brien, M., & Moran, R. (1998). *Overview of Drug Issues in Ireland 1997: A Resource Document*. Dublin: Health Research Board

O'Brien, M., Moran, R., Kelleher, T. & Cahill, P. (2000). *National Drug Treatment Reporting System, Statistical Bulletin 1997 and 1998. National data and Data by Health Board Area*. Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002a). *Occasional Paper No.1. Trends in Treated Drug Misuse in the Southern Health Board Area 1996-2000*. Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002b). *Occasional Paper No.2. Trends in Treated Drug Misuse in the North Western Health Board Area 1996-2000*. Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002c). *Occasional Paper No. 3. Trends in Treated Drug Misuse in the Midland Health Board Area 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002d). *Occasional Paper No.4. Trends in Treated Drug Misuse in the Western Health Board Area, 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002e). *Occasional Paper No.5. Trends in Treated Drug Misuse in the Mid Western Health Board Area, 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002f). *Occasional Paper No.6. Trends in Treated Drug Misuse in the North Eastern Health Board Area, 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002g). *Occasional Paper No.7. Trends in Treated Drug Misuse in the South Eastern Health Board Area 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P. (2002h). *Occasional Paper No.8. Trends in Treated Drug Misuse in the Eastern Health Board Area 1996-2000.* Dublin: Health Research Board.

O'Brien, M., Kelleher, T. & Cahill, P., Kelly, F., & Long, J. (2003). *Occasional Paper No.9. Trends in Treated Drug Misuse in the Republic of Ireland, 1996-2000.* Dublin: Health Research Board.

O'Faolain, N. (12th October, 1996). 'Citizen army fights to save the children', The Irish Times, Retrieved 23.02.2007 from:
http://www.ireland.com/newspaper/newsfeatures/1996/1012/archive.96101200054.html

O'Halloran, M. (November 2nd, 2007). 'Cowen concern at abuse of alcohol', Retrieved 02.11.2007 from:
http://www.ireland.com/newspaper/ireland/2007/1102/1193444383971.html

O'Hare, A. & O'Brien, M. (1992). *Treated Drug Misuse in the Greater Dublin Area 1990.* Dublin: Health Research Board.

O'Keeffe, C. (May 26th, 2005). 'Drugs strategy at stake as McCabe resigns', Retrieved 09.03.2009 from:
http://archives.tcm.ie/irishexaminer/2005/05/26/story395212250.asp

Office for Social Inclusion (2003). *National Action Plan Against Poverty and Social Exclusion 2003-2005.* Dublin: Stationery Office.

PA Consulting Group (1998). *Evaluation of Drugs Initiative – Department of Tourism Sport and Recreation – Final Report*. Unpublished.

PA Consulting Group (2001). *PA Evaluation of Department of Tourism, Sport, and recreation, Drugs Strategy Unit, and National Drugs Strategy Team*, December 2001. Version 3.0. Unpublished.

PA Consulting Group (2002). *Evaluation of the Progress of the Strategic Management Initiative / Delivering Better Government Modernisation Programme*. Dublin: Department of Taoiseach.

PA Consulting Group (2004). *Mid Term Review of the National Drugs Strategy: Draft Final Report to the Steering Group, Version 2*. Dublin: PA Consulting Group, Unpublished.

PA Consulting (2008). *National Drugs Strategy – Draft Report to the Steering Group (V.1 28 August)*. Unpublished.

Pinell, P. (1996). 'Modern medicine and the civilizing process', in Dunning, E. & Mennell, S. (eds.). (2003). *Norbert Elias: Vol.4*. London: Sage.

Platt, J. (1981a). 'Evidence and proof in documentary research: 1 some specific problems of documentary research', *Sociological Review*, Vol.29, No.1, pp.31-52.

Platt, J. (1981b). 'Evidence and proof in documentary research: 2 some shared problems of documentary research', *Sociological Review*, Vol.29, No.1, pp.53-66.

Policy Research Centre (2000). *Evaluation of Local Drug Task Forces Projects: Experiences and Perceptions of Planning and Implementation*, Dublin: NCI.

Pompidou Group (2000). *Legal (Pre)Conditions and Control Mechanisms with Regard to Risk Reduction – Discussion Paper*. Strasbourg: Pompidou Group.

Pompidou Group (2003). *Activity Report 2000 – 2003, Ministerial Conference Dublin (Ireland, 16-17 October 2003)*. Strasbourg: Council of Europe Publishing.

Pompidou Group (2004). *Pompidou Group Ministerial Conference, 'New Challenges for Drug Policy in Europe', Proceedings, Dublin, 16-17, October, 2003*. Strasbourg: Council of Europe Publishing.

Pompidou Group / Hartnoll, R. (2004). *Drugs and Drug Dependence: Linking Research, Policy and Practice – Lessons Learned, Challenges Ahead*. Strasbourg: Council of Europe Publishing.

Pompidou Group / Sinclair, H. (2006). *Drug Treatment Demand Data: Influence on Policy and Practice*. Strasbourg: Council of Europe.

Porter, D. (1999). *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. London: Routledge.

Prior, L. (2004). 'Doing things with documents', in D. Silverman (ed.), *Qualitative Research: Theory, Method, And Practice*, London: Sage.

Prior, L. (2003). *Using Documents in Social Research*. London: Sage.

Prior, L. (1993). *The Social Organization of Mental Illness*. London: Sage.

Quinlan, R. (March 9th, 2008). 'Bertie's drink war in wake of murders', Retrieved 09.03.2008 from:
http://www.independent.ie/national-news/berties-drink-war-in-wake-of-murders-1311592.html

Reinarman, C. (2005). 'Editorial – Librarians and other subversives: Truth can be a casualty of drug wars too', *International Journal of Drug Policy*, Vol.16, No.1, pp.1-4.

Ritzer, G. (2000). *Sociological Theory*. Fifth edition. London: McGraw-Hill.

Rubin, H. J., & Rubin, I. S, (2005). *Qualitative Interviewing: The Art of Hearing Data*. Second Edition. London: Sage.

Ryan, S. (November 9th, 2007). 'Government alcohol policies ignored and often contradictory', Retrieved 09.11.2007from:
Source: http://www.imt.ie/news/2007/11/government_alcohol_policies_ig.html

Ryan, C. (March 7th, 2008). 'Drink lobby failure 'hit suicide rate'', Retrieved from 07.03.2008:
http://www.irishexaminer.com/archives/2008/0307/ireland/drink-lobby-failure-hit-suicide-rate-57165.html

Scott, J. (1990). *A Matter of Record: Documentary Sources in Social Research*. Cambridge: Polity Press.

Scott, J.M. (1969). *The White Poppy: The History of Opium*. London: William Heinemann Ltd.

Simon, R. (1991). *Gramsci's Political Thought: An Introduction*. Revised Edition. London: Laurence and Wisheart.

Slattery, L. (November 27th, 2007a). 'A taxing issue?', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682389884.html

Slattery, L. (November 27th, 2007b). 'The economist's view', Retrieved 20.11.2007 from:
http://www.ireland.com/newspaper/health/2007/1127/1195682389888.html

Slattery, L. (January 31st, 2008). 'Rise in tax on alcohol 'a better means' of cutting consumption', Retrieved 31.01.2008 from:
http://www.ireland.com/newspaper/ireland/2008/0131/1201501795567.html

Smart, T. (June 02, 2006). "Protests at UN over declaration's silence on vulnerable groups". London: Aidsmap. Retrieved 17.08.2006 from:
http://www.aidsmap.com/en/news/31074099-15CB-4CCD-9570-4AE53495B8E6.asp

Southern RDTF (2005). *Strategic Plan 2005 – 2008 & Action Plan 2005 – 2007.* Cork: Southern RDTF.

South Eastern RDTF (2005). South Eastern RDTF Strategic Plan 2005 – 2008. Waterford: South Eastern RDTF.

South Western RDTF (2005). *South Western RDTF Strategy Document.* Dublin: South Western RDTF.

South Inner City LDTF (1997). *Recreating Hope – South Inner City LDTF Service Development Plan.*

South Inner City LDTF (2008). *Strategic Plan 2008 to 2012.* Dublin: South Inner City LDTF.

South Western RDTF (2005). *South Western RDTF Strategy Document.* Dublin: South Western RDTF.

Special Government Task Force on Drug Abuse (1983). *Draft Report of the Special Government Task Force on Drug Abuse.* Unpublished.

Staunton, D. (June 03, 2006). "UN delegates agree on global HIV declaration". Dublin: The Irish Times. Retrieved 17.08.2006 from:
http://www.ireland.com/newspaper/world/2006/0603/391678903FR03UN.html

Stimson, G.V. (1990). Revising policy and practice: new ideas about the drugs problem, in Strang, J. & Stimson, G.V. (eds.). *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s.* London: Routledge.

Szasz, T. (1975). *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers.* London: Routledge & Kegan Paul.

Tallaght LDTF (1997). Tallaght LDTF Service Development Plan. Dublin: Tallaght LDTF.

Tallaght LDTF (2000). *Review of 1997 Service Development Plan & Formulation of New Service Development Plan – Final Report.* Dublin: Tallaght LDTF.

Tallaght LDTF (2008). *Strategic Plan 2008-2013*. Dublin: Tallaght LDTF.

UN (1971). *Convention on Psychotropic Substances, 1972*. Geneva: UN. Retrieved January 23 2006 from:
http://www.incb.org/pdf/e/conv/convention_1971_en.pdf

UN (1972). *Single Convention on Narcotic Drugs, 1961, As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961*. Geneva: UN. Retrieved January 23 2006 from:
http://www.incb.org/pdf/e/conv/convention_1961_en.pdf

UN (1969). *Vienna Convention on the Law of Treaties*. Geneva: UN. Retrieved January 23 2006 from:
http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf

UNAIDS (2005a). *UNAIDS Policy Position Paper: Intensifying HIV Prevention*. Geneva: UNAIDS.

UNAIDS (2005b). *Report of the Seventeenth Meeting of the UNAIDS Programme Coordinating Board Geneva, 27-29 June 2005*. Geneva: UNAIDS. (The UN reference for this document is: UNAIDS/PCB(17)/05.10 18 August 2005).

UN ECOSOC (1997). *Commission on Narcotic Drugs Fortieth Session. Effects on Individuals, Society and International Drug Control of the Prescription of Narcotic Drugs to Drug Addicts: Report of the Secretariat*. (The UN reference for this document is: E/CN.7/1997/7).

UN GA (2006). *Sixtieth Session Agenda Item 45: Resolution Adopted by the General Assembly: 60/262: Political Declaration on HIV/AIDS*, (The UN reference for this document is: A/RES/60/262).

UN INCB (2002). *Seventy-fifth Session. Flexibility of Treaty Provisions as Regards Harm Reduction Approaches – Prepared by the Legal Affairs Section UNDCP*. Vienna: INCB. (The UN reference for this document is: E/INCB/2002/W.13/SS.5).

UNODC (2006). *HIV/AIDS Prevention and Care for Female Injecting Drug Users*. Vienna: UNODC HIV/AIDS Unit.

UNODC, WHO & UNAIDS (2006). *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*. New York: UN.

Walford, G. (1994). 'Reflections on researching the powerful', in Walford, G. (ed.). *Researching the Powerful in Education*. London: UCL Press.

Waters, J (November 5th, 2007). 'Inebriated nation needs help', Retrieved 05.11.2007 from:
http://www.ireland.com/newspaper/opinion/2007/1105/1193444563765.html

Weiss, K. (1986). 'The many meanings of research utilization', in Bulmer, M. (ed.). Social Science and Social Policy. London: Allen & Unwin.

Western RDTF (2005). *Shared Solutions – First Strategic Plan of the Western RDTF.* Galway: Western RDTF.

WHO, UNODC, & UNAIDS (2004a). *Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention.* Geneva: WHO.

WHO, UNAIDS, & UNODC (2004b). *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission.* Geneva: WHO.

WHO, UNAIDS & UNODC (2004c). *Policy Brief: Reduction of HIV Transmission in Prisons.* Geneva: WHO.

Wilde, J. (January 10th, 2008). 'State must play central role in public health', Retrieved 10.01.2008 from:
http://www.ireland.com/newspaper/opinion/2008/0110/1199313758988.html

Working Party on Drug Abuse (1971). *Report of the Working Party on Drug Abuse.* Dublin: Stationery Office.

Woulfe, J. (January 9th, 2008). 'Radical proposals to target underage drinking', Retrieved 09.01.2008 from: http://archives.tcm.ie/irishexaminer/2008/01/09/story52156.asp