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ALCOHOL, ILLICIT DRUGS AND HEALTH PROMOTION IN IRELAND, 1945-1996

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Ph.D. Thesis
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November 1999

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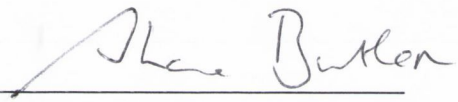
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This is to confirm that:

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Signed: 

Shane Butler

Date: 18/5/00

Acknowledgements

This thesis reflects a long-standing professional interest of mine in alcohol and drug problems and their management by health services, and over the course of years I have incurred many debts which I now wish to acknowledge.

My initial work in the addictions field was as a social worker in an alcohol unit of the Eastern Health Board's, and while I cannot be sure whether my interventions were helpful to my clients, I am in do doubt as to how much they taught me. The consultant psychiatrist with whom I worked most closely, R. D. Stevenson, was a clinician of exceptional wisdom, skill and good humour, and from him I learnt a great deal. Sadly, he died in 1997.

In the Department of Social Studies at Trinity College Dublin, where I have worked for the past fifteen years, I gained from the experience of teaching students of the Diploma in Addiction Studies, the Bachelor of Social Studies and several other courses. My supervisor, Tony Coughlan, has always been patient and encouraging, and I am grateful for his detailed reading of drafts of this thesis. All of my other colleagues, past and present, have also helped in various ways.

Professor Helen Burke of the Department of Social Policy and Social Work at University College Dublin acted as an informal advisor on this research; her encouragement and support were invaluable.

Since the thesis is essentially an historical study of Irish alcohol and drug policy, I have been helped by many of the participants or players in this arena who agreed to talk to me about their experiences; all of these, too numerous to mention here, have been acknowledged appropriately throughout the text.

The secretarial assistance of Pam Isaacson, particularly in the final stages of this thesis, has been over and above the call of duty, and I am profoundly grateful for her competence, kindness and humour.

Finally, I am grateful to my family: my wife, Phil, and our children, Emer, Grainne and Kilian, for their support.

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CHAPTER ONE

ALCOHOL, DRUGS AND HEALTH PROMOTION

Introduction

The health and social problems associated with the consumption of alcohol and of illicit drugs have long been causes of concern in international public health circles. Empirical studies (Bruun et al, 1975; Davies and Walsh, 1983; Edwards et al, 1994) have revealed that in the second half of this century alcohol consumption has increased in most Western societies, as have many indicators of alcohol-associated morbidity and mortality.[1] Both national and international health authorities have sought during this period to devise *treatment responses* for those already experiencing problems and *prevention strategies* to reduce the incidence of drinking problems. Similarly, there has been a major expansion in the range of illicit drugs widely available and widely used. This, to some extent, is a by-product of developments in the area of science and technology since drugs, like other commodities, may now be transported easily and quickly around the world away from their geographical source, and synthetic drugs may equally easily be manufactured in relatively unsophisticated laboratories. The growth in the international trade in drugs may also be explained sociologically as just one example of the wider phenomenon of *globalisation,* which refers to political and economic processes facilitating international trade and diminishing the importance of border controls.[2] While health authorities have been concerned with the provision of treatment and rehabilitation services for those who become dependent on drugs or who have other drug-related health problems, public attention has also focused on the drug control systems which have been set in place internationally. These include the use of a variety of technical and legal measures which are intended to prevent drug trafficking, and in the United States of America where they have been pursued with particular zeal these activities have been popularly described as a 'war on drugs'.

The present study is concerned with Irish health care policy and practice in relation to alcohol and drug problems in the post-World War II period, from 1945 to 1996. One of the central issues to be explored is the tension between treatment and prevention in these two closely related areas of public health. The tension referred to involves decision-making as to the relative allocation of time, energy and, above all, resources to these two areas of public health. In strictly logical terms, it seems invalid to devote the lion's share of scarce resources to curative services, while there are environmental or lifestyle factors which contribute to the incidence and prevalence of ill-health but which are largely ignored by health policy. In terms of practical reality, however, those critics who maintain that what we have in Ireland is an 'illness service' rather than a health service, can justify this allegation by simple reference to the manner in which resources are allocated within the Irish health care system. The *Commission on Health Funding* (1989) reported that health expenditure as a proportion of GNP doubled, from 4.8 to 9.6 per cent, between 1960 and 1988; and Wiley (1998) has shown that while the share of GNP/GDP devoted to non-capital health expenditure has declined between 1990 and 1996, this still – because of economic growth during this period - represented a funding increase in real terms. However, there has been no significant diversion of funding from curative to preventive services, and institutional services (mainly consisting of general hospitals, as well as the largely institution-based psychiatric and mental handicap services) continue to account for about 70 per cent of total non-capital expenditure. General hospitals alone have continued to account for about half of total non-capital expenditure.[3]

In tracing and comparing the evolution of Irish alcohol and drug policies from a health perspective, therefore, a major aim of this study is to identify the extent to which policy makers sought to combine and coordinate all

elements of policy into a balanced and rational whole. In each case it is clear that prevention policies cannot be expected to function effectively if they are solely the function of health care institutions; instead, effective preventive policies depend upon multisectoral collaboration, in which other institutions (in the industrial, financial, legal, educational and other spheres) combine with health care interests to reduce the incidence of alcohol and drug-related problems. For instance, it is difficult to see how Irish health care institutions could expect to reduce or contain the incidence of drug-related problems, if the criminal justice system did not simultaneously enforce the legal measures which are aimed at curbing the supply of illicit substances.

Although the prevention of illness and the promotion of health might generally be perceived as being socially desirable objectives, it would be naive to assume that public health is such a dominant value in society that multisectoral collaboration is guaranteed or that other institutions would automatically subordinate their own interests to the health interest. No such assumption of rationality or consensus will be made in this thesis however. Instead, the intention is to explore empirically the extent to which policy making in this area has succeeded over the period studied in drawing together the various institutional strands which have a bearing on the prevention of dependence and other alcohol and drug related problems.

While it is obviously important to maintain a clear focus on the coordination of public policy at the level of central government, there is a risk in doing so of presenting a picture which exaggerates the extent to which the policy making process is a *top-down* activity. Academic work on this topic over the past twenty years has clearly indicated the dubious validity of models which have suggested that policy is invariably made at a high or

governmental level and then passed down for execution or implementation to lower bodies. Evolving ideas, commonly referred to as 'implementation theory', have argued that the policy -making process is more complex than this, and that the distinction between policy formulation and policy execution is not as clear-cut as it was previously considered to be. On the contrary, it is argued that those who implement policy, and who may be at a relatively low level in their organisational hierarchy, are frequently involved in the type of bargaining, negotiation and general interaction which in itself is characteristic of policy making.[4] Applying these ideas to the alcohol and drugs arena in Ireland, one is reminded that health policy makers are not solely to be found in the Department of Health or other central government departments, but that health board workers, professional bodies, voluntary organisations and other community groupings may all be considered from this perspective.

The health promotion paradigm which will be used as the underlying conceptual framework for this study combines both the top-down and the bottom-up policy approaches: the former emphasises the importance of coordinating intersectoral policy activity at central government level, while the latter, both descriptively and prescriptively, argues for more participatory and communitarian inputs to the policy process. This health promotion paradigm will now be considered in detail.

Health Promotion

From the moment of its establishment in 1946 the World Health Organisation (WHO) was determined that its focus should not be exclusively on the provision of curative services for those already ill. In its foundation charter the WHO declared that:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.[5]

This definition, so utopian as to prompt one early critic to compare it with a state of perfection, 'such as was enjoyed perhaps by archangels and by Adam before the Fall',[6] presaged the broad approach to health which has been a feature of WHO activities ever since. In an era which was characterised by technological advances in the specialised areas of clinical medicine and surgery, the WHO has consistently championed the development of primary health services which are flexible and readily accessible to local communities, and has reiterated the importance for public health of basic environmental factors, such as housing, sanitation and nutrition.

The concept of health promotion has evolved gradually from the early ideals of the WHO and has been consistently aimed at enabling people to achieve health as it was originally defined in the foundation charter. The phrase 'health promotion' appears to have been first used in a Canadian policy document, *A New Perspective on the Health of Canadians,* which was published by Marc Lalonde, the Canadian Minister of National Health and Welfare, in 1974.[7] The WHO does not operate as a free-standing or isolated international health organisation, but functions as a forum where ideas from researchers and policy makers from all over the world are debated, codified and thereby given a new authority and status. Emerging ideas on health promotion were given such an authoritative status in the WHO's *Strategy for Health for All by the Year 2000* which was drawn up at an international conference on primary health care at Alma Ata in 1978.[8] However, for the purpose of this study, the clearest statement of what the aims of health promotion are and of the means most likely to achieve these aims is that contained in the *Ottawa Charter for Health Promotion* of 1986.[9]

The Ottawa Charter, which was drawn up jointly by the WHO and the Canadian Public Health Association, starts by defining health in precisely the same positive terms as those cited above from the WHO foundation charter. It anticipates criticism that health ought not to be seen as an end in itself by suggesting that health should be 'seen as a resource for life, not the objective of living'.[10] Most importantly, the Ottawa Charter identifies five overlapping and interlinked tasks which policy makers must undertake if health promotion is to become a reality. In summary, policy makers must:

* ***Build Healthy Public Policy*** - this consists of putting health on the agenda of policy makers in all sectors of government so as to ensure safer and healthier goods and services, healthier public services and cleaner and more enjoyable environments.
* ***Create Supportive Environments*** - this entails a recognition of the inter-dependence between people and their environments; if human beings do not maintain healthy living and working environments, these environments will not in turn sustain and maximise human health.
* ***Strengthen Community Action*** - health promotion is based on the idea that people should be facilitated to increase control over their own health; thus, rather than depending solely on central government initiatives or the formal activity of health care bodies and professionals, local communities should participate fully in identifying and developing strategies for the promotion of health in their own areas.
* ***Develop Personal Skills*** - this reflects the view that individuals may to a large extent determine their own health patterns by virtue of their 'lifestyles' or the choices they make in terms of diet, exercise, drug use and other such

behaviours; by being informed and by enhancing their decision-making skills, people may optimise their health.

* ***Reorient Health Services*** - while the rhetoric of health promotion has a very positive focus on the prevention of illness and on maximising the quality of life, the reality is that the traditional activities of health services, and the professionals who work within them, have been concentrated on the care and treatment of those already ill; if health promotion is to become a reality, health service professionals must be re-educated to take on the broad, holistic views and activities implicit in this new approach.

From an analytical perspective, health promotion may be regarded as seeking to incorporate two principal, and potentially conflicting, components: the first of these is the *individualistic* component which refers to individual behavioural choices or lifestyles and their impact on health, while the second is the *structural* component which refers to the impact of socio-economic and other environmental factors on the health of wider populations. Later in this chapter some of the main criticisms of health promotion will be discussed; suffice it to say at this point that if health promotion consisted solely of an individualistic approach, as did traditional health education, it would evoke even sharper criticism on the grounds that it ignored the limitations on individual choice, particularly amongst economically and politically disadvantaged groups, and thereby constituted a form of 'victim blaming'.[11]

For some authors on health promotion, these aspirations and strategies constitute a 'new public health'.[12] The use of this phrase involves a conscious harking back to the radical improvements in public health which

were achieved in urbanised and industrialised areas during the nineteenth century, through the introduction of a range of environmental measures. However, where the old public health involved the adaptation of the physical environment – such as the provision of clean drinking water and sanitation, improved housing standards, and food hygiene - health promotion, or the new public health, has a much broader and more ambitious vision of the environment which incorporates cultural, economic and political factors. Clearly therefore, the task of realising health promotion ideals is complex and formidable.

This summary account of health promotion is not intended as an uncritical espousal of the paradigm, nor is it intended to suggest that Irish drug and alcohol policy over the past fifty years *ought* to have conformed to this paradigm. The latter suggestion would be absurd since the health promotion concept, while not entirely new, has only evolved in its present form over the past twenty years. However, it will be used here as the conceptual framework for examining the curative/preventive tension in drug and alcohol policies and services in post-war Ireland, since it contains within a single coherent policy outline reference to all of the relevant major factors and issues. It is hoped that the health promotion paradigm will prove to be a useful vehicle for the presentation and analysis of drug and alcohol data, and, in turn, that the findings of this study will provide a basis for testing the general validity and practicability of health promotion ideas.

Health Promotion in Ireland

While health promotion has continued to be elaborated and refined at international level, particularly within the World Health Organisation, this paradigm has also gained considerable currency in Ireland. The *Health for All by the Year 2000* document was further developed by WHO Europe,

as a result of which 38 specific targets for its successful implementation were identified. In Ireland acceptance of these health promotion ideals was explicitly expressed for the first time in a 1986 policy document from the Department of Health entitled *Health: The Wider Dimensions.* This policy document was heavily influenced by the *Health for All by the Year 2000* ideas, although in a post-script the novelty and radicalism of the proposals were acknowledged in the statement that: 'The cynical and fatalistic will possibly dismiss such an approach as a grand design incapable of being achieved'.[13] In 1987 a health promotion group which had been working under the auspices of the Health Education Bureau (HEB) published its report, *Promoting Health Through Public Policy,* which again summarised many of the evolving health promotion ideas. Essentially, this report reiterated the view that public health was unlikely to be improved significantly by further technological advances in curative medicine, and it decried what it saw as an exclusively curative ethos within Irish health services, arguing that:

> The present role of the Minister for Health is primarily one of providing services to deal with sickness rather than promoting health ... We recommend new statutory provisions expanding the role of the Minister for Health to being responsible for the promotion of the health of the Irish people in addition to providing traditional health services.[14]

The report also recommended that this redefined role of the Minister for Health should be reflected in structural changes in the Department of Health, that the Minister should be statutorily required to produce regular health promotion plans and, finally, that a statutory Health Promotion Council should be established.

While no statutory changes resulted from these recommendations, they did bear considerable fruit. Ironically, since *Promoting Health Through Public Policy* emanated from the HEB, this agency was abolished in 1988 and replaced by a new section within the Department of Health, the Health

Promotion Unit. An Advisory Council on Health Promotion was also established, as was a cabinet sub-committee on health promotion, chaired by the Minister for Health and consisting of the Ministers for Education, Energy, Labour, Agriculture and the Environment.[15] The final development in what was seen as a new, national health promotion structure was the funding by the Department of Health of a Chair in Health Promotion in the medical school of University College, Galway.

Such was the centrality and apparent public acceptability of health promotion during the 1990s that in 1994, when the Department of Health launched its four-year strategy, *Shaping a Healthier Future,* no public or political controversy was aroused by the explicit and implicit use of health promotion concepts in this highly-publicised document. The WHO influence is clearly discernible, for example, in the contention that:

> A central aspect of the Strategy is to reorient the health services towards a health promotion approach based on encouraging people to take responsibility for their own health and on providing the environmental support necessary to achieve this. Many of the targets in this Strategy depend crucially on a co-ordinated and integrated approach to health promotion.[16]

Finally, in 1995 the Department of Health published a specific policy document, *A Health Promotion Strategy: making the healthier choice the easier choice*,[17] which largely reiterated the ideas of *Shaping a Healthier Future* and which identified goals and targets to be aimed for in the realisation of its health promotional ideals. This 1995 policy document contained a brief section on alcohol and substance misuse in the broader context of 'risk factors and lifestyle', and this section will be referred to later in this thesis in Chapters Five and Eight.

Health Policy-Making Structures and Processes

While health promotion appears *prima facie* to be an excellent notion, it is relatively easy to see beyond its idealism to the practical and philosophical difficulties inherent in this paradigm. Cultural or ideological objections to what is sometimes seen as the overweening influence of medicine in everyday life, or state paternalism in relation to healthy lifestyles, will be discussed in the next section of this chapter, but this section will look at the fundamental difficulties which arise in the creation of policy-making structures and processes capable of translating the rhetoric of the Ottawa Charter into real policy achievements.

Firstly, in relation to healthy public policy, one must ask whether it could ever be possible to achieve the degree of intersectoral coordination at central government level that would be necessary for the building of such policy. In order to gain a preliminary understanding of the range and roles of Irish central government departments which have a function in relation to alcohol and drugs, and in order to appreciate the complexity and difficulty involved in coordinating such a disparate range of activities, Table 1 sets out the major departmental functions relevant to this particular area of health promotion.

Table 1

* Role of Central Government Departments in Relation to Alcohol and Drugs

Department of Health	plays a coordinating role for all other departments in the prevention of alcohol and drug problems, as well as being directly responsible for treatment and rehabilitation policy.
Department of Education	has overall policy responsibility for health education for school-going children.
Department of Justice	has policy responsibility for liquor licensing laws, and for law enforcement in this area and in relation to drink-driving legislation and misuse of drugs legislation.
Revenue Commissioners	collect excise duties on alcoholic beverages, and, through the customs service, combat smuggling of alcohol and illicit drugs.
Department of Finance	as part of its overall finance function, sets alcohol taxes and is concerned with revenue and job-creation aspects of drinks and pharmaceutical industry, and with costs of health services.
Department of Enterprise and Employment	seek to develop the drinks industry, both in its manufacturing and retailing aspects, and to promote the pharmaceutical industry.
Department of Tourism And Trade	has an interest in the retailing of beverages in the context of its wider concern for the provision of services for tourists, and in the export of alcohol and pharmaceutical products.
Department of the Environment	has policy responsibility for drink-driving legislation.

* ***Irish central government departments as they were in 1996***

In the case of illicit drugs, there are fewer departments involved in the policy making process and there is less cultural ambivalence about this type of drug use, which may assist in the coordination of comprehensive drug policies; however, the task of policy making in this sphere is still far from simple. In the case of alcohol, there is considerable and obvious potential for a conflict of interests between departments whose approaches to this topic may vary radically; the Department of Health might be committed, for example, to improving public health through a reduction of alcohol consumption levels in Irish society, while other departments (Finance, Enterprise and Employment, the Revenue Commissioners, Agriculture, Food and Forestry, for example) might be primarily concerned with strengthening the drinks industry so as to maximise revenue for the exchequer or create additional jobs.

Baggot, in his study of British alcohol policy, has described the process where an individual department pursues its own policy agenda in a manner which is either indifferent or inimical to the agenda of other departments as 'departmentalism', and he has underlined the difficulties inherent in moving from traditional governmental activity of this type towards health promotion ideals.[18] In their study of the coordination of alcohol and tobacco policies in the United Kingdom, Harrison and Tether have also identified departmentalism as a major obstacle to the type of policy coordination which would appear to be called for under the rubric of healthy public policy.[19] They examine three specific models of policy coordination which they consider most relevant to this task. The first, a rational-comprehensive or *corporate* model, whereby all central government policy activity would be brought into line with an agreed, dominant policy objective such as health promotion, is dismissed on the grounds that it is unrealistic and impracticable. Harrison and Tether conclude that, in real governmental

affairs, consensus of this type between departments simply does not exist. The second model, known as *partisan mutual adjustment,* acknowledges that government departments and other agencies and interest groups are partisan, that is they tend to have distinctive and sometimes conflicting policy agendas; in practice, however, these bodies interact and bargain informally and incrementally, and in so doing create policy which is mutually acceptable, although falling short of what purists or advocates of the corporate approach might see as the optimum.

Harrison and Tether are critical of partisan mutual adjustment on the grounds that it is excessively conservative and *laissez faire,* and is highly unlikely to result in policy coordination which would be deemed satisfactory from a health perspective. Therefore, they argue prescriptively for a third model, the *organisational networks* approach, which is something of a compromise between the two extremes represented by the other two models. The organisational networks model of policy coordination is more systematic, coherent and rational than partisan mutual adjustment, although still falling considerably short of the ideals of the corporate or rational comprehensive model. Essentially, it is suggested that across the array of organisations involved in an area of common policy interest there are identifiable groupings or networks which communicate and negotiate on an on-going basis. Typically, these networks consist of specialist sub-units or personnel rather than total organisations: in the context of this study such sub-units might include the Health Promotion Unit of the Department of Health, the Drug Squad of the Garda Síochána, or the Youth Affairs or Psychological Service sections of the Department of Education. While the structure of the network is relatively fragile and tenuous, it has the capacity, if those involved are sufficiently committed and skilled, to create and sustain a reasonable amount of policy coordination.

Of the three policy coordination models presented by Harrison and Tether, it would appear that organisational networks is the model which is the most realistic and practical for the achievement of health promotion. Much of the literature which advocates health promotion, and this would include the Irish policy documents referred to above, has done so in a superficial, almost evangelical way, which tacitly assumes that public policy making is a rational process and that this rationality will suffice to achieve the successful delivery of health promotion. The most obvious example of this rational/managerial bias is to be found in the tendency of policy documents to set great store on the identification of quantified goals and targets which are to be achieved by a specified date; such target-setting usually fails to acknowledge the fact that there is no evidence of overall, intersectoral consensus on the desirability of health promotion, and frequently has no accompanying strategy which appears likely to achieve these goals and targets.

An interesting and highly relevant development in public administration in Ireland which took place almost at the end of the study period was the establishment by Government of the *Strategic Management Initiative* (SMI) in 1994.[20] This initiative, which was heavily influenced by public management developments in New Zealand and Australia, was largely based on the view that the achievement of important public policy objectives frequently demanded a level of intersectoral collaboration which did not routinely exist in Ireland's fragmented and 'departmentalist' central governmental system. An important aim of SMI, therefore, was the establishment of structures and processes to manage these 'cross-cutting' issues, with explicit reference being made for the first time in this country to an organisational networks style of policy formulation and implementation. This development, to some extent, influenced the decision to set up Local

Drugs Task Forces, which will be discussed in Chapter Nine, but generally it occurred too late to be a major influence on events covered in this study; it will, however, be discussed again in Chapter Ten, which is the final chapter of this thesis.

A second potential complication of the policy process which must be considered here concerns the 'bottom-up' style of policy making inherent in the Ottawa Charter's identification of community action as a necessary ingredient of health promotion. The concept of community is, of course, notoriously vague and ill-defined, yet it is one which in the social policy area is constantly deferred to and of which much is expected.[21] In the context of health promotion, however, it appears quite clear that community action refers to participation of local people in activities which prevent the incidence of health problems or abate existing problems. Ideas of this kind may also be found in the McKinsey Report upon which the administrative structures of Ireland's regional health boards were established following the Health Act 1970.[22] The Community Care Programme, one of three programmes within the conventional structure of the health boards, was not merely intended to provide for the delivery of health and social services in non-institutional settings, but was also intended to foster and encourage local participation in such services. There is also a strong tradition of voluntarism in social services in Ireland, part of which at least was rooted in the principle of *subsidiarity* ; this is a tenet of Roman Catholic social teaching which argues that, as far as possible, the performance of important societal functions should be carried out by bodies lesser than the State – such as the family, local community groups, vocational groups or others. The period from 1987 to 1996, the last nine years of the half-century studied in this thesis, has been characterised by an emphasis on *social partnership* in the management of the economy; much of the credit for the

unprecedented economic growth during this period is given to this conscious and explicit utilisation of a partnership model of public governance in which sectional interests and local groupings work together to achieve common social and economic gains.

Paradoxically, however, there has long been a perception that modern Ireland is characterised by a high degree of administrative centralisation, and it would be naive to overlook the generally sceptical views of analysts and commentators on the level of communitarian or grass-roots participation in Irish public life for much of the period studied here. Lee, for example, has argued that despite the image of Ireland as a country characterised by strong, self-reliant rural communities (an image usually associated with the vision of Eamon de Valera), the period since self-government in 1921 has in fact been marked by continuous centralisation of a political, administrative and geographic nature.[23] Similarly, Barrington, a persistent critic of what he sees as a breakdown of local democracy in Ireland, wrote in 1982:

> There is increasing acceptance in European countries that three great diseases of the modern state are alienation of the people, amoral centralised corporatism, and congested government. I think there can be no doubt but that, in this country, those three diseases are far advanced.[24]

Perhaps the most plausible explanation for this centralisation of government in modern Ireland is offered by Garvin, who suggests that during the transition to self-government in 1922 both sides in the Civil War were distrustful of the elaborate system of local government which had been inherited from the British. He argues specifically that: 'Neither side truly believed in secular participant local democracy and both foresaw that such participation would, if unfettered, lead to a widespread corruption of public life.'[25] Obviously, therefore, the present study of alcohol and drug policy making must not presume that Irish health authorities are enthusiasts for

community participation in health policy matters, whatever the current view of the World Health Organisation on this subject.

It is important before leaving this issue to refer to the tradition of self-help which is particularly strong in the alcohol and drugs field; the original work of Alcoholics Anonymous (AA), established in the USA in 1935, has now expanded to include a range of similar 'fellowships' in the addictions area.[26] AA and the other related fellowships may, on the face of it, be considered as constituting a form of community action; they are enduring mutual associations of persons with a common experience, they are non-professional by their nature, do not seek or accept outside funding and their sole concern is to provide help and support for those affected by these problems. AA and its related fellowships have been solely concerned with curative type activities (although they might not be comfortable with such a description) but it is important in the present study to explore what the consequences of this curative activity have been for the wider area of prevention and health promotion, and perhaps for Irish culture generally.

A third institutional or structural impediment to health promotion which will be alluded to here concerns the role of the medical profession and, to a lesser extent, other conventional health care professionals and institutions. What must be borne in mind is that health promotion policies did not originate from within these traditional groupings or institutions and that, while not couched in the sharply critical language of some well-known critiques of medicine,[27] they are nonetheless fundamentally critical of curative medicine. The existing health care system is dominated by doctors who have been trained, intensively and expensively, in traditional curative medicine and who on a daily basis are busily engaged in the treatment of patients with real, and often life-threatening, illnesses; such doctors may not

routinely be aware of health promotion at all. While some clinicians may contribute actively to health promotion campaigns in their specific area of interest and expertise (respiratory physicians are frequently involved in campaigns against tobacco, for instance), by and large they are too caught up with the treatment of patients to devote much time to this, and they would certainly not agree to a radical reorientation of health services if this involved a transfer of resources from their hospitals and clinics in favour of preventive activities. The Ottawa Charter's recommendation that health services should be reoriented is clearly sensible if one is in favour of health promotion; what is not so clear is whether or how the existing health services can be reoriented in the absence of strong support from this powerful and respected group of traditionally trained clinicians.

Ideological and Cultural Objections to Health Promotion

Apart from these structural or institutional impediments to health promotion, there are at the level of ideas some common objections or criticisms which will be looked at here. The most fundamental critique of health promotion discourse and practice is that which comes from academic sociologists and which argues that health promotion is essentially a moral or cultural enterprise masquerading as objective science. An early example of such sociological work was Zola's seminal paper on 'Medicine as an institution of social control' (Zola, 1972) which argued – to some extent before health promotion had got into its current stride – that ever- increasing areas of life were being drawn into the ambit of medicine without clear and open debate as to the value systems inherent in this process. Zola summarised his fears about this expansion of medicine to cover all aspects of life by citing a colleague, Freidson, who had suggested that: 'A profession and a society which are so concerned with physical and functional wellbeing as to sacrifice civil liberty and moral integrity must inevitably press for a

"scientific" environment similar to that provided laying hens on progressive chicken farms – hens who produce eggs industriously and have no disease or other cares'.[28] As health promotion has been developed in the manner described above, sociological critique has also expanded to look critically at the assumption that health is axiomatically a dominant value and that environment must be restructured and individual lifestyles altered in the interests of health.[29]

Some of the more polemical objections to health promotion are expressed in libertarian terms, with this new approach to public health being described as a form of state paternalism or 'nannyism' which intrudes to an unacceptable extent into the lives of individuals and prevents them from making personal choices. Skrabanek, an Irish community health academic who was consistently opposed to health promotion and tended to refer to it provocatively as 'health fascism', wrote in the mid 1980s:

> Even if the enforcement of a uniform 'healthy' lifestyle were possible, would not the evil of allowing others to decide what is good for us be a sufficient reason for subverting such [a] society?[30]

Ideological objections of this kind, published in British or international journals, may perhaps be considered to be of minimal influence on policy developments in Ireland; yet it is important to point out that such objections - while expressed in secular philosophical terms - have strong theological reasonances with recent Irish history. The influence of the Roman Catholic Church on social policy in Ireland has long been acknowledged and researched, and Whyte's classic study of church-state relations contains a detailed account of the infamous 'mother and child scheme' episode of 1951.[31] Opposition to this health scheme came from two main sources, the Irish medical profession and the Roman Catholic Hierarchy; the latter expressed its opposition to the proposed health scheme in terms of the social teaching of the church, which disapproved of state health services (and

indeed the state generally) playing an overweening role in the lives of citizens. The role and influence of the Roman Catholic Church in the sphere of alcohol and drug policies must therefore be examined continuously throughout this study, and, in particular, it must be remembered that some aspects of health promotion policy may be ideologically or 'doctrinally' repugnant to this powerful institution.

Before leaving the topic of potential church opposition to health promotion, it is of interest to note that about the time of Skrabanek's criticism cited above, the then Roman Catholic Bishop of Limerick, Dr Newman, explicitly criticised health promotion policy in Ireland, linking it to the earlier mother and child scheme controversy, and viewing it as a new totalitarian development which had to be resisted. Dr Newman referred to the HEB publication, *Promoting Health Through Public Policy,* and concluded:

> Some day one could expect - if government were to be sole arbiter - an injunction that one should eat porridge but not cornflakes for one's breakfast ... Already the 'thin end of the wedge' as regards that kind of thing has come with the announcement by the Minister for Health that a Bill to control smoking in public places is shortly to be introduced; also that work is proceeding on controls over the promotion and advertising of such products as tobacco, alcohol and unsuitable food (cf. *Irish Times,* 29 May, 1987). It is genuinely hard to know where it will all end.[32]

In addition to ideological objections of the foregoing variety which fundamentally challenge the ethics of health promotion, there are a number of other criticisms of this policy approach which question the accuracy and the effectiveness of much of the healthy lifestyles information. In summary, such criticisms argue that the advice given to the public on topics such as food and alcohol consumption, drug use, sexual behaviour and other potentially health-related activity is of doubtful scientific validity; it is suggested that advice of this kind exaggerates the risks involved, conceals the fact that most of those persuaded to change their behaviour will derive

little, if any, benefit from such change and, finally, that the entire business of lifestyle direction is better understood as a social movement than as a scientific enterprise.

Nadelmann, a contemporary critic of American drug policy, has argued, for instance, that the risks associated with illicit drug use have been greatly exaggerated in that society's drug education programmes, and that:

> The government, in its efforts to discourage people from using illicit drugs, has encouraged and perpetuated these misconceptions not just in its rhetoric but also in its purportedly educational materials. Only by reading between the lines can the facts be discerned that the vast majority of Americans who have used illicit drugs have done so in moderation, that relatively few have suffered negative short-term consequences, and given available evidence, that few are likely to suffer long-term harm.[33]

Of particular relevance to the present study, which looks at both alcohol and drug policy, is the provocative contention of Szasz, the well-known anti-psychiatrist and libertarian, that attempts to distinguish between acceptable drugs, such as alcohol, and unacceptable drugs, such as heroin, in terms of the science of chemistry are no more sensible than seeking to use chemistry to distinguish between ordinary tap water and 'holy' water.[34] The distinction in both cases, he maintains, is one of cultural ritual or ceremonial.

Finally, in this context, it should be noted that recent advice to the public concerning what are 'safe' levels of alcohol consumption is also not without its critics. Academic commentators, such as Skrabanek, have argued that the public is misled as to the scientific validity of the methods whereby 'experts' arrive at these recommendations,[35] while researchers employed by the drinks industry have described this entire business as 'neo-prohibitionism' or 'pseudo-science'.[36]

Aims Of This Study

While the aims of the present study have been generally referred to in the earlier part of this chapter, it is desirable to restate them formally and in more detail at this point. In overall terms, the aim of the study is to trace the evolution of Irish alcohol and drug policy in the half-century following World War II (specifically the period looked at is from 1945 to 1996) so as to determine: (1) what policies were pursued, (2) how they were arrived at, and (3) what lessons may be learnt from this about health promotion as a practical proposition within the Irish health care system. Looking at these questions in more detail, they read as follows:

1. **What were the main health and social policies pursued in relation to alcohol and illicit drugs in Ireland in the post-war period?**

It is to be expected since the period under study is a relatively long one - half a century - that there will be discernible policy changes over this time. However, in analysing such policy shifts as are identifiable, the focus will consistently be on the balance (or lack thereof) between preventive and curative services. It may be hypothesised that as we move forward in the chronological account of this period, policy in the two areas studied will increasingly reflect the evolving principles of health promotion with a corresponding diminution in the traditionally dominant sphere of curative medicine.

2. **Which were the main interest groups or organisations within the policy making process; how did they interact and to what extent was this process coordinated by either national or regional health authorities?**

The range of central government departments involved in the alcohol and drug field has already been listed above (Table 1). Ministers and civil servants from these departments are potentially key players in the policy process, but so too are many other individuals and groupings which can be readily identified as likely participants in this arena. These include: the

medical profession, teachers, the Garda Síochána, regional health boards, private health care interests, the drinks industry, the churches, voluntary social service organisations, self-help groups, community groups and others. Given this bewildering array of potential actors, the main question which must be asked concerns the structures which were utilised to coordinate the policy process and negotiate an order or compromise. It is to be expected that, as is customary in public policy, much use will have been made of committees, councils and boards; drawing on the analysis of Harrison and Tether, this 'committee' activity will be considered with a view to discovering where it stands in terms of rationality, continuity and coherence. It is possible that committee work of this type will be shown to display over time some degree of continuity or consistent concern with a particular policy approach, or, alternatively, to be a random affair, consisting of a series of *ad hoc* activities.

3. What lessons concerning the general practicability of health promotion may be learnt from this study of alcohol and drugs?

It was suggested earlier that the health promotion paradigm offered a useful theoretical framework for the analysis of data on drug and alcohol policy, but also that this detailed study of drug and alcohol policy may be regarded as a useful case-study (or more accurately two closely-related case-studies) which sheds some light on how realistic and practicable health promotion really is. Reference has already been made to structural and ideological obstacles to health promotion, and it is important to remember that in a democracy the ultimate decision either to challenge these obstacles directly or to compromise in some way lies with elected political leaders. While proponents of health promotion may sometimes rail against what they perceive to be a lack of political will or political backbone,[37] the task of political leaders is best understood as one which involves balancing the advice offered by professional health policy makers against what is deemed

to be electorally popular. In this study, one must start from the premise that health promotion policy as applied to alcohol will be countered in the minds of politicians by a realistic acknowledgment of the long-standing cultural approval of alcohol consumption in Ireland, as well as by an awareness of the economic importance of the drinks industry. There are, for example, similar factors and forces to be considered if one looks at health promotion and food; one could scarcely expect Irish politicians to commit themselves immediately and forcefully to restricting the meat or dairy industry in the interests of reducing animal fat consumption. The task facing politicians is obviously a sensitive and delicate one.

When one turns to the question of illicit drugs, however, it is to be expected that the policy process will be found to be radically different. There is a popular consensus that drugs are a social evil, and academic arguments (such as that of Szasz cited above) that distinctions between 'good' drugs and 'bad' drugs are merely a product of history and culture have not to date captured the public imagination or convinced politicians of their practical utility. In reviewing recent drug policy in Ireland, therefore, one can scarcely expect to find that deviant drug use of this kind will be represented or defended by 'respectable' lobbyists. Health promotion does not solely consist of policy coordination at central government level, of course, and there are a number of questions which arise from the bottom-up elements of the health promotion framework. Given the ideological consensus that drug use is socially undesirable, have drug users themselves had any direct input to the policy process, or indeed have they been facilitated (while they are still using drugs) to develop what the Ottawa Charter calls 'health and life enhancing skills'? Equally importantly, has health policy sought to identify those environments which are conducive to the growth of risky drug use

and, on foot of this, established community action or community development to counter these environmental factors?

In short, it is hoped that this study, concerned as it is with two related though subtly different activities, will help to shed to some light on the wider feasibility of health promotion in Ireland. Perhaps most importantly, at the conclusion of the study it may be possible to make recommendations for the re-casting of health promotion policy in a manner that takes cognisance of the political and administrative culture of this country.

Methodology

In researching this thesis the author used the following methods:

(1) documentary research;

(2) focused interviews and somewhat more informal discussions with key informants in the policy-making area;

(3) the case study method, where it appeared that the presentation of case study material would provide detailed, specific examples of wider policy trends which were being discussed;

(4) the personal experience of having worked in the alcohol and drug field in Ireland for more than fifteen years.

The first of these methods, *documentary research,* involved the study of a wide range of publications including:

* Official policy recommendations and reports, such as, for example, the 1957 Report of the Intoxicating Liquor Commission, the 1974 Report of the Committee on Drug Education and the 1991 Government Strategy to Prevent Drug Misuse;

* Standard statistical reports from official sources which refer to alcohol and drug problems, such as the Crime Reports of the Garda Commissioners (which contain figures relating to drug offences) and the 'Activities' Reports of the National Psychiatric In-patient Reporting System (which contain figures relating to alcohol and drug admissions);

* Specific research reports on different aspects of alcohol and drug problems in Ireland during this period, such as prevalence studies of drug use in various parts of Dublin, or studies linking alcohol consumption to the prevalence of a number of alcohol-related problems;

* Dáil and Seanad debates concerning drug and alcohol-related legislation for the period studied, and the legislation itself;

* Newspaper coverage of important and relevant events or issues arising during this period;

* Miscellaneous other papers by interested parties, including unpublished background papers from bodies such as the Irish National Council on Alcoholism and the Working Party on Drug Abuse;

* Academic literature on drug and alcohol policies in other countries, a full citation of which is given in the bibliography.

The second method consisted of *focused interviews with key informants,* all of whom are individually acknowledged throughout the text as well as being collectively identified and acknowledged in Appendix 1. These informants were chosen on the basis that their experience in and contribution to the alcohol and drug field during the period studied equipped them to provide the author with detailed answers to the research questions, or to confirm, dispute or qualify information which had been gleaned from other sources. The choice of informants was largely based upon the preliminary documentary research: from this preliminary research the individuals chosen emerged as having been influential in the policy process, either over a protracted time period or from a shorter period in relation to a specific, significant issue. The choice of informants was also influenced by the author's own work experience in this field, and in some instances an interview with one respondent had a *snowball* effect in that it contained a strong recommendation that the author should also interview another named person who, it was suggested, could shed some light on particular issues. In only one instance did a person of whom an interview was requested refuse to be interviewed, and in this instance it appeared as though the potential informant was so ideologically committed to one perspective that an academic discussion of these matters was difficult and distasteful. Inevitably perhaps, it proved easier for the author to interview people about

historic material, when passions had cooled as it were, than to deal with more recent times and issues.

The focused interviews were individualised and unstructured and respondents were asked questions, which had been prepared in advance, pertinent to their own areas of activity and interest. With just one exception, interviews were not audio-taped lest this should prove threatening to respondents; instead, answers were hand-written during the interview and subsequently rewritten as quickly as possible – always within the next twelve hours. In some cases, informants were questioned on a number of occasions to get further clarification on certain points, and some informants took the initiative to re-contact the author with further ideas or information on matters about which they had been initially unclear. In addition to these relatively formal interviews, the author made many telephone calls and had numerous informal conversations with informants who provided data on specific points; these contacts are also acknowledged in Appendix 1.

The third method utilised was the case study method, which was intended to provide detailed and specific examples of general policy trends. In Chapter Seven this method is used to illustrate the conflictual relationship which developed between the Eastern Health Board and local community groupings in neighbourhoods characterised by social deprivation and a high prevalence of heroin use. In Chapter Five the case study method is also used to illustrate the difficulties experienced by health boards in reorienting their alcohol treatment services.

Finally, the author drew heavily on his own experience of having worked since 1972 in the health and social services or in a related educational area in Ireland. During this period he worked for six years in an alcoholism treatment unit in the Eastern Health Board and for fourteen years as a

coordinator of the Diploma in Addiction Studies at Trinity College, Dublin. This work experience enabled him to gain a detailed knowledge of the main issues, the actions and the chronological sequence of events. This experience also carries with it, of course, a risk of partisanship or bias, but it is hoped that by framing the research question in an academic way and by relying primarily on documentary evidence such a risk is minimized.

Structure of the Thesis

The lay-out of this thesis consists of two main sections, one dealing with alcohol policy and the other dealing with illicit drug policy, while the final chapter combines analytically the conclusions from these two sections. The importance of the final chapter (Chapter Ten) lies in the fact that it is here that the basic research question concerning the feasibility of the health promotion paradigm in Ireland will be most sharply considered, and it is here also that recommendations will be made for a reframing of health promotion in a style which reflects the Irish situation.

There are four chapters (Chapters Two, Three, Four and Five) which deal with alcohol issues. Chapter Two sets the context by reviewing the recent historical background to the study period, including the temperance movement in nineteenth-century Ireland and the later emergence of the Pioneer Total Abstinence Association. Sociological views concerning the ambivalence of the Irish towards alcohol will be considered, as will the influence of the disease concept (which originated in the United States) from the 1930s onwards. Chapter Three examines the period from 1945 to 1973, the highlight of which was the diffusion of the disease concept of alcoholism to Ireland, while Chapter Four looks at the period from 1973 to 1988, a time when the disease concept was under attack from the emerging public health perspective. The alcohol section of the thesis is then concluded in Chapter Five with a detailed examination of the work of the

Health Promotion Unit on the creation of a national alcohol policy, which represented the most ambitious application of health promotional concepts to the alcohol field in Ireland.

The section on drug issues contains four chapters, Six, Seven, Eight and Nine. The first of these, Chapter Six, deals with the early attempts to create a policy response to illicit drug problems in Ireland between 1966 and 1979, and sets this activity in the context of international drug policy, particularly the historic divergence between British and American policy in this sphere. Chapter Seven then goes on to look in detail at the effectiveness of these policy developments when measured against what was described as an 'opiate epidemic' in working class areas of Dublin between 1980 and 1985; it generally concludes that policy during this period was based uncritically on individualistic assumptions, so that community participation in the response to heroin problems was never facilitated by the health authorities. Chapter Eight then looks in detail at the work of the Health Education Bureau in the area of lifeskills programmes, an approach which appeared to have much to offer drug prevention in the emerging era of HIV/AIDS and in the era of what is sometimes termed the *normalisation* of recreational drugs, but which foundered in a welter of moral and political controversy. Chapter Nine examines in detail the period from 1986 to 1996, when Irish drug policy and service provision changed in response to the new threat to public health created by the link between needle-sharing amongst intravenous drug users and the transmission of HIV, the virus which can lead to AIDS.

Finally, Chapter Ten draws together the conclusions from the two earlier sections, considers them analytically in the light of the research question and makes specific recommendations for the future of health promotion in Ireland.

Chapter One: Footnotes

[1] K. Bruun et al, *Alcohol Control Policies in Public Health Perspective.* (Helsinki: Finnish Foundation for Alcohol Studies, 1975).

P. Davies and D. Walsh, *Alcohol Problems and Alcohol Control in Europe.* (London: Croom Helm, 1983).

G. Edwards et al, *Alcohol Policy and the Public Good.* (Oxford University Press, 1994).

[2] The international nature of drug problems is discussed in policy terms in: *Report of the Committee of Inquiry into the Drugs Problem in the Member States of the Community.* (Strasbourg: European Parliament, 1985). For a sociological discussion of the international trade in drugs, utilising the concepts of *globalisation* and *commodification* see H.Parker, J.Aldridge and F. Measham, *Illegal Leisure: The normalization of adolescent recreational drug use.* (London: Routledge, 1998).

[3] *Report of the Commission on Health Funding.* (Dublin: Stationery Office, 1989); M. Wiley, 'Health Expenditure Trends in Ireland: Past, Present and Future', in A. Leahy and M. Wiley (eds), *The Irish Health System in the 21st Century* . (Dublin: Oak Tree Press, 1998).

[4] For an account of implementation theory see C. Ham and M. Hill, *The Policy Process in the Modern Capitalist State (2nd ed.).* (Brighton: Wheatsheaf Books, 1993).

[5] Cited in A. Clare, *Psychiatry in Dissent: Controversial Issues in Thought and Practice.* (London: Tavistock, 1976), p.9.

[6] A. Lewis, 'Health as a Social Concept', *British Journal of Sociology, 4* (1953), p.110.

[7] M. Lalonde, *A New Perspective on the Health of Canadians.* (Ottawa: Information Canada, 1974).

[8] World Health Organisation, *Primary Health Care (Report of the International Conference on Primary Health Care, Alma Ata, 6-12 September, 1978).* (Geneva: WHO, 1978).

[9] World Health Organisation, *Ottawa Charter for Health Promotion.* (Geneva: WHO, 1986).

[10] Ibid, p.1.

[11] For a critical discussion of individualistic health education and its victim-blaming tendencies see J. Naidoo, 'Limits to Individualism', in S. Rodmell and A. Watt (eds), *The Politics of Health Education: Raising the Issues.* (London: Routledge and Kegan Paul, 1986), pp 17-37.

[12] For the use of this phrase by proponents of health promotion, see J. Ashton and H. Seymour, *The New Public Health: The Liverpool Experience.* (Milton Keynes: Open University Press, 1988); for a more critical sociological use of the phrase, see A. Petersen and D. Lupton, *The New Public Health: Health and Self in the Age of Risk.* (London: Sage, 1996).

[13] *Health: The Wider Dimensions (A Consultative Statement on Health Policy).* (Dublin: Department of Health, 1986), Appendix 1.

[14] *Promoting Health Through Public Policy.* (Dublin: Health Education Bureau, 1987), p.56.

[15] For a ministerial account of these activities and their rationale see R. O'Hanlon, 'Launch Address' in C. Kelleher (ed.) *The Future For Health Promotion.* (Galway: Centre for Health Promotion Studies, 1992), pp 3-8.

[16] *Shaping a Healthier Future: A Strategy for Effective Health-care in the 1990s.* (Dublin: Stationery Office, 1994), p.48.

[17] *A Health Promotion Strategy: making the healthier choice the easier choice.* (Dublin: Department of Health, 1995).

[18] R. Baggot, *Alcohol, Politics and Social Policy.* (Aldershot: Gower, 1990).

[19] L. Harrison and P. Tether, 'The Co-ordination of UK Policy on Alcohol and Tobacco: The significance of organisational networks', *Policy and Politics, 15* (1987), pp 77-90.

[20] SMI was established in 1994, but the first major publication outlining its application to Irish public administration is, *Delivering Better Government: Second Report to Government of the Co-ordinating Group of Secretaries.* (Dublin: Stationery Office, 1996). See also R. Boyle, *The Management of Cross-Cutting Issues.* (Dublin: Institute of Public Administration, 1999).

[21] For an analytical account of this core sociological concept see H. Newby, 'Community and Urban Life' in P. Worsley (ed.), *The New Introducing Sociology.* (London: Penguin Books, 1987), pp 238-272.

[22] McKinsey and Co., *Towards Better Health Care.* (Dublin: Department of Health, 1970/71).

[23] J. Lee, 'Centralisation and Community', in J. Lee (ed.), *Ireland: Towards a Sense of Place* . (Cork University Press, 1985), pp 84-101.

[24] T. Barrington, 'Whatever Happened to Irish Government?', *Administration, 30* (1982), p.107.

[25] T.Garvin, *1922: The Birth of Irish Democracy* . (Dublin: Gill and Macmillan, 1996), p 90.

[26] For a concise account of the origins, philosophy and efficacy of AA see E. Nace, 'Alcoholics Anonymous', in J. Lowinson et al (eds), *Substance Abuse: A Comprehensive Textbook* (2nd ed.). (Baltimore: Williams and Wilkins, 1992), pp 486-495).

[27] Amongst the best-known of these critiques are: I. Illich, *Limits to Medicine: Medical Nemesis. The Expropriation of Health.* (London: Marion Boyars, 1977) and J. Kennedy, *The Unmasking of Medicine.* (London: Allen and Unwin, 1981).

[28] I. Zola, 'Medicine as an Institution of Social Control', *Sociological Review,* 20 (1973), p.503.

[29] See, for instance, A. Petersen and D. Lupton, op.cit.; and R. Bunton, S. Nettleton and R. Burrows (eds), *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk.* (London: Routledge, 1995).

[30] P. Skrabanek, 'Preventive Medicine and Morality', *The Lancet (i)* (1986), p.144.

[31] J. Whyte, *Church and State in Modern Ireland, 1923-1979 (2nd ed.).* (Dublin: Gill and Macmillan, 1980).

[32] J. Newman, *Puppets of Utopia: Can Irish democracy be taken for granted?* (Dublin: Four Courts Press, 1987), p.75.

[33] E. Nadelmann, 'U.S. Drug Policy: A Bad export', *Foreign Policy, 70* (1988), p.93.

[34] T. Szasz, Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers. (London: Routledge and Kegan Paul, 1975).

[35] P.Skrabanek, 'Nonsensus Consensus', *The Lancet* , 335 (1990), pp 1446-1447.

[36] For an example of this literature, which is clearly sponsored by the drinks industry, see D. Heath, 'Policies, politics, and pseudo-science: A cautionary tale about alcohol controls', in D. Anderson (ed.), *Drinking to Your Health; The Allegations and the Evidence.* (London: Social Affairs Unit, 1989), pp 38-52.

[37] For an example of this type of critical comment on the lack of political will see D. Cahalan, *Understanding America's Drinking Problem: How to Conbat the Hazards of Alcohol.* (San Francisco: Jossey-Bass, 1987), p.196.

CHAPTER TWO

ALCOHOL POLICY AND ALCOHOL ISSUES IN IRELAND - THE RECENT HISTORICAL EXPERIENCE

Importance of the Socio-Political Context

The health promotion paradigm described in Chapter 1 will be used as the yardstick against which Irish health policy on alcohol in the Post-World War II period will be measured. This paradigm was of course conceived in the politically neutral, and perhaps slightly unreal, trans-national setting of the World Health Organisation; it would obviously be naive, therefore, to assume that it might be applied in a straightforward technical or instrumental way to alcohol issues in Ireland, or elsewhere, without reference to local political culture.

The aim of this chapter, therefore, is to establish a socio-political context for the detailed presentation of Irish alcohol policy matters which will occupy the next three chapters. This contextual material will primarily consist of a review of relevant historical events in Ireland during the century prior to World War II, but it will also include an account of alcohol policy developments in the USA during the 1930s and the 1940s. The rationale for the inclusion of this latter material is that the 'alcoholism movement', which originated in the USA during the 1930s, was to be diffused internationally and was, consequently, to have a major impact on Irish policy in the post-War period; its influence on the World Health Organisation will be discussed specifically and in more detail in Chapter 3.

Barrington (1987), in her study of health service developments in twentieth century Ireland, touches briefly on the underdeveloped state of public health in late nineteenth century Ireland; by comparison with Great Britain, there was little commitment to public hygiene or to other environmental measures which prevent disease.[1] In seeking to establish what support there might have been in nineteenth century Ireland for alcohol policies currently advocated by health promotionists, it is not to the medical profession or to

public health institutions that one turns but rather to the moral and political activities which comprised that century's temperance movement. In doing so, it is important to clarify that temperance activity must be considered from both the moral or ideological standpoint *and* from the political standpoint; however morally persuasive or philosophically valid the temperance perspective may have been to those at whom it was aimed, its advocates could not count their work as successful if it did not result in legislative or broader policy results. The following discussion will therefore focus on the degree of popular support for the anti-alcohol sentiment of nineteenth century temperance activists as well as on the political effectiveness of these activists.

Temperance in Nineteenth Century Ireland

In her history of the temperance movement in nineteenth century Ireland, Malcolm (1986) deals at length with the tensions between those who favoured *moderation* and those who favoured *teetotalism.*[2] While a literal interpretation might suggest that temperance is synonymous with moderation, the view which came to dominate the temperance movement - although never to the point of consensus - was that alcohol problems might best be prevented by total abstinence or teetotalism.

From the mid-nineteenth century onwards, it is possible to distinguish between two different, although somewhat overlapping, pressure groups which sought to persuade the Irish public to stop drinking and to persuade national and local authorities to introduce strict alcohol controls, if not total prohibition. The first of these to be discussed here consisted of the 'social scientists' of this era, in particular the members of the *Dublin Statistical Society,* which during the 1850s changed its name to the *Statistical and Social Inquiry Society of Ireland* (SSISI), the name by which it is still

known. This society became much concerned with the social and health issues associated with alcohol consumption, and attempted, using the concepts and methods of the period, to provide scientific support for the temperance movement which was then being led by those other powerful lobbyists, the various Christian churches.

McCoy (1991) in a recent SSISI paper has summarised and commented on the temperance publications of this earlier period, concentrating particularly on the six papers on this topic which were read to the society by James Haughton, a Quaker philanthropist, between 1849 and 1858.[3] In an 1849 paper, for example, which argued that 'drink was at the root of all crimes', Haughton attempted to refute the suggestion of *The Times* that temperance reformers such as himself were 'enthusiasts': 'We support our argument not by the crude theories of mere enthusiasts, but by the coolly expressed opinions of those best fitted, by station and education, to testify in our favour'.[4] Understandably, since social research methods were undeveloped at this time, Haughton and his SSISI colleagues appeared to rely excessively on anecdotal evidence, to fail to distinguish between factual data and value judgement and to display a host of other scientific shortcomings. The debate concerning the relationship between scientific research and public policy on alcohol, even a century and a half later, is still quite lively, as will become clear later in this thesis,[5] but certainly it seems that Haughton and other temperance advocates within SSISI failed significantly to persuade either the Irish public or its legislators of the validity of their message. Malcolm's treatment of this material generally confirms that it was not SSISI members, who appear to have been an elitist group with poor political skills, but the churches which were most influential in the temperance movement in Ireland from the mid-nineteenth century onwards.

Foremost among the clerical advocates of temperance was the Capuchin priest, Fr Theobald Mathew (1790-1856) whose crusade during the early 1840s resulted in millions of Irish people pledging themselves to teetotalism.[6] The success of Fr Mathew's campaign was, it is generally agreed, largely attributable to his personal charismatic qualities; huge crowds flocked to his meetings in order to take the pledge directly from him and he was popularly regarded as a saint and a miracle-worker. The success of his temperance crusade was, however, short-lived and, partially because of his failure to create an organisational structure for this work, it was in disarray long before his death in 1856.

Although alcohol issues were debated frequently at Westminster and although strict licensing systems were introduced in the second half of the nineteenth century, it must ultimately be concluded that Fr Mathew appears to have had no lasting impact on either the drinking habits of the Irish or on public policy on this matter. It is important for the presentation and analysis of alcohol policy data in Chapters 3, 4 and 5 that the failure of this extraordinary crusade should be explored, and there are two main explanatory factors which suggest themselves from the literature. The first of these, which concerns the attempt to enlist the support of politicians, is best illustrated perhaps by looking at the relationship between Fr. Mathew and the leading parliamentarian of the day, Daniel O'Connell. The Liberator, as he was popularly known, was at this time engaged in his Repeal campaign, that is the campaign to repeal the Act of Union and to re-establish a native Irish parliament. O'Connell's strategy of mobilising support through the holding of 'monster' meetings had much in common with Fr. Mathew's temperance rallies, and in Kerrigan's and Malcolm's interesting accounts of the relationship between these two men it is clear that this was characterised on both sides by wariness, ambivalence and rivalry.[7]

O'Connell, a *bon viveur* himself, was initially careful not to antagonise the temperance crusaders or to provoke the wrath of Fr Mathew. The intention of Fr Mathew was to keep his crusade non-political and - perhaps even more ambitiously - non-sectarian. Despite this intention, O'Connell largely succeeded in harnessing the energy and the enthusiasm of local temperance groups, even to the extent of having temperance bands providing the music for his Repeal meetings. He generally exploited the temperance issues for his own political purpose, while at the same time expressing public support for teetotalism; this culminated in 1849 in O'Connell's decision to take the pledge himself, a commitment which he had to abandon after a year or so for health reasons!

However, O'Connell never lost sight of the economic importance of the drinks industry or, specifically, of the importance of the support consistently given to him by the industry in his political base in Dublin. As the temperance crusade went into decline, he distanced himself from it, publicly stating that it had passed 'too heavy a censure ... on the former condition of the country by suggesting that the Irish were a drunken people'; the Scots, he suggested, drank considerably more.[8] Malcolm summarises the approach of O'Connell, the politician, to Fr Mathew's crusade as follows:

> In championing teetotalism, O'Connell thus did not want to sacrifice the support he had long received from the drink industry; it was a highly precarious balancing act. From 1840 to 1842 he continued to appeal strongly to teetotallers, but as the crusade waned and Repeal became more securely established, O'Connell began to adopt a much more critical attitude towards the anti-drink movement ... By 1843 O'Connell no longer needed to pander to the views of the teetotallers. He was careful not to criticise Father Mathew personally, but ... the support of the drink industry was now more important to him than that of the teetotal crusade. He had captured teetotalism and securely harnessed it to the chariot of Repeal.[9]

The point is not that O'Connell was especially Machiavellian, nor that Fr Mathew was especially inept politically. What is at issue here is that the political priorities of the Liberator did not include temperance; one could reasonably expect then that temperance would only feature in his political activities when this seemed likely to advance his major political goal, repeal of the Act of Union. As a working politician, with little or no ideological commitment to temperance, O'Connell was sensitive to shifting electoral views on this subject and he appears to have decided from about 1843 that the electorate did not favour the teetotalist views of Fr Mathew and his followers. This leads on to a consideration of the second explanatory factor in the analysis of the temperance movement's decline, namely the attitude of the Roman Catholic Church towards alcohol and more particularly towards the moderationist/teetotalist debate.

The fact that the temperance movement was led by a priest, Fr Mathew, should not be taken as evidence that it reflected the views or enjoyed the unequivocal support of the majority of the bishops, or the clergy generally, within the Roman Catholic Church. It is worth bearing in mind that Fr Mathew, as a member of a religious order, enjoyed a degree of freedom which would almost certainly not have been enjoyed by a secular diocesan priest. Fr Mathew's beliefs were of the teetotallist variety whereas mainstream Roman Catholic views in Ireland at this time were moderationist. Abstinence from alcohol was not automatically expected of priests in nineteenth century Ireland, and being an alcohol consumer was not an inpediment to preferment within the Roman Catholic Church. The reality was that during this period many bishops and priests drank alcohol, as they still do and apparently always have done; furthermore, publicans, brewers and distillers were members in good standing and financial patrons of the Church, and Church leaders were no more willing to alienate them

than was Daniel O'Connell. An important point which might easily be overlooked concerns the historical and continuing use of wine in the celebration of the Eucharist; as long as this liturgical practice continued, it would be difficult for the Roman Catholic Church to develop and plausibly propagate a doctrine which argued that alcohol was intrinsically evil, as the Protestant temperance movements did.[10]

In summary, therefore, it is clear that the Roman Catholic Church in Ireland was unconvinced about Fr Mathew's crusade and about the validity of teetotalism. Church leaders were not unaware that alcohol played a part in the creation and maintenance of a range of social evils, but this they attributed to the excessive use or *abuse* of the substance rather than to any problem inherent in the substance itself. It was not until 1898, half a century after Fr Mathew's death, that the *Pioneer Total Abstinence Association,* the mainstream temperance organisation within the Roman Catholic Church in Ireland right down to the present day, was established by Fr James Cullen, a Jesuit priest.[11]

The Pioneers, as they came to be known, differed radically from earlier temperance activists both institutionally and ideologically. Although Fr Cullen was, like Fr Mathew, a member of a religious order, his work from the outset was monitored by the Roman Catholic Hierarchy, and the association which he founded was immediately integrated into the mainstream institutional life of the Irish Church. This involved the firm rejection of the idea that there should be a non-sectarian or inter-denominational temperance movement; the full title of Fr Cullen's organisation was the 'Pioneer Total Abstinence Association of the Sacred Heart' and members wore a badge depicting the Sacred Heart of Jesus Christ, devotion to which was specifically Roman Catholic.

Fr Cullen's work was acceptable to the bishops not merely because they gained institutional control of it, but because in ideological terms it appeared to avoid the hard-line teetotalism which to many Roman Catholics smacked of Protestantism. Archbishop Walsh of Dublin, a prominent member of the Catholic Hierarchy at the end of the nineteenth century, was particularly dubious about teetotalism but was mollified by Fr Cullen's *Temperance Catechism,* of which he wrote: 'It is no small merit that your catechism is free from every trace of that aggressiveness which unfortunately so often forms a prominent feature in the writings of would-be temperance reformers'.[12] The phrase 'Pioneer' was intended to convey the idea that the members of this association were likely to be few in number, a spiritual elite who voluntarily renounced alcohol consumption for religious motives; there was absolutely no suggestion that alcohol was inherently evil or that all Roman Catholics should be abstainers. A recent publicity leaflet by the Pioneers (which is undated but was most likely to have been printed in the 1970s) summarises the consistent ideological position of that organisation, and part of this is reproduced in Table 2.

TABLE 2*

A Pioneer is a Volunteer who

1. Wants to make an act of generosity for love of our Divine Lord;
2. Works to lessen tragedies caused by drink;
3. Lives a normal life made happier by his self-sacrifice;
4. Makes himself free and independent of alcohol in order to be a service to others.

A Pioneer is

NOT a Prohibitionist objecting to others taking a drink in moderation;
NOT a Puritanical killjoy frowning on those who obtain lawful pleasure from drink;
NOT a weakling fleeing from alcohol.

* Source: Pioneer Total Abstinence Association.[13]

It is important, therefore, to assess the significance of the Pioneers from a policy perspective. It would be naïve to dismiss this association as being of little or no consequence to the policy process since, unlike the Fr Mathew crusade, it survived as a large and mainstream institution within the Roman Catholic Church in Ireland. Ideologically, however, it cannot be regarded as being on a par with fundamental Protestant forms of temperance, since it did not view alcohol as being inherently evil, did not regard abstinence from alcohol as being a moral imperative for all church members, and did not lend itself to lobbying for alcohol prohibition. It did, however, contain within a relatively tight organisational structure large numbers of people who were conscious of the negative impact which alcohol consumption could have on individuals and on society, and who were prepared to become involved periodically in lobbying for legislative and policy change in this sphere even though the organisational *raison d'etre* was primarily spiritual.

Levine (1992) has provided a useful sociological analysis of temperance cultures internationally in the late nineteenth and early twentieth century which may be drawn upon in concluding this account of temperance in nineteenth century Ireland.[14] The term 'temperance culture' is used by him to refer to societies which contained within them large and enduring temperance movements during the period in question. While he does not suggest that temperance sentiment permeated all aspects of these societies, Levine argues that such sentiment had mainstream support there, thus allowing these movements to survive and to continue to exert wide influence. Because of the relative brevity of the 1840s crusade, Ireland does not qualify for inclusion in this category, although Levine does comment on the extraordinary work of Fr Mathew. Ultimately, this study identifies nine temperance cultures: 'The English-speaking cultures of the

US, Canada, the UK, Australia and New Zealand; and the northern Scandinavian or Nordic societies of Finland, Sweden, Norway and Iceland'.[15]

In his analysis of why these societies should have developed temperance cultures, Levine makes the point, which is a standard feature of sociological analysis in this field, that 'problematising' alcohol consumption or suggesting specific preventive measures should not be presumed to be a direct reflection of objective conditions. In other words, he warns against too ready an acceptance of the view that temperance, with its anti-alcohol sentiment, arose in those societies which had in objective terms the worst alcohol problems. In developing his analysis of how societies differentially 'construct' alcohol problems, Levine concludes that there were just two significant factors which distinguished temperance from non-temperance cultures: the first of these refers to preferred beverage type and argues that temperance cultures arose in societies where people drank a considerable portion of their alcohol in distilled liquor (spirits) form; the second merely points out that in all instances temperance cultures were predominantly Protestant.

The point which Levine makes about spirit drinking is that, since it involves a beverage which is extremely potent, it is likely to lead more frequently to drinking to drunkenness and, therefore, to have a higher potential for social disruption. He contrasts the Northern European countries, where spirit drinking is more common, with Southern European countries with their integration of wine drinking into their cultures; in the latter, he suggests, the main alcohol problems are health problems which arise from steady long-term consumption, rather than the immediate social and behavioural consequences of bouts of hard liquor drinking.

However, Levine believes that a high consumption of spirits is not sufficient to account for the emergence of a temperance culture, and he goes on to argue that teetotalism is uniquely associated with Protestantism.[16] This association between Protestantism and temperance is presented by Levine in the context of the classic sociological studies of Weber and Durkheim, studies which contrasted the individualism and the emphasis on individual self-control of Protestantism with the more communitarian belief and social systems of Roman Catholicism.[17] The Protestant distrust of alcohol and its effect on self-control is described as follows by Levine:

> The name of the movement provides a major clue to understanding its appeal. Historians and journalists have sometimes been confused by the name of the nineteenth century alcohol movement because they believed that 'temperance' was the wrong name for what (in America) was largely a crusade for total abstinence. But temperance advocates always insisted that it was the perfect name because *temperance means self-control.* From the early nineteenth century on, they argued that alcohol was dangerous and destructive precisely because it destroyed drinkers' ability to regulate their own behaviour. The whole temperance crusade was built upon a now 200-year-old reinterpretation of the effect of alcohol that centred on its capacity to weaken and destroy self-control and self-discipline.[18]

Interestingly, when applied to temperance in Ireland in the nineteenth century, Levine's analysis offers explanations both for why this movement started and why it ultimately failed. Although statistics as to the form in which alcohol was consumed in pre-famine Ireland are rather inadequate, historians such as Kerrigan and Malcolm suggest that during this period there was a significant increase in spirit consumption; this was accompanied by an apparent increase in crime, and there was particular concern with the consumption of *poitín,* the illicit spirit which was commonly made in rural areas.[19] However, as a predominantly Roman Catholic society, Ireland was neither culturally sympathetic to the notion that alcohol was inherently evil nor persuaded that alcohol consumption invariably resulted in loss of self-control.

There are perhaps just two major implications of this historical material for twentieth century health promotion: the first concerns the difficulties likely to be faced by those who would seek to prevent the incidence and prevalence of alcohol problems through engaging politicians in the construction of healthy public policy; the second refers directly to the ideological content of any such policy. The first implication, in summary, is that health promotionists are unlikely to achieve their aims unless they develop an understanding of the policy process and role of politicians within this process. Commonsense suggests that the behaviour of Daniel O'Connell with regard to alcohol reforms may well be the norm for politicians rather than idiosyncratic or aberrant; essentially, one can expect politicians to retain an independent and somewhat sceptical stance towards proposals for alcohol reform, and to constantly balance the reasoned arguments of would-be reformers against what is deemed to be electorally popular and also what is seen as economically desirable from a broader Governmental perspective. Fr Mathew had proved himself to be a skillful strategist in his dealings with Church leaders, but he displayed little political skill in his contacts with O'Connell and the Repeal movement. Health promotionists who consider their case to be self-evidently laudable or scientifically incontrovertible, but who fail to understand the motives of policy makers and the intricacies of the policy process may have no reasonable expectation of doing any better than Fr Mathew.

Finally, if one accepts that the prevailing socio-cultural norms in Ireland in relation to alcohol are those of other Roman Catholic countries, there would appear to be very little scope for health promotion which is of a hardline teetotal or prohibitionist type. This is not to say that health promotion, as described in Chapter One, has no chance of becoming a reality as it relates to alcohol, but merely to suggest that Irish health policy makers may be

more likely to succeed when they build upon the enduring 'moderationist' streak rather than attempt to replace it with something' dryer' or more prohibitionist.

The Intoxicating Liquor Commission 1925

It would be wrong to suppose that political debate and policy response to alcohol issues in nineteenth century Ireland was exclusively concerned with the teetotal/moderation dispute or with the control of alcohol through the licensing legislation; an attempt to provide a practical solution to the difficulties of individual problem drinkers was offered through admission to the district lunatic asylums which had been set up from the 1817 onwards.[20] In his history of the asylums, Finane (1981) points out that asylum administrators tended to attribute a reasonably large proportion of admissions to 'intemperance in drink'. At the turn of the century, he estimated, about ten per cent of admissions were described in this way, although generally it appeared that the authorities were satisfied that, once detoxified, these inmates were not insane and so would neither need nor benefit from prolonged institutionalisation.[21]

If successful health promotion involves reorienting health services from their preoccupation with clinical medicine and treatment provision towards prevention, then it is useful in the case of *alcoholism treatment* to attempt some assessment of how it was viewed in the period before World War II. The *Intoxicating Liquor Commission*, which sat and reported in 1925, provides a useful overview of this subject: the Commission was the first major official committee to consider alcohol issues following self-government, and its report includes minutes of the oral evidence and questioning of witnesses as well as its conclusions and recommendations.[22]

The Intoxicating Liquor Commission was established by the Minister for Justice, Kevin O'Higgins, with relatively narrow terms of reference: specifically, it was charged with the task of examining the question of the large numbers of licensed premises in the country and the possibility of reducing these numbers. The Commission was chaired by a solicitor and most of its members were either Dáil deputies or members of the Senate, although it did have one member who was a Roman Catholic priest. While there was no member of the medical profession on the Commission, it summoned a well-known medical witness and gave considerable attention to the question of rehabilitating 'habitual drunkards'. Under the provisions of the Inebriate Act 1898, a state inebriate asylum or reformatory had been established at Ennis, Co. Clare; however, because of the lack of funding, the failure of the medical profession to support this venture and the legal complexities involved in its admission procedures, this first foray into specialist alcoholism treatment had failed completely by 1925.[23]

The philosophy which underlies the Commission's report is set out in an introductory section entitled 'Principles Applied', from which it is clear that the members were moderationists rather than teetotallers, closer, as it were, to Daniel O'Connell and Archbishop Walsh than to James Haughton and Fr Mathew. There had been a number of submissions from a variety of temperance organisations, all of them calling for radical curbs on the retailing of alcohol: 'their proposals included complete Sunday closing; the reduction by one half of the number of licensed premises in An Saorstát; the abolition of mixed trading; the suppression of wine licenses and the further restriction of registered clubs'.[24] These proposals were unequivocally rejected by the Commission on the grounds that they were socially unacceptable and politically impracticable. The overall tone of this report is remarkably close to those being written from a public health perspective

fifty and sixty years later[25] in its belief that a balance must be struck between controlling consumption, through fiscal measures and restricted opening hours of licensed premises, and, at the same time, retaining popular support:

> It is, moreover, abundantly clear from all human and legislative experience that there are limits to the compulsory suppression of drinking, and that when carried beyond those limits it defeats its own object by tending to promote more injurious forms of excess as well as evasion of the law by common consent.[26]

On the question of the management of habitual drunkards there was an interesting and paradoxical division of opinion between some of the witnesses; those from the criminal justice system favoured a treatment or rehabilitation approach, while the sole medical witness expressed total scepticism abut medicalising such problems. The former opinion is exemplified in the following remarks of Mr Troy, a District Justice in the Tipperary/Waterford area:

> I think the habitual drunkard should be looked upon as a man with a disease, and that steps should be taken to cure him, so as to give him a chance of getting over the disease, such as the use of an Inebriates' Home. It would be easier to deal with a man in that way.[27]

On the other hand, Dr Arthur Shadwell, an English medical witness who had been summoned because of his expertise in the area of alcohol policy, was dismissive of the value of treating or rehabilitating individual problem drinkers; he replied when questioned on this subject that medical science had made no progress on this front - 'The habitual drunkard is impossible. You cannot do anything with him'.[28]

Dr Shadwell's views, which had been formed over many years, were that public policy should seek to minimise alcohol problems by limiting access to retail outlets and by controlling price, all, of course, within the bounds of what was electorally acceptable. It is interesting to note, in view of the military rhetoric surrounding drug issues from the 1970s onwards (the 'war

on drugs' era), that Dr Shadwell reminded the Commission of Lloyd George's remark during World War I: 'We have three enemies, Germany, Austria and drink, and drink is the worst of them'. [29] He did not, while recognising the problems associated with alcohol, go on to advocate a full-scale war on this 'enemy', but, instead, expressed compromise views similar to those contained in the Commission's report.

Ultimately, the Commission recommended some reduction in the number of licensed premises in Ireland and the retention of the stringent fiscal and licensing measures which had been set in place over the previous half century, and which were deemed to have reduced the level of societal disruption due to drinking. While the Commission did not go beyond its brief and attempt to dictate what should be the practice of the lunatic asylums, it resolutely opposed the expansion of such activity into the sphere of a specialist alcoholism treatment system. The suggestion that recidivist drunken offenders should be diverted from the criminal justice system into a reformatory or rehabilitative system provoked the following response:

> [W]e recommend that where a person is convicted of drunkenness three times in one year, he should, on the third and every subsequent conviction within the year, be sent to gaol without the option of a fine ... Inebriate homes are at best degrading institutions, and we have not sufficient evidence to justify us in recommending the revival of the State home for inebriates. We think the only effective home for such people is a goal and the only suitable occupation plenty of hard labour. The only places where inebriates who have money cannot get drink are the gaol and the asylum.[30]

This harsh recommendation was not implemented, but for the subsequent twenty years, until the end of World War II, the general policy of alcohol control advocated in this report remained in place and there were no policy moves to develop treatment systems.

It should be noted, therefore, in conclusion, that at this time there was no medicalisation of drinking problems in Ireland, no evidence of the influence

of what would later be called the 'disease concept of alcoholism'. Habitual drunkards, as they were termed, were not readily or definitively categorised, and though routinely admitted to the country's asylums, they were not seen in the same light as other inmates. Perhaps the marginal position of these problem drinkers is most succinctly described by an Assistant Commissioner of the Garda Síochána, whose evidence to the Intoxicating Liquor Commission contained the following account:

> [T]hey get into a state of semi-lunacy and a doctor has got to certify them. They are put into an asylum, but they can get out soon again. They cannot be kept under the lunacy jurisdiction once they get sober. They get out, start off again, and the whole thing goes on in a vicious circle.[31]

The Emergence of the Disease Concept in the USA

Ideologically, the policy recommendations of the Intoxicating Liquor Commission continued the ethos which had been dominant in Ireland during the second half of the nineteenth century; in terms of modern health promotion theory, this can be described as a policy compromise which sought to reduce the harm associated with alcohol consumption, while acknowledging both that there were limits to what was culturally and electorally acceptable *and* that there were positive aspects to alcohol consumption. On the latter point, for example, the Commission said:

> Those who most strongly condemn the public-houses would do well to remember that in most of our Irish villages it is, for better or worse, the poor man's club, and nearly always the only one available.[32]

In the USA, on the other hand, there had been a strong temperance culture throughout the nineteenth century, based on the view that alcohol was intrinsically addictive and generally destructive of the moral character and health of all who consumed it. The specific temperance movement which came to dominate this arena in the early twentieth century was, in fact, known as the *Anti-Saloon League.* [33] The temperance leaders of this period in the USA were, as Gusfield (1968) described them, 'utopian moralists';[34]

their conviction was that the prohibition of alcohol would eliminate all social problems. When Prohibition was about to take effect in January 1920, a well-known preacher addressed his congregation in the following terms:

> The reign of tears is over. The slums will soon be a memory. We will turn our prisons into factories and our gaols into storehouses and corncribs. Men will walk upright now, women will smile and the children will laugh. Hell will be forever rent.[35]

By the early 1930s, however, when it was clear that Prohibition was unenforceable, that it had conferred few advantages on society and that it had in fact brought many problems in its train, advocates for its repeal were themselves making utopian type claims for the benefit of returning to legalised alcohol. In 1933, in the midst of America's Great Depression, political support for Prohibition finally ran out and Franklin Roosevelt presided over the dismantling of what is sometimes referred to as the 'noble experiment'.

The task of re-establishing a system of alcohol controls after the failure of the ultimate preventive measure, legal prohibition, was protracted and complex, but in this post-Prohibition era it was the emergence of a new curative policy focus which was to prove to be most important, not just for the USA, but for a wide range of other western societies. This curative approach, most commonly known as the *disease concept*, not unreasonably eschewed what was seen to be the discredited anti-alcohol sentiment of the temperance movement. It conceptualised alcohol problems in terms of the defects or deficits of a small number of drinkers rather than in terms of any inherently negative attribute of alcohol itself. Jellinek, an American physiologist who was a key player in these events, pointed out in 1960 that there had been a number of strands to this alcoholism movement:

> Around 1940 the phrase 'new approach to alcoholism' was coined, and since then this phrase has been heard again and again, every time that the Yale Centre of Alcohol Studies, the National Council on Alcoholism, Alcoholics Anonymous or

> individual students of the problem make an utterance to the effect that alcoholism is a disease.[36]

Alcoholics Anonymous (AA), to reverse the order favoured by Jellinek, is a self-help organisation for problem drinkers which was founded in Akron, Ohio, in 1935 by Bill Wilson, a New York stockbroker, and Bob Smith, a physician who worked in Akron.[37] The Fellowship, as AA is commonly referred to by its members, grew slowly in the USA up to the end of World War II, following which it took on the international character it has since retained. The AA programme of recovery is encapsulated in its well-known Twelve Steps, and it is clear from even a cursory glance at this programme that its methods and ethos tend towards spirituality to a far greater extent than towards technical rationality of a clinical kind.[38]

Viewed from a health promotion perspective, however, it must be stated that AA concentrates exclusively on treatment (albeit of a spiritual variety) of individual sufferers, without reference to the possibility of prevention. The AA approach is vague on the question of causality and it certainly does not purport to be scientific, but the general view which may be gleaned from its literature and from discussion with members is that alcoholism is caused by the defects of individuals rather than by any negative property of the substance itself. The Steps contain reference to 'defects of character', and AA's Big Book contains the much-quoted view that alcoholism is a 'mental obsession and a physical allergy'.[39]

When considering AA's influence on social policy, it is important to note that the Fellowship was strictly enjoined by its Twelve Traditions (the movement's basic organisational principles which were codified in a final and definitive way in 1950) not to act as an interest group by lobbying for legislative or other policy change. It could be argued that AA survived and thrived, unlike similar organisations which had preceded it, because it fitted

so well with the policy climate of post-Prohibition America; by attributing causal responsibility for alcoholism to individual factors rather than to alcohol *per se* it could be seen as justifying the repeal of Prohibition and rebutting the claims of surviving temperance advocates. This was, however, merely an unintended consequence of the establishment of AA, since the organisation – as set down in its Traditions – completely dissociated itself from lobbying or political activity of any kind. The loose structure of AA and the centrality of the principle of personal and organisational anonymity were intended to ensure that the Fellowship would remain forever outside of public controversy and policy debate, and would instead focus exclusively on the welfare of its members.[40] Thus, while Jellinek's use of the phrase 'new approach to alcoholism' undoubtedly reflected a common perception that there was an organised and coherent alcoholism movement in the USA from the 1930s onwards, it has to be made clear that AA was not formally aligned to or an explicit participant in any such movement.

The National Council on Alcoholism, also referred to in the Jellinek quote, was originally launched in 1944 in New York under the title of National Committee for Education on Alcoholism. This was a body which *was* set up to lobby for greater public acceptance of the disease concept of alcoholism; specifically, it sought not merely ideological approval but institutional and financial commitment to the idea that alcoholism was a disease which could be and should be treated within the healthcare system. The founder of the National Council on Alcoholism was Marty Mann, often described as the first female member of AA; although her decision to 'go public' clearly violated the doctrine of anonymity and caused some dissension within the Fellowship, she proved to be a very effective lobbyist. Marty Mann's influence was not confined to the USA but, as will

be seen in Chapter Three, she was to play an important role twenty years later in the establishment of a similar national council in Ireland.[41]

The final strand in the American alcoholism movement was the involvement of biological and behavioural scientists in researching this area. Of particular importance in this regard was the Yale Centre of Alcohol Studies (referred to in the Jellinek quote) which developed out of research on alcohol being conducted in that prestigious university's Laboratory of Applied Physiology during the 1930s.[42] For lobbyists such as Marty Mann the activities of researchers in this field were of value, not because they resulted in immediate and radical scientific breakthroughs, but because they could be used to lend rational/scientific authority to a policy shift which might not necessarily command universal consensus. Many of those who advocated the disease concept claimed that not merely was their social movement new but that it was also scientific. In conventional policy terms, therefore, the State had no *right* to restrict the freedom of citizens in this regard; the right to drink alcohol was a fundamental freedom which could not be denied merely because of the vulnerability of a tiny minority of drinkers, any more than the State could make a foodstuff illegal because some consumers were allergic to it. In the evolving alcoholism movement, the major *duty* which came to be identified was the duty of society and State to make provision for accessible alcoholism treatment facilities. There was a concomitant duty on alcoholics to seek treatment, but, it was argued, many alcoholics failed to do so because of the relative scarcity of treatment resources and because of the stigma associated with this disease; this latter phenomenon was generally referred to in terms of 'the hidden alcoholic'.[43]

However, if there were tensions between Marty Mann and AA, so also were there tensions between her and the scientific community. As an effective

lobbyist and strategist, Mann was less interested in subtle, incremental scientific advances than in claiming unequivocal scientific support for the movement she represented. For example, she claimed that there was a clear biological basis for a discrete unitary disorder called alcoholism, where the scientists themselves were unconvinced of this;[44] furthermore, the inclusion of social scientists in this arena led, predictably perhaps, to the growth of interest in a broad range of drinking behaviours and drinking problems rather than to a narrow focus on alcoholism. Some sense of the conflict which arose between those who were zealous proponents of the disease concept and the rather more impious social scientists may be gained from this retrospective comment of Bacon (1979):

> Alcoholism has been the great cult excitement of the last 34 years. I was one of the people who helped build up the cult, in the early days before I got thrown out when I said, "Well that wasn't quite what I meant". Alcoholism was to be the wheelhorse of change; it was not to be the change. It was taken over ... Recently the cult has become so powerful, 1960-1972, that it has taken over traffic problems and youth problems, and they are all called alcoholism, which of course is a lot of nonsense if the word is to refer to a disease-like entity of some sort or a life disorder of some sort. Alcohol problems are much, much bigger than that.[45]

However just as Fr Mathew's social impact was greater than that of the scholars of the Statistical and Social Inquiry Society of Ireland, so too did Marty Mann prove more influential than any of the researchers at Yale or at subsequent research centres. While there was some residual temperance sentiment which suggested that the alcoholism movement had been duped by the drinks industry,[46] the American public generally gave credence to the idea that alcoholism was an individual disease and to all that this implied.[47]

Summary and Implications

The material reviewed in this chapter suggests that, broadly speaking, there were two main policy options available to Irish policy makers in relation to alcohol in the Post-World War Two era. The first option would be to

continue with the policy line which had emerged over the previous century: this was a pragmatic approach which sought to reduce potential health and social damage by controlling consumption through fiscal measures, licensing legislation and the general criminal justice system - all, of course, based on the premise that there was no popular or institutional support for strict temperance or prohibition. This Irish approach had many inter-sectoral features of the kind advocated by latter-day health promotionists, but it also had a role - albeit a minor and rather begrudging one - for treatment and rehabilitation within the mental hospital/asylum system.

The other option would be to adopt or import the 'new scientific approach' of the Americans by institutionalising the disease concept of alcoholism in Ireland. There was, of course, no reason to suppose that the disease concept would inevitably be diffused to or accepted within Ireland, given the very different societal context. The disease concept was obviously understandable and, to some extent, functional in a society which had made a fundamental decision to legalise alcohol in the wake of its disastrous policy experiment with prohibition. The Irish societal context was very different: there had been no such experimentation with prohibition and there was consequently no need for a radical policy shift to redress the problems created by prohibition.

The task of Chapter Three, therefore, is to explore Irish alcohol policy processes and events in the period from 1945. Because of the global pre-eminence of American culture and technology in the post-war years, it is reasonable to expect that some diffusion of the disease concept would occur. However, because of the radically differing societal context already referred to, it would be unreasonable to expect an immediate or speedy policy shift (of a rational comprehensive type) in Ireland towards the disease

concept. What needs to be studied is whether or how the Irish social, political and cultural context altered so as to make the adoption of the disease concept more likely; such a policy shift, if it can be identified, is of course likely to be of an incremental nature. The survival and retention of previous existing Irish alcohol policy might reasonably be expected to be dependent upon explicit periodic re-statement, all with a view to demonstrating its continuing value and efficacy; Chapter Three will seek *inter alia* to discover if such re-statements were made, by whom and to what effect. In all of this, of course, it will be important to assess the role played by the Department of Health in managing this policy process, in the light of the various policy coordination models discussed in Chapter One.

Chapter Two: Footnotes

[1] R. Barrington, *Health, Medicine and Politics in Ireland 1900-1970.* (Dublin: Institute of Public Administration, 1987), pp 12-14.

[2] E. Malcolm, *'Ireland Sober, Ireland, Free': Drink and Temperance in Nineteenth Century Ireland.* (Dublin: Gill and Macmillan, 1986).

[3] D. McCoy, *Issues for Irish Alcohol Policy: A Historical Perspective with Some Lessons for the Future.* (Paper read before the Statistical and Social Inquiry Society of Ireland, 24 October, 1991).

[4] Ibid., p.4.

[5] For a detailed and focused consideration of this topic see 'The Interaction of Alcohol Research and Policy: Case Studies from Australasia, North America and Europe', *Addiction,* 88 (Supplement, January 1993).

[6] The two major secondary sources drawn on for this material are E. Malcolm, op.cit. and C. Kerrigan, *Father Mathew and the Irish Temperance Movement 1838-1849* (Cork University Press, 1992). These are two balanced accounts of the temporary nature of Fr Mathew's crusade which avoid the hagiographical tone of some earlier historical studies of these events.

[7] See Ch. 5, 'Teetotallers and Repealers', in Kerrigan, op.cit.

[8] E. Malcolm, op.cit., p.130.

[9] Ibid. p.l30.

[10] Malcolm (p.278) refers to the controversy among some Protestant temperance advocates towards the end of the nineteenth century concerning the nature of the wine used by Jesus and his disciples; it was argued by some that this wine was unfermented or, in modern terms, alcohol-free wine.

[11] Malcolm (Ch.6) provides a detailed account of Fr Cullen's work, paying particular attention to the differences between the Pioneers and the Fr Mathew movement. The principal source, however, for information on the Pioneers is the detailed and authoritative study which was published to mark the centenary of the association's founding: D. Ferriter, *A Nation of Extremes: The Pioneers in Twentieth Century Ireland.* (Dublin: Irish Academic Press, 1999).

[12] Cited in Malcolm, op.cit., p.312.

[13] *What It Means To Be A Pioneer.* (Undated leaflet published by the Pioneer Total Abstinence Association of the Sacred Heart).

[14] H. G. Levine, 'Temperance Cultures: concern about alcohol problems in Nordic and English-speaking cultures' in M. Lader, G. Edwards and D.C. Drummond (eds), *The Nature of Alcohol and Drug Related Problems.* (Oxford University Press, 1992), pp 15-36.

[15] Ibid, p.16.

[16] Ibid, pp 22-27.

[17] The classic studies in question are Weber's *The Protestant Ethic and the Spirit of Capitalism* and Durkheim's *Suicide.*

[18] Levine, op.cit., p.25.

[19] For a discussion of illicit distillation in the 1830s, see Kerrigan, op.cit., Chapter 1.

[20] There are a number of recent histories of Irish asylums which are of relevance. Perhaps the most analytical of these is M. Finnane, *Insanity and the Insane in Post-Famine Ireland.* (London: Croom Helm, 1981).

Another study which touches on the treatment of drinking problems in Irish asylums is J. Robins, *Fools and Mad.* (Dublin: Institute of Public Administration, 1986).

For historical accounts of two well-known asylums, one public and one private, see J. Reynolds, *Grangegorman: Psychiatric Care in Dublin since 1815.* (Dublin: Institute of Public Administration, 1992) and E. Malcolm, *Swift's Hospital: A History of St Patrick's Hospital Dublin 1746-1989.* (Dublin: Gill and Macmillan, 1989).

[21] M. Finnane, op. cit., pp 146ff.

[22] *Report of the Intoxicating Liquor Commission..* (Dublin: Stationery Office, 1925).

[23] For an interesting account of the Ennis inebriate asylum see B.Smith, 'Ireland's Ennis Inebriates' Reformatory: A 19th Century Example of Failed Institutional Reform', *Federal Probation* (March 1989), pp 53-64. This study of the Ennis inebriate asylum not only discusses the legal and admininistrative complexities associated with setting up this institution but also emphasises the importance of the fact that there existed at this time no effective therapeutic technologies; this led to feelings of despondency on the part of all concerned and hastened the institution's demise. As Smith put it: 'Quite bluntly no-one knew how to cure a drunk' (p. 64).

[24] Report of the Intoxicating Liquor Commission, cit.sup., p.4.

[25] See, for example, *World Health Organisation Expert Committee on Problems Related to Alcohol and Consumption.* (WHO Technical Report Series 650, 1980).

[26] Although this is a direct quote from the *Report of the Intoxicating Liquor Commission* (p.3) it should, even after three quarters of a century, be pointed out that the wording is borrowed without acknowledgement from A. Shadwell, *Drink in 1914-1922: A Lesson in Control.* (New York: Longmans Green and Co., 1923), p.152.

[27] Evidence of District Justice Troy to the Intoxicating Liquor Commission, 6th April 1925.

[28] Evidence of Dr Shadwell to the Intoxicating Liquor Commission, 5th May 1925.

[29] Ibid.

[30] *Report of the Intoxicating Liquor Commission,* cit.sup., Recommendations paragraph 16(a).

[31] Evidence of Assistant Garda Commissioner to the Intoxicating Liquor Commission, 23rd March, 1925.

[32] *Report of the Intoxicating Liquor Commission,* cit.sup., p.3.

[33] There is an extensive literature on the Anti-Saloon League and its success in achieving Prohibition. One of the most cited and enduring studies is: J. Gusfield, *Symbolic Crusade; Status Politics and the American Temperance Movement* (2nd ed.). (Urbana: University of Illinois Press, 1986).

[34] J. Gusfield, 'Prohibition: The Impact of Political Utopianism', in J. Braeman et al (eds), *Change and Continuity in Twentieth Century America.* (Columbus: Ohio State University Press, 1968).

[35] The Rev. Billy Sunday, cited in H.G. Levine and C. Reinarman, 'From Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy' in R. Bayer and G. Oppenheimer (eds), *Confronting Drug Policy: Illicit Drugs in a Free Society.* (New York: Cambridge University Press, 1993), p.162.

[36] E. Jellinek, *The Disease Concept of Alcoholism.* (New Haven: Hill House Press, 1961), p.1.

[37] What is closest to an authorised history of AA, written with the full cooperation of the Fellowship and unrestricted archival access is: E. Kurtz, *Not God: A History of Alcoholics Anonymous* (Expanded Edition), (Center City, Minnesota: Hazelden, 1991). This history of AA is scholarly and analytical (it started as a Ph.D. thesis for Harvard) but is perhaps overly sympathetic in its treatment of the subject matter. For an equally scholarly but somewhat more critical perspective on AA see D. Beauchamp, *Beyond Alcoholism: Alcohol and Public Health Policy.* (Philadelphia: Temple University Press, 1980).

[38] Alcoholics Anonymous, *Twelve Steps and Twelve Traditions.* (New York: AA Publishing, 1952).

[39] Known colloquially as the "Big Book', this biblical text was first published in 1939: *Alcoholics Anonymous.* (New York: AA World Publishing, 1939). The view that alcoholism is 'a mental obsession and a physical allergy' is developed in a preface entitled 'The Doctor's Opinion'.

[40] The Twelve Traditions of AA generally reflect a singleminded concern with members' sobriety and a determination to avoid politics and public debate. This is best captured in Step 6: 'An AA group ought

never to endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose'; and Step 10: 'Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never to be drawn into public controversy'. Bill Wilson, who was the principal founder of AA, was known until his death in 1971 simply as Bill W; he took the idea of anonymity so seriously that he refused to go on the cover of *Time* magazine even with his back turned (*Time,* June 14, 1999, p. 117).

[41] For a discussion of the work and influence of Marty Mann see Beauchamp, op. cit. Also, see K. Middleton Fillmore, 'Competing Paradigms in Biomedical and Social Science Alcohol Research: The 1940s Through the 1980s' in P. Roman (ed.), *Alcohol: The Development of Sociological Perspectives on Use and Abuse.* (New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1991), pp 59-84.

[42] K. Middleton Fillmore, op.cit.

[43] See Chapter 3 of Beauchamp, op.cit.

[44] These claims by Mann and the dubious response from medical researchers are discussed in detail in B. Johnson, *The alcoholism movement in America: A study in cultural innovation.* (Unpublished doctoral dissertation, University of Illinois, Urbana-Champaign, 1973).

[45] S. Bacon, 'Discussion: Social Science', in M. Keller (ed.), Research Priorities on Alcohol: Proceedings of a Symposium. *Journal of Studies on Alcohol* (Supplement 8), 1979, pp 289-321. Cited in K. Middleton Fillmore, op.cit., p.61.

[46] See R. Room, *Governing Images of Alcohol and Drug Problems: The Structure, Sources and Sequels of Conceptualizations of Intractable Problems.* (Unpublished doctoral dissertation, University of California, Berkeley, 1978), pp 135ff.

[47] 'By 1987, a Gallup poll showed that about 90 per cent of the population of the United States endorse the idea that alcoholism is an illness and that a large majority believe that alcoholism can only be arrested through medical treatment'. (S. Peele, 'Can Alcoholism and Other Drug Addiction Problems be Treated Away or Is the Current Treatment Binge Doing More Harm than Good?', *Journal of Psychoactive Drugs, 20* (1988), p.375.

CHAPTER THREE

THE DISEASE CONCEPT IN THE ASCENDANT 1945-1973

Introduction

The two major options for Irish policy makers in relation to alcohol during the post World War II era were, as outlined in Chapter Two, to continue with a broad range of public policy measures aimed at preventing or reducing alcohol-related damage or, alternatively, to adopt the disease concept of alcoholism which was more narrowly concerned with curative services for individual problem drinkers. The material presented in this chapter will clearly indicate that until the early 1970s it was the latter option which was favoured: for more than a quarter of a century Irish health and social policy, insofar as it related to alcohol, demonstrated a dominant concern with clinical concepts and practices, almost to the total exclusion of health promotional or preventive activities. The aim of this chapter, therefore, is to trace and describe the major events, activities and institutions which made up this process, while at the same time seeking to identify the interest groups most actively involved either in advocating this medicalisation of drinking problems or in arguing against it. Given the key role which one could expect of the Department of Health in health policy formulation, and which is certainly envisaged by health promotion theorists[1], it is obviously important to focus on the role played by the Department of Health in this regard throughout this period.[2]

Before proceeding with this account of developments in Irish alcohol policy, it is important to refer back to the international influence wielded in this sphere by the World Health Organisation (WHO) following its establishment in 1946. While the WHO generally displayed an interest in and commitment to what would later come to be referred to as 'health promotion' rather than an exclusive concern with the practice of medicine or with curative services, it deviated significantly from this policy approach in its handling of alcohol issues. The early WHO reports on alcoholism[3]

clearly reflect the influence of E.M. Jellinek, one of the most prominent researchers at the Yale Centre of Alcohol Studies, who worked as a consultant to the WHO from 1950 to 1955.[4] Understandably, Jellinek took with him to the WHO, through which he projected onto the international scene, all the preoccupations of the USA with the 'new scientific approach' to alcoholism. A 1952 publication of Jellinek's,[5] based on a survey of AA members, purported to depict the progression of alcoholism as a disease, suggesting that the disease process unfolded in an orderly, linear sequence, with each symptomatic stage inevitably building upon the previous stage. This chronological progression of alcoholism was graphically presented in a popular format, usually referred to as the 'Jellinek Chart'; a quarter of a century later the sociologist Robin Room suggested that 'this chart, particularly as adapted by Glatt (1970), is probably the most widely diffused artifact of the alcoholism movement's disease concept'.[6]

In overall terms, the impact of Jellinek on the WHO - and through this authoritative body on national health authorities - was to advance all the major tenets of the disease concept. Alcoholism was presented unambiguously to the world as a discrete disease which could be defined, which had a predictable history and which should be treated as other diseases were treated; the etiology of alcoholism, while not fully understood, tended to be viewed in terms of individual deficit or predisposition, and it was suggested that there was no relationship between societal levels of alcohol consumption and the incidence and prevalence of alcoholism.[7] The Department of Health in Ireland was, therefore, subjected on this topic to a consistent and ostensibly authoritative stream of policy recommendations which pushed it in the direction of the disease concept favoured in the USA. In this context, the questions which must be asked are whether or how the Department of Health was influenced by the WHO.

There was no obligation on the Department to accept WHO advice, but the manner in which it evolved its own approach to alcohol can be regarded as an example of its capacity to tackle complex health policy issues and to assess the value and relevance of external policy recommendations for the local Irish scene.

The Mental Treatment Act 1945

The Mental Treatment Act 1945 was the first mental health legislation to be enacted in the period since self-government; it was for its time a progressive statute in that it provided for the first time in Ireland for the voluntary admission of patients to psychiatric institutions and established a rudimentary set of safeguards against wrongful or unnecessary detention. It also provided a statutory basis for the creation of a range of outpatient psychiatric facilities, although such community-based services and facilities were not to be developed to any great extent for a further twenty years. In the context of the present research, the Mental Treatment Act is important because it made specific provision for both the voluntary and compulsory admission to psychiatric hospital of 'addicts', this word clearly being intended to include those addicted to alcohol. It is perhaps helpful to cite in full the definition of an addict contained in the legislation:

> In this Act - the word 'addict' means a person who -
>
> (a) by reason of his addiction to drugs or intoxicants is either dangerous to himself or others or incapable of managing himself or of ordinary proper conduct, or
>
> (b) by reason of his addiction to drugs, intoxicants or perverted conduct is in serious danger of mental disorder.[8]

In addition to some difficulties with the concept of 'ordinary proper conduct' which were raised during the legislative process and which will be discussed below, there is of course a fundamental difficulty with a

definition of an addict which appears to regard the underlying concept of addiction as self-explanatory and in no need of definition. However, the importance of this inclusion of and reference to addicts in the Mental Treatment Act was that it provided a specific statutory basis for the expansion of alcoholism treatment within the Irish mental health system which was to take place in subsequent years. Critics of the scale of alcoholism treatment in Ireland, particularly the growth in inpatient care which took place from the late 1960s onwards, certainly were unhappy with this provision of the legislation, and it became clear that it would be omitted from new mental health legislation.[9] Dermot Walsh, a psychiatrist who through his varied roles as clinician, epidemiologist and Inspector of Mental Hospitals exerted considerable influence on the Irish psychiatric care system for more than thirty years, described this provision of the 1945 legislation and its consequences as he saw them in the following terms:

> The 'medicalization' of alcohol problems continued at the same rate here as elsewhere and was codified by the provisions of the 1945 Mental Treatment Act which in addition to encouraging the voluntary admission of 'alcoholics' to psychiatric hospitals made provision for their compulsory admission as well ... One consequence of this was that in line with increased consumption of alcohol, admission for this condition had become the most common cause of admission to psychiatric hospitals and units and by the mid 1970s constituted one-half of all male admissions and one third of all admissions for both sexes.[10]

In view of these subsequent developments in the demands made by and resources allocated to alcoholism treatment in the Irish mental health system, it is important to consider in detail what the policy intent of the Minister for Health was in including this provision in the legislation. Was it the Minister's intent that the psychiatric services should adopt a more positive and welcoming attitude to alcoholism? Did this inclusion of addiction in the legislation signify a coherent and decisive policy shift by the Minister and his department towards the disease concept?

Based on a careful study of such documents as are available on the enactment of the Mental Treatment Act 1945, the answer to these questions is generally negative.[11] An obviously striking fact is that, although the legislation had been in preparation for many years, the addiction provisions were not in the Bill (Mental Treatment Bill 1944) but were introduced as an amendment by the parliamentary secretary, Dr Ward, at the committee stage. One can speculate that this amendment would not have been introduced were it not for the intervention of the Irish Medical Association (IMA); the IMA had been generally positive in its response to the Mental Treatment Bill, but an editorial article in the January 1945 issue of its journal critically noted the absence of any reference to alcoholism in the proposed legislation:

> There is no mention in the Bill of methods for the control and treatment of drug addicts and alcoholics. This is an important, and in itself, a very difficult question. It bristles with legal difficulties, apart altogether from the medical aspects of the conditions and, of course, any doctor be he a general practitioner or a psychiatrist, knows how urgent this matter is. Much suffering and misery is caused particularly by the chronic alcoholic who cannot be controlled and who cannot be fully treated under the present system.[12]

More conclusively however, in introducing the definition of addiction into legislation the parliamentary secretary made it clear that it was not intended that this inclusion should have an immediate impact on the way in which general psychiatric services and facilities were administered. Dr Ward's basic contention was that at some future time it might be possible to set up a separate system of specialist addiction services and that, against this eventuality, some specific statutory provision must be made. Following a lengthy comment on the difficulty and complexity of alcohol and drug problems, he summarised his policy intent on this matter:

> I should tell the House that, at this stage, we can only provide the necessary [legal] machinery, and that until such time as suitable institutions are available we cannot deal adequately with the problem that this amendment is intended to deal with. It will only be in case of urgency, or particular emergency, that addicts will be received in the ordinary institutions. In the course of time it is hoped that we may be able to provide special institutions ...[13]

It was suggested by one opposition deputy that the inclusion of the phrase 'ordinary proper conduct' in the text of the bill was unacceptably vague and that it would put great pressure on admitting psychiatrists, particularly where relatives were anxious to have troublesome drinkers locked up; generally, it was argued by a number of opposition deputies that these definitions of an addict would prove problematic for the psychiatric service.[14] Dr Ward, in a series of exchanges which became increasingly fractious, would only concede that these deputies made 'a good enough debating point'.[15] While it is conceivable that some of this debate was of a mischievous kind, aimed at annoying Dr Ward who was not noted for his tolerance or even temperament,[16] it will emerge later in this chapter and in Chapter Four, that there was serious substance to the reservations expressed by these opposition deputies.

It can safely be concluded, therefore, that the inclusion of the addiction provision in the Mental Treatment Act 1945 did not represent a decisive and well thought-out policy shift towards the disease concept. The amendment represented, instead, an eleventh hour decision to acknowledge this complex issue, largely on the basis that at some future time - when resources or technical developments permitted - alcoholism would be tackled more decisively in specialist settings. Dr Ward's attitude towards the treatment of alcoholics in the general psychiatric system may well have been the same as that which had traditionally prevailed - alcoholics were admitted to psychiatric institutions only on sufferance - but, as circumstances changed, what proved to be important was not his rationale for this amendment but simply the fact that there was now an explicit statutory basis to this practice. Even though it was not Dr Ward's or his department's intention, as other forces and interest groups promoted the disease concept of alcoholism in Ireland the Mental Treatment Act appeared

to support the view that the psychiatric hospital should become, in the phrase of Dermot Walsh, the 'preferred locale'[17] for dealing with alcohol-related problems in this country.

Alcoholics Anonymous in Ireland

The establishment of AA and its importance as one of the central strands in the new approach to alcoholism in the USA has already been described in Chapter Two. In considering its introduction to and impact upon Irish society, it should be remembered that AA was not a scientific or technical innovation which might be guaranteed an uncomplicated diffusion throughout western society. Kurtz, the author of the Fellowship's authorised history, has described it as a social movement clearly rooted in the culture and society in which it originated: 'in a score of ways, Alcoholics Anonymous was at least by association as American as baseball, apple pie and the fourth of July'.[18] There is no reason, therefore, to suppose that its establishment in Ireland was inevitable or straightforward, and in view of the centrality of spiritual themes in AA it is particularly important to consider how it was viewed by the Roman Catholic Church in Ireland.

The first AA meeting in Ireland, which is also reputed to have been the first AA meeting in Europe, took place in late 1946 when Conor F., home from the USA on holiday, met Richard P., an inpatient in St Patrick's Hospital, a meeting which was facilitated by Dr Norman Moore, Medical Director of St Patrick's.[19] It is worth noting, with reference to the discussion of AA and religious issues which will be presented below, that St. Patrick's Hospital was generally regarded as a Protestant hospital, and it is also part of the lore of AA that Conor F. had earlier visited St John of God's Hospital (a Catholic hospital) from which he was sent away with the proverbial flea in

his ear. In any event, Richard P., who was apparently a chronic alcoholic, immediately responded to AA, in the process persuading Dr Moore of the value of this new American approach to alcoholism treatment. By the time Conor F. returned to Philadelphia in early 1947, a small AA network had been established, based in the Country Shop, St Stephen's Green, Dublin.

Table 3*

Membership Figures for AA in Ireland

Year	1946	1956	1966	1976	1986
Membership	45	1,100	2,250	5,750	9,000

* AA Souvenir Booklet, 1986

These figures refer to the thirty-two counties and must, given the loose membership structure of the Fellowship, be regarded as approximations

The increase in membership of AA in Ireland, as can be seen in Table 3, was steady rather than meteoric; nonetheless, these figures show that AA filled a need for increasing numbers of Irish people over its first forty years here and so became well placed to be an influence not merely on individual alcoholics but also on the wider society.

In its souvenir booklet published in 1986 for the Fellowship's fortieth anniversary in Ireland the struggle to keep AA going during its early years is described, and the following two imperatives for organisational survival discussed:

> Two things were evident from the start:
>
> (a) either the Catholic Church in Ireland was made an ally or AA in Ireland was sunk, and
>
> (b) either AA publicised itself in Dublin or it would perish of dry rot.[20]

The latter task was relatively easily accomplished since the Dublin papers were willing to publish letters, news stories and features concerning the

Fellowship. Indeed, despite frequent Fellowship references to the stigma attaching to alcoholism and to the alleged distaste of 'respectable' society for anything to do with alcoholism, there is no evidence that the newspapers in Ireland were anything other than interested and encouraging; AA was treated neither with indifference nor hostility, and its basic ideological stance on alcoholism as a multifaceted disease was generally presented in an uncritical way.[21]

The potential for conflict with the Roman Catholic Church is perhaps best understood through a study of the defensive way in which apologists for AA presented their case, but in essence there were two main issues which could have proved to be stumbling blocks. The first of these concerns the question of moral culpability: the Roman Catholic Church in Ireland, indeed the Church universally, might have interpreted AA's claim to the 'sick role'[22] as being an invalid or dubious attempt to exonerate alcoholics from moral responsibility for their misbehaviour. As late as 1960, the theologian Fr Seán O'Riordan, a long-time defender and advocate of AA, felt it necessary to explain to a conference on *The Priest and Mental Health* that the compulsive nature of alcoholism meant that these excessive drinkers *wanted* to recover from their habit but *could* not:

> Modern psychology, however, throws a good deal of light on it. Such a craving is a 'compulsion' which cripples its victims alcoholically, as other compulsions cripple men in other spheres of human life. It operates to diminish, sometimes substantially diminish, his responsibility for his behaviour, and it is resistant to all direct attempts to counter it, even when these come from within the personality of the sufferer, in virtue of his rational and spiritual will.[23]

The second and probably the more serious issue concerns the spiritual nature of AA's programme. While it might appear that AA's insistence on spiritual values, on moral inventories and on the importance of having recourse to a Higher Power would be totally compatible with Roman Catholicism, the truth was that such an explicitly spiritual programme ran

the risk of being seen as threatening to usurp the role of the Church. AA was fortunate to find an ally in Canon J.G. McGarry, Professor of Pastoral Theology at St Patrick's College, Maynooth, and editor of *The Furrow*, who throughout the 1950s allowed this influential publication to be used consistently in support of the Fellowship.[24]

The very first *Furrow* article on AA was written in 1952 by Seán O'Riordan, consisting of a summary and discussion of a similar article in an American pastoral magazine.[25] O'Riordan cited from this American article the proposition that: 'Alcoholics Anonymous insists more vigorously on the practice of Christian ascetics and the spiritual life than do priests of the Church of Christ'.[26] This was obviously dangerous stuff, where AA appeared to claim that help from the Higher Power, operating through its Fellowship, rivaled or outstripped the Roman Catholic Church which tended to see itself as the supreme channel of Divine Grace. In his 1960 conference paper to an audience of priests and medical doctors, O'Riordan was still dealing with this delicate theme:

> Some priests have been chary about invoking the help of this movement because of its undenominational character. Would not a similar movement but on specifically Catholic lines, they ask, be much better suited to our conditions and be more effective too, since then *all* the Church's sources of grace would be brought directly into play in helping the alcoholic back to sobriety and steady living?[27]

On a related theme, O'Riordan had argued in an early paper that: 'The organisation is not, of course, a secret society in any sense'.[28] This defence was necessary because AA, with its trappings of secrecy and anonymity, did evoke images of secret societies which - both of a religious and a political nature - were well-known in Ireland. If one applies the old sociological concepts of *in-group* and *out-group,*[29] the convention of anonymity is understandable in the sense that, in societal terms, alcoholics perceived themselves to be an out-group - misunderstood, stigmatised and

marginalised - who used their anonymity to protect themselves. However, having joined together in Fellowship, they obviously established their own in-group, and, understandably perhaps, tended at times to emphasise the defining characteristics of alcoholics in positive terms rather than solely in terms of pathology. While it did not represent official AA teaching and may not always have been taken seriously by a majority of members, this positive depiction of themselves and their Fellowship could on occasion appear to outsiders like a form of inverted snobbery; it was as if alcoholics claimed to be rather superior to others and to belong to an exclusive club. This aspect of AA and the provocative self-image which some alcoholics cultivated was exemplified in yet another *Furrow* article published in 1953 by an author who simply signed himself 'a Victim':

> In conclusion I would like to emphasise that alcoholism is more often than not simply the result of heredity, environment or other untoward circumstances entirely outside the victim's volition. Men of the highest intellect and culture and with the most generous outlook fall the easiest victims to its insidious approach, their very sensitiveness to all that is false, unjust and anomolous in a topsy-turvy world rendering them all the more vulnerable ...[30]

In the main, however, AA managed its entry into Irish society with considerable skill, and with the support of Canon McGarry and the deft handling of potentially dangerous issues by Fr O'Riordan, avoided direct conflict with the Roman Catholic Church. In fact, its strength in Ireland is unusual, given that, as Levine has shown, AA has generally not thrived in predominantly Roman Catholic cultures, which - as discussed in Chapter Two - were deemed by Levine to be non-temperance cultures.[31] A delegation of Irish AA members travelled to Rome in 1972 to commemorate the Fellowship's silver jubilee in Ireland, and while there had an audience with Pope Paul VI; one of the party later described this audience for *Furrow* readers, noting with surprise that the Pope, while welcoming, knew virtually nothing about AA! [32]

In summarising this material in terms of its implications for health policy in Ireland, what is most important and bears repeating is that AA had absolutely nothing to say on the subject of prevention or health promotion. The AA programme was, as in its country of origin, entirely concerned with the recovery of individual alcoholics; recovery, of course, was seen as a life-long task of which total abstinence from alcohol was the *sine qua non*. By concentrating attention on 'exotic' drinkers AA contributed, albeit unintentionally, to a process of deflecting attention away from the wider context of drinking in Irish society.[33]

As discussed in Chapter Two, AA was precluded by its Traditions from contributing to a policy debate or from lobbying in relation to the question of alcohol and alcohol control policies; by implication, however, because of its individualistic approach to etiology, it called into question the value of control policies such as those enunciated in the Intoxicating Liquor Commission 1925. It will also be recalled from Chapter Two that in the USA Marty Mann had circumvented the Fellowship ban on lobbying by doing so through the National Council on Alcoholism. Later in this chapter, a similar role played by Richard P., Ireland's first AA member, in the Irish National Council on Alcoholism (INCA) will be looked at in detail.

Liberalising the Licensing Laws

The licensing legislation which regulated the opening hours of Irish public houses was, as referred to in Chapter Two, quite restrictive, particularly in relation to Sunday trading. In the mid-1940s, licensed premises in the four county boroughs of Dublin, Cork, Limerick and Waterford were allowed to do general trading between 1pm and 3pm (or to be precise 1.30 and 3pm in Dublin), and between 5pm and 7pm. In rural areas, however, there was no general opening on Sundays, but *bona fide* trading was allowed between

1pm and 5pm (8pm in the summer).[34] The *bona fide* system was a traditional arrangement which allowed genuine (hence the phrase *bona fide*) travellers to have access to licensed premises for refreshments at times when the general retailing of alcoholic beverages was not allowed. Being more than three miles (or in urban areas five miles) distant from one's usual residence made one a *bona fide* traveller, and by the 1940s this was being widely used by drinkers as a pretext for having longer drinking hours than were legally available in the local pub. As the car became a more common form of transport, the *bona fide* system obviously increased the dangers of road traffic accidents as drinkers were inclined to drive in groups to '*bona fide* houses', particularly those pubs on the outskirts of Dublin which specialised in this trade.

In 1948 and again in 1950 a Fianna Fáil backbencher, Mr Martin Corry, unsuccessfully introduced private members' bills which would allow general Sunday opening throughout the country; his rationale on each of these occasions was that there was no longer any popular support for Sunday closing, that the law was being constantly flouted and that the Gardai were generally unwilling to enforce it. Mr Corry's bills were defeated, not on public health grounds but by a more fundamentalist moral argument. In 1948, following a clear denunciation of the Corry bill by the Roman Catholic hierarchy, there was little political support for the idea that rural Ireland should be allowed to drink on Sundays and, in the course of a long and colourful speech in Dáil Eireann, Oliver Flanagan of Fine Gael asked the following questions:

> Does he desire to see a state of affairs prevail in this country whereby on the dark wintry Sundays in rural districts, the young boys and young men will, immediately they leave Mass, plunge their way into various public houses and remain there? ... Does he know that intemperance exists to a very large extent in this country at the moment? ... Does he know that champagne is cheaper today than it has been for a considerable time past, thanks to Fianna Fáil?[35]

There must, even in 1948, have been a certain amount of wry amusement at this image of the flower of Irish manhood crowding into bars and gorging itself on cheap champagne after Sunday Mass, but Deputy Flanagan's basic sentiments were shared by a majority of Dáil Deputies and Deputy Corry's bill fell at its first hurdle. In 1950 the Roman Catholic hierarchy responded to the Corry private member's bill with even greater ferocity, citing Canon Law in support of its contention that any political activity directed towards generalised Sunday opening was sinful; as John Whyte put it, 'not only was the proposed legislation wrong, but even to make a case for it was wrong'.[36]

In 1956, however, the Minister for Justice appointed a Commission of Inquiry consisting of twenty-two people, chaired by the Master of the High Court and including representatives of the licensed trade, trades unions, Bord Fáilte, the Pioneer Total Abstinence Association and Dáil Eireann to 'enquire into the operation of the laws relating to the sale and supply of intoxicating liquor and to make recommendations'.[37] Significantly, there was no health representative on this body, nor does there appear to have been any coherent health submission to the Commission, either by way of oral evidence or written documentation.[38] Like its 1925 predecessor, this Commission insisted that popular support was essential for the successful enforcement of licensing legislation, and the advice which it received from representatives of the judiciary and the Garda Síochána - particularly in relation to Sunday trading - was that existing legislation was now so unpopular as to be virtually unenforceable. The Garda Commissioner had also supplied evidence to the Commission to the effect that drunkenness was no longer a serious problem in Ireland: 'In 1955, prosecutions for drunkenness totalled 3,782 as compared with 7,165 in 1925 and 45,670 in 1912'.[39] While the Commission could only speculate as to the causes of

this improvement, it still expressed the view that extending the hours of opening of retail outlets would not have a negative impact on this trend.[40]

What was specifically different from the 1925 exercise was the absence of a public health voice to articulate, as Dr Shadwell had done, the view that alcohol, despite its cultural acceptability and economic significance, was a noxious agent for which control policies were legitimate, if not absolutely necessary. Instead, the tone of the Commission's report, and the subsequent parliamentary debate which led to the enactment of the Intoxicating Liquor Act 1960, suggested that the policy context was in a process of change. The idea that the State, in the interests of public health, public order or morality, might seek to control the drinking habits of its citizens was now coming to be seen as paternalistic and old-fashioned. While there was a minority report and a number of dissenting observations (none of which, it should be added, advocated anything approximating to a public health approach), the general tone of the main report was that the mature citizens of a modern democracy could not be denied a more flexible licensing code. The major recommendations, accordingly, were that the *bona fide* system should be abolished, that closing time on weekdays should be 11.30pm and that Sunday opening throughout the country should be from 12.30pm to 2.00pm and 5.00pm to 9.00pm.

Not only did the Pioneer representative sign the majority report but, subsequently, in the September 1957 issue of its monthly magazine, *The Pioneer*, a correspondent, writing under the pen-name Chaunticlere, vigorously defended the recommended changes, suggesting that the strongest opposition to them would come from publicans who had specialised in *bona fide* trading and staff unions which would resist the longer opening hours.[41] This correspondent was aware of the irony

involved in a situation where a temperance activist was in favour of extended opening hours, in the face of opposition from some who were directly involved in retailing liquor: 'Again, many [Pioneers] may find themselves more than a little dismayed to be cast in the roll *[sic]* of the champions of liberality while the licensed trade act as the apostles of temperance'.[42]

This support of the Pioneers for the proposed liberalising of the licensing laws did not however represent an official or consensus view of the Roman Catholic Church in Ireland, and shortly before the publication of the Intoxicating Liquor Bill 1959, the Roman Catholic hierarchy issued a statement decrying the recommendations of the Commission. The central thesis of the hierarchy's brief statement was that:

> Increased facilities for obtaining intoxicating liquor by the extension of the general opening hours will inevitably lead to a greater extension of alcoholism which, in modern conditions has most serious moral and social effects in the increase of delinquency and in widespread danger to life on the roads.[43]

The passage of this legislation through the Oireachtas was lengthy and all aspects of the proposed changes were debated exhaustively, but it became clear that the Government (a single-party Fianna Fáil Government) was determined to implement the major policy recommendations of the Commission. The Taoiseach, Sean Lemass, made generally placatory remarks apparently aimed at the bishops,[44] but it was the Minister for Justice, Oscar Traynor, who dealt specifically with the bishops' contention that, if enacted, this legislation would lead to an increase in the incidence of alcoholism. The Minister reported that inquiries to the Department of Health had revealed that the annual number of patients treated for alcoholism in the country's mental hospitals was of the order of one fortieth of one per cent of the adult population.[45] He went on:

> There have been suggestions that alcoholism - as distinct from drunkenness - is a serious problem in this country and that it is on the increase. If by alcoholism is meant addiction to alcohol, necessitating treatment in mental institutions, I think I can reassure the house that alcoholism is not a national problem. Alcoholism is a problem, of course, even if a few people only were suffering from this disease, for addiction to alcohol must be recognised for what it is, a disease that requires medical treatment for the rehabilitation of the alcoholic.[46]

In concluding this argument, Mr Traynor cited one of the Jellinek-inspired WHO reports in support of his contention that there was no significant association between *per capita* consumption of alcohol and the incidence of the disease of alcoholism.[47] It is, of course, difficult to know how convinced the Minister for Justice was of the scientific validity of the disease concept, but it is highly probable that having decided to ignore the advice of the bishops, he appreciated its political value. The enactment of this liberalised licensing legislation presented the health sector with an opportunity to voice its opinion on the health implications of making alcohol more accessible to the populace, an opportunity which it had not been given through representation on the Commission in 1956 and 1957. It seems reasonable to infer, however, that during the process of inter-departmental consultation, which is part of the wider legislative process, the Department of Health had simply accepted the WHO line on alcoholism as a disease and had transmitted these views to the Department of Justice. The disease concept appeared to put a scientific gloss on drinking problems, making obsolete moral and political arguments such as those of the Catholic bishops.

The most sustained, fundamentalist criticism of the Bill during its passage through the Dáil came once again from Deputy Oliver Flanagan of Fine Gael. His attacks on the Government on this issue were, as were many of his contributions to parliamentary debate, trenchant and entertaining. However, in the context of the overall debate, his appeal on this occasion to

his colleagues to reject the Bill and 'to stand over the teaching of the Catholic Bishops as Catholics in a Catholic Parliament'[48] was beginning to sound anachronistic and to fall on largely deaf ears. There was little opposition to the Intoxicating Liquor Bill in the Seanad, and one Senator in particular, Tomás O'Maoláin, greeted it euphorically as symbolic of the new and modern Ireland which was thought to be emerging:

> This is the sixth decade of the twentieth century and this is a civilised community. We are no better and no worse perhaps than others but certainly we are as well-conducted as any. We are building up a modern progressive democracy. There is no reason why we should fear to get into line with other modern and progressive States which trust their people to be rational in using the liberal facilities they provide for drinking.[49]

The Intoxicating Liquor Act 1960 was the first, and for a long time the only, instance of Irish legislative behaviour which ignored the advice of the Roman Catholic hierarchy.[50] It was suggested in Chapter Two that a major aspect of political activity within parliamentary democracies is its attempt to reflect popular opinion as accurately and sensitively as possible. In enacting this relatively liberal licensing code, the Government obviously felt that the Irish public was so committed to this change that it could take the unprecedented risk of ignoring the bishops. The argument of the bishops was that, regardless of public opinion, it was morally and socially wrong to make alcohol more readily accessible; the duty of legislators, in the view of the hierarchy, was to retain and enforce the existing legislation, much as they would enforce unpopular finance legislation where failure to do so would result in social chaos.[51] There was, as previously stated, no public health voice raised in support of the bishops; on the contrary, the Minister for Justice could and did invoke the WHO to argue that the views of the hierarchy were unscientific and out-of-date.

The Irish National Council on Alcoholism

In 1964 the journalist Michael Viney published a series of articles on alcoholism in the *Irish Times;* these articles were later published in booklet form and were apparently well received by many people.[52] Viney's articles were thoroughly researched and well written, and by and large they reflected and promoted the disease concept of alcoholism which had been developed in the USA and diffused internationally through the WHO. Although AA had by now established itself in Ireland on an apparently sound footing and although alcoholics continued to be admitted to the country's psychiatric hospitals, Viney was critical of what he saw as the lack of a sustained and coherent national response to this problem, and recommended the establishment of a 'National Council on Alcoholism', comparable to that which existed in Britain and the USA. He suggested that an attempt to establish such a council had failed some years previously because 'even supposedly intelligent and highly-educated men were afraid of the stigma they thought would attach to such patronage'.[53] In 1966, however, following a visit to Ireland by Marty Mann of the American National Council on Alcoholism, the Irish National Council on Alcoholism (INCA) was set up in Dublin.

Although INCA was later to portray itself as being representative of 'an influential cross-section of Irish professional and business personalities',[54] it would appear that the initiative for its establishment came from a somewhat narrower range of interests, primarily representing psychiatrists in the private sector and AA members. One of these private sector psychiatrists, Dr John Cooney of St Patrick's Hospital, acknowledged this later when, in a 1980 publication, he wrote that he took 'some pride in the fact that the Irish National Council on Alcoholism was set up in 1966 through the initiative of a few psychiatrists'.[55] In fact, four of the seven

subscribers to the organisation's Memorandum of Association were private sector psychiatrists, while two, although they did not publicly declare themselves as such, were prominent members of AA.[56] There is no evidence that the Department of Health played any role in the establishment of INCA, and, as will be discussed later in this chapter, statutory health funding for INCA remained low until 1973.

The aims of INCA were set out in detailed legalese in its Memorandum and Articles of Association, but, in summary, it can be said that it had one dominant aim, which was to promote the disease concept of alcoholism at the level of public awareness, the level of treatment service provision and at the level of scientific research.[57] Like its American counterpart, INCA deliberately avoided any criticism of alcohol or any suggestion that, in public health terms, alcohol was a dangerous substance; its strict neutrality on this issue was exemplified in the manner in which its Articles of Association, having set out its main aims, enjoined the organisation to 'pursue these objects without making any judgement upon the consumption of alcohol per se'.[58] Thus there was to be no advice to the public about moderate drinking, or no focus in its publicity on questions of toxicity or addictiveness; instead, INCA intended to follow the line laid down by its American progenitor by emphasising the primacy of individual predisposition in the etiology of alcoholism. In the sphere of practical politics this neutrality also meant that INCA had no qualms about seeking or accepting financial support from the drinks industry, and the organisation's First Annual Report coyly acknowledged the importance for its survival of 'a substantial donation from a world-famous Brewery in Dublin'.[59]

The influence of AA on INCA was not confined to the presence of two members of AA on the council : the first Executive Director of INCA was

Richard Perceval, none other than Richard P. who as the first Irish-based member of AA had done so much to advance the cause of AA in Ireland. Following the precedent of Marty Mann in the USA, Mr Perceval - who had been involved between 1962 and 1966 with the establishment of a British Council on Alcoholism - had now set aside his anonymity to engage in the kind of political lobbying which was impossible under the aegis of AA. The views expressed by Mr Perceval were similar to those to be found in the American alcoholism scene; although he railed against what he saw as the lack of understanding of alcoholism and the associated stigma, it is difficult in retrospect to find evidence for the existence of any significant or orchestrated opposition to the disease concept in Ireland at this time. A 1970 pamphlet of Perceval's, which contained the contention that 'the ideal climate of opinion is one in which dependence upon alcohol is openly regarded as something just as real, just as serious as tuberculosis - but no more culpable'[60] was in fact published by Veritas, the main publishing outlet for the Catholic Church in Ireland, which had previously been known as the Catholic Truth Society of Ireland.

Given INCA's neutrality on the issue of alcohol and its preoccupation with treatment for individual alcoholics, it is not surprising to find that Perceval's views on primary prevention were somewhat limited. He took it for granted that there was no meaningful connection of a causal kind between alcohol and alcoholism, and therefore saw little sense in public health messages which might advocate safe or moderate drinking. In an article published in *The Pioneer* at around the time that INCA was established, he wrote:

> Prevention in its true sense is impossible, as we do not know the cause. But *secondary* prevention or the reduction of damage is feasible by education, by information and by understanding. It is possible to produce a climate of opinion in which anyone who has the primary symptoms of alcoholism will feel it is a duty - *not* a disgrace - to do something about it.[61]

Just as Marty Mann had made exaggerated claims for the scientific status of the views which she promoted through her organisation in New York (claims which were frequently disputed by members of the scientific community), so too did Richard Perceval present his own views as being objectively and scientifically beyond dispute, while those who disagreed with him were portrayed as misguided or moralistic. Although INCA established an advisory and referral service at its Dublin headquarters, most of its activities during its early years were of a promotional or educational type; this mainly consisted of giving or arranging public talks on the disease concept, as well as using the media to disseminate its message. Whatever about the content of this message, it has to be concluded that, as INCA's first Director, Richard Perceval was an energetic and apparently effective lobbyist.[62]

As already stated, the Department of Health played no role in the establishment of INCA; indeed INCA remained a voluntary body all through the twenty-two years of its existence, even after it began to be completely funded by the regional health boards in 1973. The attitude of the Department of Health towards INCA was generally positive and encouraging, but this did not extend as far as making any financial commitment to its support; in fact at the time of its establishment, the Minister for Health, Seán Flanagan, expressed the hope that INCA would receive whatever funding it required from industrial and business concerns.[63] The brief comments on INCA which are to be found in the 1966 Report of the *Commission of Inquiry on Mental Illness* (to which, tacitly at least, the Department of Health gave its approval) suggest that the Department understood and approved of INCA's philosophy and action plan. There was one subtle but important point, however, which suggested that the Commission did not fully appreciate what INCA's (or at least

Perceval's) position was: this was in relation to prevention, where the Commission expected that 'this Council will serve an important preventive and advisory function by spreading knowledge on the dangers of excessive and indiscriminate drinking'.[64] As is clear from the earlier discussion of his views, Perceval regarded alcoholics as hapless victims of a mysterious ailment rather than as people who indulged in excessive or indiscriminate drinking, and he showed no inclination to provide education along 'sensible drinking' lines for the Irish public.

INCA was, as has been made clear, a council on 'alcoholism' and not a council on 'alcohol'. At least in its early years, it was powerfully influenced by AA and this influence, allied to that of psychiatry, conspired to advance the cause of treatment almost to the total exclusion of prevention. The Department of Health played no role in setting up INCA, neither did it overwhelm INCA with support in its early years; it gradually moved beyond the stage of merely offering moral support to a time (which will be discussed in Chapter Four) where it provided full financial support for the organisation. Just as it had seen no health implications to the liberalising of the licensing laws, so too did the Department of Health appear to have identified nothing problematic in this tendency of INCA's to focus solely on treatment and to exonerate alcohol of any causal responsibility for alcohol-related problems.

Treatment Services for Alcoholics

The material covered in this chapter generally indicates that for a quarter of a century after World War II a range of influences and interests in Ireland shifted public policy towards the disease concept of alcoholism, away from its previous alcohol control ethos. For the health care system in Ireland the major implication of this shift was the expectation, if not the demand, that

there would be an expansion of treatment and rehabilitation services for alcoholics; furthermore, there was an expectation that in attitudinal terms alcoholism would become a 'respectable'[65] disease and that any moralism or residual stigma would be eliminated from within the health care system. The pace of this policy change was slow and gradual, and one cannot identify any dramatic turning point. There are, however, two further events, the establishment of the Voluntary Health Insurance (VHI) Board in 1957 and the publication (already alluded to) of the *Report of the Commission of Inquiry on Mental Illness* in 1966, which deserve some comment before concluding this account of the acceptance of the disease concept within Irish health policy during this time.

The Voluntary Health Insurance Board was established by statute in 1957; its aim was to allow people in the middle and upper income groups, who were not eligible or had only limited eligibility for the means-tested public health service, to insure themselves and their dependents against the high costs of hospital treatment and maintenance. VHI was a state-sponsored, non-profit organisation which was given a monopoly on the sale of health insurance in Ireland, a monopoly which endured until the mid 1990s when it was withdrawn as part of Ireland's integration into the European Community. The VHI scheme was made additionally attractive to subscribers by the tax relief on insurance premiums allowed by the Minister for Finance, and it proved from the outset to be a viable and popular system.[66]

One unanticipated consequence of this development was that middle-class alcoholics, who had previously been reluctant to seek treatment in the spartan public mental hospitals, were now a good deal more willing – courtesy of their VHI cover - to agree to admission to the relatively

salubrious private hospitals. These hospitals were rooted in a religious and philanthropic tradition, rather than in the 'for-profit' ethos of modern American health-care institutions;[67] nonetheless, it is scarcely a coincidence that once a funding system was set in place which guaranteed a flow of alcoholic patients through their institutions, these hospitals (and their consultant psychiatrists who began to specialise in alcoholism treatment) began to play a much more vocal role in advocating the disease concept. There were obvious financial incentives for hospitals to develop alcoholism treatment programmes for these patients, who were available in constant numbers, who made relatively little demands of the nursing and medical system once detoxified, and whose bills - thanks to VHI - were sure to be paid.[68]

The question of differences of attitude and practice in relation to alcoholism treatment between psychiatrists in private hospitals and their colleagues in the public sector will be considered more explicitly in Chapter Four. However, during the period 1945-1973, which is dealt with in the present chapter, there was no evidence of conflict between these two groups. Instead, the position was, as exemplified in the INCA situation, that psychiatrists from the private sector campaigned without equivocation - and, it must be said, without being critically challenged - for the universal acceptance of the disease concept. A particularly good example of such advocacy is to be found in a 1963 paper, addressed primarily to general medical practitioners, by Dr John Cooney of St Patrick's Hospital, Dublin. The lead role played by the private hospitals is suggested by the figures cited by Dr Cooney: 'In 1960, 532 alcoholics were treated in private mental hospitals in Ireland, while 107 were that year admitted to district mental hospitals'.[69] He also told his readers that:

> If one is to treat alcoholism successfully whether in hospital or in general practice one must feel as well as believe that the

> alcoholic is ill and suffering from a disease just as surely as a diabetic is suffering from his excess blood sugar ... [B]y their acceptance of the disease concept of alcoholism they [doctors] can influence public opinion and help bring about an attitude whereby the alcoholic is regarded not as a moral degenerate but as a sick man ...[70]

The clearest and most unequivocal public policy acceptance of the disease concept, which must surely have been pleasing to psychiatrists from the private sector, to members of AA and to the newly established INCA, was contained in the *Report of the Commission of Inquiry on Mental Illness.* This Commission was established by the Minister for Health in 1961 to review and make recommendations on the functioning of the country's mental health services and legislation; it reported in 1966, generally recommending a move towards community rather than residential services. On the question of alcoholism, the Commission fully endorsed the disease concept, prefacing its discussion and recommendations by the summary statement: 'Alcoholism is a disease and is regarded by the World Health Organisation as a major health problem'.[71] The recommendations referred both to community and residential treatment facilities; in the former case it was suggested that general practitioners, in consultation with consultant psychiatrists, could offer valuable treatment to alcoholic patients, while in the latter it was suggested that specialist in-patient units should be created within the public psychiatric system to complement the work being done in this field by the private hospitals. The Commission concluded that specialist staff were needed to cater for alcoholics; but '[i]n view of this fact and of the relatively small number of alcoholics needing residential treatment the Commission considers that alcoholic units in three or four regional centres would meet the country's needs'.[72]

The recommendation that GPs should be involved more in the treatment of alcoholics largely represented a pious aspiration and no coherent strategy was ever devised to make this a reality; there is evidence admittedly that the

Irish situation in this regard is broadly similar to that which prevails elsewhere.[73] However, the conclusion that Ireland had only a small number of alcoholics needing residential treatment and that four regional units would suffice in the public health sector must surely be regarded as a policy miscalculation of quite heroic proportions. The logic underlying this policy perspective was similar to that invoked during the debate on the Intoxicating Liquor Bill 1959: it was assumed that the incidence of alcoholism was static and, accordingly, that there was no reason to believe that increased public access to alcohol or increased consumption rates would lead to increased demands for treatment and rehabilitation. Statistical data documenting the huge increase in the treated prevalence of alcoholism from the late 1960s onwards will be presented in Chapter Four; suffice it to say here that within five years of the Commission's report the number of alcoholism admissions to Irish psychiatric hospitals and units had doubled, and within ten years one in four admissions to the inpatient mental health system had a primary diagnosis of alcoholism.[74] The prospect of confining such admissions to four regional alcohol units quickly disappeared; the reality was that alcoholism treatment made big demands on all forms of inpatient care - on private psychiatric hospitals, on health board psychiatric hospitals and on the emerging general hospital psychiatric units.

Summary and Conclusion

It was surmised at the end of Chapter Two that the alcohol control policies which had evolved in Ireland from the second half of the nineteenth century, and which had found particularly clear expression in the Intoxicating Liquor Commission 1925, would not withstand the challenge of the American disease concept unless they were periodically restated and their value and legitimacy defended. The material discussed in the present chapter clearly demonstrates that no such defence or restatement of the alcohol control

perspective was made in Ireland in the quarter of a century following World War II. Furthermore, it has emerged that none of the main interest groups or institutions which might have taken exception to the disease concept did, in fact, do so.

On the contrary, all the major players in this arena gave a general, if somewhat gradual, welcome to the 'new scientific approach' to drinking problems. The Roman Catholic Church in Ireland was described in Chapter Two as having no fundamental objection to alcohol consumption; in the present chapter, the Church was described as objecting only to the extension of the opening hours of pubs, and in particular to Sunday opening, but as being otherwise open to and accepting of the various ideological and institutional strands of the disease concept. Similarly, the criminal justice system supported the new policy line, as did treatment professionals in the mental health field - particularly following the establishment of VHI.

There is no evidence, however, that the Department of Health played a key role in either initiating or coordinating this policy process. To use the language of health promotion, the Department of Health demonstrated no appreciation of 'healthy public policy': it did not anticipate that making alcohol more accessible would ultimately have negative health consequences or see that that there were legitimate health arguments to be made against the new licensing scheme. Instead, it appeared to stand back from events, merely allowing things to happen for much of the period looked at in this chapter. The Department was obviously aware of and influenced by the WHO's commitment to the disease concept, as exemplified by its advice to the Minister for Justice at the time the Intoxicating Liquor Bill 1959 was being debated. However, it was only when a considerable momentum had gathered in favour of the disease concept that the Department of Health gave

a clear and explicit commitment to the disease concept in 1966, through its acceptance of the Report of the Commission of Inquiry on Mental Illness.

The policy making process was not, therefore, of the rational-comprehensive variety:[75] No formal policy analysis took place to clarify what cultural values were involved in this sphere, nor were policy objectives identified and then matched with the means likely to lead to their achievement. Instead, the policy process appears to fit the classic incremental pattern described by Lindblom. Means and ends are not clearly distinguished in this process of 'partisan mutual adjustment', where the test of a good policy is not that it conforms to agreed values or achieves identified objectives, but rather that it secures the agreement of as many as possible of the various interests involved. The great strength of the disease concept, in policy terms, was that it appeared to please everybody; from the drinks industry, through the drinking public to those involved in alcoholism treatment there was consensus as to the value and validity of this perspective.

However, the disease concept of alcoholism was antithetical to practically every tenet of the health promotion model outlined in Chapter One. At the level of healthy public policy, as this is understood within the health promotion paradigm, the disease concept implied that multisectoral cooperation in legislative and general policy terms was neither necessary nor useful. Similarly, the disease concept saw no value in such health promotion ideas as *lifestyle* or *environment*.. Drinking lifestyles were irrelevant within a biomedical perspective which suggested that alcoholics were a minority, born with a predisposition to this disease; if you were unfortunate enough to be born with this predisposition, then even low alcohol consumption invariably triggered the disease process, while the

majority not so afflicted could more or less drink with impunity. Finally, the idea of strengthening community action as a means of promoting health also had little chance of being operationalised where AA, a self-help group for sufferers of this disease, gained ever-increasing respect and credibility for their own version of the disease concept. AA was certainly a 'bottom-up' policy initiative, and one which was to be enormously influential in the growth of other self-help health movements, but it was dismissive of the possibility of prevention or health promotion and, instead, reinforced the view that what was important was the provision of treatment facilities.

Even by the time the Commission of Inquiry on Mental Illness was giving its approval to the disease concept and INCA was being established to lobby for this viewpoint, there were indications that some of its most basic tenets might be flawed. Perhaps the most critical indicator was the increase in the treated incidence and prevalence of alcoholism, which raised the question of whether there might not be a causal connection between these increased demands on the health service and increased societal levels of alcohol consumption.

Chapter Four will trace events from 1973 to the late 1980s to ascertain whether during this period there was any increased adherence to health promotional approaches in the alcohol sphere in Ireland. In particular, the role of the Department of Health will be considered, and its effectiveness in monitoring developments in this field and in coordinating new policy responses assessed. The specific structure within the Department of Health for carrying out these duties was, of course, a limited one; alcoholism constituted just one element in the work of the Mental Health Division which, in turn, was just a part of the wider departmental system. Among the issues to be explored is whether INCA, which from 1973 on was

funded entirely from statutory health sources, was capable of moving from its initial preoccupation with the disease concept towards a wider public health perspective, or whether the Department of Health was able to cooperate with INCA in developing new policy initiatives.

Another source of relevant research data and policy proposals for the Department of Health in relation to alcohol and health was the Medico-Social Research Board (MSRB) which was established in 1965 under the Health (Corporate Bodies) Act 1961; the functions of the MSRB were to undertake research in the general medico-social area and to advise the Minister on relevant policy implications. The National Psychiatric Inpatient Reporting System, which was set up by the MSRB in 1965, began to issue annual reports on the inpatient activities of the country's psychiatric hospitals and units from the early 1970s, thus making it possible to monitor the changing impact of alcohol on the mental health services. Another research institute which could and did contribute to the flow of information and research findings on alcohol consumption and its consequences was the Economic and Social Research Institute (ESRI). However, it is only within the rational-comprehensive model of policy making that it is assumed that the policy making process is clearly or invariably influenced by research findings; in Chapter Four what needs to be examined is how and to what effect these researchers presented their findings both to the public and to high-level policy makers.

Chapter Three: Footnotes

[1] For a general discussion of health promotion theory see Chapter One of this thesis. The most specific statement of policy in this area from the Department of Health is: *A Health Promotion Strategy: making the healthier choice the easier choice.* (Dublin: Department of Health, 1995).

[2] The Department of Health as a single department was set up in 1948; prior to this there had been an amalgamated Department of Local Government and Public Health. In 1997, which is just outside the time period covered in this thesis, the name of the department was changed to *Department of Health and Children.*

[3] Within the WHO structures, alcoholism became part of the mental health system. A number of technical reports were produced by the Alcoholism Subcommittee, amongst which the most influential was: WHO, Expert Committee on Mental Health, Alcoholism Subcommittee, *Second Report.* (WHO Technical Report Series, no.48; 1952).

[4] For a brief discussion of Jellinek's work and influence at WHO see Chapter Twelve of K. Bruun, L. Pan and I. Rexed, *The Gentleman's Club: International Control of Drugs and Alcohol.* (University of Chicago Press, 1975). For a more detailed study of Jellinek and his influence, see P. Page, 'E. M. Jellinek and the evolution of alcohol studies: a critical essay', *Addiction,* 92 (1997), pp 1619-1637.

[5] E. M. Jellinek, 'Phases of Alcohol Addiction', *Quarterly Journal of Studies on Alcohol, 13* (1952), pp 673-684.

[6] R. Room, *Governing Images of Alcohol and Drug problems.* (Ph.D. Dissertation, University of California, Berkely, 1978), p.55.

[7] This was stated explicitly in the 1952 WHO report (see reference 3 above). Also see reference 47 below.

[8] *Mental Treatment Acts 1945-1961: Statutory Provisions, Regulations, Explanatory Notes* (Part B, Section 3). (Dublin: Stationery Office, 1962), p.19.

[9] In 1981 the Health (Mental Services) Act was passed by the Oireachtas but, most unusually, was never implemented; compulsory hospitalisation of addicts was not permitted by the 1981 Act. The *White Paper: A New Mental Health Act* (Dublin: Stationery Office, 1995), which contains detailed proposals for new legislation, also excludes addicts from the categories of patients who can be compulsorily hospitalised, and it should be noted that the English Mental Health Act 1983 also excluded addicts from this process.

[10] D. Walsh, 'Alcohol and Alcohol Problems Research 15 - Ireland', *British Journal of Addiction, 82* (1987), pp 747-748.

[11] An attempt to study the Department of Local Government and Public Health files on this legislation proved fruitless; they are neither in the

National Archives nor in the Department of Health, and appear to have been destroyed.

[12] 'Mental Treatment Bill 1944' (Editorial Article), *Journal of the Medical Association of Eire, 16* (1945), p.8.

[13] *Dáil Debates* (Vol.96), Column 1009.

[14] Ibid, Columns 1010-1011.

[15] Ibid, Column 1012.

[16] For an account of Dr Ward's mercurial temperament and ultimate political downfall, see R. Barrington, op.cit., pp 168-175.

[17] D. Walsh, 'Alcohol and Ireland', *British Journal of Addiction, 82* (1987), p.119.

[18] E. Kurtz, *Not God: A History of Alcoholics Anonymous.* (Expanded Edition). (Center City, Minnesota: Hazelden, 1991), p.164. There has been a significant increase in research in recent years into AA and its diffusion to countries outside the USA ; see for example K.Makela et al, *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies.* (University of Wisconsin Press, 1996).

[19] There are passing references to the coming of AA to Ireland in a number of secondary sources. Of these, probably the most authoritative is: *Alcoholics Anonymous in Ireland 1946-1986: A souvenir booklet to commemorate forty years of AA in Ireland.* (Dublin: AA General Service Conference of Ireland, 1986). The practice of referring to person by a first name and the initial letter of a family name (as in Conor F. and Richard P.) is an AA convention which conforms to its core belief in anonymity.

[20] Ibid. (Pages are not numbered in this 16-page booklet).

[21] This theme of rejection and stigmatisation is constantly repeated in AA discourse. For example, an AA member speaking at a conference on 'The Priest and Mental Health' in 1960 spoke as follows: 'In 1946 an Irish American, Conor, who was paying his first visit home in 24 years, as he had stopped drinking only three years previously, was urged by his wife to start a group in Ireland. He was rebuffed on all sides and told there were no alcoholics in this country. Fortunately, however, he met a doctor, who understood alcoholism, and as a result contacted Richard and, together with a few others, founded the first group in Europe in Dublin 1946' [E.F. O'Doherty and S.D. McGrath, *The Priest and Mental Health.* (Dublin: Clonmore and Reynolds, 1962), pp 148]. However, the AA souvenir booklet cited in notes 19 and 20, contains no evidence of antipathy towards the Fellowship and much evidence of goodwill and support from the media.

[22] The concept of the 'sick role' originated in the writings of Talcot Parsons, and was the first sustained attempt to look at what it meant to be sick in sociological terms. In the context of the disease concept of alcoholism, it might be taken to imply firstly that alcoholics cannot be held responsible for becoming alcoholic and secondly that because of their sickness they should be exempted from their usual social duties.

T. Parsons, *The Social System.* (London: Routledge and Kegan Paul, 1951).

[23] S. O'Riordan, 'Alcoholism', in E. F. O'Doherty and S.D. McGrath, op.cit., p.151. It is interesting to note that this, as with many more of the references to AA from this period (1950s and 1960s), uses the male pronoun at all times; this may simply reflect the lack of concern for gender equality and appropriate language which characterised this time, but it probably also reflects the view that alcoholics were – and perhaps were expected to remain - predominantly male.

[24] The following are the major articles published in *The Furrow* which were sympathetic to AA and to the wider disease concept:
S. O'Riordan, 'Round the Reviews', *The Furrow* (January 1952), pp 31-40;
S. O'Riordan, 'Round the Reviews', *The Furrow* (May 1952), pp 203-210;
"A Victim", 'Alcoholism', *The Furrow* (March 1953), pp 139-146;
"A Member", 'Alcoholics Anonymous', *The Furrow* (November 1953), pp 638-647;
"AA Member", 'Rehabilitating the Alcoholic', *The Furrow* (May 1956), pp 276-284;
"IGA", 'The American Church and AA', *The Furrow* (February 1957), pp 79-86;
John C. Ford, 'The Priest's Role in Alcohol Problems', *The Furrow* (May 1960), pp 285-300.

[25] S. O'Riordan, *The Furrow* (January 1952), cit.sup. This article drew the attention of Irish readers to an article entitled 'Science, Religion and Alcoholism' which had been published in the American Catholic monthly magazine *Integrity* the previous September.

[26] S. O'Riordan, *The Furrow,* (January 1952), p.36.

[27] S. O'Riordan, 'Alcoholism', in E. F. O'Doherty and S.D. McGrath, op.cit., p.151. Fr O'Riordan's paper was presented at a conference on the theme of 'the priest and mental health' held under the patronage of the Catholic Archbishop of Dublin, Dr John Charles McQuaid, at which Dr McQuaid also delivered the opening address. Fr O'Riordan would presumably have been well aware of Dr McQuaid's dislike of inter-church activities and of his penchant for setting up welfare associations which were specifically Catholic. In 1998, twenty five years after his death, the McQuaid archive of the Archdiocese of Dublin was opened up to scholars; this writer sought the help of the diocesan archivist but, surprisingly, no reference to AA has been found there so far. Although several new biographical studies of John Charles McQuaid are apparently being written, the only published study to date is J. Feeney, *John Charles McQuaid: the man and the mask.* (Cork: Mercier Press, 1974).

[28] S. O'Riordan, *The Furrow,* (May 1952), p.205.

[29] The concepts of 'in-group' and 'out-group', which grew from the early sociological writing of William Graham Sumner, simply refer to the way in which groups of people who share what is a significant common interest begin to define themselves as constituting a group by

describing themselves as 'us' and contrasting themselves with non-members, who are 'them'.

30 "A Victim", *The Furrow,* (March 1953), p. 146.

31 Levine's ideas about temperance cultures and the influence of religious groupings are discussed in Chapter Two.

32 "A Dublin Member of AA", 'Vatican and Alcoholics Anonymous', in 'News and Views', *The Furrow,* (March, 1972), p.182.

33 The view which has been consistently expressed by social scientists is that it would be imprudent to concentrate the research focus on those abnormal drinkers who come to the attention of psychiatry. Bacon, one of the early contributors to this field, wrote that: 'For students of society, the individuals so described represent such a tiny and exotic portion of the whole community that resulting generalizations have not been sociologically informative, although they have posed questions and suggested hypotheses of great interest'. (S.D. Bacon, 'Sociology and the Problems of Alcohol: Foundations for a Sociologic Study of Drinking Behaviour', *Quarterly Journal of Studies on Alcohol, 4* (1943), p.404.

34 Factual data on opening hours during this period are contained in: *Reports of the Commission of Inquiry into the operation of the Laws relating to the Sale and Supply of Intoxicating Liquor 1957.* (Dublin: Stationery Office, 1957).

35 *Dáil Debates* (Vol.113), Columns 50-51.

36 J. H. Whyte, *Church and State in Modern Ireland, 1923-1979 (Second Edition).* (Dublin: Gill and Macmillan, 1980), p.178.

37 These are the precise terms of reference laid down by the Minister for Justice. They are cited from the Reports - see reference 34 above.

38 The Reports contain listings of all those who made submissions - see reference 34 above.

39 *Reports of the Commission of Inquiry into the operation of the Laws relating to the Sale and Supply of Intoxicating Liquor 1957,* cit.sup., p.5.

40 Ibid, p.5.

41 This 'Chaunticlere Discusses the Controversy about the Liquor Laws', *The Pioneer* (September, 1957), pp 18-19.

42 Ibid, p.19.

43 *Statement of the Irish Bishops on the Intoxicating Liquor Laws issued at their June 1959 meeting at Maynooth.* (*The Furrow*, August 1959, p.553).

44 *Dáil Debates* (Vol.178), Columns 384-393.

45 *Dáil Debates* (Vol.177), Column 948.

[46] Ibid, Column 948.

[47] The Minister quoted the following:
'Per capita consumption rates, even the most refined ones, should never be interpreted as indicating a high or low degree of alcoholism or change in the incidence of alcoholism ...'
The source was an *Alcoholism Sub-Committee of the WHO* (No. 48, 1952).

[48] *Dáil Debates* (Vol. 180), Column 1029.

[49] *Seanad Debates* (Vol.52), Column 1601.

[50] In the first edition of his classic study *Church and State in Modern Ireland 1923-1970* (Dublin: Gill & Macmillan, 1971), John Whyte described the Intoxicating Liquor Act 1960 as follows: 'But in the history of Church-State relations it marks a significant landmark. For it provides the only example so far recorded of a recommendation from the hierarchy being simply rejected by an Irish government' (p.330).
From the late 1970s, of course, there were to be several examples in the area of sexual morality where Irish governments rejected the advice of the hierarchy.

[51] This was the line taken, for example, by Dr Michael Browne, Bishop of Galway in 'The New Proposals', *The Pioneer,* (April, 1960), p.26.

[52] *Alcoholism in Ireland: An Inquiry* by Michael Viney [This is an undated Irish Times reprint which was almost certainly published in 1964]. It is a measure of the prestige of Michael Viney's journalism, and in particular his writings on alcoholism and the wider mental health field, that he was appointed to membership of the Commission of Inquiry on Mental Illness in July 1965, four years after the Commission had commenced its work.

[53] M. Viney, op.cit., p.49. No detail or corroborative evidence is given by Viney in support of this claim that an attempt to set up a council on alcoholism had failed because of the stigma attaching to this issue.

[54] *Report to the Minister for Health by the Irish National Council on Alcoholism* (January 1973), p.23.

[55] J. Cooney, 'Alcoholism and the Psychiatrist', *Journal of the Irish Medical Association, 73* (1980), p.105.

Dermot Walsh wrote more specifically: 'In 1968 *(sic)* a group of psychiatrists from the private sector came together to found the Irish National Council on Alcoholism'. D. Walsh, 'Alcohol and Alcohol Problems Research 15. Ireland', *British Journal of Addiction, 82* (1987), p.748.

[56] *Memorandum and Articles of Association of the Irish National Council on Alcoholism, 1966.*

The four psychiatrists were Drs Cooney and Moore from St Patrick's Hospital, Dublin, and Drs McGrath and McCarthy from St John of God Hospital, Dublin. No public sector health care professional was among the subscribers. One subscriber, Aiden MacSweeney who was described as a chemist with a Cork address, was a well-known AA activist; another was Sackville O'Connor Mallins who was described as a retired army officer and who was arguably the best known of all the early AA organisers in Ireland – his story, entitled 'The Career Officer' is contained in the AA 'Big Book' - *Alcoholics Anoymous : The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism.* (London: AA Sterling Area Services, 1973), 523-531. The final subscriber to the Memorandum and Articles of Association of INCA was the Chief Justice, Cearbhall O'Dalaigh, who appears have been a supportive figurehead rather than an active member.

[57] The 'objects' of the organisation are set out in Article 2 of the *Memorandum and Articles of Association* . cit.sup.

[58] Ibid, Article 2(e).

[59] *Irish National Council on Alcoholism, Annual Report February 1967-February 1968.*

[60] R. Perceval, *Alcoholism and Drug Abuse.* (Dublin: Veritas, 1970), p.15.

[61] R. Perceval, 'Lack of Understanding', *The Pioneer,* (July /August 1966), p.25.

[62] For an example of the way in which Perceval described those who disagreed with him, the following quote is illustrative: 'For the past four years I have been working for an English Council which is trying to educate public opinion about alcoholism, and I have been astonished by the total lack of understanding exhibited by very many intelligent people' [Perceval, 1966, p.25]. With regard to Perceval's energy, the first Annual Report (reference 59) contained the following: 'The Executive Director has spoken at some 50 meetings which involved audiences totalling almost 10,000. He also took part in nine TV or Radio programmes. A number of the meetings were held in Schools or Youth Clubs and in this way a large number of young people have had an opportunity of learning facts about alcohol and alcoholism'.

[63] *Irish Times* (17th November, 1966).

[64] *Report of the Commission of Inquiry on Mental Illness.* (Dublin: Stationery Office, 1966), pp 82-83.

[65] An undated pamphlet from the American National Council on Alcoholism argued that: 'The main task of those working to combat alcoholism in this country today is to remove the stigma from this disease and make it as "respectable" as other major diseases such as cancer and tuberculosis'. Cited in P. Davies, 'Motivation, Responsibility and Sickness in the Psychiatric Treatment of Alcoholism', *British Journal of Psychiatry, 134* (1979), p.449.

[66] For an account of the establishment of VHI see R. Barrington, op.cit., p.146ff.

[67] The advent of such 'for-profit' health care systems and their impact in Britain during the Thatcher era is described in: J. Higgins, *The Business of Medicine: Private Health Care in Britain* (London: McMillan Education, 1988).

[68] For a detailed discussion of how the provision of financing can change the ideology of treatment see C. Weisner and R. Room, 'Financing and Ideology in Alcohol Treatment', *Social Problems, 32* (1984), pp 167-184.

[69] J. Cooney, 'Alcoholism and Addiction in General Practice', *Irish Medical Journal, 53* (1963), p.54.

[70] Ibid, 54-56.

[71] *Report of the Commission of Inquiry on Mental Illness,* cit. sup., p.77.

[72] Ibid, p.82.

[73] One of the most influential studies on the difficulties of developing 'therapeutic commitment' to alcoholism amongst GPs and other primary care workers is: S. Shaw, A. Cartwright, T. Spratley and J. Harwin, *Responding to Drinking Problems.* (London: Croom Helm, 1978).
A small scale study of Irish GPs during 1993/94 revealed low therapeutic commitment to such clients - J. Connolly, 'Doctors and Drinkers', unpublished M.Ed. thesis, St Patrick's College, Maynooth, 1994.

[74] These statistics are derived from the annual 'Activities' reports published on Irish psychiatric hospitals and units by the Medico-Social Research Board and latterly by the Health Research Board. This National Psychiatric Inpatient Reporting System has been in existence since 1965. In 1957 the Report of the Inspector of Mental Hospitals recorded the diagnosis of all admissions, revealing that alcohol-related admissions for that year were a mere 6% of all admissions.

[75] See Chapter One for a discussion of the alternative policy making models.

CHAPTER FOUR

CONFLICTING PARADIGMS: THE DISEASE CONCEPT AND THE PUBLIC HEALTH PERSPECTIVE ON ALCOHOL IN IRELAND 1973 - 1988

Introduction

If the period 1945-1973 discussed in Chapter Three was characterised by an emerging consensus concerning the scientific validity and political acceptability of the disease concept of alcoholism in Ireland, then the period 1973-1988, which is the subject of the present chapter, may be characterised as one of conflict. This conflict was between the disease concept and what came to be known as the *public health perspective* on alcohol; this latter perspective, which was articulated internationally from the mid 1970s onwards, conformed in remarkable detail to the wider health promotion paradigm which was also being developed at this time.

The aims of this chapter are to describe the public health perspective, to show how it differs radically from the disease concept and, most importantly, to consider in the context of the policy-making models discussed in Chapter One how these two conflicting paradigms jostled for dominance in the Irish health care scene of this period. It will be shown that the ultimate aim of those who favoured the public health perspective on alcohol was to achieve in this domain what would later be called 'healthy public policy', while simultaneously generating a popular groundswell of support for the idea that alcohol problems could be prevented by healthier lifestyles, or specifically by careful self-monitoring of personal alcohol consumption levels. Healthy public policy in this context refers to the multisectoral coordination of legislation and general governmental activity, with a view to maximising public health and minimising the incidence of alcohol-related problems. Such policy coordination, were it to be achieved, would mean that the health interest was granted precedence over the various conflicting interests represented by other sectors of government, such as those concerned with finance and revenue or with job creation.[1]

The task facing those who advocated the public health perspective was obviously formidable coming, as it did, in the immediate aftermath of the popular acceptance of the disease concept. For policy makers and for the general public there was understandable confusion that, having been so recently persuaded of the scientific nature of the disease concept, they were now being asked - again for ostensibly scientific reasons - to abandon it and replace it with a diametrically different policy.

It will be recalled from Chapter Three that the disease concept had achieved political legitimacy over a protracted time period, due almost certainly to the wide-ranging lobbying and advocacy which was done on its behalf rather than to any demonstrable scientific merit. In embarking on this study of attempts to have the public health perspective enshrined in policy, it is obvious that such attempts would be unlikely to meet with success unless they too could establish and draw from a broad base of support. What needs to be examined, therefore, is how and by whom the public health perspective was advocated. Certainly, its supporters could have little hope of success if they, either implicitly or explicitly, subscribed to a rational - comprehensive model of policy making and in so doing assumed that the scientific merit of their position was self-evident and would guarantee its political acceptance and implementation.

The data contained in Tables 4 and 5 are presented here to provide a context for the account of the public health perspective which is to follow and also as an illustration of how data can be interpreted in differing and conflicting ways, depending upon the perspective from which they are viewed.

TABLE 4

Annual Consumption of Alcohol Per Head of Population in Ireland (Aged 15 and Over) in Litres of Pure Alcohol *

Year	Total
1960	4.88
1961	5.36
1962	5.30
1963	5.50
1964	5.78
1965	5.87
1966	5.89
1967	6.01
1968	6.37
1969	6.91
1970	7.26
1971	7.68
1972	8.20
1973	8.88
1974	9.28
1975	9.22
1976	8.99
1977	9.20
1978	9.78
1979	9.97
1980	9.56
1981	9.02
1982	8.78
1983	7.97
1984	8.13
1985	8.56
1986	8.40
1987	8.12
1988	8.42
1989	8.65
1990	9.03
1991	9.12

* *Sources:* CSO *Statistical Abstract,* various issues, Revenue Commissioners *Annual Report,* various years

TABLE 5

Alcohol-Related Admissions As A Proportion Of All Admissions To Irish Psychiatric Hospitals And Units For Selected Years*

Year	All Admissions	Alcohol Admissions	Percentage of all Admissions
1958	11,231	644	5.7
1965	15,350	1,638	10.7
1972	22,964	4,143	18.0
1979	27,358	7,158	26.2
1986	29,392	7,132	24.3
1993	27,005	5,718	21.2
1995	26,440	5,262	19.9

* *Sources:* *Report of the Inspector of Mental Hospitals for 1958,* and *Annual Activities Reports* of the Medico-Social Research Board and Health Research Board.

To proponents of the disease concept, the increases in alcohol consumption depicted in Table 4 (perhaps most significantly in the period 1960-1980 when annual *per capita* alcohol consumption doubled) might not seem alarming. The base from which these increases grew was extremely low; by international standards Irish consumption figures were modest, even at their highest point; and, in any event, to those who emphasised the etiological significance of individual predisposition consumption rates were of little concern.[2] Similarly, the increases in hospitalised morbidity shown in Table 5 might be seen by those who favoured the disease concept as indicating nothing other than an increase in the *treated prevalence* of the condition, reflecting the expanded provision of services and a greater willingness on the part of alcoholics to come forward for treatment rather than an increase in the real incidence and prevalence of drinking problems. A further elaboration of this point of view would suggest that the increased take-up of treatment services was a temporary phenomenon, fed by the backlog of longstanding but previously untreated problem drinkers, which

would gradually decrease over time. The decrease in alcohol admissions which is evident, though scarcely a dramatic decrease, from the mid -1980s will be discussed later in this chapter in terms of the policy decision on alcohol admissions advocated from this time on.

From the public health perspective, however, these increases in *per capita* consumption simply reflect a greater public commitment to a drug which is toxic, addictive and implicated in a range of health, social and behavioural problems. Furthermore, it might be argued, the extreme patterns of Irish drinking, with a relatively high proportion of teetotallers and a correspondingly high proportion of heavy drinkers, is not reflected in this simple average, which is the statistic commonly used in international comparisons.[3] Similarly, the data in Table 5 might be construed from a public health perspective as both reflecting an understandable increase in alcohol-related problems and the folly of thinking that such a broad spectrum of pathology could be 'treated away' by the healthcare system. While those who espoused the disease concept continued to place their hopes in treatment systems, the emerging public health perspective was much less sanguine about what treatment might deliver, seeing an emphasis on treatment as a distraction from the more urgent and complex function of prevention.[4]

The Emergence of the Public Health Perspective Internationally

It was pointed out in Chapter Two that despite the general consensus which had marked the evolution of the disease concept in post-Prohibition America, a number of social scientists had expressed reservations about both the logic and the social desirability of this development. This sceptical approach to the disease concept was maintained as a central feature of the involvement of social scientists in the burgeoning alcohol research field in

the USA and internationally. At the heart of this scepticism was the consistently expressed view that the promotion of the disease concept was more accurately to be thought of as a social movement than as the application of new scientific knowledge. One American sociologist, Seeley, in what proved to be a remarkably prescient critique published in 1962, argued as follows:

> As far as public communication is concerned, however, I think the bare statement that 'alcoholism is a disease' is most misleading, since (a) it links up with a much-too-narrow concept of 'disease' in the public mind, and (b) it conceals what is essential - that is, that a step in public policy is being *recommended,* not a scientific discovery announced. It would seem to me infinitely preferable to say, 'It is best to look on alcoholism as a disease because ...' and to enumerate reasons. This would both take the public into our confidence (and hence really educate) and permit withdrawal of the recommendation if it seemed wiser at a later date. The latter ought to be much easier and more comprehensible than a first announcement of a seeming scientific fact and its later contradiction with no new evidence.[5]

Such criticisms of the disease concept by social scientists were not, however, confined to America but were taken up at international level. A 1969 paper by Christie and Bruun, two reputable Scandinavian sociologists with a particular interest in alcohol studies, argued trenchantly that this insistence that 'alcoholism is sickness' was acceptable and popular not despite but *because* of its vagueness and logical inconsistency; they described the disease concept, and related WHO ideas about illicit drugs, as 'big fat words' the function of which was to act as 'grease in the social machinery'.[6] In other words, Christie and Bruun rejected the idea that there was any technical or scientific base to the disease concept, and saw it instead as a pseudoscientific construct which allowed society to ignore the value and policy dilemmas inherent in this area. Where earlier generations had been accustomed to lively debate and controversy between 'wets' and 'drys', contemporary citizens of western democracies were being persuaded (according to Christie and Bruun) that science had made such debate redundant. The style of policy making favoured by these two sociologists

was the rational comprehensive style in which value judgements could be clearly differentiated from scientific or technical developments; should this ever be achieved, it would bring 'conceptual refinement' to alcohol policy making, in the process 'giving to the experts what belongs to them, and to us all the decision on ethics which belongs to all of us'.[7]

In addition to these and other[8] theoretical papers which predicted many negative social consequences stemming from an uncritical acceptance of the disease concept, empirical research also called into question some of its basic tenets. The success of the alcoholism movement in the USA had attracted substantial research funding; paradoxically, much of the empirical research undertaken with this financial support then contributed to the debunking of the alcoholism movement which had already been going on at a theoretical level.

Of major importance in this regard was the survey research carried out at the University of California, Berkeley, into the drinking habits of random samples of the population. Cahalan (1970) and Cahalan and Room (1974) found that drinking problems did not follow the progressive pattern described by Jellinek and members of AA. Instead, their longitudinal study showed that half of those drinkers identified in their base-line research as having an alcohol-related problem were drinking in a non-problematic way at three-year follow-up. They also found, however, that the proportion of problem drinkers remained the same, because those drinkers who moved from problem drinking to non-problem drinking were replaced by other drinkers moving in the opposite direction.[9]

The net effect of this research was to challenge the belief implicit in the disease concept (and explicitly and graphically portrayed in the Jellinek

Chart[10]) that alcoholism progressed inevitably and inexorably unless the alcoholic became totally abstinent, and also to challenge the 'two population theory' - the view that alcoholism was a discrete disease so that drinkers could be categorically divided into 'alcoholics' and 'social drinkers'. Further blows to the scientific integrity of the disease concept resulted from continued reporting of moderate or controlled drinking among diagnosed and treated alcoholics who, according to the disease concept, ought to have quickly deteriorated, ultimately reaching the legendary 'rock bottom' at the lower end of the Jellinek Chart.[11]

Predictably, research findings of this nature led to a radical questioning of the validity and utility of the disease concept, with its view of alcoholism as a discrete unitary disorder, as an explanatory device for what was now coming to be seen as a broad spectrum of problems. It was increasingly suggested that alcohol-related problems were multi-dimensional, involving physical and mental health and behaviour, and that such problems did not necessarily involve *dependence* or alcoholism. The publication of a WHO report *Alcohol-Related Disabilities* [12] in 1977 signalled a decisive move by that body away from its previous promotion of the disease concept. An editorial in *The Lancet* which discussed this report wondered whether its real message was that 'the hunt for a definition of alcoholism should be abandoned as the pursuit of what was never more than an imaginary animal', but concluded that the WHO could not abandon 'the reality of addiction to alcohol'.[13] Ultimately, the WHO adopted a biaxial classificatory system diagnosing alcohol problems as falling into one of two categories: *alcohol dependence* or *alcohol-related problems*. There were criticisms of the concept of alcohol dependence (or the alcohol dependence syndrome, as it was often referred to) by some social scientists, who regarded it as little more than a semantic change from alcoholism, and as

providing a spurious legitimation for the continuing pre-eminence of the medical profession in the field of alcohol problems.[14] Nonetheless, this biaxial classification of drinking problems has remained within the WHO's *International Classification of Diseases* since 1979.

In the evolution of alternatives to the disease concept, another major landmark was the publication in 1975 of a collaborative study, *Alcohol Control Policies in Public Health Perspectivee*, by the Finnish Foundation for Alcohol Studies, in conjunction with WHO.[15] This report argued that aggregate levels of alcohol consumption were among the best predictors of a society's incidence and prevalence of alcohol-related problems; in other words, this signalled a return to a 'drier' policy perspective with its suggestion that the best way to reduce the incidence of such problems was through the limitation of consumption through various control measures. The WHO in an Expert Committee Report on *Problems Related to Alcohol Consumption* (1980) definitively confirmed this policy shift when it recommended that Member States should adopt alcohol control policies - principally through fiscal measures aimed at keeping prices high, but also through a range of other regulatory measures - all with a view to reducing consumption levels.[16] Quite clearly, acceptance and implementation of this WHO report by Member States would necessitate a coordinated governmental response, and over the next decade, both in its specific alcohol proposals and in its wider health promotion activities, the WHO developed a framework which Member States could use, if they so wished, in establishing coordinated and comprehensive 'national alcohol policies'.[17]

When one recalls the policy approach adopted by the Intoxicating Liquor Commission 1925, the concept of a national alcohol policy appears neither original nor unrealistic in an Irish context. The question, however, is

whether in the changed policy climate of the 1970s and 1980s, where alcohol consumption had become normalised, policy makers had the political will to revert to the drier policies now called for by the WHO.

In concluding this account of the emergence of the public health perspective internationally, some reference must also be made to the growing body of evidence from evaluative research that the outcomes of conventional alcoholism treatment programmes were disappointingly poor. Evaluation of the outcomes of alcoholism programmes typically involves some measure of social and emotional functioning, rather than an exclusive focus on whether or not patients remain abstinent in the post-treatment period.[18] Alcoholism treatment, as it evolved after the Second World War, consisted largely of counselling and psychotherapy rather than pharmacotherapies, and so was not amenable to the double-blind randomised controlled trial which is the optimum research methodology used in medicine for testing the efficacy of new drug treatments. This methodology involves the random allocation of patients to a *treatment group,* which is administered the drug being tested, or to a *control group,* which is given a placebo or inert substance; neither the patients nor their clinical and nursing staff know which medication is real and which is placebo, thus making it possible to distinguish between pharmacological effects and those effects which are attributable to psychological suggestibility.

Regardless of methodological difficulties, there was a remarkable consistency to the findings of outcome studies, and, shockingly perhaps, the main conclusion was that conventional alcoholism treatment conferred little or no therapeutic benefits on its patients.[19] One controversial and much cited British study (Orford and Edwards, 1977),[20] which randomly allocated alcoholics to a standard in-patient programme (which included

individual and group counselling, didactic lectures and introduction to AA) or to a single out-patient session of advice-giving, at least approximated to optimum research conditions. The results of this study showed that at two-year follow-up there were no significant differences in outcome between the two groups; in other words, patients who were given one well-prepared session of advice, lasting for a couple of hours, did just as well as patients who spent a month in hospital.

Since the disease concept had its origins in the USA and since enthusiasm for treatment had been particularly high in that country, it is important to refer also to some American evaluative literature. One of the most highly regarded American studies of alcoholism in the post-war period was *The Natural History of Alcoholism,* the first edition of which was published in 1983.[21] Its author, a Harvard psychiatrist, George Vaillant, was well-known for his longitudinal research into mental health and coping across the life span, but in this book his focus was exclusively on alcoholism. He describes how his interest in and commitment to alcoholism treatment grew during his clinical involvement with the *Cambridge and Somerville Program for Alcohol Rehabilitation* (CASPAR), to the point where he was satisfied that he 'was working for the most exciting alcohol program in the world'.[22] However, when he switched from a clinical to a research mode and did follow-up studies of the CASPAR patients, he found that this programme was no more successful or effective than any other. His overall conclusion was that there was no evidence that any of the conventional treatment and rehabilitation programmes added to or accelerated what he described as a commonly occurring process of natural healing or spontaneous recovery; one of his fears, in fact, was that treatment programmes might cut across and delay spontaneous recovery. His views are summarised as follows:

> Recently the *Annals of Internal Medicine* editorialized that 'the treatment of alcoholism has not improved in any way in

> twenty-five years' (Gordis, 1976). Alas, I am forced to agree. Perhaps the best that can be said for our exciting treatment effort at Cambridge Hospital is that we were certainly not interfering with a normal recovery process. How can I, a clinician, reconcile my enthusiasm for treatment with such melancholy research data?[23]

While Vaillant may have wrestled with his conscience on this issue, it should be pointed out that the overall momentum of what its critics were coming to describe as 'the alcoholism treatment industry' in the USA was in no way impeded by these negative research findings.[24] On the contrary, the concept of *recovery* was broadened to include, not just those who were dependent upon drugs or alcohol, but relatives and friends who were increasingly referred to as 'dysfunctional families', 'enablers', 'codependents' or 'adult children of alcoholics'.[25]

In returning the focus to the Irish scene for the remainder of this chapter, the intention is to study the impact here of the public health perspective and to assess the extent to which it succeeded in gaining ground from the curative emphasis inherent in the disease concept. The major question is whether the health promotional view was articulated clearly and forcefully to such an extent that it was taken up at governmental level.

Finally, for summary purposes and to highlight the differences between these two policy perspectives, their main tenets are set out in Table 6.

TABLE 6 [26]

The Disease Concept of Alcoholism and the Public Health Perspective *

Disease Concept	Public Health Perspective
Alcohol is a relatively safe drug	Alcohol is a dangerous drug
The only serious problem associated with alcohol is alcoholism/alcohol dependence	There is a wide range of alcohol-related problems - health, behavioural, accident, occupational - of which dependence is just one element
The provision of treatment for alcoholics should be the main concern of health authorities	The provision of treatment is expensive, of little efficacy and of relatively little importance - health authorities should strive to introduce comprehensive alcohol control policies at national level

* *Source*: Butler (1994)

The Role of INCA During a Period of Attempted Revisionism

The Irish National Council on Alcoholism (INCA) had been set up, as described in Chapter Three, following a visit to Dublin by Marty Mann of the American National Council on Alcoholism and, originally at least, it reflected its progenitor's almost exclusive concern with curative matters. In presenting an account of how the public health perspective emerged in Ireland as a challenge to the disease concept of alcoholism, an exploration of the role of INCA will be used as a convenient device for drawing together a wide range of material relating particularly to: (1) *reorienting the health services* and (2) *healthy public policy,* two of the key concepts of health promotion discussed in Chapter One.

While it might seem illogical to focus on INCA, a body which had so clearly nailed its ideological colours to the mast from its inception, there are valid reasons for so doing. The first such reason is that INCA was the only national organisation which lobbied for change in the alcohol policy arena, and, in the absence of any specialist alcohol policy unit in the Department of Health, it had a unique opportunity to make its mark in this field. Furthermore, it was given statutory funding and formal recognition by the Minister for Health in 1973, describing itself thereafter as a 'government-approved voluntary body'.[27] The second reason is that INCA, from the early 1970s onwards, contained within its ranks most of those people who might be seen as the key players in this arena; these included psychiatrists from both the public and private sectors, whose views on the desirability of a continuously expanding treatment system might not necessarily coincide, as well as researchers and epidemiologists who might reasonably be expected to be familiar with the emerging public health perspective.[28] What needs to be considered, therefore, is how INCA adapted or adjusted to the notion that it should be primarily concerned with prevention. If politicians, civil servants, the media and the general public were to be persuaded of the validity of health promotion, the persuasion was most likely to come from INCA.

The difficulty involved in this process of adjustment or transition from a curative to a preventive emphasis became apparent in 1973, at the very moment when INCA had all the appearance of being on the crest of a wave. In October 1971, INCA had held a conference in Dun Laoghaire which attracted the interest of the then Tánaiste and Minister for Health, Erskine Childers. Unlike Seán Flanagan,his predecessor, Erskine Childers was wholeheartedly and unequivocally committed to the disease concept and believed that the time was ripe for a serious policy initiative in this area. He

also thought that such an initiative should be coordinated by INCA, and one of his officials wrote as follows to the Chairman of INCA, Mr Justice Cearbhall O'Dálaigh:

> The Tánaiste is anxious that the interest and enthusiasm created by the recent Conference should not be allowed to disappear and he wishes to know, therefore, what are the views of INCA as to what our next steps should be. He visualises that INCA should consult with others engaged in this field who should be given an opportunity of submitting such evidence as they may see fit.
>
> We have no definite guidelines to lay down as to how you should tackle this task but what we have in mind is that you should examine the problem, in the light of the knowledge gleaned from the Conference, and consider in broad outline what practical action you would recommend for the immediate future.[29]

In response to this request INCA spent the whole of 1972 in a process of consultation and discussion, following which a lengthy report was submitted to the Minister for Health in January 1973.[30] In setting out in summary form its recommendations for 'publicity and propaganda', the report put explicit emphasis on the value of 'stressing the disease concept and thereby removing the stigma of alcoholism, in order to encourage the acceptance of treatment at an early stage'.[31] However, the copy of the report subsequently available at INCA headquarters contained the following footnote:

> There is a minority viewpoint that over-emphasis on the disease concept has grave disadvantages in that it concentrates too much on individual susceptibility and fails to recognise that quantity, frequency and the use that alcohol is put to by the individual are of greater importance. Moreover, by stressing the disease concept there is the implication that these factors are NOT important. (This footnote was added in November 1973 subsequent to the submission of the Report to the Minister for Health).[32]

A similar footnote records the suggestion that all alcohol beverage containers should carry a Government warning to the effect that 'This beverage contains alcohol and is therefore liable to produce dependence';[33] this footnote was also omitted from the Minister's copy, as was another suggestion that wives of alcoholics should be given free legal aid if they

wished to separate from husbands whose drinking disrupted family life and caused emotional damage to children.[34]

These additional footnotes, which were omitted from the copy given to the Minister, clearly suggest that within INCA an alternative perspective was emerging at this time. The decision to conceal from the Minister the existence of ideological disagreement of such a fundamental kind is completely understandable in the light of INCA's obvious determination to use this opportunity to achieve more formal recognition and financial support from the Minister. The Minister's enthusiasm for INCA was almost certainly based on the apparent consensus attaching to the disease concept, and might not have survived a report which dealt openly with ideological conflict and which highlighted the associated policy dilemmas. However prudent it may have been for INCA to present a united front at this particular juncture, it still left the organisation with the difficult task of deciding where it stood in relation to the two polarised paradigms, the disease concept and the public health perspective. Would INCA, as the expert advisory body on these matters, continue to urge the Minister for Health to develop curative services or would it lobby for a multisectoral alcohol control system in accordance with the public health perspective?

Reorienting the Health Services

The task of 'reorienting health services' was one of the five principal tasks of health promotion identified in the Ottawa Charter.[35] Whether INCA had the capacity to act as an effective advocate of this process of reorientation was always in doubt because of the dominant position of doctors, and of psychiatrists in particular, in its membership. It would be naive to expect doctors, whose authority and financial security were overwhelmingly based upon curative service provision, to transform themselves overnight into

lobbyists for a preventive system in which the validity and effectiveness of curative services were seriously questioned.

However, the doctors within INCA did not function as an homogeneous group articulating a common or 'party' line. One source of disagreement which manifested itself periodically was the tension between public and private medicine. Alcoholism admissions to the Irish psychiatric system had risen steadily from the mid 1960s to a point in the late 1970s where they accounted for a quarter of all admissions. A health policy paper which was published by the National Economic and Social Council (NESC) in 1983 commented critically on this trend, pointing out that whereas alcoholism had accounted for 25% of all psychiatric admissions in Ireland during 1979, these admissions had made up less than 7% of English admissions for the same year.[36] However, if one breaks down the Irish mental health admission statistics by type of hospital (and, broadly speaking, there are three types of inpatient system - *health board hospitals, general hospital psychiatric units* and *private psychiatric hospitals*), it becomes clear that alcoholism admissions were a great deal more common in private psychiatric hospitals than in either of the other two systems. For instance in 1979, the year selected by NESC for comparative purposes, alcoholism admissions accounted for 40% of private hospital admissions, but only 23% of health board admissions.[37]

Understandably, psychiatrists from the private hospitals were unlikely to undermine what was an important therapeutic and commercial function of these institutions by using INCA to lobby for a radical reorientation of the health services, away from treatment towards prevention. There were, however, some public sector psychiatrists in INCA[38] who did not subscribe fully to the disease concept or to its associated enthusiasm for treatment.

The opinions which were consigned to footnotes in INCA's report of 1973 and deemed unsuitable for the eyes of the Minister for Health were those of Dr R.D. Stevenson, a consultant psychiatrist with the Eastern Health Board and clinical director of St Dymphna's Hospital, the largest health board alcoholism treatment unit in the country. Dr Stevenson had become a member of INCA within a few years of its establishment, but had gradually moved away from the disease concept, arguing that it depicted alcohol in an excessively benign light, excused irresponsible drinking and made unrealistic claims for the efficacy of alcoholism treatment.[39]

Another fault line within INCA lay in the differing perspectives between those doctors who were solely or principally clinicians and those who were committed to research. In this latter category, the two members of INCA who were most consistently and explicitly to champion the public health perspective and to question the wisdom of putting resources into specialist treatment services were Dr Geoffrey Dean, Director of the Medico-Social Research Board, and Dr Dermot Walsh who was in charge of mental health epidemiology in the same institute.[40]

Because of his many publications, it is relatively easy to trace Dermot Walsh's increasing scepticism with and eventual repudiation of the disease concept. At the INCA Conference which was held in Dun Laoghaire in 1971, Professor Norman Moore, who was Medical Director of St Patrick's Hospital (Dublin's oldest and best-known private psychiatric hospital) and a founder member of INCA, summarised and drew recommendations from the overall proceedings. Norman Moore's perspective is best exemplified perhaps in his statement that: 'The nature of the physical change [involved in alcoholism] is unknown, but its solution, I believe, lies with the laboratory scientists. One day I think they will give us the answer'.[41] In a

further comment referring to the lack of research in this country, Moore went on to say that: 'Dr Dermot Walsh's research into the field of addiction problems in Ireland has been a splendid exception to the general criticism concerning the lack of research'.[42] Approbation from this source was understandable at this time because Dermot Walsh still subscribed to the disease concept, albeit with some scepticism. In a 1972 paper, for instance, Walsh was still broadly positive about the increased numbers of patients being admitted to hospital for alcoholism; he wrote:

> In Local Authority hospitals the first admission increase from 1965 to 1969 was from 258 first admissions to 560 first admissions, an increase of 117 per cent; whereas for private hospitals the increase was from 441 first admissions to 621, an increase of 41 per cent. This confirms that a greater number of working class people are accepting treatment in Local Authority hospitals and that it is this increase in working class admissions which accounts for the greater part of the 69 per cent increase observed from 1965 to 1969. If this hypothesis is true it represents a very rapid and heartening change for the good in the changed community attitude towards alcoholism and the willingness of persons to seek treatment for the condition. Whether treatments will prove effective is something which we cannot evaluate at the moment ...[43]

Over the next few years, however, through his work in the Medico-Social Research Board and his international consultancy and research,[44] Dermot Walsh was increasingly drawn into the network of those who advocated the public health perspective, coming in the process to reject unequivocally the disease concept.

In 1976, for instance, the European Regional Office of the WHO, in conjunction with the Addiction Research Foundation of Toronto, initiated an international study of alcohol problems and the role of the state in controlling or preventing such problems. This study, known as the International Study of Alcohol Control Experiences (ISACE), involved seven 'states': Poland, Finland, Switzerland, Holland, Ireland, Ontario and California. Dermot Walsh, together with the economist Dr Brendan Walsh,

represented Ireland on this project; his participation in ISACE was, however, on behalf of the Medico-Social Research Board[45] rather than INCA, and in this role he became explicitly critical of INCA and its commitment to the disease concept. This detailed, critical perspective is captured, for example, in one of the ISACE publications in which Dermot and Brendan Walsh commented on how excessive drinking or drunkenness was then perceived in Ireland:

> At the same time, there is an increasing tendency, due to the efforts of various bodies such as the Irish National Council on Alcoholism, Alcoholics Anonymous, and the medical profession, to regard alcoholism as a "disease". This conceptualization leads to a different type of permissiveness, in that it implies an inability to control drinking rather than an unwillingness to do so. At the same time, many wives as well as husbands see in this disease concept of alcoholism the legitimization of a man's heavy drinking and the condoning of behaviour that otherwise would be condemned[46]

It is clear, therefore, that INCA was not in a position to advise the Minister for Health unequivocally on this issue of alcoholism treatment; its internal ideological split on this matter simply made this an impossibility. What appears to have happened from the mid-1970s is that an uneasy truce prevailed within INCA on the subject of alcoholism treatment: those who favoured the curative approach were less vociferous than they might have been, while those who were critical also restrained themselves, so that the agency avoided overt conflict and survived. While this tactic of peaceful coexistence guaranteed INCA's survival, it also (as will be shown later in this section) greatly hindered its ability to act as an effective lobbyist for the remainder of its organisational life.

An additional complication for all those concerned with alcoholism treatment in Ireland was the advent of a new American approach to alcoholism treatment known as the *Minnesota Model.* This particular variant of the disease concept had evolved, as its name suggests, in the State of Minnesota

from the 1950s onwards, and was epitomised in the activities of the Hazelden Foundation.[47] While it borrowed heavily from the therapeutic philosophy of AA and related Fellowships,[48] it differed fundamentally from these Fellowships in its advocacy of confrontation as a therapeutic tool and also in its espousal of highly structured inpatient programmes with lengthy aftercare. To those who believed that treatment should be de-emphasised in Irish health policy, the Minnesota Model represented a most untimely evangelical argument for the retention and expansion of curative services.

If the Roman Catholic Church in Ireland had been slow to warm to the disease concept (as described in Chapter Three), it more than compensated for this delay by the alacrity it displayed in promoting the Minnesota Model. Almost without exception, it was priests and nuns who advanced the cause of the Minnesota Model and, by comparison with the vacillation of INCA, their work in this regard was an object lesson in effective lobbying. Why the Minnesota Model should have been so attractive to Irish religious at this time is not absolutely clear. This was a time when members of religious orders became interested in doing pastoral work outside what had been their mainstream activities in the educational and healthcare systems, and addiction treatment – particularly when it made such explicit use of spiritual themes as was the case with the Minnesota Model - appears to have been seen as a new and highly appropriate form of pastoral care. In any event, the first Irish treatment programme to be set up on these lines was at the Stanhope Social Service Centre in the north inner-city of Dublin; this was a structured outpatient programme which was created in 1976 by Sr Marie Joseph O'Reilly of the Irish Sisters of Charity, modelled on the programme she had trained in at St Mary's Hospital in Minneapolis and run with considerable financial support from the Eastern Health Board.[49]

However, a much greater impact on the treatment scene in Ireland was made by the opening in early 1978 of the Rutland Centre, an inpatient unit which was set up in a disused convent in Clondalkin, Dublin, with accommodation for twenty-four clients. The Rutland Centre offered an intensive and highly-structured treatment programme, with an average inpatient stay of six weeks, followed by a two-year aftercare period. This centre was set up by Fr Raphael Short, a priest of the Passionist Order, who had trained in clinical psychology and subsequently spent some time in the USA, studying the Minnesota Model. In 1977 Fr Short approached the then Minister for Health, Charles Haughey, with a request for financial support for his proposed treatment centre. The submission to the Minister was couched in the usual terms of the Minnesota Model, describing the addicted person as 'out of touch with reality'[50] and, through its emphasis on the 'drug-free' nature of the proposed treatment methods, implicitly criticising the existing medical approach to addiction treatment in Ireland. Fr Short's proposal was unambiguously clear and optimistic:

> Drawing on the experience and success of similar centres in the United States, particularly in the State of Minnesota and assisted by their personnel, this centre hopes to offer an alternative form of alcoholism treatment which is drug free and based on the principles of crisis intervention and Reality Therapy. Where the model operates in the United States, a recovery rate of 60-70% is claimed, based on a criterion of three years sobriety from the date of discharge.[51]

Perhaps if the Department of Health had a specialist policy unit dealing with alcohol issues, or if it had received clear policy advice from INCA questioning the claimed 'success rates' or discouraging it from financing this new development, the Minister might have rejected Fr Short's submission. What happened, however, was that the Minister agreed to provide £23,000 from the Hospital Trust Fund towards the capital costs of the new centre and £70,000 per annum from the health budget for staff salaries; the Rutland Centre was regarded as a pilot project which would be

monitored for two years, following which the Department of Health and the Eastern Health Board would reconsider financial support for this venture.

The Eastern Health Board debated the establishment of the Rutland Centre at its meeting of 12th January 1978,[52] although the reality of the situation was that Mr Haughey's commitment to this project effectively presented the Board with a *fait accompli.* Enthusiasm for the Rutland Centre was muted, to say the least, and from the minutes of this meeting (and from general recall of this period[53]) it is possible to discern a sense of shock that somebody who was not a medical doctor should seek and be granted considerable health funding for an alcoholism treatment centre. Statistics provided for this meeting of the Eastern Health Board suggested that the Board's own specialist alcoholism unit, St Dymphna's, was both dealing with a much larger number of patients than the Rutland Centre could ever aspire to cater for *and* providing a more comprehensive service (including detoxification and other medical care). The annual cost of the St Dymphna's service was approximately £100,000, while the projected annual cost of the Rutland Centre was £120,000. In the circumstances, there was something almost pathetically revealing about the comment in the minutes of this meeting to the effect that: 'A request by Dr Stevenson [Clinical Director of St Dymphna's] for additional support staff is being examined'.[54] What this suggested was that the Eastern Health Board was experiencing difficulties in providing its own long-established alcoholism unit with the level of resources it was thought to require, while at the same time acting, on Ministerial orders, as a conduit for the payment of substantial funding to a new voluntary agency, concerning which it had many reservations.

A final example of the misgivings of the conventional healthcare system and the medical profession towards these interlopers, into what had been an exclusively medical domain, may be found in the contribution to this meeting of Professor Stephen Doyle, a physician at St Lawrence's Hospital and a member at this time of the Eastern Health Board. Professor Doyle expressed great reservations about the Rutland Centre on the grounds that it proposed to detoxify alcoholics without having the services of a full-time doctor; he pointed out that *delirium tremens* had a mortality rate of ten per cent and that 'to treat it in Clondalkin made a big "medical hole" in the proposals'.[55] This objection was quickly made to appear spurious when Fr Short wrote to each member of the Board pointing out that it had never been intended to detoxify patients in the Rutland Centre, which was after all a drug-free facility, but that patients would be admitted only after they had been detoxified elsewhere under medical supervision.[56]

In any event, the Rutland Centre was opened for business in early 1978 and its official opening was performed by Mr Haughey on 17th May of that year. It proved to be merely the first in a line of Minnesota-based residential units which would open in Ireland over the next fifteen years or so,[57] all of which would collectively contribute to the further popularisation of the disease concept, at a time when the WHO and other health-care authorities were calling for a transfer of resources and energies to health promotion. One of the innovations associated with this new American-style treatment system, which was commented upon by the Minister for Health in his address at the opening of the Rutland Centre, was the emergence of a new treatment professional, the *alcoholism counsellor.*[58] In the USA these counsellors were mainly alcoholics who were in 'recovery', but in Ireland the picture was rather more mixed, with nurses, social workers and other professionals displaying an enthusiasm for this new title.[59] Obviously, the

emergence of this new professional group - almost exclusively committed to the curative perspective and to 'recovery' - militated further against the growth of a health promotional or preventive perspective on alcohol in Ireland.

Another consequence of the advent of the Minnesota Model was the broadening of the client population to include spouses, children and other family members and friends of alcoholics, all of whom were drawn into the therapeutic net on the basis that alcoholism was a 'family disease' or that those close to the alcoholic could frequently be classified as 'enablers'.[60] Perhaps the most extreme example of this trend was the growing popularity of the label of ACOA (Adult Child of an Alcoholic); this reflected the belief that adults who had grown up in the care of an alcoholic parent were frequently, if not invariably, subject to life-long emotional and personality difficulties and so in need of specific and ongoing treatment or support.[61]

There is no evidence that either in relation to the funding of the Rutland Centre or to the wider topic of the Minnesota Model the Department of Health ever consulted INCA. This new American approach to alcoholism treatment did not, on the face of it, have the support of either of the two dissenting factions within INCA: those opposed to the disease concept were unlikely to be enthusiastic about what was, essentially, a new and evangelical version of this concept, while those still committed to a curative perspective were dubious about a model which was not under the control of the medical profession and which threatened to poach customers away from the private hospital sector.[62] INCA made no policy pronouncements on this development, almost certainly because of its own unresolved internal conflicts. However, Fr. Short and subsequent advocates of the Minnesota Model displayed an approach to lobbying which would be referred to in

Irish as *an modh díreach:* they made direct, unapologetic approaches to those in a position to fund their services, arguing for the self-evident value of this model and, as often as not, they succeeded. Had INCA been functioning as a coherent body, capable of dispassionate policy analysis and advice, it might have pointed out to the Minister for Health that claims for the efficacy of the Minnesota Model were exaggerated and were certainly not based upon conventional scientific research;[63] it might also have drawn the Minister's attention to the evolving public health perspective and the *volte face* of the WHO on this topic. Even had it done so, however, there is no reason to believe that INCA would have dissuaded the Minister for Health from his support for what appeared to be a popular development in the area of treatment services.

The disagreement and lack of common purpose which characterised INCA became particularly clear in the spring of 1985, when two policy developments in the alcoholism treatment area were announced (coincidentally, it appears) at about the same time.[64] The first of these was the publication of *The Psychiatric Services: Planning for the Future,*[65] the final report of a study group appointed by the Minister for Health in 1981 to draw up guidelines for the development of the country's mental health services. *Planning for the Future* (as this report is commonly described) was made public in March 1985 and was subsequently accepted as the official policy blueprint for public psychiatric services in Ireland for the foreseeable future. In relation to alcohol, *Planning for the Future* advocated a health promotional or public health perspective which will be discussed in the next section of this chapter. In relation to alcoholism treatment, however, the report unequivocally denounced the prevalence of psychiatric inpatient treatment as being excessively high, given the results of evaluative research which indicated that brief community-based

interventions were as effective as lengthy inpatient treatment.[66] The alternative to inpatient treatment which *Planning for the Future* proposed was the establishment of community alcohol services within the sectorised mental health system. The concept of sectorisation refers to the administrative rearrangement of public mental health services, involving the delivery of services to designated geographic catchment areas, or sectors, by mental health teams headed by consultant psychiatrists. While it was conceded that specialist alcoholism counselling should be retained, it was recommended that counsellors should be integrated as far as possible into the sector teams.[67]

The second policy development in this area was the decision by the Voluntary Health Insurance (VHI) organisation to limit its insurance cover of inpatient treatment for alcoholism and drug dependence. In March 1985, as part of its annual renewal procedures, VHI began to inform its subscribers that henceforth inpatient cover of alcoholism treatment would be limited to two admissions, not exceeding 42 days each and with at least 180 days between them.[68] In addition to this limitation, VHI also announced that all hospital cover was to be reduced to a maximum of 180 days *per annum* and that maternity cover was to be reduced, for routine deliveries, from seven to five days. Although there was considerable media coverage and public discussion of all these changes in the VHI scheme, by far the greatest controversy arose in relation to the alcoholism treatment changes.

Claims for inpatient alcoholism treatment at this time were consistently less than one per cent of all claims received annually by the VHI, but their significance lay in the length of stay involved and also in the high rate of readmission.[69] Average length of stay in general hospitals (for VHI claims) in 1985 was 8 days; for psychiatric admissions (excluding alcoholism)

average length of stay for this year was 48 days, and for alcoholism admissions it was 30 days.[70] The VHI decision to reduce its cover of alcoholism treatment not only corresponded to the policy advocated in *Planning for the Future,* but it also brought the organisation closer to the norm which was evolving within American health insurance companies, which by this time was tending to provide cover for just a single inpatient rehabilitation programmes of 28 days duration.

INCA made no public pronouncements about either of these two policy developments. Dermot Walsh had been a member of the study group which produced *Planning for the Future;* his epidemiological data were a central feature of this report and his overall determination to reduce rates of hospitalisation and lengths of stay was evident throughout the report. The private sector psychiatrists within INCA might be indifferent to the proposed changes in the treatment of alcoholism in public hospitals, but they were certainly not indifferent to the proposed changes in VHI's financing of alcoholism treatment in their own sphere.

A 'straw poll' reported by the *Irish Medical Times* in early April 1985 showed that psychiatrists in private hospitals were unanimous in their condemnation of this VHI change, while their colleagues in the public health sector were ambivalent, with some giving clear approval to these limitations on inpatient cover.[71] The flavour of the debate at this time may be gleaned from the press coverage of a public lecture at St Patrick's Hospital:

> Dr John Cooney, Associate Medical Director of St Patrick's Hospital, said in a lecture on 'The Problem Drinker' that the VHI's measures were quite arbitrary and could not be justified, given the natural history of alcoholism and the necessity for properly organised treatment programming designed to achieve recovery rather than mere sobriety.
>
> The VHI organisation would appear to be unaware of the major advances in treatment of latter years in this country,

> with consequent restoration to health and happiness of so many alcoholics and their families ...
>
> It was also highly disquieting to contemplate the prospect of the alcoholic being forced to go underground and conceal his or her problem, after all these years of painstaking and often frustrating endeavour to remove the stigma of alcoholism.[72]

On the other hand, in a rare and mischievous public statement of the view that private psychiatric hospitals were part of the problem rather than part of the solution, Sr Marie Joseph, who had founded the Stanhope Street Alcoholism Centre and who subscribed to the Minnesota Model, wrote:

> During my more than 20 years of work with alcoholics I have found the greatest obstacle to their recovery to be the people who take responsibility for them and provide for their comforts. No better place to do both than in the private hospital.
>
> If alcoholics are kept secure and comfortable they won't stop drinking no matter how much they want to. They can't. The best help that can be given is to expose them to the full consequences of their drinking.
>
> To the VHI I would say 'you have done a good day's work! Stick to it![73]

It is important to note, however, that publicly aired disagreements of this kind were merely about the relative merits of one form of alcoholism treatment as opposed to another and *not* about whether treatment as a whole should play a subsidiary role to health promotion - which is what *Planning for the Future* had advocated.

During the period of public debate about the VHI changes, INCA once again played no public role and issued no public statement on this topic. A few months prior to this, one of the Executive Directors of INCA, Mr Shane Gray, had told a Council meeting that 'the absence of a clear policy in some areas, and lack of consensus among Council members on particular issues, made it difficult sometimes to respond satisfactorily to media enquiries'.[74] Clearly, the issue of VHI changes with regard to alcoholism treatment was a case in point, but in the absence of Dermot Walsh - who

had indicated that he was 'not in full agreement' with a draft response to VHI which had been circulated to members - a relatively mild letter of protest was sent to VHI on the matter.[75]

As was shown in Table 5, earlier in this chapter, there were in fact decreases in the numbers of alcoholics being hospitalised following the acceptance and implementation of *Planning for the Future* . These decreases consisted of reductions both in absolute numbers and in alcohol admissions expressed as a proportion of all mental health admissions, but they were relatively modest, slow to materialise, and could not be taken as evidence of any major 'reorientation of the health services' in this sphere. It must be concluded, therefore, that during the period 1973-1988 INCA did not consistently and successfully advocate or lobby for a reorientation of health services - where this phrase refers to a downplaying of the importance of curative services relative to prevention or health promotion. While it included in its membership some professionals, such as Dermot Walsh and Geoffrey Dean, who were keen advocates of the emerging public health perspective, INCA also contained many members who were totally committed to traditional alcoholism treatment: its ambivalence on the issue was also reflected in the fact that, during the revitalisation of the treatment system which followed the advent of the Minnesota Model, it sought and received from the Department of Health what amounted to a monopoly on the training and accreditation of alcoholism counsellors.

Building Healthy Public Policy

The concept of 'building healthy public policy' is another of the concepts identified in the Ottawa Charter as being central to the general health promotion project.[76] In the context of alcohol and its associated problems, healthy public policy essentially would consist of the drafting and

implementation of comprehensive national alcohol policies, as advocated by public health activists generally and by the WHO specifically. The fundamental belief which underlies this perspective is that alcohol, although a legal and culturally acceptable drug, is toxic, addictive and implicated in a wide range of social and behavioural problems; consequently, it is argued, the most obvious way to lower the incidence and prevalence of alcohol-related problems is to reduce consumption. Healthy public policy is intended to involve in a coordinated way all sectors of government in achieving this ambition, and not just the health sector. Thus, for example, the education sector might be expected to inform the public (and young people in particular) of the link between individual consumption levels and risk; the law enforcement sector might be expected to enforce all aspects of a tough licensing system which curtailed access to alcohol; and finance and revenue sectors might be expected to use fiscal measures to reduce or limit consumption rather than as a tool to maximise revenue for the Exchequer or to create jobs. A summary of this healthy public policy approach to the prevention of alcohol-related problems was contained in Chapter 13 of *Planning for the Future,* along with the view that INCA as 'the primary advisory body in the field of alcohol-related problems in this country' should be involved in the formulation of a national alcohol policy.[77]

The aim of this section is to examine how in fact INCA performed on this front. Realistically, when one considers how difficult the organisation found it to handle the single issue of treatment policy, there is no reason to expect that it would perform more coherently or effectively in this complex multisectoral area. The difficulties facing INCA in advocating healthy public policy stemmed both from its own internal organisational difficulties and from the external policy climate. The internal issues, of course, refer to the lack of ideological consensus which characterised the organisation from

1973 onwards: put simply, it is reasonable to assume that the main support for healthy public policy came from those few Council members with research interests, and that members who were primarily committed to clinical services may have been less interested in preventive activity on the grand scale envisaged here. The external factors consist principally of the opposition to alcohol control policies which could be anticipated from the general populace, from the drinks industry and from other sectors of government.

It was argued at the conclusion of Chapter Three that the great strength of the disease concept lay in its universal appeal rather than in any inherent scientific validity: it was popular with the public because it suggested that only those who were 'alcoholic' needed to exercise caution in their drinking habits; popular with the drinks industry for the same reason; and popular with clinicians because it encouraged the growth of a vibrant treatment industry. In its attempt to sell the public health perspective and the necessity for healthy public policy in the alcohol sphere, INCA may have had access to supporting scientific data of a reputable kind, but it is difficult to conceive of a more unpopular policy line than that which flowed from this research. The message to the public was that all drinkers - and not just heavy drinkers or dependent drinkers - should be circumspect in their drinking habits; indeed some proponents of the public health perspective argued that all drinkers, regardless of their consumption levels, should reduce their consumption by one-third.[78] Worse still, the concept of healthy public policy did not rely solely, or even primarily, on techniques of persuasion to alter drinking habits, but argued for control policies (such as price increases, curtailment of access to retail outlets and bans on alcohol advertising and promotion) which had an undeniably paternalistic air to them. In ideological terms, the concept of coordinated national alcohol

policies was generally described by representatives of the international drinks trade as a form of neo-prohibitionism or 'health fascism', although high-minded, libertarian rhetoric of this kind could never really conceal their underlying fear for their profit margins.[79] Finally, it would be unrealistic to expect sectors of government which were primarily concerned with the revenue-generating or job-creation aspects of the drinks industry to have any great welcome for healthy public policy in this sphere.[80]

To what extent then did INCA succeed in reconciling its own internal ideological differences in relation to healthy public policy, and what strategy did it use in seeking to persuade legislators and central government officials of the validity of this policy? The clearest evidence that INCA did somehow revise its thinking and shift from its original neutrality on the subject of alcohol [81] is to be found in two policy documents which were prepared in 1979 and 1980; the 1979 document was a submission to the Minister for Health, while the 1980 document was a submission to the Minister for Justice.[82] The submission to the Minister for Health was a short document which summarised the data and conclusions from the influential *Alcohol Control Policies in Public Health Perspective.*[83] The message to the Minister for Health was summarised succinctly as follows: 'Changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption; thus control of alcohol becomes a public health issue'.[84] The submission to the Minister for Justice was somewhat lengthier and drew heavily on research from the Medico-Social Research Board; it concentrated on the prospects of using licensing legislation and road traffic legislation to reduce dangerous alcohol consumption and its conclusion was:

> Since the prevalence of alcoholism and other alcohol-related problems increases with the growth of consumption of alcohol at national level, control of availability is an essential feature of preventive measures.
>
> Control can be exercised by limiting access to alcohol itself - particularly to young people - and by revising and enforcing legislation, as suggested in this paper.[85]

Both of these documents obviously represented an ideological shift for INCA from its earlier preoccupation with alcoholism and its treatment; they were nonetheless moderate statements of the public health perspective, lacking stridency or emotionalism, and their emphasis on young people's drinking - a topic on which there tends to be almost universal albeit bland consensus - helped to diminish any sense of neo-prohibitionism which might otherwise be attributed to them. Regardless of the content of these two documents, however, the strategy adopted by INCA in lobbying for political acceptance of this approach is equally in need of scrutiny. In fact, the decision taken by INCA was to send these documents to the two Ministers and to follow this up with direct meetings with the Ministers or, more hopefully, a series of meetings in which the research basis for and the practical value of the public health perspective could be spelt out.[86] The view within INCA was that the Council was a reputable and respected body (it had, incidentally, strong connections with both the Fianna Fáil and Fine Gael parties) which could use its status to lobby discreetly for policy change in this area.[87] Neither of the two submissions was published and no public pronouncement of any kind was made on this change of policy within INCA; indeed to members of the public who gave any thought to this subject it must have appeared as though the organisation still adhered to the disease concept, which had been advocated so cogently and publicly by its first Director.

The decision to rely on direct lobbying at a high level, rather than to publicise these issues through the media, appears to have failed completely,

since successive ministers simply did not meet INCA representatives or treat them with the gravity and deference which they seemed to regard as their due. The strategy was criticised retrospectively by Dr R.D. Stevenson. He told this writer repeatedly that he regarded it as a mistake not to have lobbied publicly and actively on this front, and in 1986 he wrote: 'We all give an impression of deep concern for the public welfare. But have had zero influence on the course of events because we have never rocked the boat. We have always gone through normal channels'.[88] Similarly, Mrs Mary O'Hagan, one of INCA's two Directors, spoke at a public meeting in 1984 of the frustration being experienced by the organisation in communicating with the Minister for Justice.[89] In theoretical terms, the INCA strategy corresponds closely to the *organisational networks* model, one of the three models of policy coordination described by Harrison and Tether, which was summarised in Chapter One.[90] It was not inevitably a losing strategy: if INCA had the commitment and the political skills to use its contacts with politicians and senior civil servants, it might well have succeeded in achieving some elements at least of healthy public policy. It is instructive to remember how advocates of the Minnesota Model had made direct and usually profitable contact with politicians. By contrast, INCA attempts to 'network' with Ministers, senior civil servants and other influential players in this arena appear to have been excessively genteel and inept, and to have made virtually no progress.

Reading through INCA papers from the period 1979 to 1988, one cannot escape the conclusion that, in large measure, its failure to act as an effective advocate of the public health perspective stemmed from the fact that the organisation itself was half-hearted and ambivalent on this issue. It would be wrong to see the two submissions which have been discussed as representing a consensus within the Council, or as representing an agenda

which was being actively and consistently pursued. Instead, the reality was that INCA throughout this period remained in a state of ideological confusion and ambiguity, and was also in an increasingly moribund state organisationally with meetings being held infrequently and little business being conducted. The minutes of the Council meeting for 24th September, 1984, for example, included a summary of a discussion concerning the relationship between INCA and the Health Education Bureau; it is clear from this excerpt just how tenuous INCA's pursuit of the public health perspective was at this time:

> Mrs O'Hagan suggested that the Council has always been concerned with 'alcoholism' while the Bureau have *[sic]* also been concerned with 'alcohol'.
>
> Dr Dean suggested that INCA had always emphasised the disease concept of alcoholism - a concept which was particularly acceptable to the drinks industry ... He believed the Council should state clearly that its objective was to reduce consumption.[91]

Despite engaging in periodic reviews and attempts to regain a clear focus as to its *raison d'être,* [92] INCA failed to renew itself or to regain the consensus which had characterised its early years. It ultimately appeared to fall between two stools in the sense that it never fully committed itself to the public health perspective, although it also lost its close contacts with AA and with those who still subscribed to the disease concept. An attempt in 1984 by one of its Directors, Mrs Mary O'Hagan, to establish a formal link with the Hazelden Foundation of Minnesota became the occasion of a rather embarrassing critique of INCA. Hazelden is the largest and best-known of the foundations which promotes the Minnesota Model, and Mrs O'Hagan had hoped that it would be interested in setting up a formal collaboration with INCA which would involve Hazelden in the training of Irish alcoholism counsellors, while INCA would also act as a distribution agent for Hazelden educational and training materials. A report from Mrs O'Hagan to INCA outlined the stringent criteria laid down by Hazelden's

representative, Mr Gordon Grimm, at a meeting which took place in June, 1984. In summary, Hazelden was reluctant to become involved with any organisation which was not 'highly dynamic' and obviously influential in its own community; it also favoured the involvement of 'recovering alcoholics' at a senior level. 'He [Mr Grimm] asked how often the Council and Executive Committee met, and remarked that the fact that the Council had not met since the last AGM would not indicate particular commitment as far as Hazelden was concerned'.[93] Nothing came of this venture, presumably because of Hazelden's lack of faith in INCA, although Hazelden went on soon afterwards to set up its own counsellor training programme in *Aiseiri* (a treatment centre in Tipperary with which it already had links) and to open a European distribution centre in Cork.

One of the few occasions on which INCA appears to have become engaged in direct and explicit lobbying for the introduction of alcohol control policies occurred in 1984 when there was a review of the licensing laws by the Joint Committee on Legislation. Following a written submission to the Joint Committee, INCA was invited to make an oral submission and did so through its two Directors, Mrs Mary O'Hagan and Mr Shane Gray. The responses of the Dáil Deputies and Senators suggest that they were unfamiliar with this new policy line being advocated by the INCA representatives, and that they were both surprised and unhappy at the importance which was now being attached to control systems. Deputy Desmond O'Malley quoted from the statistics, supplied by INCA, which compared alcohol consumption rates internationally, and asked the two INCA representatives and a representative from the Pioneer Total Abstinence Association what all the fuss was about:

> We all express great concern about the level of it, the dangers and the difficulties. We consider it very bad here. I would have thought it was bad and I would have thought it was getting worse. Look at it, we are almost the most liquor

> free country in Europe. We are .9 of a litre above the very bottom in terms of absolute alcohol and our decrease since 1980 in the consumption of alcohol is greater than all other countries except one. We started near the bottom and we are even nearer to the bottom now. I must confess those figures are rather heartening but they tend to conflict with the general picture that is painted. How would your two organisations reconcile these figures with the general picture and the certain degree of pessimism that there is in regard to alcoholic consumption? [94]

Shane Gray responded to this by pointing out how *per capita* consumption rates lead to crude comparisons because of differing age structures and abstinence rates, but the overall tone of the members' responses was sceptical and dismissive. This is best summed up in the remarks of Senator Shane Ross, who with Deputy Alan Shatter, was most critical of the demand for coercive, paternalistic alcohol policies:

> There is a certain emphasis on restriction in the document which the INCA produced and to a certain extent it treats people as children in saying 'This is good for you; this is bad for you! There is an emphasis on penalties. I would endorse what Deputy Shatter said, where the emphasis should come is on education and not on restrictions. Whatever restrictions you introduce will be widely abused.[95]

There is a certain irony in this response to INCA, since it so closely resembles the policy line which INCA itself had advocated for the first few years of its existence, namely, that alcohol as a substance cannot be villified; that aggregate consumption levels are unimportant, and that education is a much more appropriate preventive tool than coercion. Ostensibly, INCA had been using its top-level contacts and its general reputation to lobby for the public health perspective for at least five years before the Joint Committee on Legislation addressed itself to the licensing legislation; the response of the politicians on this occasion suggested, however, that they had not previously heard of this approach and, furthermore, that it was unwelcome.

In 1981 a formal umbrella organisation known as the Drinks Industry Group (DIG), representing both manufacturers and retailers, was

established with a view to unifying and strengthening the voice of the industry.[96] While the public health perspective and its proponents could scarcely take credit for it, the fact was (as Desmond O'Malley had noted) that *per capita* alcohol consumption levels - which had doubled between 1960 and 1980 - began to drop in 1980.[97] The DIG was determined to combat the negative image of alcohol which it believed was now being portrayed by public health advocates, and to oppose the notion that the state should use fiscal or other control measures to reduce consumption levels. A number of research reports and consultancy documents were prepared for the DIG, mainly by Professor John O'Hagan of the Department of Economics at Trinity College, Dublin, to further the industry's cause.[98] These reports, some of which were made public and used for advertising and promotional purposes, generally attacked the public health perspective by illustrating the economic significance of the drinks industry and challenging what was seen to be an already excessive burden of taxation on alcoholic beverages. Philosophically, as one would expect from an economist, the notion of using fiscal policy to limit consumer behaviour was regarded as an unwarranted interference with consumer sovereignty. Practically, it was contended that alcohol was 'price inelastic', which means that demand is relatively insensitive to price and that demand for the commodity would not reduce automatically following a price increase; on this basis, it was argued that price increases might merely result in consumers spending more money on alcohol rather than consuming less, which in turn might add to the social costs of drinking rather than reduce them.

It was conceded that there are 'negative externalities', or costs which society as a whole must bear as a consequence of allowing individuals relative freedom to consume alcohol, but economists have generally argued that

these costs to the Exchequer are more than covered by the high taxes levied on Irish drinkers.[99]

The experience of INCA in attempting to persuade the Ministers for Justice and Health to adopt alcohol policies of a somewhat 'drier' nature is not, of course, unique in the international scene. A special 1993 issue of the journal *Addiction* [100] dealt exclusively with the interaction between alcohol researchers and policy makers and, through a series of case studies from Europe, North America and Australia, showed how researchers had achieved, at best, limited success in this venture. An interesting and provocative paper by Secker, an Australian public sector manager who had worked for two and a half years as Director of Liquor Licensing in Western Australia, set out to explore why, 'although reasonably conclusive research exists on several topics in the liquor availability field - research has had a very limited direct impact on policy formulation'.[101] Secker suggests that generally alcohol researchers do not understand the policy formulation process or the motives and thinking of the main actors who are involved in this process. His views on Government ministers and their approach to alcohol policy formulation are presented here (Table 7) in a summarised version which, while undoubtedly patronising and stereotypical, go some way to explaining the relative success of those who lobbied for an expanded treatment sector and the almost total failure of those who lobbied for healthy public policy.

TABLE 7

Assumptions About Government Ministers Which May Safely Be Made By Alcohol Researchers*

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* They drink liquor (often heavily) and any suggestion in research that liquor consumption should be reduced might be viewed as implied criticism of their habits;

* they want good news and no bad news;

* they are pragmatic seekers of the best balance of forces playing on them at that time;

* they are short-term thinkers and prefer proposals that have clear, short-term benefits;

* they cannot understand research or statistical methodology, and are often not convinced by conclusions even if they do understand them;

* they are poor finishers - once a decision is made and the pressure is off, they lose interest in the decision and move on to the next topic.

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* Adapted from Secker (1993).

Politicians who provide money for new alcoholism treatment services, whether or not there is research evidence as to the efficacy of such services, are gratified by the immediate popular support for such a move; they are also reasonably sure that there will be no opposition to such an allocation of resources. By contrast, a policy decision to embark on healthy public policy in the form of alcohol controls would entail a long-term commitment to what might appear to be extremely moralistic ideals, in the certain knowledge that such policy will be immediately controversial and unpopular. This is not to say that researchers and organisations which draw on research findings are incapable of influencing the formulation of public policy, but rather that their success is dependent on gaining understanding of the policy process and working consistently to influence the key decision makers in the light of this understanding. Secker, on the basis of his

experience, believes that lobbyists for the drinks industry are generally knowledgeable and adept when it comes to 'networking' ministers, their advisers and their civil servants. It is also important to point out, however, that the drinks industry has access to what can appear to be unlimited resources when it comes to funding its lobbying activities, while those who advocate the public health perspective usually operate within far more modest budgets.

In November 1986, INCA held a one-day conference with the title 'Alcohol, Preventing the Harm - Towards a National Policy', in line with the view expressed in *Planning for the Future* that INCA had a key role to play in the formulation of a national policy. Reading through the conference papers,[102] it is relatively easy to see the battle lines which were being drawn but difficult to see how these differences could be reconciled. Dr Norman Kreitman, a British psychiatrist with considerable research experience in the alcohol field, argued trenchantly for a national alcohol policy which would reflect public health concerns; while Harry Hannon, representing the drinks industry, repudiated all suggestions that alcohol was a dangerous drug, arguing that 'The problem of abuse is a people problem, not a product problem'; and Liam Flanagan, Secretary of the Department of Health, discussed treatment services but gave no indication that his department was committed to playing a coordinating role in formulating a national policy which would reconcile all these conflicting interests.[103]

This was, to some extent, to be INCA's last hurrah; the organisation which had been paralysed because of its own unresolved ideological tensions for almost fifteen years now ran into financial difficulties. It failed to get the relatively modest grant (about £30,000)[104] which it had been receiving from the Department of Health to supplement its income from the eight health

boards, and in 1988 the Council voted to wind itself down. At the end of November 1988, INCA ceased operations; its National Director, Sally Edwards, worked on contract with the Health Promotion Unit for about six months following INCA's closure and one long-serving clerical worker moved into a permanent position with the Department of Health. The decision of the Department of Health to stop this subvention clearly indicated that it no longer wished to support the organisation, but it was an indirect and relatively passive action and it was not accompanied by any policy statement from the Department of Health clarifying or explaining its decision to withdraw support. Utilising a health care metaphor, one could see the Department's behaviour as unplugging the life support machine rather than taking a more active role in terminating the life of a chronically ailing organisation. The Department of Health, as detailed in Chapter Three, had played no part in setting up INCA, nor had it displayed initiative in any other area of alcohol policy; its indirect closure of INCA was, therefore, at least consistent with its track record in this area.

In seeking to understand why INCA closed at this point, the answer seems relatively straightforward from an internal organisational perspective. The various protagonists within INCA appear to have found it easier to capitulate and close the organisation down in the face of this new, albeit passive, hostility from the Department of Health than to mount a public campaign to stay open. While commercial sponsorship to stay open was potentially available, this might have involved accepting money from the drinks industry, which would have highlighted and widened the existing internal split. Perhaps what is more important, though less easy to discern, is the motivation of the Department of Health in effectively closing INCA. It will be recalled from Chapter One that health promotion ideas and ideals were being articulated explicitly for the first time in Ireland during these

years. In 1986 the Department of Health had published *Health: The Wider Dimensions* which generally reflected the WHO vision of health promotion, and which specifically had decried the lack of a coordinated policy approach to alcohol and alcohol problems.[105] In 1987 a similar document, *Promoting Health Through Public Policy,* was published by the Health Education Bureau, leading to the closure of the Bureau and the establishment within the Department of Health of a Health Promotion Unit.[106]

One could surmise, therefore, that the simultaneous closure of the Health Education Bureau and INCA represented, as indeed the rhetoric of the period suggested, a coherent shift towards the realisation of these health promotion ideals. On the alcohol front, this could be seen as a demonstration of impatience with INCA and the beginning of a new era in which the Department of Health saw itself as leading the way in health promotion. Such a vision of the Department of Health taking a central role in building healthy public policy on alcohol would, of course, seem rather far-fetched in the light of its historic inactivity in this sphere, the most recent indicator of which was Liam Flanagan's pointed avoidance of commitment on this issue at the 1986 INCA conference.

Even though INCA had not been involved for many years in highly public advocacy or lobbying activities, its closure meant that there was now *no* independent lobby group with an interest in alcohol problems. Alcoholics Anonymous continued to flourish, but retained an interest only in individual problem drinkers and avoided any involvement with policy issues, in accordance with its Traditions. It is worth noting that in the United Kingdom, where there had been no political welcome for healthy public policy on alcohol by the Thatcher Government,[107] the DHSS had nonetheless taken the initiative in establishing a single, well-funded body,

Alcohol Concern, which lobbied with a large degree of autonomy and professionalism in the face of strong opposition from the drinks industry.[108]

Summary and Conclusions

The primary aim of this chapter was to describe the emergence internationally of the public health perspective and to explore how it was represented during the period 1973-1988 in the Irish health policy scene. It was shown that to all intents and purposes the public health perspective was diametrically opposed to the disease concept, involving a return to the point of view previously expressed in Ireland by the Intoxicating Liquor Commission of 1925.[109] While this 'drier' policy perspective could claim to be based on a sounder scientific footing than previous attempts at alcohol control policies (which had tended more strongly towards a moral or temperance ethos) it was greatly hindered by the general cultural tolerance of alcohol and the specific view of alcohol problems which had grown up in the hey-day of the disease concept in post-war Ireland.

It was argued at the end of Chapter Three that the introduction of the disease concept to Ireland could be understood in policy terms as approximating to Lindblom's incremental model of policy making; within this framework the test of a good policy is not that it is demonstrably effective in a rational-technical sense or that it is clearly in tune with public values, but simply that people like it. The major difficulty for proponents of the public health perspective was that it was generally unpalatable and appeared to have little hope of gaining widespread popularity. The decision to use the 'organisational network' approach to policy making - which involved a relatively elite group within INCA making approaches to political elites - was understandable and commendable from a public health point of view,

but was ultimately of little value in view of the nature of the issues and the ambivalence and ineptitude of INCA itself.

Chapter Five will largely concentrate on the activities of the Health Promotion Unit from 1988 onwards, and will look specifically at the work of this unit in attempting to formulate a national alcohol policy. There is a suggestion in the style in which this task was addressed - within a central government department on the instruction of a minister - of the rational-comprehensive or corporate model. The suggestion is that the health interest in relation to alcohol will be clearly identified and all other policy sectors made subordinate to this. Given the complexity of the issues, the strength of the various interest groups (the treatment industry as well as the drinks industry) and the weak track record of the Department of Health on this issue, it seems unlikely that much progress could be made in devising and implementing a national alcohol policy which fully satisfies the aspirations of health promotionists.

However, with the demise of INCA, the only potential source of policy change in the alcohol and health area appeared to be the Health Promotion Unit of the Department of Health, and it is the work of this unit on the task of formulating a national alcohol policy which will be the main topic of Chapter Five.

Chapter Four: Footnotes

[1] For a discussion of the concept of healthy public policy and its place in the wider health promotion framework see Chapter One of this thesis.

[2] See D. Conniffe and D. McCoy, *Alcohol Use in Ireland; Some Economic and Social Implications.* (Dublin: ESRI, 1993) for a detailed discussion of recent Irish alcohol consumption trends.

[3] Although the Pioneer Total Abstinence Association went into decline from the 1960s, Ireland continued for the duration of the period under study to have a higher proportion of non-drinkers in its adult population than any other EU country. See C. Hupkens, R. Knibbe and M. Drop, 'Alcohol Consumption in the European Community: uniformity and diversity in drinking patterns', *Addictions, 88* (1993), pp 1391-1404.

[4] For a restrained professional analysis of the relative importance of treatment versus prevention see Royal College of Psychiatrists, *Alcohol: Our Favourite Drug.* (London: Tavistock, 1986); for a popular and less restrained critique of treatment see S. Peele, *Diseasing of America: Addiction Treatment out of Control.* (Lexington, Mass.: Lexington Books, 1989).

[5] J. Seeley, 'Alcoholism as a Disease: Implications for Social Policy', in D. Pittman and C. Snyder (eds), *Society, Culture and Drinking Patterns.* (New York: John Wiley, 1962), p.593.

[6] N. Christie and K. Bruun, 'Alcohol Problems: The Conceptual Framework', in M. Keller and T. Coffey (eds), *Proceedings of the 28th International Congress on Alcohol and Alcoholism.* (Highland Park, New Jesey: Hillhouse Press, 1969) p.72.

[7] Ibid, p.72.

[8] Another well-known critical paper, written from a sociological perspective was: D. Robinson, 'The Alcohologist's Addiction', *Quarterly Journal of Studies on Alcohol, 33* (1972), pp 908-916.

[9] D. Cahalan, *Problem Drinkers.* (San Francisco: Jossey-Bass, 1970); D. Cahalan and R. Room, *Problem Drinking Among American Men.* (New Brunswick, New Jesey: Rutger Centre of Alcohol Studies, 1974).

[10] See notes 5 and 6 to Chapter Three.

[11] The phrase 'rock bottom' has been popularly used in AA, particularly with reference to the Jellinek chart, and suggests that continued drinking by 'alcoholics' leads inevitably to a slide to a point where further deterioration is impossible; the only change thereafter is death or recovery.

[12] G. Edwards, M. Keller, J. Moser and R. Room, *Alcohol-Related Disabilities.* (WHO Offset Publication No. 320). (Geneva: WHO, 1977).

[13] *The Lancet, 1* (1972), 'WHO and a New Perspective on Alcoholism', pp 1087-88.

[14] See, for instance, S. Shaw, 'A Critique of the Concept of the Alcohol Dependence Syndrome', *British Journal of Addiction, 74* (1979), pp 339-348.

[15] K. Bruun et al, *Alcohol Control Policies in Public Health Perspective.* (Helsinki: Finnish Foundation for Alcohol Studies, 1975).

[16] World Health Organisation, *Problems Related to Alcohol and Consumption* (WHO Technical Report Series, 650). (Geneva: WHO, 1980).

[17] For a summary account of this development by one of its key proponents at WHO, see J. Moser, 'What does a national alcohol policy look like?', in I. B. Glass (ed.), *The International Handbook of Addiction Behaviour.* (London: Tavistock/Routledge, 1991), pp 313-319.

[18] There is a detailed critical account of what evaluation entails in R. Moos, J. Finney and R. Cronkite, *Alcoholism Treatment: Context, Process and Outcome.* (New York: Oxford University Press, 1990).

[19] A well-known review of outcome studies in the 1970s and early 1980s is: W. Miller and R. Hester, 'The effectiveness of alcoholism treatment: what research reveals', in W. Miller and N. Heather (eds), *Treating Addictive Behaviors: Processes of Change.* (New York: Plenum Press 1986), pp 121-174.

[20] J. Orford and G. Edwards, *Alcoholism: A Comparison of Treatment and Advice, with a Study of the Influence of Marriage.* (Oxford University Press, 1977).

[21] G. Vaillant, *The Natural History of Alcoholism.* (Harvard University Press, 1983). A revised and updated second edition was produced more recently: *The Natural History of Alcoholism Revisited.* (Harvard University Press, 1995).

[22] G. Vaillant (1983), p. 284.

[23] Ibid., p.285.

[24] See S. Peele, op.cit.

[25] For examples of popular and influential literature on this expanded network of pathology and its treatment see the following:
S. Wegscheider, *Another Chance: Hope and Health for the Alcoholic Family.* (Palo Alto: Science and Behavior Books, 1981);
J. Woititz, *Adult Children of Alcoholics.* (Florida: Health Communications Inc., 1990);
A. Wilson Schaef, *Co-Dependence: Misunderstood - Mistreated.* (San Francisco: Harper, 1986).

[26] S. Butler, 'Alcohol and Drug Education in Ireland: Aims, Methods and Difficulties', *Oideas, 42* (1994), pp 125-140.

[27] This, for example, was how INCA described itself in the IPA's *Administration Yearbook and Diary* (1987): 'The primary aim of the Council, a government-approved voluntary body, is to promote measures to prevent alcoholism, to encourage its early diagnosis and provide motivation to treatment by those who suffer from it ...'
Despite being funded by subventions from the regional health boards and the Department of Health, INCA enjoyed great autonomy in the sense that the Council was self-selecting and had no Ministerial or other externally imposed members.

[28] The private sector psychiatrists who were Council members at this period were: Drs Tubridy and McGrath of St John of God's Hospital, Stillorgan; Drs Moore and Cooney of St Patrick's Hospital, Dublin and Dr Lane-O'Kelly of Belmont Hospital, Waterford. Public sector psychiatry was representedby Dr Stevenson and Professor Browne of the Eastern Health Board, and by Dr Walsh who also had a major research interest in alcohol problems through his role as head of mental health research at the Medico-Social Research Board. The other medical member of the Council at this time was Dr Dean, Director of the Medico-Social Research Board, an epidemiologist who, as will be shown below, was instinctively sceptical of curative approaches to drinking problems.

[29] *Appendix A, Report to the Minister for Health by the Irish National Council on Alcoholism.* (January 1973).

[30] See note 29. This was a lengthy report which covered a wide range of relevant topics.

[31] Ibid., p.49.

[32] Ibid., p.49.

[33] Ibid., p.50.

[34] Ibid., p.51.

[35] Essentially, the concept of reorienting health services refers to the perceived necessity to shift health professionals and institutions from their traditional preoccupation with curative services to preventive or health promotional concerns.

[36] National Economic and Social Council, *Health Services: The Implications of Demographic Change* (NESC Paper, No. 73). (Dublin: NESC, 1983), p.46.

[37] A. O'Hare and D. Walsh, *Activities of Irish Psychiatric Hospitals and Units 1979.* (Dublin: Medico-Social Research Board, 1981).

[38] Apart from Drs Stevenson, Walsh and Brown (who were referred to in Note 28), another public sector psychiatrist, Dr Fennelly, Clinical Director of St Joseph's Psychiatric Hospital in Limerick, became a member of the Council during the 1970s.

[39] These views are based on numerous discussions with Dr Stevenson over a period of six years (1977-1983) during which this writer worked in St Dymphna's Hospital.

[40] The support of the Medico-Social Research Board (MSRB) for the public health perspective is discernible in its annual reports throughout the 1970s. Another publication which specifically confirms this swing towards a public health perspective resulted from a collaborative venture between the MSRB and the Department of Medical Sociology at the University of Aberdeen; this was: P. Davies and D. Walsh, *Alcohol Problems and Alcohol Control in Europe* (London: Croom Helm, 1983).

[41] *Appendix B, Report to the Minister for Health by the Irish National Council on Alcoholism* (January 1973).

[42] Ibid.

[43] D. Walsh, 'Alcoholism and the Irish', *The Journal of Alcoholism, 7* (1972), p.44.

[44] Dermot Walsh had been involved in epidemiological research in the general mental health field in Ireland since the early 1960s and went on to develop international contacts in this field. Between 1966 and 1974 he was Consultant in Mental Health to the European Regional Office of the WHO.

[45] In general, the ISACE researchers demonstrated that there had been a convergence of drinking behaviours in the period since World War Two in all of the participating countries: this involved a decline in Temperance sentiment, an expansion of the drinking population, an increase in *per capita* consumption and an associated increase in a wide range of alcohol-related problems. The main publications from this study were:
K. Makela et al, *Alcohol, Society and the State (Vol.1): A Comparative Study of Alcohol Control.* (Toronto: Addiction Research Foundation, 1981);
E. Single et al, *Alcohol, Society and the State (Vol.2): The Social History of Control Policy in Seven Countries.* (Toronto: Addiction Research Foundation, 1981);
N. Giesbrecht et al, *consequences of Drinking: Trends in Alcohol Problem Statistics in Seven Countries.* (Toronto: Addiction Research Foundation, 1983).

[46] D. Walsh and B. Walsh, 'Drowning the Shamrock: Alcohol and Drink in Ireland' in E. Single et al, op. cit., p.120.

[47] For a succinct statement of the philosophy and strategies of this approach to alcoholism treatment, see D. Anderson, *Perspectives on Treatment: The Minnesota Experience.* (Center City, Minnesota; Hazelden, 1981).

[48] For a detailed academic study of the various models of alcoholism treatment with which AA is confused see W. Miller and E. Kurtz, 'Models of Alcoholism Used in Treatment; Contrasting AA and Other Perspectives With Which It Is Often Confused', *Journal of Studies on Alcohol, 55* (1994), pp 159-166.

[49] Information on the Stanhope Centre is based on this writer's close involvement with the centre and its founder, Sr Marie Joseph, over many years.

[50] Fr Short's submission to Mr Haughey was later circulated to members of the Eastern Health Board and it is quoted here from the *Minutes of the Eastern Health Board Monthly Meeting* held at St Brendan's Hospital, Grangegorman on 12th January 1978, p.7.

[51] Ibid, p.7. (It should be pointed out that the 'recovery rate' claimed here has never been substantiated by evaluative research published in conventional refereed journals: see note 63 below).

[52] Ibid.

[53] This writer was working as a social worker in St Dymphna's Unit at this time and can recall the resentment felt by some colleagues at the generous funding of this new centre which appeared to consist of a narrow service for a relatively small number of highly-selected patients, while St Dymphna's offered comprehensive services - social, medical and psychiatric screening and treatment – to all comers.

[54] Minutes of Eastern Health Board Meeting of 12 January 1978, p.6.

[55] *The Irish Times* 14th January 1978. (It is worth noting that the official minutes of the Eastern Health Board's meetings at this time are very limited, and that newspaper accounts of these meetings often revealed more detailed and interesting accounts of EHB debate than were contained in the official minutes).

[56] Letter (26.1.1978) from Fr Raphael Short to all members of the Eastern Health Board – made available to this writer by Noreen Kearney, an EHB board member at this time.

[57] In 1996 the following residential rehabilitation units run along these lines were in operation:
Rutland Centre, Dublin;
Aiseiri Centre, Cahir, Co Tipperary;
Aiseiri Centre, Wexford;
Tabor Lodge, Belgooly, Co Cork;
Talbot Grove, Castleisland, Co Kerry;
Hope House, Foxford, Co.Mayo;
Bushy Park, Ennis, Co Clare.
In addition to these 'ideal types' of Minnesota Model service, the model was also influential in many other public and private services.

[58] Press Release on Behalf of the Department of Health: Address by Mr Charles J. Haughey, T.D., Minister for Health and Social Welfare at the official opening of the Rutland Treatment Centre on Wednesday, 17th May, 1978.

[59] An account of the evolution of alcoholism counsellor / or training programmes within INCA is to be found in: M. O'Hagan and T. McGovern, 'The Alcoholism/Drug Dependency Counsellor, Health Care Professional in the U.S. and Ireland' in *Proceedings of Health*

for All - Meeting the Challenge (12th World Conference on Health Education). (Dublin: Health Education Bureau, 1987), pp 987-988.

[60] See S. Wegscheider, op. cit.

[61] See J. Woititz, op. cit., for a detailed exposition of this position. It should also be noted that the *Directory of Alcohol, Drugs and Related Services in the Republic of Ireland (3rd edition)*. (Dublin: Health Promotion Unit, 1996) includes a listing for the 'Adult Children of Alcoholics Group' which is described as running weekly meetings based on a 12 –Step programme for adults affected by a parent's drinking.

[62] Within a short space of time the private hospitals began to incorporate elements of the Minnesota Model into their own programmes. For an interesting defence of the *ancien regime* by a social worker see R. Anderson, *Irish Social Worker, 2* (1983), p.16.

[63] As discussed earlier in this chapter, outcome studies in the alcoholism treatment field have generally arrived at disappointing conclusions. As late as 1994, in a major review of outcome studies, Hodgson decided (charitably, it might be argued) that there was insufficient evidence to form any conclusion as to the efficacy of the Minnesota Model: R. Hodgson, 'The treatment of alcohol problems', *Addiction, 89* (1994), pp 1529-1534. However, a much-quoted meta-analysis of outcome studies by Miller and his colleagues, published a year later, reveals absolutely no support for the central elements of the Minnesota Model (confrontational counselling, educational lectures and films, and general alcoholism counselling): W.Miller, et al, 'What Works? A Methodological Analysis of the Alcohol Treatment Outcome Literature' in R. Hester and W.Miller (eds), *Handbook of Alcoholism Treatment Approaches : Effective Alternatives* (2nd ed.). (Boston: Allyn and Bacon, 1995), pp 12-44.

[64] Interview with Mr Tom Ryan, General Manager of the VHI on 16th September, 1988. Mr Ryan insisted that VHI had decided to change its policy on addiction treatment and that the timing of this announcement fortuitously coincided with the publication of *Planning for the Future.*

[65] *The Psychiatric Services: Planning for the Future.* (Dublin: Stationery Office, 1985).

[66] To illustrate its general point that intensive inpatient alcoholism treatment did not deliver better outcomes than brief community-based treatment, *Planning for the Future* referred specifically to Orford and Edwards,op. cit.

[67] *Planning for the Future,* pp 109-110.

[68] VHI produced no formal policy statement on this change, merely announcing it to individual subscribers in its information leaflet sent to subscribers when annual renewals were due.

[69] Information from VHI Annual Reports, supplemented by additional data from VHI's research department.

[70] Ibid.

[71] *Irish Medical Times,* 5th April, 1985.

[72] *The Irish Press,* 22nd March, 1985.

[73] Letter to *The Irish Times,* 2nd April, 1985.

[74] Minutes of Meeting of the Irish National Council on Alcoholism held on 14th September, 1984.

[75] Minutes of Meeting of the Irish National Council on Alcoholism held on 10th April, 1985. The phrase 'not in full agreement', to describe Dermot Walsh's dissension from the draft reply to VHI, is obviously a bureaucratic euphemism.

[76] See Chapter One for an account of the Ottawa Chapter as a summary of the WHO philosophy on health promotion.

[77] *Planning for the Future,* cit.sup., pp 112-113.

[78] For an interesting and provocative espousal of this line - which is comparable to advice that everybody should eat less animal fats - see R. Kendell, 'Drinking Sensibly', *British Journal of Addiction, 82* (1987), pp 1279-1288.

[79] The British drinks industry group, known as the Portman Group, was particularly vociferous in its rejection of the control of supply perspective. See D. Anderson, *Drinking to Your Health; The Allegations and the Evidence.* (London: Social Affairs Unit, 1987).

[80] The clearest evidence that Government alcohol policy was dictated by revenue rather than health interests perhaps is to be found in the decision announced in a 1984 general policy document, *Building on Reality 1984-1987* (Stationery Office, 1984), to reduce the excise duty on spirits. This occurred because the price of spirits had gone up in the Republic of Ireland, leading to fairly large-scale smuggling of spirits from Northern Ireland; rather than try to stop the smuggling, the Government decided pragmatically that it would ensure that revenue came to the Southern rather than than the Northern Exchequer. See J. Fitzgerald, T. Quinn, B. Whelan and J. Williams, *An Analysis of Cross-Border Shopping.* (Dublin: ESRI, 1988).

[81] It will be remembered that the INCA Articles of Association forbade the organisation from forming or expressing any negative judgement on alcohol *per se.*

[82] INCA Submission to the Minister for Health (1979).
Availability Control Policy - Consumption of Alcohol (INCA Submission to the Minister for Justice, 1980).

[83] See K. Bruun et al, cit. sup.

[84] INCA Submission to the Minister for Health (1979), p.1.

[85] Availability Control Policy - Consumption of Alcohol (INCA Submission to the Minister for Justice, 1980), p.6.

[86] The researcher's conclusions on this point are based on his knowledge of and involvement with the area during this period, particularly his discussions with Dr R.D. Stevenson and to a lesser extent with Dr Dermot Walsh.

[87] The Chairman of INCA at this time was Mr Justice Declan Costello, a former Fine Gael T.D. and Attorney General. Dr Cooney also had strong Fine Gael connections - he was a brother of Patrick Cooney, a Fine Gael Minister during the 1970s and 1980s. Dr Tubridy was for many years a member of the Fianna Fáil National Executive, and was related by marriage to the Andrews family, which had longstanding Fianna Fáil connections.

[88] R. D. Stevenson, personal communication, (undated but written almost certainly (1986).

[89] Mrs O'Hagan was responding to a conference paper by this writer on the subject of alcohol and drug problems at the *Value for Effort* conference organised by the Health Education Bureau in Athlone on 23rd November 1984. Her view as one of two Executive Directors of INCA was that the Council was being indefinitely put off and delayed by politicians, and she expressed a belief in the need for a public campaign on this issue.

[90] The organisational networks model described by Harrison and Tether calls for political skills and public relations skills, the kind of skills which INCA had demonstrated in its advocacy of the disease concept during its first decade.

[91] Minutes of the Meeting of the Irish National Council on Alcoholism held on 14th September, 1984.

[92] Shane Grey, who was one of INCA's Executive Directors between 1982 and 1985, made valiant but ultimately fruitless efforts to bring a new sense of mission to the organisation. Under his direction a certain amount of 'dead wood' - in the shape of non-attending members - was pruned, and new members invited onto the Council. It was only during this period that the first women members were appointed to the Council.

[93] Report on Meeting with Mr Gordon Grimm, Senior Executive and Director of Education and Training, Hazelden, and with Ms Marilyn Brisett, Director of Counsellor Training, Hazelden; 18th June, 1984 (Circulated to Members of INCA's Executive Committee for Meeting of 22nd June, 1984).

[94] *Joint Oireachtas Committee on Legislation; Review of Licensing Laws: Minutes of Evidence of Oral Submissions, 24th September, 1985,* p.30.

[95] Ibid., p.27.

[96] The 1996 IPA *Administration Yearbook* (p.302) has the following account of the DIG: 'The group was set up in 1981with the objective of persuading government to reduce alcohol taxation to realistic levels.

Other functions include the development and promotion of sensible approaches to alcohol use in Ireland...'.

97 See Table 4.

98 The following reports were published by the DIG:
The Economic Importance of the Drinks Industry in Ireland. (1982);
The Taxation of Alcoholic Beverages in Ireland. (1983);
A Summary of Retailers of Alcohol in Ireland (1983);
The Drinks Industry in Ireland (1986).

99 See, for instance, B. Walsh, *Drinking in Ireland.* (Dublin: ESRI, 1980); D. Coniffe and D. McCoy, op.cit.

100 *Addiction, 88 (1993), Supplement January 1993* (The Interaction of Alcohol Research and Policy).

101 A. Secker, 'The policy-research interface: an insider's view', *Addiction, 88* 1993, pp 1155-1205.

102 *Proceedings of INCA Conference, Alcoholism Preventing the Harm: Towards a National Policy* (November 27, 1986).

103 Ibid.

104 Information about the closure of INCA and the small amount of money needed to keep it afloat came from Sally Edwards, its last Director.

105 *Health: The Wider Dimensions.* (Dept of Health, 1986), p.25.

106 *Promoting Health Through Public Policy* (Health Education Bureau, 1987). The closure of the Health Education Bureau will be discussed in detail in Chapter Eight.

107 The British Government's Central Policy Review Staff (colloquially known as the 'Think Tank') issued a report, *Alcohol Policies* in 1979 which the Government refused to publish. This report, which called for alcohol control policies to limit or reduce consumption levels, was eventually published abroad to the embarrassment of the Government; for a discussion of these events in Britain see R. Baggott, 'Alcohol, Politics and Social Policy', *Journal of Social Policy, 15* (1987), pp 467-488.

108 R. Baggot, op. cit.

109 See Chapter Two of this thesis.

CHAPTER FIVE

FORMULATING A NATIONAL ALCOHOL POLICY 1988-1996

Introduction

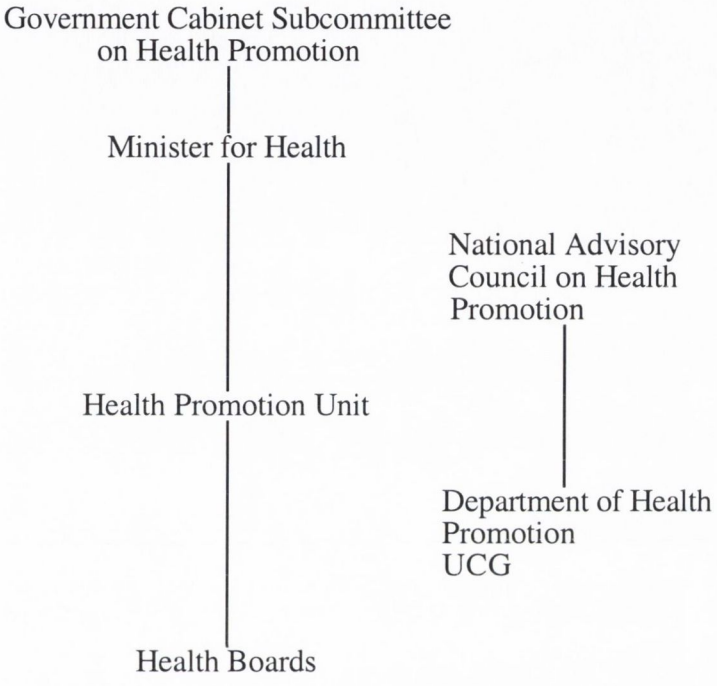
This chapter, the last chapter of the thesis to deal exclusively with alcohol, will examine developments between 1988 and 1996, the period in which health promotion concepts were most explicitly applied to alcohol policy and expectations on this issue were most raised. It will be recalled from Chapter Four that the contest between the disease concept and the public health perspective in the period leading up to 1988 had been a very unequal affair. The public health perspective had not been publicised to any great extent, had not developed a popular support base and, insofar as it had made any impression on the consciousness of politicians and senior civil servants, had been treated as an unwelcome and discordant intrusion into the relative harmony of an alcohol policy scene hitherto dominated by the disease concept.

However, as discussed in Chapter One, a framework of health promotion structures had now been set in place, commencing with the establishment of the Health Promotion Unit (HPU) - complete with its own policy advisory body - in the Department of Health in 1988. On the face of it, this framework (see Table 8) was detailed and comprehensive; it included the creation of a specific Cabinet Subcommittee, suggesting that there was now serious political political commitment to this new approach to health policy, as well as the funding of a new Chair of Health Promotion at University College Galway, which gave an enhanced scientific and professional status to health promotion in Ireland. Generally, the creation of this framework suggested that health promotion was now set to become a reality rather than remain at the level of mere rhetoric.

TABLE 8 :

Health Promotion In Ireland: The Core Structures*

International Bodies: World Health Organisation
European Community



* *Source:* Kelleher, 1992[1]

Early during this period, the HPU did some exploratory work on the possibility of drafting a national alcohol policy, and later the Minister for Health formally charged the unit and the National Advisory Council on Health Promotion with this task. How successful were these bodies in drafting this comprehensive national alcohol policy along the lines recommended by the WHO, and what political support for such a policy development emerged during this period? These are the main questions to be addressed in this chapter, but attention will also be paid to the success of the HPU and the health boards in fostering bottom-up initiatives, either at community level or in terms of the development of individual lifestyles, all with a view to reducing the incidence of alcohol-related problems.[2]

The Intoxicating Liquor Act 1988

Before embarking on an account of how the HPU tackled the formidable task of drafting a national alcohol policy, it is important to discuss the Intoxicating Liquor Act 1988, which was enacted immediately before the HPU began its work in this field. What is important in considering this particular statute is not merely to enumerate the various changes contained therein, but also to utilise the debate which took place during its passage through Dáil and Seanad as a measure of the policy climate in which a national alcohol policy was to be formulated.

The 1988 legislation had been in the offing for several years: the 1984 planning document *Building on Reality* initially proposed the granting of full liquor licences to restaurants; the Joint Oireachtas Committee on Legislation had considered the licensing laws in 1985; and an Intoxicating Liquor Bill 1986 had lapsed with the dissolution of the twenty-fourth Dáil in early 1987. In early 1988, Deputy Seán Barrett of Fine Gael introduced a Private Member's Bill known as the Intoxicating Liquor (Children and Young Persons) Bill. This bill was received with general sympathy from all sides of the Dáil but ultimately failed to get support because the Minister for Justice, Gerry Collins, made it clear that his own bill was now ready for the legislative process.

The rationale underlying this Fianna Fáil bill, known simply as the Intoxicating Liquor Bill 1988, was presented in detail by Mr Collins at the beginning of the Second Stage debate in Dáil Éireann on 26th April, 1988. The difficulties and - from a health promotion perspective - the contradictions inherent in this legislation are evident from the Minister's opening remarks:

> There are a number of reasons for bringing forward this important Bill. Its most important objective is to help curb

> drink abuse, particularly as far as under-age drinking is concerned. At the same time, to meet public demand in relation to certain aspects of the legislation, the Bill makes some adjustments in the prohibited hours and proposes that special provisions be made to enable restaurants of an acceptable standard to serve a full range of alcoholic drinks.[3]

What the Minister was proposing to do was to continue generally with the liberalising trend in the licensing system which had commenced in 1960, while at the same time hoping to curb 'drink abuse' through the introduction of some specific amendments in relation to under-age drinking. The logic of this legislative proposal was much closer to that of the disease concept than to that of the public health perspective; the implication was that increasing the number of retail outlets and extending the hours during which alcohol could be legally purchased would not necessarily affect the incidence and prevalence of alcohol-related problems. The public health perspective, on the other hand, did not view problem drinking as categorically different from 'social' drinking and tended to the view that policy aimed at reducing the incidence and prevalence of problems could only succeed when it was aimed at the totality of societal drinking behaviours. Edwards et al (1994), in a later and influential version of this argument, summarised the public health perspective thus:

> Society's drinking problems will on the large scale be dealt with effectively through understanding and influencing the total and dynamic system which comprises society's drinking, and effective policies cannot be modeled exclusively in terms of picking off little pieces of the continuum, or trying to manipulate extremes of behaviour.[4]

The 1988 bill proposed specifically to:

- allow approved restaurants full liquor licences without the necessity of 'extinguishing' existing licences (Sections 5 –24);
- extend the opening hours on Sundays till 11.00pm (Section 25);
- extend the 'drinking-up' period from ten minutes to half an hour, thereby effectively allowing pubs to remain open till 11.30pm in winter and 12.00 midnight in summer (Section 27);

- abolish the 'holy hour', the mandatory closing period from 2.30pm to 3.30pm, in Cork and Dublin (Section 25).

One of the main measure to prevent problems amongst under-age drinkers was contained in a proposal to omit the word 'knowingly' from Section 31 of the new legislation which made it an offence for retailers to sell drink to those under the age of eighteen; the existing legislation was regarded as difficult to enforce since it could not readily be proved that a publican had 'knowingly' sold drink to an under-age customer. It was also proposed to make it an offence for those under the age of eighteen to purchase alcohol (Section 33), and to allow the Gardaí to confiscate alcoholic drinks from under-age drinkers if they were in possession of such drinks in a public place (Section 37). The legislation also made provision for a voluntary 'age card' scheme which would assist publicans in determining the age of customers who might be under-age (Section 40). On balance, however, it would have to be concluded that the Intoxicating Liquor Bill 1988 concentrated on young drinkers as though they primarily were involved in problem drinking, while the general thrust of the legislation was to make alcohol more accessible to adult drinkers. In terms of the public health perspective - as summarised in the above quote from Edwards and his colleagues - the bill as a whole was inherently contradictory, if not downright hypocritical.

The Dáil and Seanad debates on this legislation contain no reference to public health or health promotion and there is no indication that politicians had been lobbied from such a perspective. Deputy Seán Barrett, who had earlier introduced his own Private Member's Bill on this subject, did admittedly argue that 'If we are serious about dealing with alcohol abuse, surely the minimum we should do is to fund to a reasonable extent such important bodies as the Irish National Council on Alcohol'.[5] Deputy Barrett

was generally positive about the bill, however, and it was left to his Fine Gael colleague, Deputy Brendan McGahon, to continue the apocalyptic tradition of Oliver Flanagan. In an interesting, if not always coherent, speech, Brendan McGahon argued that:

> Far from tackling the dreadful scourge of under-age drinking, it is likely to increase the many casualties which unfortunately occur in the late teens. I agree with the requirement that no drink should be served to people under 18 years but does anybody here really believe that it will be implemented? ... The problem of under-age drinking is now out of control. The next generation will reap the whirlwind of the wind sown by the seduction of children by breweries in the last 20 years.[6]

On the whole, however, there was a large measure of consensus across parties that the Minister had done well on this complex policy issue; the independent, NUI Senator, John A. Murphy, exemplified this view when he considered the bill from an historical perspective, concluding: 'Anyway, in the whole context, the State has done well in its public policy on drink, a sensible and balanced policy on the whole, I think'. [7]

While there was no evidence that politicians had been lobbied by representatives of the health sector, it was abundantly clear that intensive lobbying had been done by two competing interest groups, the restaurateurs and hoteliers who were eager to be given full liquor licences and the existing vintners who were strongly opposed to this development. The vintners' argument reflected the fact that they had traditionally enjoyed a monopoly on the sale of alcoholic drinks for consumption 'on the premises' and that they were reluctant to see this monopoly ended by the granting of special restaurant licences. On this occasion, the vintners were less concerned with presenting a libertarian defence of the right of adults to have ready access to alcohol than they were with portraying themselves as guardians of public order; their contention was that granting new licences to restaurateurs not only gave an unfair advantage to the restaurateurs, but also was likely to be

uncontrollable when all food outlets became *de facto* bars. In the Seanad, for example, Senator Tom McEllistrim addressed himself as follows to the Minister for Justice:

> It has also been mentioned to me - and I would like the Minister to give me an assurance on this - that fish and chip shops will get a licence eventually. That has been claimed by some publicans.[8]

Deputy Michael McDowell, during the Dáil debate, spoke of the monopoly value of the existing licences and the investment which vintners had made in these licences, although ultimately arguing that 'The licensing laws were not designed to create monopoly rights for anybody'.[9] The Minister, Gerry Collins, was also quite open and explicit about the difficulties involved in legislating in an area of competing sectional interests which, as he put it, could degenerate into 'an unmerciful tug-of-war'.[10]

The Minister's legislative proposals were enacted without substantial change, and the granting of special restaurant licences was arranged in a way that reflected what might be considered a customary political compromise between conflicting interests. Restaurateurs who had argued for full liquor licences for their premises were placated in the sense that this was now legally permissible, while the vintners were placated by the stringent conditions attaching to these new licences. Restaurants could only apply for a licence when they conformed to high catering and accommodation standards which were certified by Bórd Fáilte; they had to have a waiting area which was not a bar; drink could only be served to a person for whom a substantial meal was ordered, and the once-off licence fee was £3,000. The spectre of fish and chip shops and other fast-food outlets selling drink around the clock amidst scenes of wild abandon had been well and truly laid to rest.

Section 47 of the Intoxicating Liquor Act 1988 was, on the face of it, the only section of this new legislation which reflected health promotion principles: it prohibited supermarkets and self-service groceries from displaying alcoholic beverages alongside food-stuffs, and was intended to stop impulse buying of drink and to introduce greater control over purchases than could reasonably be expected at busy checkouts.[11] It restricted the sale of alcohol in supermarkets to special intoxicating liquor counters and, in its own modest way, could be compared to the system of state monopoly outlets in countries which had a strong temperance tradition and which wished to demonstrate through their sales' systems that alcohol, though licit, was a 'demerit' good.[12] Section 47, however, has never been brought into operation by the Minister for Justice and there has been no indication that this situation is likely to change.[13]

While there were increases in the numbers of successful prosecutions for sale of alcohol to under-age drinkers following the 1988 legislation,[14] research into the scale of under-age drinking over the past decade (1986-1996) suggests that this behaviour has increased to the point where it is now normative rather than deviant. Morgan and Grube (1994) surveyed drinking behaviour amongst Dublin post-primary school pupils during 1991 and found evidence of dramatic increases in drinking since a comparable survey which they had conducted eight years earlier.[15] For example, of their total sample - which extended across the range of post-primary ages from twelve to nineteen - four-fifths of the pupils had consumed alcohol at some time as opposed to two-thirds eight years earlier. Abstainers at the age of 17 now made up only seven per cent of this age-group as opposed to twenty-one per cent eight years earlier. These researchers did not come up with definitive explanations as to why young people were drinking at an earlier age than previously, but suggested that one causal factor was the

change in the normative climate surrounding alcohol; in comparison to the earlier survey, young people now thought that there was relatively less disapproval of their drinking both by parents and peers and that, in fact, parents and peers were now more likely to approve of their drinking.[16]

In general, it would have to be concluded that the enactment of the Intoxicating Liquor Act 1988 revealed little evidence of political awareness of or support for the public health perspective on alcohol. Similarly, the preliminary evidence suggested that following this legislation the trend towards increased under-age drinking continued apace, so that it could not even be said that in this narrow section of the drinking continuum there had been success in curbing what the Minister described as 'drink abuse'. In fact, when one recalls the Oireachtas debate on the 1988 Act, it is tempting to conclude that Brendan McGahon alone got it right. If one takes the parliamentary debate and enactment of the Intoxicating Liquor Act 1988 as a measure of the policy climate in which the HPU was about to begin its work on the formulation of a national alcohol policy, then one is forced to the conclusion that the HPU could scarcely be confronted with a more difficult or hostile environment within which to achieve this goal.

The Health Promotion Unit and the National Alcohol Policy

Following the closure of INCA in 1988, its last director, Sally Edwards, worked on contract with the HPU for a period of about six months, during which time she did some preliminary work on the possibility of formulating a national alcohol policy.[17] However, it was not until the establishment of the various health promotion structures set out in Table 8 that the task of drafting such a policy became part of the official agenda of the HPU. During 1990, the Minister for Health formally requested the Advisory Council on Health Promotion to take on this task, with the HPU acting as

its resource body for research, secretarial and general support. The Advisory Council had obviously been hindered by the sudden death of its first Chairperson, Dr Ivo Drury, in 1989, but following his replacement in 1990, work began on the national alcohol policy. In February 1991, advertisements were placed in the newspapers describing the task being undertaken by the Advisory Council on Health Promotion and inviting interested parties to make written submissions. The public notice, in part, read as follows:

> The Government has decided that a National Alcohol Policy should be formulated. In pursuance of that decision, the Minister for Health has requested the Advisory Council on Health Promotion to develop a broadly based policy, and to make recommendations to him for presentation to Government.
>
> The Council is examining alcohol, its availability, consumption, use and abuse under broad headings including historical, social, cultural, economic and legal factors, together with such matters as education, advertising, prevention, diagnosis and treatment strategies, etc., and particularly the issues of youth and alcohol, and the role of parents and family ...[18]

There was in the style of this notice a definite suggestion of the rational comprehensive approach to policy making, at least insofar as it related to the work of the Advisory Council on Health Promotion. The implication was that the Advisory Council was embarking on a root and branch assessment of all aspects of alcohol production, importation, retailing and consumption in Ireland; research findings would be sought and utilised, and the draft policy submitted to the Minister would represent a rational attempt at maximising health.

Within a short period of the beginning of this process, two events occurred which effectively transferred control of alcohol-policy affairs from the Advisory Council to the HPU. By a sad coincidence, the new Chairperson of the Advisory Council, Dr Ciarán Barry, died in early 1991 just as submissions on the national alcohol policy were coming in from interested

individuals and institutions. He was not replaced until late 1992 when Frances Fitzgerald, a social worker who had been an activist in the Women's Political Association, was appointed to the position; within weeks of her appointment, Frances Fitzgerald was elected to Dáil Éireann as a Fine Gael deputy and this new party political role necessitated her resignation from the Advisory Council on Health Promotion. She was never replaced, and in the absence of an independent Chairperson - effectively from 1991 to the end of the period studied in 1996 - responsibility, as well as a large measure of power and influence, within the health promotion structure devolved to the Principal Officer in the HPU.

The second event which strengthened the hand of the civil service in the formulation of a national alcohol policy was the decision taken in May 1991 to establish a separate Working Group to concentrate on this task. Of the sixteen surviving, non-civil service members of the Advisory Council, only three were retained on this new Working Group while six other people, who were thought to have specific experience and expertise in the field of alcohol, were co-opted for this task.[19] This decision was reasonable, since the 'broadly based'[20] Advisory Council could not be expected to have specific expertise in the field of alcohol; however, the *ad hoc* status of this Working Group and the fact that it was chaired by the Principal Officer of the HPU, Noel Usher, rather than by an independent outsider was to have a major influence on the pace and style of its deliberations.

As described in Chapters Three and Four, the Department of Health had previously displayed no initiative in relation to alcohol policy; in particular, it should be recalled that in 1986, when addressing INCA's conference on the then hypothetical question of a national alcohol policy, Liam Flanagan (Secretary of the Department of Health) had pointedly refrained from

expressing any enthusiasm for or commitment to such a project. The decision to commit the Advisory Council and the HPU to the business of drafting the policy had been that of Dr Rory O'Hanlon, Minister for Health from 1987 to 1992 and architect of the new health promotion structure. Whether Dr O'Hanlon fully appreciated the economic and political difficulties inherent in applying health promotion principles to alcohol policy is difficult to judge; it is reasonable to assume, however, that Department of Health officials had a keen awareness of how contentious this area could prove to be, as well as a realisation that subsequent Ministers for Health might not share Dr O'Hanlon's interest in or commitment to this subject.

In any event, it was the HPU - a section of the Department of Health - which now dominated the policy making process. The new Working Group met for the first time in June 1991, by which time about 150 written submissions had been received and a number of commissioned reports from the Economic and Social Research Institute (ESRI) had been completed. These ESRI reports did not make easy reading for those in favour of the public health perspective; they were compiled by two economists, Denis Coniffe and Danny McCoy, and their overall conclusions were broadly similar to those contained in the commissioned reports of the Drinks Industry Group. In summary, they argued:

- that the drinks industry was of major importance to the Irish economy in terms of revenue, job creation and exports;
- that Irish alcohol consumption rates were modest by international standards;
- that the perceived commitment of Irish people to alcohol consumption, as measured by the proportion of gross disposable income spent on alcohol, had previously been exaggerated by the failure to understand differences in the accounting conventions used in international comparisons;

- that alcohol consumption in Ireland was much more sensitive to income than to price, and, in any event, that Ireland's already expensive alcohol could not readily be made more expensive in the context of tax harmonisation within the Single Market of the European Union.[21]

The Working Group had the opportunity to meet the authors of these ESRI reports, but this meeting served only to confirm that they had little sympathy for the WHO's preferred strategy for the reduction of alcohol-related problems. A further paper which reviewed Irish drinking habits from an anthropological perspective was subsequently commissioned, to some extent as an antidote to the views of the economists, but this took some time and made little impact on the Working Group.[22]

The Working Group was now chaired by the Principal Officer of the HPU, a civil servant who – in the generalist tradition of the Irish civil service - could expect to spend at most four to five years in this section before being transferred back to more mainstream curative concerns and functions in the Department of Health. The task which he faced in relation to the formulation of a national alcohol policy was, by any standard, a difficult one. Irish alcohol policy, at this time in the early 1990s, still largely reflected the tenets of the disease concept (as described in Chapters Three and Four), the end result of a process of incremental drift which had taken place since the end of World War II. Now, however, the idea of an immediate and radical policy change had been put on the agenda, and expectations had been raised on this score by the Minister's public announcement of his decision to draft a national alcohol policy. The expectations of health promotionists were, as described in Chapter Four, of a return to a 'drier' policy perspective with various alcohol control strategies being utilised to reduce consumption. The preliminary work by the HPU and the Advisory Council had merely served, however, to illustrate how polarised this policy situation was. Those who were familiar with or

sympathetic towards the public health perspective on alcohol were few in number, even perhaps in the Department of Health itself, and the task of the HPU appeared to be that of coordinating this small group so as to make the maximum impact in this area.

Of the three policy models discussed in Chapter One, it would seem that *partisan mutual adjustment* of an incremental style corresponds most closely to the way in which the HPU handled the task of formulating a national alcohol policy; the concept of *nondecision-making* in public policy-making, which was devised by Bachrach and Baratz (1963; 1970), also has some application and this will now be considered here.[23] This concept was used to argue that power in the policy-making sphere does not solely consist of the overt process of influencing events so that one policy option is favoured rather than another; nondecision-making refers to power which is exerted in more subtle, covert ways to ensure that particularly contentious issues or debates are kept off the policy-making agenda. One could surmise that, given their long history of inactivity in this field, senior civil servants in the Department of Health would have preferred to avoid becoming embroiled in policy debate in which the public health perspective was pitted against the disease concept. However, the Minister's enthusiasm for his newly-created health promotion structures and his determination to tackle alcohol problems from this perspective appeared to spell an end to the nondecision-making era. Like it or not, the HPU was now expected to play a central role in tackling these difficult policy issues and in drafting definite policy proposals for submission to Government. The tactics employed by the HPU in responding to this challenge will now be described; generally it may be argued that in overall terms these tactics constitute an extension of nondecision-making in the sense that they protracted the decision-making process, successfully prevented the issues from becoming publicly

contentious, and, while creating an impression of openness and consultation, served to retain control of policy-making within the civil service structure of the HPU.[24]

Between June 1991 and March 1992, the Working Group met delegations from some of the organisations which had already made written submissions; the organisations selected for participation in this formal consultation process were those deemed to be most influential.[25] While this consultation process is commonplace in public policy-making and is at least of symbolic value, it appeared in this instance to be largely ritualistic and wasteful of time; in the experience of this writer, none of the groups consulted in this way made any additional points in their oral submissions, and generally they did not present their arguments as clearly or as effectively at these meetings as they had done on paper.[26]

In March 1992, the Chairman of the Working Group wrote to its members suggesting that the best way to 'develop the direction and content of the Report' was to look at policy options in the light of working papers on about half a dozen topics to be drafted by the HPU.[27] Between March and September 1992, these working papers were drafted and circulated to members, but only two meetings of the Working Group took place. In February 1993, following an inquiry from this writer as to whether the Working Group would meet and finish its task, the Chairman replied as follows:

> Following receipt of the observations of each of the members of the Working Group a draft comprehensive report on this Policy was prepared by the Health Promotion Unit which reflected, to the greatest extent possible, the various views expressed by the members.
>
> The draft Report was then circulated to members of the Advisory Council on Health Promotion and was to be considered at their subsequent meeting scheduled for November. However, this subsequent meeting of the

> Council had to be postponed for reasons beyond the control of the Unit. We are in the process of convening another meeting of the Advisory Council to consider the draft Report following which we propose submitting it to the Minister.[28]

A request by this writer to be sent a copy of the draft report went unanswered.[29] In his chairing of the Working Group, the Principal Officer of the HPU departed quite radically from the usual conventions of committee work. The Working Group was bombarded with documents but never really met to try to reach a consensus or to agree a set of underlying principles which might inform a comprehensive health promotion approach to alcohol. For the fifteen months when it had ostensibly been an active body, the Working Group had done nothing other than meet delegations from various interest groups and read background literature on this thorny policy issue. Now, at a point when it might be expected to tackle the subject, the Chairman simply stopped convening meetings, without informing members that no further meetings would take place or that a document which purported to reflect their views, had been drawn up by the HPU. This latter document was not signed by the members of the Working Group and was not made available to the six members who had been co-opted, although it was presumably circulated to the four members who had come from the Advisory Council.

Despite the optimism expressed by the Chairman (in the letter cited above) that a national alcohol policy would be quickly drafted and sent for Government approval, this process was not completed until September 1996, some three and a half years later. Over the years, references to the national policy cropped up in various health policy documents without any explanation as to why this delay was taking place or what the difficulties were. As early as 1992, the *Green Paper on Mental Health* had described the multi-sectoral nature of the health promotion approach to alcohol problems and indicated that: 'The Council is well advanced with its task'.[30]

Two years later, however, in May 1994, *Shaping a Healthier Future,* Minister Brendan Howlin's healthcare strategy for the remainder of the decade, identified the necessity to promote moderation in alcohol consumption as one of its targets; the rhetoric was now somewhat more restrained and less radical in its view of health promotion in this sphere and, without going into detail, promised 'A national policy on alcohol which will be adopted and launched during the next twelve months'.[31] The entire health promotion concept and Irish health promotion structures were the subject of yet another policy document, *A Health Promotion Strategy: Making the Healthier Choice the Easier Choice,* published by the HPU in July 1995. This contained only a brief reference to:

> The development of a national policy to promote moderation in alcohol consumption and reduce risks to physical, mental and family health associated with alcohol misuse - such policy to be adopted and launched during 1995.[32]

Some members of the Working Group remained under the impression that it would be reconvened, since it seemed unlikely that the HPU would present a report ostensibly representing the collective views of the Group without first clearing the report with the members. In fact the Group was never reconvened, and the first time that most members saw the national alcohol policy document was following its publication in September 1996, some four years after the Working Group had last met.[33] During this protracted gestation period, surprise or disquiet was expressed from time to time by interested parties at what was seen as an inordinate delay in completing this task. An editorial in the *Irish Medical Times* during October 1995, for example, castigated the Department of Health for its delay in publishing a policy document on 'alcoholism'; this paper had been told that the policy document would be published within the next few months, a promise which was received with scepticism because 'there has already been evidence that the Department is being particularly slow to meet this issue head on'.[34] From a policy analysis point of view, this latter comment is probably a good

deal more revealing than its author intended. It is not part of the culture of the Irish civil service to tackle issues 'head on', where this implies the espousal and single-minded promotion of a policy line which is deemed to be socially worthy but which lacks popular and political support. While the foregoing account of the handling of the national alcohol policy issue by the HPU clearly suggests a continuance of nondecision-making, it is important to attempt to understand the motivation of the senior civil servants in the HPU in dragging their heels on this matter. Much has been written about the rigidity, secrecy and conservatism of senior civil servants in Ireland and about the difficulty involved in persuading them to take on a policy-making role, as opposed to simply implementing existing policy.[35] Against this, policy analysts appreciate that Government Ministers come and go with great regularity and that they vary greatly in terms of their competence in and commitment to the ministries to which they are appointed; in these circumstances, it is understandable that senior civil servants - sometimes referred to sardonically as the 'permanent government' - wield a good deal more policy making influence than is officially theirs under the legal convention of *corporation sole.* [36]

The Minister for Health who charged the Advisory Council on Health Promotion with the task of drafting a national alcohol policy in 1990 was Dr Rory O'Hanlon; however, by the time this policy document was agreed by Government and publicly launched in September 1996, the following had all served for varying periods of time as Minister for Health: Dr John O'Connell, Mary O'Rourke, Brendan Howlin and Michael Noonan. None of these subsequent Ministers rescinded the decision to develop a national alcohol policy, yet neither did it appear to be a political priority for any of them.[37] It must have been apparent to the staff of the HPU that none of these Ministers was philosophically committed to the radical style of health

promotion which would have been necessary in order to make healthy public policy a reality in the alcohol sphere; furthermore, even if there had been a Minister with a philosophical commitment to alcohol control policies, it must have been equally apparent that other Ministers (see Table 1, Chapter 1) would not readily subordinate their own sectoral interest to the overall health interest.

It can be argued, therefore, that the motivation of the HPU in protracting the process of formulating a national alcohol policy is generally explicable in terms of traditional references to conservatism and incrementalism as features of the Irish civil service. Specifically, it is plausible to argue that the civil servants were reluctant in the first instance to have the notion of a comprehensive national alcohol policy dominated by the health interest placed on the public policy agenda; however, having had this task imposed upon them by an enthusiastic Minister, they confirmed its impossibility in terms of *realpolitik* and, in order to avoid divisive public debate and the embarrassment of revealing serious flaws in the entire health promotion edifice, opted for a protracted policy-making process. Indeed, there is reason to believe that left to its own devices the HPU would have deferred the launch of the national alcohol policy even further; Minister for Health, Michael Noonan, appears to have decided that it was timely to launch the national policy in September 1996 because during this month the Dáil Select Committee on Legislation and Security was holding hearings on the licensing laws and was considering a further extension of the opening hours. There had been no public health contribution to the debate on the Intoxicating Liquor Act 1988, and with all policy matters in abeyance till the national policy was launched, a similar gap in the debate could easily have occurred again on this occasion. The strongest evidence that the launch of the national policy was a Ministerial decision which took the HPU by

surprise is to be found in the fact that at the public launch of the policy on 19th September, 1996 - having been in preparation for almost six years - there was still no published policy document; instead, the media were supplied with what appeared to be a hastily-prepared Executive Summary and it was made known that this was an 'advance copy' and that the full policy document and summary were 'with the printers'.[38]

The full report [39] which was published a few weeks after the official launch was, as was customary for health promotion documents, presented and packaged in a most attractive style. The report was entitled *National Alcohol Policy - Ireland* and consisted of three main sections. Section 1 set the context for the national alcohol policy by reviewing alcohol consumption trends in Ireland: it compared the Irish drinking experience with the experience of other countries, summarised the data on alcohol problems, and finally looked at the positive aspects of alcohol consumption – including the economic role of alcohol in Ireland. Section 2 then introduced and described the public health perspective on alcohol before going on to review a range of *individual* and *environmental* strategies which could be utilised in pursuit of public health objectives in this area. Sections 1 and 2 were well written and authoritative, but Section 3 which presented a 'Plan of Action' was from a health promotional point of view both the most important and the most disappointing element of the report. This final section was couched in the language of strategic management, referring to target groups and target settings, all in the context of the role which non-governmental agencies and Government departments other than Health had to play in the implementation of the policy. However, a close reading of this Plan of Action makes it clear that, in the process of compiling the report, the HPU did not succeed in making fruitful strategic alliances with other sectors of Government, with the drinks industry or with community

groupings so as maximise the prospects for real health promotion in relation to alcohol. Section 3 was characterised throughout by the vagueness and the aspirational quality of its language, which was primarily about traditional attempts at 'encouraging' and 'making aware', and contained absolutely no suggestion of new alcohol controls being introduced as part of a healthy public policy initiative. Any fears that the drinks industry might have felt about the new national alcohol policy being a form of neo-Prohibitionism must surely have been dispelled by a quick reading of this report, since it could not in truth be said that there was even a single concrete proposal contained therein which was substantially different to anything that had previously been tried.

Newspaper accounts of the launch of the national alcohol policy also suggest that the Minister for Health was ambivalent and generally uncomfortable with the whole subject of alcohol controls. He told reporters that he 'would be telling the Select Dáil Committee on Legislation and Security, which was currently reviewing the licensing laws, that he was opposed to any extension of hours'.[40] On the other hand, when it was suggested to him by journalists that the policy might have been tougher and that it lacked 'teeth', he revealed his unease with the paternalism inherent in alcohol control policies; his reply was:

> It's very hard to legislate for virtue. It's even difficult enough to legislate for good behaviour. The kind of island I would like to see is where we would have what I would describe as sovereign individuals who are well educated and mature and that when you give them information which is relevant to their own well-being they will make individual sovereign decisions in their own interest.
> I think that's the best approach.[41]

In concluding this account of the launch of the national alcohol policy, it is important to point out that it was not merely the vagueness and aspirational quality of its content which might have made it seem unconvincing to those who might have hoped for a more incisive policy; what was equally

discouraging was that implementation of its plan of action was reliant on the cooperation of partners from other sectors of Government - cooperation which had not previously been forthcoming - while the overall monitoring of its implementation seemed set to remain with the HPU.[42]

The failure of the HPU to deliver a coordinated national alcohol policy along rational comprehensive lines was of course largely predictable; the debate which surrounded the Intoxicating Liquor Act 1988 had made it clear that the social or policy climate remained inimical to the aspirations in this sphere of public health activists. What emerged from this lengthy period of policy formulation is almost certainly best described, in terms of the models of policy coordination outlined in Chapter One, as *partisan mutual adjustment.*[43] It was a policy compromise in which all interested parties had to adjust their expectations and settle for something less than what they might have regarded as the optimum policy outcome. The Drinks Industry Group (DIG) would undoubtedly have preferred a policy document which reiterated what is saw as the simple truths of the disease concept, namely that their product was a perfectly safe one and that it was unfortunate that there were some 'bad' or defective consumers;[44] nonetheless, the DIG must have been extremely happy with the eventual policy document which rehearsed all their usual arguments about the economic significance of their industry, while at the same time acknowledging the protective role of alcohol in reducing the risk of coronary heart disease. Public health activists, on the other hand, must surely have felt disappointment that the concept of a single corporate alcohol policy based upon health principles, did not emerge from this lengthy process, while at the same time welcoming its commitment to enhanced alcohol awareness programmes. The main question which emerges from a consideration of this process of bargaining and compromise is whether the public health perspective could have been

represented better: could the HPU have negotiated along the lines of the policy coordination model described by Harrison and Tether[45] as *organisational networks,* or if it had failed to do so up to the launch of the national alcohol policy, had it the potential to develop this approach to policy making? These are the questions which will be addressed in the following section.

The Health Promotion Unit as an Organisational Networker?

It will be recalled from Chapter One that in their review of policy making models for the coordination of alcohol and drug policy, Harrison and Tether concluded that the likelihood of achieving a rational-comprehensive or a corporate model, in which health was the dominant policy objective to which all other departmental or sectoral interests were subordinated, was negligible. They were critical of partisan mutual adjustment, not because they saw it as an inaccurate account of the reality of policy making in this area, but because in terms of public health values they deemed it to be excessively *laissez faire.*

Prescriptively, Harrison and Tether went on to recommend a third policy coordination approach which they termed the organisational networks model. This, in many ways, was a compromise between the other two models in that it accepted that the rational-comprehensive model was Utopian, but argued that the health interest could be tactically pursued through a relatively loose framework or *network* of organisations, and that the results of such a process would be greater than those which could be achieved through the more informal system of partisan mutual adjustment. They also argued that in many instances such a network would consist of sections or sub-units of large organisations rather than whole organisations. It was suggested that sometimes such sub-units were at the periphery of

their parent organisation and might have more in common with sub-units of other organisatins than with their parent organisation. It could, for instance, be argued that in relation to alcohol problems among young people, the HPU had more in common with the Psychological Service of the Department of Education, or the Juvenile Liaison Section of the Garda Síochána or the Probation and Welfare Service of the Department of Justice than with the rest of the Department of Health

The question which Harrison and Tether's concept of organisational networks raises is whether the HPU has the capacity to either play a central role - the spider at the centre of the web, as it were - or even to participate actively as an equal partner in such a network. Before looking critically at this question, it is useful to recall the five key elements of the Ottawa Charter on Health Promotion (set out in Chapter One) and to consider their application to Irish alcohol policy.

These elements are:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills;
- reorienting health services.

The final document, *The National Alcohol Policy: Ireland*,[46] must be seen as effectively acknowledging the impossibility of realising the first of these elements, healthy public policy, in the alcohol sphere; the notion that other sectors of government would defer to the health interest proved to be illusory and, despite some residual references to multi-sectoral cooperation,[47] it was clear that there was to be no unified and authoritative national alcohol policy aimed at promoting health. In fairness to the HPU, it could not really be said that any country had achieved the goal of

healthy public policy in the alcohol domain originally envisaged by the WHO, and indeed the WHO itself in its *European Charter on Alcohol* (drawn up in December 1995) had greatly moderated its tone in this regard.[48] The last of the Ottawa Charter elements, reorienting health services, will be considered in the next section, but it is the middle three - creating supportive environments, strengthening community action and developing personal skills - which will now be considered in the context of the HPU's networking capacity.

National Alcohol Policy: Ireland accepted, albeit tacitly, that there could be no authoritative top-down policy which would effectively control alcohol availability and consumption in Ireland. The task of the HPU in relation to the development of life skills, the creation of supportive environments and the fostering of community action may be regarded, therefore, as a facilitative one, generally aimed at changing communal attitudes to alcohol as well as actual drinking behaviours. The evidence summarised in the completed policy document clearly demonstrated that alcohol had become increasingly normalised in Ireland, regarded, that is, as a relatively safe commodity which featured in various ways in everyday life. For example, the summary of the economic arguments about price and income elasticities confirmed that Irish consumption was in overall terms price inelastic, and that at most all that could be achieved through pricing was some degree of switching to low alcohol drinks; on the other hand, Irish alcohol consumption is generally income elastic, suggesting that economic growth is likely to lead to a disproportionate increase in consumption.[49] One other statistic which clearly illustrates the increased prominence and availability of alcohol in Irish social life is that referring to special exemption orders, the granting of extensions of opening hours for special occasions: in 1967 the courts had granted 6,342 of these orders, but by 1994 this had increased to

55,290.[50] Finally, in this context, the national alcohol policy document referred to the pervasiveness of alcohol advertising and to the promotion of sporting, social and cultural events by the drinks industry; it did not, however, refer specifically to the controversial sponsorship of the Gaelic Athletic Association's (GAA) All-Ireland Hurling Championship by Guinness Ireland.[51]

While it is not completely beyond the bounds of possibility that the HPU could play a major role in fostering increased communal awareness of alcohol-related problems and in facilitating bottom-up activities designed to relegate alcohol to a lower place in Irish society than it currently occupies, the prospects of such a strong networking role for the HPU must be deemed to be poor. Perhaps the strongest argument to justify this judgement is to be found in a review of how the Unit performed in drafting the national alcohol policy over a six-year period, if not indeed over the eight years since the health promotion structures had been set in place. In summary, the HPU had worked at a very slow pace on this project since its inception, completely controlling events and taking no risks when issues seemed contentious or controversial. It is difficult to see the HPU happily negotiating or collaborating with community groups or other interested parties on alcohol issues other than in the cautious, controlling way which characterised its relationship with the Working Group; if the civil servants had such difficulty in allowing members of the Working Group to participate in drafting the national policy document, then it is hard to envisage them adopting a radically different approach in the future.

The organisational networks model, as already described, is dependent on a peripheral sub-unit within a large organisation displaying a willingness to pursue common policy goals through collaboration with other peripheral

sub-units or other interest groups outside its parent organisation. In the case of the HPU and its policy-making activity in the alcohol sphere, this might, for example, involve the Unit in forming a strategic alliance with: self-regulating bodies such as the Advertising Standards Authority of Ireland; professional bodies such as the Irish College of General Practitioners or the Irish Association of Alcohol and Addiction Counsellors; specific lobby groups such as Mothers Against Drink Driving; trade associations such as the Licensed Vintners Association, and many other relevant groups. The style of negotiation implied by this model is a style which is characterised by boldness, initiative and some degree of risk-taking, rather than by timidity and caution - where the peripheral sub-unit is constantly looking over its shoulder lest it incur the wrath of the parent organisation.

The HPU is, however, just one section of the Department of Health and civil servants who work in this unit, in keeping with the tradition of generalism in the Irish civil service,[52] can expect to spend just a few years there before being transferred back to more mainstream departmental duties. There is, therefore, no real incentive for civil servants posted to the HPU to develop a passionate commitment to reducing alcohol-related problems or to any other aspect of health promotion; indeed, one could argue that passion and risk-taking of this kind would be viewed with considerable suspicion by colleagues and superiors, and would ultimately be damaging to career prospects. It is, therefore, not surprising that over the years during which it mulled over the final shape of the national alcohol policy the HPU refrained from becoming embroiled in any public debate on issues which were controversial in this sphere.

An interesting example of this distancing of itself from controversial issues is to be seen in the HPU's response to the sponsorship of the Hurling Championship by Guinness Ireland, to which reference has already been made. The voluntary codes of alcohol advertising which had evolved over many years are described in *National Alcohol Policy: Ireland,* [53] as is their updating for broadcast media by the Minister for Arts, Culture and the Gaeltacht in 1995; the Guinness sponsorship of the Hurling Championship did not breach the 'letter of the law' of these codes, yet it could be argued that it is contrary to their general spirit and that it contravenes the WHO's *European Charter on Alcohol* which suggests that Member States:

> Implement strict controls, recognising existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance, through the linking of alcohol consumption with sports.[54]

Dr Mick Loftus, a general medical practitioner and coroner for North Mayo, was a co-opted member of the Working Group which had been set up to draft the national alcohol policy; he was also a former President of the Gaelic Athletic Association (GAA) and in that capacity objected to the Guinness sponsorship of the Hurling Championship. His objections were well publicised, although ultimately futile, and he opted to absent himself from Hurling Finals - at which past Presidents of the GAA are traditionally given a place of honour - as a mark of protest. The HPU, however, made no public comment about this, nor did it play any role in fostering the growth of *Dothain,* an organisation founded by Dr Loftus to encourage moderate drinking.[55]

The most glaring example of the HPU's disinclination to become involved in lobbying activities - either on its own or as a network coordinator - is to be found, however, in relation to the public controversy which surrounded the implementation of the Road Traffic Act 1994. This legislation reduced

the permitted blood alcohol concentration (BAC) for drivers from 100mgs per 100ml of blood to 80mgs per 100ml, thereby bringing the Irish code broadly into line with other European jurisdictions.[56] The Road Traffic Act 1994, in addition to lowering the permitted BAC for drivers, contained a number of other new measures which collectively represented a tougher approach to drink driving; these measures included:

- an automatic two-year driving ban for first conviction of driving over the new limit, as well as a fine of up to £1,000;
- a requirement that all disqualified drivers should pass a driving test before having their licenses returned;
- power for a garda and a designated doctor to enter a hospital or a private dwelling so as to take a blood or urine specimen from a driver involved in a traffic accident;
- power for the Minister for the Environment to vary the permissible alcohol level by regulation (as opposed to by legislation) and to set different limits for different classes of drivers.

In public health terms, this toughening of the drink driving legislation obviously promised a much safer and healthier environment, given the generally accepted evidence that alcohol consumption slows reaction time and impairs drivers so as to significantly increase the risk of road traffic accidents.[57]

The Road Traffic Act 1994 was introduced by Mr Michael Smith, a Fianna Fáil Minister for the Environment at a time when Fianna Fáil and the Labour Party were in coalition. During the Second Stage debate on the legislation there was general support across the political spectrum in Dáil Éireann for its approach to drink driving. Speaking on behalf of Fine Gael, Deputy Avril Doyle hoped that:

> The serious penalties for breaching the law will, I hope, bring about a climate of intolerance to drink driving, a greater awareness of the value of human life and of how much unnecessary death, suffering and expense could be

> avoided ... Perhaps, it would be honest if we admitted we are doing too little too late on this issue.[58]

Deputy Doyle went on to 'pay tribute to Mrs Gertie Sheils and Mothers Against Drunk Driving who, as a result of personal tragedy and suffering, have invested great energy and effort into increasing the collective consciousness of the nation of our appalling record of drink driving'.[59] (This was a reference to an Irish organisation, *Mothers Against Drunk Driving*, which like its international counterparts had been formed by parents of children and young people killed by drunk drivers so as to lobby for reform of the drink driving legislation.) It was recognised that this legislation, in the words of one Fianna Fáil backbencher, called for a 'social revolution in terms of the attitudes of Irish people to drink driving',[60] but with the exception of Deputy Austin Deasy of Fine Gael most deputies seemed to think that popular opinion had now swung in favour of such a revolution. Deputy Deasy began his contribution by making it clear that he did not condone drunken driving, but then went on to argue that the reduction in the legally permissible BAC was excessive, that it would be particularly hard on people living in rural areas and that 'We can be too puritanical at times.'[61]

The new legislation came into effect on 2nd December, 1994, provoking over the subsequent two months a public debate of unprecedented ferocity, which appeared to confirm the political astuteness of Austin Deasy. Those opposed to the legislation included various retailing bodies - the Vintners' Federation of Ireland, the Licensed Vintners' Association, the Irish Hotel Federation and others - and, as the campaign against the new law developed, Dáil deputies, particularly those representing rural constituencies.[62] Unusually, and perhaps reflecting some of its own internal organisational conflicts of this period, the Garda Representative Association (GRA) publicly opposed the new penalties; this public

opposition of the GRA to the new drink driving law drew an immediate critical response from the Garda Commissioner, who argued that the police role was one of enforcement and that the GRA should leave law-making to the elected legislators.[63]

Support for the new legislation, during this two-month period of intense public debate, came from the Irish Medical Organisation, the National Safety Council, the Automobile Association, Mothers Against Drunk Driving, and a range of individuals - some of them, like Dr Mick Loftus, who were already seasoned campaigners and some who were less accustomed to public debate.

The debate from a policy analysis perspective was interesting since it involved discussion not just of drink driving issues but of the wider role played by alcohol in Irish social and cultural life. As a spectator event, the debate was exciting and at times highly entertaining, since both sides expressed themselves very forcefully on this most emotive of topics. Those opposed to the new law generally described it as draconian, suggesting that its enforcement over the Christmas period had created a reign of terror which had economically ruined the drinks trade and destroyed the social fabric and mental health of the country, and of rural areas in particular. By 23rd December, for instance, Frank Fell of the Licensed Vintners' Association and Tadhg O'Sullivan of the Vintners' Federation were reporting that their members had experienced a disastrous Christmas. Frank Fell announced dramatically that 'the Christmas is finished' and that predictions that 400 jobs would be lost in the Dublin bars would have to be revised upwards 'to thousands if this continues'.[64] Describing the rural situation, Tadhg O'Sullivan pronounced it to be 'chronic at the moment'

with the 'gardaí being put in a position where they are likely to lose the support of the community not through any fault of the gardaí'.[65]

While the support of the Irish Medical Organisation, the Health Research Board and a number of coroners for the new law was reported in the newspapers,[66] the tone of many independent columnists was scathing in its rejection of the tougher penalties. In the *Irish Times,* for example, Nuala O'Faoláin suggested that 'Michael Smith will be remembered, for one sole thing - for the Christmas no-one dared use the car'[67], while, in a more venomous tone, her colleague, Kevin Myers, lambasted the Dáil deputies who had let through this 'odious Bill' which was so culturally inappropriate to Ireland.[68] He went on:

> We were told early this year that over 300 people had failed breath tests last Christmas. This, no doubt, would have been a splendid use of resources in the northern wastes of Sweden where news desks go on red alert and police-leave cancelled if it is suspected that there is a driver on the roads who has recently consumed a liqueur chocolate. But in this Republic, it was a bizarre and almost immoral squandering of State resources.[69]

As a final example of this spirited debate, the Christmas *Sunday Tribune* reported that Dr Patricia Casey, 'a leading professor of psychiatry and member of the Medical Council', was opposed to the new drink-driving laws which she saw as extreme and as inimical to the mental health of men:

> Professor Casey, who stresses she is totally opposed to drunk driving, points out that the "pub culture is very important for men, particularly as their roles are challenged in modern society, often by women."
>
> "Where else, if not to the pub, have many men to go to relax?" she asks. "It is often their only contact with other men on a social level and it is even more valuable to them because it is sometimes all-male ..."
>
> Professor Casey says it would be unfortunate if the pub, "a social setting where people meet friends and neighbours to chat about sport and politics" were to be abandoned out of fear of the new legislation.
>
> "... Another factor worth considering", she says, is that the "problem drinker will drink and drive anyway..."[70]

On January 24, 1995, the two vintners' associations organised a protest march to Dáil Éireann which was estimated to have drawn a crowd of 3,000 protesters.[71] By this date, there had been a change of Government; the new Government consisting of the so-called 'Rainbow' coalition of Fine Gael, Labour and Democratic Left, with Fianna Fáil now consigned to opposition. The new Minister for the Environment was Mr Brendan Howlin, who had spent the previous two years as Minister for Health and who had introduced *Shaping a Healthier Future*, the health strategy document which had explicitly invoked health promotion principles.[72] Notwithstanding this personal familiarity with health promotion - as well, presumably, as some familiarity with the work of the HPU on the drafting of a national alcohol policy - Mr Howlin agreed to an immediate review of the penalties for drink driving contained in the new legislation and, on March 7, 1995, he announced a series of amendments. The 80mg BAC was retained as the legal limit, but penalties were scaled on the basis of the degree to which BACs exceeded this limit: for example, drivers whose BAC was 81-100mgs were disqualified for just three months on a first conviction, while those whose BAC was 101-150mgs were disqualified for a year on first conviction. The requirement that disqualified drivers should have to pass a driving test before being allowed to regain their licenses was dropped for all routine disqualifications.[73]

This softening of the penalties for drink driving just two months after the legislation came into effect was welcomed by politicians of all parties, as it was by the vintners, despite their expressions of regret that Mr Howlin had not restored the 100mg limit.[74] The only well-publicised repudiation of the Minister's decision was that of Gertie Sheils of the Mothers Against Drunk Drivers group:

> Ms Sheils said the reduction of penalties for drunken driving was "a victory for vested interests". She added: "They [the

> publicans] gave an ultimatum to the Government to do something with the law and that is what has happened. The Government capitulated. Are we going to see every law changed to suit a vested interest group?"
>
> "We are totally devastated by this watering down of the new Road Traffic Act which we felt was a deterrent. The penalties were the real deterrent and once you start watering down the law people lose respect for the law.[75]

The politicians, who had endured an unusually intense and bruising public debate on this topic for the months of December 1994 and January 1995, undoubtedly did not agree with this conclusion of Gertie Sheils; the view expressed by Deputy Avril Doyle - that the Road Traffic Act 1994 was 'too little too late' - now seemed like a serious political miscalculation. In revising the penalties for drunk driving, the politicians appear to have accepted that opposition to the new legislation was widespread and enduring, rather than an ephemeral phenomenon largely created and sustained by the drinks industry.[76]

From a health promotion perspective, the Road Traffic Act 1994 could be seen as an example of intersectoral collaboration in which Department of the Environment legislation served an obvious public health purpose. Despite the fact that it was ostensibly engaged in formulating a national alcohol policy and therefore might be expected to welcome and publicly support this legislation, the HPU remained mute throughout this entire controversy. By remaining aloof from the debate, the HPU clarified - if clarification were necessary - its position as a traditional civil service section which opted to look back cautiously into its parent department rather than commit itself to a public role in leading and shaping the effort to retain the Road Traffic Act 1994. Perhaps to expect otherwise was naive: the doctrine of 'corporation sole' which has already been alluded to regards all departmental activity as ministerial activity, and it would have been virtually impossible for civil servants in the HPU to take on a high-profile lobbying role on this issue

when their minister showed no inclination to do so. Furthermore, the apparent ease and speed with which Brendan Howlin moved from his position as a health promoting Minister for Health to a Minister for the Environment who reduced the severity of penalties for drunk driving must have confirmed for civil servants that political commitment to health promotion was largely rhetorical.

One can speculate that if this debate had taken place in the United Kingdom, a major role would have been played by Alcohol Concern - precisely because Alcohol Concern is an autonomous health promotion agency rather than a central government department. Whether or not it would have made any difference to the political outcome of this episode, the major public health message that might have been articulated by an active health promotion agency concerns the common usage of the phrase 'drunk drivers' and the implied suggestion that such drivers are categorically different from ordinary responsible drivers who simply happen to have taken a few drinks. Just as the public health perspective generally suggests that the categorical distinction between *alcoholics* and *social drinkers* is illusory and that alcohol-related problems are to be found across a spectrum of drinkers, so too does it argue that risk and actual accidents are not confined to a separate category of habitual, heavy-drinking drivers. The comment of Professor Casey to the effect that the reduction of the BAC to the new limit of 80mgs would be ignored by 'problem drinkers' might have been met with the rejoinder that, since problem drinkers were in a minority in any event, the major public health benefit would accrue from the observance of the law by the vast majority of drivers whose alcohol consumption was moderate to start with. From a public health perspective, the primary aim of the drink driving law is not to punish a deviant minority of 'drunken drivers' but to deter drivers as a whole from increasing the risk of road traffic accidents.[77]

However, the main point is that the HPU did not become involved in this debate and that the connection between the Road Traffic Act 1994 and the public health perspective on alcohol was not expressed clearly and publicly throughout this entire episode.

Reorienting the Health Services

Finally, it is necessary to consider whether, at a time when the Department of Health was engaged in the task of formulating a national alcohol policy along health promotion lines, it made any progress in 'reorienting the health service' - that is in challenging or diminishing the dominance of the alcoholism treatment ethos within the Irish health care system. This subject has already been dealt with extensively for an earlier period (1973-1988) in Chapter Four, but the issues remain essentially the same: was it possible to divert resources away from specialist alcoholism services, either towards interventions to be delivered at primary health care level or towards activities which were specifically preventive? Given the general popularity of the disease concept, the specific impact of Alcoholics Anonymous and the Irish National Council on Alcoholism, and the advent of the Minnesota Model, it would seem obvious that attempts to reorient the health services in this way were bound to be difficult.

One health promotion strategy which was particularly popular in the United Kingdom during the 1980s can be regarded, in terms of the Ottawa Charter, either as an example of reorienting health services or, alternatively, as an example of developing personal skills: the strategy in question consists of advice-giving to individual drinkers or to the general public concerning the relationship between level of consumption and risk for various forms of alcohol-related problems.[78] The logic of this health promotion strategy was, of course, diametrically opposed to that inherent in the disease

concept, which regarded consumption levels as unimportant in the light of its general preoccupation with vulnerability as an inherited individual factor. As it gained popularity in Britain, the trend was towards advice-giving - either through individual contact, as in the patient-GP relationship, or through media promotion - which suggested that risks could be minimised through limiting alcohol consumption to 'safe' or 'sensible' weekly levels. The consensus was that for men the safe weekly level was 21 units of alcohol, while for women it was 14 units, with a unit consisting of a British measure of spirits, a half-pint of a beer or a glass of wine. The choice of these levels was somewhat arbitrary, rather than precisely scientific, but the effectiveness of the campaign was predicated upon its acceptance by the public as an authoritative, scientific statement of fact. Kendell (1987) acknowledged the arbitrary nature of the choice of safe drinking levels, adding: 'But at least we have had the wit to heed the warning Lord Melbourne gave to his cabinet about the price of corn - "It is not much matter which we say, but mind, we must all say the same".'[79]

However, despite the adoption and promotion of this preventive strategy by various royal medical colleges, the Health Education Council and Alcohol Concern, there was little evidence of its success,[80] and in December 1995 - showing gross disregard for Lord Melbourne's warning - the British Minister for Health, unilaterally raised the safe drinking limits to 28 units per week for men and 21 units per week for women.[81] By this time, paradoxically, WHO and other authoritative thinking had come to view the concept of safe drinking levels as inaccurate and potentially harmful; strictly speaking, there is no risk-free drinking, and the publicising of these allegedly safe levels might even encourage some drinkers to increase their consumption, just as road signs may persuade motorists to drive faster when they indicate that they are driving at less than the legal speed limit.

The revised public health message, while retaining the logic of the link between consumption level and risk, now consisted of the simple, but by no means unproblematic, advice that 'less is better'.[82]

From the time of its establishment in 1988, the HPU appeared to vacillate on the subject of safe drinking level advice. In 1989, it published a 'drinking diary'[83] and some other material which drew explicitly from British concepts and literature, but it kept all of its activities in this sphere low key and never initiated any large-scale mass media campaigns utilising this approach. By 1991, when its stock of literature was running low, the Principal Officer in the HPU was reluctant to authorise reprints, largely, it appears, on the grounds that any publicity on this topic might provoke conflict amongst members of the Working Group who were working on the national policy.[84] Despite this, the major health strategy document *Shaping a Healthier Future* contained the following target:

> To ensure that, within the next four years, 75 per cent of the population aged fifteen years and over knows and understands the recommended sensible limits for alcohol consumption. While these limits are subject to ongoing research, the present international consensus is 14 units per week for a woman and 21 units for a man.[85]

Two years later, however, when the national alcohol policy document was finally published, the HPU acknowledged that safe (or at least low risk) drinking levels were no longer being advocated and that the recommended health promotion message now consisted of the simple dictum 'less is better'.[86] One can regard the relative inactivity of the HPU on this issue as demonstrating shrewdness in opting not to commit itself to a health education line which quickly came to be seen as dubious; alternatively, of course, one can regard it as yet another example of civil service caution and the preoccupation with avoiding mistakes.[87] However one chooses to interpret the HPU's activity on this front, it seems fair to conclude that health promotion of this type – which could be regarded as falling under the

Ottawa Charter rubric of 'developing personal skills' – further demonstrates the difficulty and complexity of operationalising principles which in the abstract seem straightforward and non-problematic.

As already discussed in Chapter Four, the policy intent of *Planning for the Future* (1984), was to reduce admissions, lengths of stay and the general burden of alcohol problems on the Irish psychiatric hospital system. The principal means towards the realization of this policy intent was the establishment of community-based alcohol counsellor posts within the restructured, sectorised mental health services.[88] This policy line represented a compromise in terms of how public mental health services should handle alcohol problems, falling as it did between the extremes of simply continuing to devote large-scale hospital resources to these problems or, alternatively, refusing to allow alcohol problems to be treated at all within the psychiatric system.[89] The rationale for this policy shift towards non-residential services was, as outlined in Chapter Four, that detoxification rarely demanded hospital admission, while evaluative research had failed to demonstrate that inpatient rehabilitation delivered results superior to those of out-patient rehabilitation.

In the years succeeding the publication of *Planning for the Future* the regional health boards moved, at varying paces and with somewhat varying service structures, to create non-residential alcohol counseling services; in its *Green Paper on Mental Health* (1992) the Department of Health commented approvingly, albeit superficially, on these developments, but it never conducted any review or evaluation of these new services.[90]

Table 9 :

Alcohol-related Admissions as a Proportion of all Admissions to Irish Psychiatric Hospitals *

Year	All Admissions	Alcohol Admissions (% of all admissions)
1985	29,082	7,272 (25%)
1986	29,392	7,132 (24%)
1987	27,856	6,492 (23%)
1988	28,432	6,478 (24%)
1989	27,250	6,608 (24%)
1990	27,765	6,377 (23%)
1991	27,913	6,592 (24%)
1992	27,148	6,081 (22%)
1993	27,008	5,718 (21%)
1994	26,687	5,551 (21%)
1995	26,440	5,262 (20%)

* *Source:* Annual Activities Reports of the Medico-Social Research Board / Health Research Board.

The decrease in psychiatric inpatient admissions for alcohol problems in the period 1985-1995 is illustrated in Table 9, but, as with other aspects of alcohol policy, these data are open to conflicting interpretation. Dermot Walsh continued to be in charge of the Health Research Board's mental health research programme during this period, as well as acting as Inspector of Mental Hospitals for the Department of Health. His view, stated frequently and publicly, was that the decline in alcohol-related admissions was not as speedy or as radical as he would have liked. The Report of the Inspector of Mental Hospitals for 1992, for example, included his contention that: "Admissions for alcohol related disorders remain disturbingly high despite the Inspectorate's recommendation in recent years about the importance of providing alternative, non-residential services for this category of patient."[91]

In most ways, however, Dermot Walsh would have to be regarded as something of a lone voice, since popular discourse and media representation of these issues still seemed to be rooted in the disease concept and,

specifically, in the uncritical espousal of the value of treatment services. In 1988, for example, the *Irish Times* ran a four-part series on alcoholism which largely consisted of a rehearsal of traditional views reflecting the validity of the disease concept, and giving no real sense of how controversial or contentious this area was. The first part of this series included an uncritical presentation of American ideas about Adult Children of Alcoholics, as well as a statement from Dr Patrick Tubridy of St John of Gods Hospital, who estimated that 'there are about 175,000 alcoholics in Ireland and for every alcoholic drinking there are 10 people who are totally miserable'.[92]

Similarly, in 1991 Dr John Cooney (while a member of the HPU's working group on a national alcohol policy) published a popular book on alcoholism in which he restated and defended the disease concept and, by implication, the value and importance of treatment. Extracts from this book were published in the *Irish Times,* again without critical comment or rebuttal. The general tenor of Cooney's advocacy of the disease concept had not changed, as may be gleaned from this quote:

> I am convinced that were it not for the disease concept of alcoholism far fewer people would have come forward for help, and might not have been encouraged to do so. Here in Ireland this concept is being threatened at the present time. If we regress to the moralistic 'sin' model of long ago, then the victims of alcohol abuse will receive the second-class treatment deemed appropriate for victims of a bad habit, self-inflicted.[93]

In early 1994, following a radio interview in which Dermot Walsh was critical of the value of or necessity for inpatient alcoholism treatment, the *Irish Medical Times* published an unsigned editorial which argued strongly against him on the basis that '*Planning for the Future* and the *Green Paper on Mental Health* notwithstanding, the facilities available for the diagnosis and treatment of alcohol abuse are inadequate to say the least'[94] This editorial gave rise to a correspondence over the next few weeks in the letters

columns of the *Irish Medical Times*, in which some of the contributors were hard-hitting in the extreme. Professor Tom Fahy of the Department of Psychiatry at University College Hospital, Galway, defended Dermot Walsh, suggesting that the editorial had been written by a private sector psychiatrist and that psychiatrists from this background were primarily concerned to protect their commercial interests in inpatient treatment programmes. Professor Fahy also thought that a comprehensive national alcohol policy with a preventive or health promotional rationale was the best way forward, and that psychiatrists should admit that they had relatively little to contribute in this sphere.[95]

On the other side in this debate was a Dublin GP, Dr Patrick Nugent, who described Dermot Walsh's views as 'very personal', suggested that Walsh had an antipathy towards alcoholics and that he should stop queering the pitch for doctors who were committed to alcoholism treatment.[96]

One interesting example of the ability of those who favoured inpatient treatment to lobby for the retention of structured inpatient programmes is to be found in the events which took place at St Brigid's Hospital, Ballinasloe, in early 1995.[97] This hospital, owned and run by the Western Health Board, had set up a residential alcoholism programme in 1980 catering for about fifteen patients who typically stayed for six weeks. Three nurses from the hospital had been trained as counsellors by the Irish National Council on Alcoholism and had worked exclusively in this service thereafter. These nurse counsellors resisted organisational pressure to transfer to community alcohol service posts during the early 1990s, and when the Health Board attempted in 1995 to close the unit (which had been housed across the road from the main hospital in a former doctors' residence) they displayed great political skills in mobilising former patients,

as well as local and national politicians, to successfully resist this move. The closure of the unit was debated at a meeting of the Western Health Board and at a special meeting of Ballinasloe Urban Council, and received extensive coverage in the local press.[98] Part of the case made by those who lobbied successfully for the retention of the St Brigid's Unit was that its existence merely gave to medical card holders what VHI subscribers took for granted - inpatient rehabilitation which could never be adequately replaced by outpatient counselling services.[99]

Given this degree of contentiousness about the respective merits of inpatient and outpatient treatment programmes and the residual popularity of hospital admissions, it is perhaps not surprising that the Department of Health made no dramatic effort to reorient the health services in respect of alcoholism treatments. While, as stated above, no comprehensive evaluation of the newly established community alcohol services took place, there are some grounds for believing that rather than providing an alternative for problem drinkers who would otherwise occupy hospital beds, these services generated a new clientele.[100] Much of the counsellors' work was with 'concerned persons', that is spouses and other relatives or associates of problem drinkers, or with problem drinkers whose difficulties were unlikely to result in hospitalisation. This is not to say, of course, that counselling with such clients is undesirable or of no proven efficacy, but merely to point out that its development and scale was an unanticipated consequence of the decision to create specialist community alcohol counsellor posts. Furthermore, despite the intent to retain alcohol counsellors as an integral part of the mental health services, they operated in many areas as relatively autonomous teams with only tangential contact with the parent mental health system.[101]

Conclusion

The aim of this chapter was to assess the newly-established health promotion structures in terms of their performance in formulating and implementing a national alcohol policy. It was suggested from the outset that this task seemed excessively ambitious in view of the success of the disease concept in resisting the public health perspective during the period leading up to 1988. The debate surrounding the enactment of the Intoxicating Liquor Act 1988 once again confirmed that the policy climate had not become noticeably 'drier' or more receptive to a national alcohol policy along health promotional lines, although the Minister for Health created expectations of such a policy development through his decision to assign this task to the Advisory Council on Health Promotion and the HPU. It would have to be concluded that the Advisory Council never functioned as the autonomous body envisaged in these early and relatively heady days of health promotion; indeed for almost all of the period considered in this chapter it never functioned at all. To some extent this is attributable to the deaths of the first two chairpersons and the political career of the third, but it also suggests that neither at Ministerial nor at civil service levels was there any real commitment to this particular structure. Similarly, it has to be concluded that the Cabinet Sub-Committee on Health Promotion was little more than a fiction throughout this period.[102]

The HPU remained in firm control of the formulation of the national policy document, therefore, and it has been argued here that its management of this task reflected a traditional civil service preoccupation with minimising conflict and avoiding controversy; the organisational networks model of policy formulation, with its emphasis on negotiation and the establishment of informal alliances, simply did not fit the style of the HPU, which was after all a section of a central government department. The hollowness of

the rhetoric of intersectoral collaboration was shown up particularly during the intense debate which followed the implementation of the Road Traffic Act 1994; during this debate on alcohol consumption, driving and risk, the HPU remained silent rather than, as might have been expected, coming to the assistance of beleaguered colleagues in the Department of the Environment.

In their summary of all the relevant research evidence and its implications for alcohol policy, Edwards et al (1994) argued that:

> Alcohol problems have too often been left to the ebb and flow. It is the job of policy so far as possible to capture and control that tide in the public interest.[103]

Applying this metaphor to the period 1988-1996, the HPU must surely have seen itself as cast in the role of King Canute; the tide of alcohol consumption and related problems which it was expected to tackle or reverse seemed immune to all conventional policy responses. The use of fiscal measures to limit consumption, which is advocated in international literature, was largely irrelevant in a country where alcohol consumption is price inelastic, and, in any event, our membership of the EU does not readily allow us to increase the price of what is by European standards an already expensive commodity. Similarly, there is little political or public support for other alcohol control measures. The popularity of the disease concept and of treatment services also makes it difficult to advocate any radical reorientation of the treatment system, and there was no groundswell of popular support for such a reorientation from local community groups or regional health boards during this time.

In concluding this section of the thesis which deals with alcohol problems, perhaps the main conclusion, therefore, is that the period from 1945 onwards was characterised by an incremental drift towards a public alcohol

policy where the disease concept was dominant. Attempts to apply health promotion concepts, however rational such concepts appear or however sincere their advocates, had no success in terms of *realpolitik.* In Chapter Ten these issues will be considered again in relation to and in comparison with policy on illicit drugs, which forms the subject matter of Chapters Six, Seven, Eight and Nine. For the next four chapters, therefore, the focus will be on newer psychoactive drugs, use of which - particularly from the 1960s onwards - became more prevalent internationally. Drugs such as cannabis, heroin or ecstasy were not culturally normative in Ireland, nor was their use legally integrated into economic systems in this country. Therefore, despite the fact that in pharmacological terms they may have much in common with alcohol, it is to be expected that it is this deviant status which they occupy in Ireland, as in practically all other countries, which will explain policy responses to their use here.

Chapter Five: Footnotes

[1] C. Kelleher (ed), *The Future For Health Promotion.* (Centre for Health Promotion Studies, University College Galway, 1992), p.132.

[2] Following on from Chapter Four, the aim is to establish whether the public health perspective on alcohol fared any better between 1988 and 1996 than it had previously.

[3] *Dáil Debates* (Vol.379), Column 1992.

[4] G. Edwards et al, *Alcohol Policy and the Public Good.* (Oxford University Press, 1994), p. 205.

[5] In what might be considered a death-bed conversion, INCA had changed its title from Irish National Council on *Alcoholism* to Irish National Council on *Alcohol* a few months prior to its closure.

[6] *Dáil Debates* (Vol.379), Column 2102.

[7] *Seanad Debates* (Vol.119), Column 1970.

[8] Ibid, Column 1565.

[9] *Dáil Debates* (Vol.380), Column 1701.

[10] *Dáil Debates* (Vol.379), Column 2297.

[11] Offences against this section could result in fines of up to £500 and an endorsement of the retailer's license.

[12] This word 'demerit' is sometimes used colloquially in alcohol policy debate to signify that alcohol, while nowhere near heroin or other illicit drugs in terms of the negative characteristics attributed to it, is still not a respectable commodity.

[13] A briefing document from the Department of Justice, which this writer received while a member of the Working Group on a National Alcohol Policy, suggested that the Minister was reluctant to bring this section into operation because: (a) it appeared that under-age drinkers did not generally purchase alcohol in such retail outlets; (b) its implementation would entail considerable expense for businesses, and (c) because a complaint had been made to the European Commission that Section 47 discriminated against those involved in wine production, wholesaling and retailing. While all of these points have apparent validity, it should be noted that in deciding not to implement Section 47 the Minister dropped the Act's only health promotional section.

[14] The Annual Reports of the Garda Commissioner show that in these years the prosecutions and convictions for sale of drink to persons under 18 years of age were as follows:

Year	Prosecutions	Convictions
1985	22	9
1986	6	5
1987	21	7

1988	29	9
1989	121	83
1990	118	62
1991	166	76
1992	83	55
1993	102	54
1994	96	56
1995	109	49

[15] M. Morgan and J. Grube, *Drinking Among Post-Primary School Pupils.* (Dublin: ESRI, 1994).

[16] Ibid.

[17] Sally Edwards discussed her work at the Department of Health with this writer both during her time there and on a number of subsequent occasions.

[18] This notice, over the name of Dr Ciarán Barry, Chairman of the Advisory Council on Health Promotion, was published in most Irish broadsheet newspapers during the first week of February, 1991.

[19] Members of the Advisory Council on Health Promotion who remained on the National Alcohol Policy Working Group were:

Dr John Cooney (Psychiarist);
Ms Eilis Fitzpatrick (Public Health Nurse);
Professor Cecily Kelleher (Professor of Health Promotion, U.C.G.)

Those co-opted were:

Mr Shane Butler (Addiction Studies, T.C.D.);
Professor Eileen Kane (Department of Anthropoligy, St Patrick's College, Maynooth);
Dr Mick Loftus (G.P. and Coroner for North Mayo);
Mr Paddy Moriarty (Chairman, ESB);
Mr Chris Murphy (Drug Awareness Programme, Catholic Social Services Conference, Dublin);
Mr Michael Walsh (Programme Manager, Special Hospital Programme, Eastern Health Board).

The Working Group was chaired by Mr Noel Usher, Principal Officer, Health Promotion Unit; other HPU officials who contributed were:

Mr Gerry Coffey;
Ms Anna-May Harkin;
Ms Carmel Tobin.

Much of the following account of the formulation of the national alcohol policy is drawn from this writer's recollection of events as a member of the Working Group and from the Group's business papers.

Perhaps the most notable omission from the Working Group was Dr Dermot Walsh, whose national and international reputation in the alcohol research field might have been expected to gain him an

automatic place on this Group. A letter from this writer to Mr Usher (19.7.91) suggesting that Dr Walsh should at least be invited to address the Working Group, resulted in an invitation to Dr Walsh, but no suitable time was found for him to do so. The most plausible explanation for this exclusion of Dermot Walsh is the concern of the HPU to avoid conflict between himself and Dr Cooney, although the HPU may also have been reluctant to involve Dr Walsh in an area where his research expertise and familiarity with the issues may been regarded as excessive and intimidating for the HPU itself and other members of this group.

[20] The phrase 'broadly based' seems to have had a curious attraction for the HPU; it was often used in a positive sense to justify the make-up of the Advisory Council on Health Promotion, yet it was used in this instance (the first real task of the Advisory Council) to suggest that the Advisory Council was unsuited to a specific policy formulation exercise.

[21] These ESRI reports were published the following year as one volume, D. Coniffe and D. McCoy, *Alcohol Use in Ireland: The Economic and Social Implications.* (Dublin: ESRI, 1992).

[22] This report, *A Literature Review of Social Indicators of Alcohol Consumption in Ireland* , was compiled by Abdullahi Osman El-Tom of the Department of Anthropology, St Patrick's College, Maynooth. It was completed in April 1992.

[23] P. Bachrach and M. Baratz, 'Decisions and Nondecisions: An Analytical Framework', *American Political Science Review,* 57 (1963), pp 632-642.

P. Bachrach and M. Baratz, *Power and Poverty: Theory and Practice.* (Oxford University Press, 1970).

[24] All of the following is drawn from this writer's experience as a member of the Working Group.

[25] Amongst those who made oral submissions were: The Drinks Industry Group; RTE; the Advertising Industry; Mothers Against Drunk Driving; National Safety Council; Irish College of General Practitioners; Psychological Society of Ireland; Irish Association of Alcohol and Addiction Counsellors; Irish Congress of Trade Unions; Irish National Teachers Oganisation.

[26] This writer participated in most of these meetings between delegations from various interest groups and the Working Group. The most memorable of these consultation meetings was with the Drinks Industry Group; this was a tense affair in which the DIG reiterated its traditional belief that drinking problems were caused by deficits in a small number of consumers rather than by any danger inherent in 'the product' and generally portrayed the attempt to create a national alcohol policy as a form of neo-Prohibitionism.

[27] Letter to Shane Butler from Noel Usher, Chairman of the Working Group (March 12, 1992).

[28] Letter to Shane Butler from Noel Usher (February 4, 1993).

[29] Letter from Shane Butler to Noel Usher (February 11, 1993); the next communication this writer received from the HPU on the subject of the national alcohol policy was following its launch in September 1996.

[30] *Green Paper on Mental Health..* (Dublin: Stationery Office, 1992), p.26.

[31] *Shaping a Healther Future: A Strategy for Effective Health-care in the 1990s.* (Dublin: Stationery Office, 1994), p.49.

[32] *A Health Promotion Strategy: Making the Healthier Choice the Easier Choice.* (Dublin: Department of Health, 1995), p.22.

[33] This again is based on this writer's papers from the Working Group and his memory of this time; he has particular memories of meeting fellow members who wondered when the Group would be reconvened and the task concluded. Members of the Working Group who were not also members of the Advisory Council on Health Promotion were not shown any draft document; they were not told that the a final document had been agreed by Government; and were not invited to the official launch of *National Alcohol Policy: Ireland* which was described in its Acknowledgements as being 'based on the report of a Working Group which was established by the Advisory Council on Health Promotion' - *National Alcohol Policy : Ireland.* (Dublin: Stationery Office, 1996), p. 9.

[34] 'Policy on alcoholism', *Irish Medical Times,* October 13, 1995.

[35] The major policy document which deals with this is: *Public Services Organisation Review Group (Devlin Report)* . (Dublin: Stationery Office, 1969).

For a critical discussion of the culture of the Irish civil service see J. Lee, *Ireland 1912-1985: Politics and Society.* (Cambridge University Press), pp 540-562.

[36] For an interesting discussion of the role of civil servants in policy making, see E. O'Halpin, 'Policy Making' in J. Coakley and M. Gallagher (eds), *Politics in the Republic of Ireland.* (Galway: PSAI Press, 1992), pp 167-181. The concept of *corporation sole* refers to a legal principle which prevailed for the entire period studied in this thesis and which regards all departmental activity as Ministerial activity for which the Minister is accountable. This concept was something of a fiction in that concealed the very real influence wielded by civil servants.

[37] The policy decisions of Brendan Howlin in relation to drink driving, following his move to the Department of the Environment from Health, will be discussed below.

[38] Letter to Shane Butler from Fergal Goodman, Private Secretary to the Minister for Health (September 20, 1996).

[39] *National Alcohol Policy: Ireland.* (Dublin: Stationery Office, 1996), p.63.

[40] *Irish Times*, September 20, 1996.

[41] Ibid.

[42] The policy document suggested *inter alia* that: 'The Department of Health will, as a matter of urgency, look to: Establish a dedicated National Alcohol Surveillance Function to co-ordinate and monitor the National Alcohol Policy' (p.60). Apart from obvious and cynical expressions of doubt as to how the Department of Health defines urgency, there is some ambiguity here concerning this 'surveillance function'. The Department of Health Promotion at University College Galway had become involved in the final drafting of the national alcohol policy report (primarily through one of its researchers, Dr Ann Hope) and this academic department also appears to have continued to do so some work for the HPU on this 'alcohol surveillance function' but the resulting work has not been published. In its 1997 *Statement of Strategy,* issued as part of the broader Strategic Management Initiative, one of the strategic policy developments listed, without elaboration, by the Department of Health was its intention to 'implement the recommendations of the National Alcohol Policy' - *Statement of Strategy.* (Dublin: Department of Health, 1997), p.31. Strictly speaking, the implementation of this policy falls outside the study period of this thesis, but at the time of this writing in autumn of 1999 there has been no discernible implementation of the policy. It is interesting to note that in early 1999 the Irish Catholic Bishops' Conference published a pamphlet entitled *The Temperate Way* which was intended to mark the centenary of the founding of the Pioneer Total Abstinence Association; the bishops drew attention to the 1995 Alcohol Charter which was drawn up by the European Region of WHO, and suggested that the State (north and south) should set up a task force to study the legal and social implications of this Charter. It would appear that the bishops were completely unaware of the existence of the national alcohol policy.

[43] The three models - rational comprehensive, partisan mutual adjustment or incrementalism, and organisational networks - are discussed in Chapter One.

[44] The allergy metaphor is often used in this context; it is argued that alcoholics constitute a small proportion of potential consumers whose allergy to the product cannot be rationally used as a basis for banning or restricting its general availability.

[45] See Chapter One, pp 14-16.

[46] The national alcohol policy document does not draw explicitly from the Ottawa Charter as did some other Department of Health policy documents.

[47] References to multi-sectoral collaboration are mainly to be found in Section 3, the 'Plan of Action', where the Departments of Health, Education, Justice, Enterprise and Employment and (by implication) Finance are mentioned. On the whole, as has been argued in the text, this section seems unconvincing because of the vagueness of the plan,

which refers to 'encouragement', 'recommendation' and 'awareness raising' rather than to more authoritative measures.

[48] *European Charter on Alcohol* (Drawn up at a WHO conference on Health, Society and Alcohol, held in Paris in December 1995).

[49] The statistics on Irish alcohol consumption contained in the policy document confirm this trend; in line with the improved national economic situation, consumption which had dropped and then plateaued during the 1980s has started to rise again since 1991/92.

[50] *National Alcohol Policy Ireland,* cit.sup., p.47.

[51] This historic and emotionally charged event is now referred to as the Guinness All- Ireland Hurling Championship.

[52] The tradition of 'generalist' civil servants refers to the fact that civil servants were recruited on the basis of a good, general education, rather than on the basis of specialist or professional education, and once inducted into the system they moved around. To develop expertise or unusual knowledge or interest in a particular area was contrary to the civil service culture and not necessarily good for one's career. See B. Chubb, *The Government and Politics of Ireland* (2nd ed.), (London: Longman, 1982), ch.13.

It is worth noting that one of the HPU civil servants (named in footnote 19), Anna-May Harkin, was a sociologist who had come to HPU following the closure of the Health Education Bureau in 1988. Despite her formal qualifications and expertise, she was a Higher Executive Officer - which is a relatively low rank. Paradoxically, during the years when the HPU was meant to be working on a national alcohol policy, Ms Harkin went on a career break to WHO Europe in Copenhagen where she worked on European alcohol policy issues. In 1996 there was a small number of professional grade civil servants based permanently in the HPU (a Chief Education Officer and a couple of dietary advisers) but authority still largely resided in the mainstream civil servants whose tenure there was of a shorter duration.

[53] *National Alcohol Policy Ireland,* cit.sup., pp 49-52, and 84-85.

[54] Strategy 10 from *European Charter on Alcohol,* cit.sup.

[55] Based on discussions with Dr Loftus, both during the period that the Working Group on the National Alcohol Policy was meeting and subsequently.

[56] The permitted BAC varies considerably from one jurisdiction to another: in the UK it is 80mg, in Germany 80mg, in France 70mg, in the Netherlands 50mg and in Sweden 20mg.

[57] See G. Edwards et al (1994), cit.sup., ch.7.

[58] *Dáil Debates* (Vol. 433), Column 780.

[59] Ibid, Column 782.

[60] This comment was made by a Fianna Fáil deputy, Batt O'Keefe *(Dáil Debates,* (Vol. 433, Column 913).

[61] *Dáil Debates* (Vol. 433, Column 832).

[62] As well as drawing from his own press cuttings from this period, this writer acknowledges the value of the booklet published by the Dublin Healthy Cities Project, i.e.: C. McLernon, R. Bateson and M. Hynes, *Press Coverage of the 1994 Legislative Change In The Drink-Driving Laws In Ireland.* (Dublin Healthy Cities Project, 1995).

[63] 'Culligan says GRA views on drink-driving irresponsible', *Irish Times,* December 23, 1994.

[64] 'Controversy over new drink-driving law intensifies', *Irish Times,* December 23, 1994.

[65] Ibid.

[66] For example, see 'Doctors are fully behind drink rigour', *Irish Press,* December 31, 1994. (This reported comments in favour of the new legislation by the Irish Medical Organisation).

[67] Nuala O'Faoláin, 'Attitudes to drinking need fine tuning, not hammering', *Irish Times,* January 2, 1995.

[68] Kevin Myers, 'An Irishman's Diary', *Irish Times,* December 28, 1994.

[69] Ibid.

[70] 'Drink law has social risk', *Sunday Tribune',* December 23/24/25, 1994.

[71] This estimate of the size of the vintners' protest is from the *Evening Press,* January 24, 1995.

[72] As Minister for the Environment, Mr Howlin was also a member of the Cabinet Sub-Committee on Health Promotion. There is no evidence that this sub-committee has ever really functioned, and certainly during this controversy there was absolutely no evidence of a concerted political response to retain the legislation and so help to create a healthier environment.

[73] 'Howlin Announces Drink Driving Charges'. (Press Release on behalf of the Department of the Environment, March 3, 1995). An amended Road Traffic Bill was quickly introduced and enacted, becoming the Road Traffic Act 1995.

[74] 'TDs favour drink-driving charge', *Irish Times,* March 8, 1995.

[75] Ibid.

[76] 'Holiday Road Deaths Set To Decline By 10 Say Garda', *Irish Independent,* December 24, 1994.

[77] For an authoritative discussion of all the policy issues involved in drink-driving legislation see H. Ross, *Confronting Drunk Driving: Social Policy for Saving Lives.* (Yale University Press, 1992).

[78] This sensible drinking recommendation was presented in a relatively popular way in: Royal College of Psychiatrists, *Alcohol: Our Favourite Drug.* (London: Tavistock, 1986). For a more recent scientific statement on this topic see Ch.3 of G. Edwards et al (1994), cit.sup.

[79] R. Kendell, 'Drinking Sensibly', *British Journal of Addiction,* 82 (1987), p.1281.

[80] Heather (1996) summarises British evidence as to the lack of success of this media and primary health care campaign on sensible drinking. A household survey by the Office of Publication Censuses and Surveys in 1996 showed that while most respondents had heard of the idea of measuring alcohol intake in units, only between 20% and 40% of those who had heard of this could correctly identify the number of units in specified drinks. Furthermore, only 15% of men and 16% of women could identify the sensible drinking limit for their own sex. (N. Heather, 'The Public Health and Brief Interventions for Excessive Alcohol Consumption: The British Experience', *Addictive Behaviours,* 21 (1996), pp 857-868.

[81] Heather discusses this unilateral change by the British Government and the belief of most commentators that it was the result of pressure from the drinks industry (N. Heather, op.cit., p.863).

[82] Whether vague health educational messages of this kind will make any impact remains to be seen. To those who consider the 'less is better' message, it may seem strange that the same advice is being offered to a person who drinks large amounts everyday as it is to someone who has a small sherry every Christmas.

[83] *Drinkwise: A Self Help Guidance Diary.* (Dublin: Health Promotion Unit, n.d.) However, the date of publication has been confirmed as being 1989 by Carmel Tobin of the HPU.

[84] This writer was contacted by a staff member of the HPU and asked for an opinion as to whether the sensible drinking guidelines were still approved in Britain or elsewhere; this coincided with the publication of Dr John Cooney's book (see footnote 93 below), and the fear was that Dr Cooney as a member of the Advisory Council on Health Promotion and the Working Group on the National Alcohol Policy might object to the *Drinkwise* approach.

[85] *Shaping a Healthier Future,* cit.sup., p.49.

[86] *National Alcohol Policy : Ireland,* cit.sup., p.28.

[87] There is an interesting discussion of this aspect of Irish civil service culture and attempts to change it in the lengthy 'Perspectives' section of J. Lee, *Ireland 1912 –1985: Politics and Society.* (Cambridge University Press, 1989),pp 540-562.

88 As explained in Chapter Four, the concept of sectorisation refers to the restructuring of public psychiatric services so as to move away from highly centralised service provision and give a designated mental health team responsibility for a defined geographic area or sector.

89 Occasionally it has been suggested that alcohol problems might be moved administratively from the Special Hospital Programmes of the health boards to Community Care Programmes, and in the Southern Health Board this has happened to some extent at least (see *Southern Health Board, A Strategy to Prevent and Treat Alcohol and Drug Abuse).* (SHB, 1994).

90 *Green Paper on Mental Health,* cit.sup., Chapter 5.

91 *Report of the Inspector of Mental Hospitals for the year ending 31st December 1992.* (Dublin: Stationery Office, 1995), p.3.

92 *Irish Times,* April 18, 1988.

The estimate, it must be said, appears spurious, and Dr Tubridy's opinion that there are ten people miserable as a consequence of each alcoholic gives a sum of: 175,000 + 1,750,000 = 1,925,000. In other words almost two million people out of a population of three and a half million are either alcoholic or 'totally miserable' because of alcoholism. This almost matches the contention by Sinéad O'Connor in her full-page poem in the *Irish Times* (June 10, 1993) that 96% of people are 'Adult children'!

93 J. Cooney, *Under the Weather: Alcohol Abuse and Alcoholism - How to Cope.* (Dublin: Gill and Macmillan, 1991), p.7.

94 'Treating alcoholism in Ireland', *Irish Medical Times,* February 18, 1994.

95 *Irish Medical Times,* February 25, 1994.

96 *Irish Medical Times,* March 11, 1994.

97 A number of Western Health Board employees, including both managers and counsellors, discussed this incident with this writer.

98 'Fears expresed over future of specialist alcohol treatment unit', *Connacht Tribune,* April 7, 1995.

'Recovering alcoholics plea is to save the hospital addiction unit', *Connacht Tribune,* April 14, 1995.

'Plea for residential alcohol course in bid to help "cure" nineteen year old alcoholic', *Connacht Tribune,* April 28, 1995.

99 'If we were in the VHI there would be no problem. He could go in anywhere in the morning ...', *Connacht Tribune,* April 28, 1995.

100 This is based on unpublished research by this writer for the South Eastern Health Board's Regional Addiction Studies Day (April 12, 1996); the seminar paper based on a study of three community alcohol

services was entitled 'Developments in Community Alcohol Services since Planning for the Future'.

In two of the three services looked at the alcohol counsellors operated from their own premises with relatively little contact with the parent mental health system; in these two services the bulk of the problem drinkers counselled during 1994 (84% and 100%) had not been admitted for inpatient detoxification, although there continued to be large numbers of admissions for detoxification in these two areas. In the third area, where the alcohol counsellors were more closely integrated with the mental health service, 57% of problem drinkers counselled during this year had been picked up through hospital admission for detoxifications.

[101] Despite the fact that most of the alcohol counsellor posts have been taken up by psychiatric nurses, these counsellors have now eschewed traditional nursing duties, such as administering and supervising medication; the result is that home detoxification is almost non-existent, as is the administration of disulfiram (Antabuse) by nurse/counsellors.

[102] Because of the Constitutional confidentiality attaching to the Cabinet, it is not easy to pronounce definitively on whether or not the sub-committee ever functioned; on the basis of discussions with a number of civil servants, this writer believes that in fact it never met. In a review of health promotion in Ireland, Cecily Kelleher has commented cryptically that: 'A new cabinet sub-committee for health promotion was formed comprising relevant ministries influencing health status, though in fact this group never met in plenary' – C.Kelleher, 'Promoting Health' in J.Robins (ed), *Reflections on Health: Commemoration of Fifty Years of the Department of Health 1947-1997.* (Dublin: Department of Health, 1997), p. 37.

[103] G. Edwards et al (1994), op.cit., p.212.

CHAPTER SIX

HEALTH POLICY AND ILLICIT DRUG USE IN IRELAND: THE EARLY YEARS 1966-1979

Introduction

International drug control systems evolved and expanded throughout the twentieth century, having had their origins in the International Opium Convention at The Hague in 1912.[1] In Ireland the enactment of the Dangerous Drugs Act 1934 was a brief and politically uncontentious affair which appears to have been prompted solely by this country's accession to the Geneva Convention of 1931. The overall tone of the debate on this legislation may be gleaned from the comments of an opposition deputy who described it as 'a Bill which is carrying out an international agreement, but there is really no necessity or need for the Bill so far as the condition of this State is concerned'.[2] There is also no evidence to suggest that the inclusion of references to and definitions of *addicts* in Section Three of the Mental Treatment Act 1945 (which was discussed in Chapter Three of this thesis) was occasioned by any immediate concern with psychoactive substances other than alcohol. It was not, in fact, until the 1960s - a decade which is universally associated with increased drug use as part of a burgeoning youth culture - that the authorities in Ireland became convinced of the necessity to initiate policy change in this area. This Chapter, as well as Chapters Seven, Eight and Nine, will be concerned with describing and analysing these policy developments from the mid 1960s to the late 1990s.

As with earlier chapters which dealt with alcohol policy, the intention is to use the health promotion framework which was set out in Chapter One as an heuristic device for exploring the tension between treatment and prevention. As has been seen in these chapters, the public health perspective on alcohol, which embodied all the main tenets of health promotion, made only minor gains over the period studied in the face of the enduring popularity of the disease concept. Irish political culture was generally not receptive to the drier policy implications of the public health perspective, and no effective

lobby emerged to challenge this and bring about the kind of radical change that would be necessary if health promotion were to become a reality in this sphere.

If there was a reluctance to set in place alcohol control policies in Ireland, as in most Western societies, it might be predicted that the exact opposite would be the case in relation to the use of other psychoactive drugs. Internationally, public policy on these latter substances relied heavily on control systems, with customs authorities, police and the full weight of criminal justice systems being employed to reduce or eliminate their supply. Given our accession to the Geneva Convention of 1931 and subsequent enactment of the Dangerous Drugs Act 1934, it is to be expected that Irish drug policy would continue to broadly conform to this international trend, and, equally perhaps, it is to be expected that the creation of treatment services for problem drug users would be subordinate to or at least heavily influenced by this underlying prohibitionism.

Despite the existence of a high degree of support internationally for drug control systems, amounting to a consensus for all practical purposes, interesting and important policy differences emerged between Britain and the USA during the first half of the twentieth century. In the USA the Harrison Act 1914, or to be precise, the interpretation of this legislation by the Supreme Court, effectively gave the criminal justice system dominance in this area; American ideological commitment to drug prohibition was strictly and consistently adhered to, with doctors being forbidden to prescribe maintenance doses for patients who either could not or would not remain drug free.[3] In Britain, on the other hand, the Rolleston Committee of 1926 established the right of medical practitioners to prescribe on a maintenance basis, where detoxification had not led to a continuing drug-

free life and where maintenance prescribing offered the prospect of social stability and a generally normal lifestyle.

In the period following the Second World War, American social scientists became interested in comparing their own drug policy with what they referred to as the 'British system' and invariably they concluded that British policy and practice was more humane and pragmatic than its American counterpart.[4] However gratifying approbation of this kind may have been to the British authorities, they became unconvinced of the wisdom of continuing indefinitely along the lines laid down by Rolleston and, following the Second Brain Report 1965 (so named after the committee's chairman, Sir Russell Brain), the management of addicts within the National Health Service became a good deal more restrictive than it had been for the previous forty years. In particular, the prescribing of heroin was severely curtailed and largely replaced by oral methadone; specialist addiction treatment centres, which came to be popularly known as 'clinics', were set up; and a notification system or register of addicts was established, making the medical management of addicts analogous to the management of infectious diseases.[5]

Most British commentators have become convinced in retrospect that American enthusiasm for the 'British system' was misguided and that it primarily reflected the internal tensions of the American policy scene rather than any objective evidence of the efficacy of the Rolleston approach. Stimson and Lart (1994), for example, argue that the Rolleston recommendations proved satisfactory from the 1920s to the 1960s simply because there were so few addicts in Britain during this period, and because such addicts as did exist tended to be culturally conventional and socially stable people - such as healthcare professionals who became addicted

because of their ready access to drugs, or 'therapeutic' addicts who developed an addiction as a result of over-prescribing by their doctors. From the mid 1950s, however, the emergence of a drug scene involving the hedonistic use of drugs by socially disorganised and predominantly young people – fed to some extent by doctors who were seen to be abusing their their prescribing rights - revealed the deficiencies in the so-called British system, leading to its revision following the Second Brain Report.[6]

The British experience during the 1960s was that a policy of medicalising addiction and leaving its management solely to the discretion of individual doctors was too simplistic, while the American experience at this time was that its policy of giving total 'ownership' of drug problems to the criminal justice sector was also unsatisfactory. As discussed above, the American approach to addiction up to the 1960s had been to criminalise it and virtually exclude the medical profession from any involvement with it. During the 1960s, largely through the collaborative work of Vincent Dole, a metabolic disease specialist, and Marie Nyswander, a psychiatrist, at the Rockefeller Institute in New York, American policy and practice changed, albeit partially and grudgingly, to allow for the creation of maintenance programmes for opiate addicts. This American maintenance system, which is now practised more or less universally, involves the use of methadone, a synthetic opiate, rather than heroin; methadone is a long-acting drug which provides its users with relief from withdrawal symptoms through a single daily dose and, if prescribed at a sufficiently high dosage, may reduce the incentive for simultaneous use of street heroin by virtue of its so-called 'blockade' effect. The difficulty which Dole and Nyswander had in having their methadone maintenance programmes accepted, despite impressive research evidence as to their efficacy, stemmed from the underlying moral rejection of drug use within the American policy system. Those opposed to

methadone maintenance took the view that drug use, outside of a straightforward therapeutic context, was morally unacceptable, and that methadone prescribing was simply licensed drug dealing rather than legitimate medical practice. Dole and Nyswander, on the other hand, argued that opiate addiction was a metabolic disorder and that long-term methadone treatment was comparable to the prescription of insulin for diabetes.[7]

Both of these arguments appear somewhat simplistic when viewed from a social policy perspective, as though both sets of protagonists – those who argue that drug dependency is an illness and those who view it simply as criminal behaviour - are trying to close down the debate and score an easy victory, while ignoring the complexity of the issues and the inherent dilemmas and contradictions. Those who simply see drugs as morally evil tend to ignore the use which society routinely makes of a drug such as alcohol, while simultaneously ignoring the fact that there is no universal consensus against psychoactive drug use; large groups of people, particularly young people, do not accept that drug use is either morally unacceptable or so risky as to be not worthwhile.[8] Equally, there is no easy way, or certainly no scientific way, to determine what is legitimate medical practice, and this question inevitably involves value conflicts as well as financial and status issues.[9] It would seem, in any event, that societal management of problem drug use always involves negotiation between a number of governmental sectors, particularly the healthcare and criminal justice sectors, and that successful collaboration between sectors is complicated by one sector's claim to absolute moral or scientific supremacy.

By the time, therefore, that Irish policy makers came to address drug issues in the mid 1960s it was already clear from the international experience that the provision of treatment services within the overall framework of drug prohibition was a complex and contentious matter. The primary aim of eliminating the supply of drugs, even when supported by tough criminal justice sanctions, had not been achieved and, arguably, was never going to be achieved; there was, it appeared, a demand for mind-altering drugs which was resistant to both supply reduction and demand reduction strategies. Equally importantly perhaps, there was no medical technology which could effectively stop people using drugs if that was their choice, and treatment policy was caught between insisting that detoxification and rehabilitation - aimed at achieving a drug-free status - should be the sole activity of the health care system or accepting that some form of harm minimisation or harm reduction interventions – such as methadone maintenance for opiate dependence – was also a legitimate option.

The Working Party on Drug Abuse 1968-1971

In studying Irish policy on illicit drugs from the 1960s onwards, it is convenient to start by considering the *Working Party on Drug Abuse,* which was the first official committee to examine drug problems in Ireland and to make recommendations as to future policy.[10] The background to the establishment of this Working Party will be discussed in detail later in this section, but for the moment it is sufficient to note that it was set up by the Minister for Health, Seán Flanagan, in December 1968 with the following terms of reference:

> To examine the extent of drug abuse in Ireland at present; to advise the Minister on the steps which might be taken to deal with the problem, including measures to discourage young persons from starting the use of drugs (e.g. publicity, education, example, etc.); to advise on the action to be taken to assist in the rehabilitation of persons who have acquired the drug habit.[11]

While these terms of reference suggest a rational-comprehensive approach to policy making, with the Minister for Health calling together a group of experts to look at all aspects of drug problems in Ireland and to plan a concerted public policy response, a study of the background to the establishment of the Working Party suggests that the organisational networks model of policy making may well be a more valid framework within which to study the background to these events.

The *Report of the Commission of Inquiry on Mental Illness* 1966 had touched briefly on the subject of drug use and addiction, concluding that while there was no evidence of a drug scene in Ireland at this time: 'The Commission considers that drug addiction could reach serious proportions in this country unless a constant effort is maintained to prevent the abuse of habit-forming drugs'.[12] The Department of Health did not begin any formal monitoring of illicit drug use or related problems in the wake of this recommendation, nor did it initiate any other policy development in this area; but, as will now be discussed, it set up the Working Party on Drug Abuse some two years later - somewhat reluctantly it would appear- as a result of ongoing lobbying and media coverage of the drugs issue.

The organisational networks model of policy coordination was described in Chapter One as falling somewhere between the rational comprehensive, or corporate, model and the partisan mutual adjustment model. Essentially, the organisational networks model sees policy development as arising from the relatively informal, but systematic, communication which takes place between individuals representing large organisations or interest groups; this negotiation of a common policy interest does not necessarily involve top-level personnel within large corporate bodies, but is more likely to involve peripheral or specialist sub-units. In explaining the events leading up to the

establishment of the Working Party on Drug Abuse by the Minister for Health, the role played by the Garda Síochána and, in particular, the networking skills of Sergeant Denis Mullins of the Garda Drug Squad cannot be over-emphasised.[13]

The 'Special Branch' was the name popularly given in the 1960s to that section of the Garda Síochána which had responsibility for political and paramilitary crime and which also liaised with international policing organisations. Denis Mullins, who was a detective sergeant in the Special Branch, had become convinced from the mid 1960s that drug problems in the Dublin area were serious and growing, although at this time there was no official acceptance of this point of view. While some drugs were being imported from abroad either by users themselves or by small-time drug dealers, it appeared to Mullins that the main source of supply for the emerging drug scene in Dublin came from robberies of chemist shops and Dublin Health Authority dispensaries. His first successful venture into drug policy was to persuade his own authorities, in 1967, to set up a small specialist unit within the Garda Síochána, and he himself headed up this 'Drug Squad' despite his relatively low rank. Belying all stereotypes of police officers as cautious, conservative and incapable of communication except through their own internal hierarchy, Denis Mullins made contacts across a range of interested individuals and groups who could help him in lobbying for policy development in the drugs field. These contacts were with a variety of people - psychiatrists, pharmacists, social workers, teachers, priests and journalists - and he managed to create a reputation for being caring and compassionate towards drug users, rather than being solely committed to law enforcement and to securing convictions. Dr Noel Browne, for instance, who was part of the Denis Mullins network, commented in Dáil Eireann at the committee stage of the Health Bill 1969

that the Garda Síochána were 'wonderfully understanding in their approach to and handling of this problem'.[14]

It is interesting to compare the work of Denis Mullins on this issue with that of Mr Christy O'Connor of the College of Pharmacy, who also became a lobbyist for drug policy development. Christy O'Connor was drawn into the Mullins network initially to do laboratory analysis of seized drugs and to provide expert testimony in court, but he went on to develop a much wider interest in drug policy as a whole.[15] Recalling the efforts which he made to have drug problems recognised by the authorities, he told a journalist subsequently:

> They kept dismissing the reports that drug abuse was a growing problem. They always referred to it as being a small problem in comparison to the enormous alcohol problem. They seemed to want to damp down anxiety about it. But not only were the government and courts lacking in knowledge about the problems of drug abuse but doctors and pharmacists were also oblivious to the problems.
>
> I found in my work on drug abuse that two significant factors in the spread of drug abuse was *[sic]* the overprescribing of dangerous drugs by doctors and the almost non-existent supervision of drug supplies kept in chemist shops and dispensaries. I could see quite clearly in my work in court that they knew virtually nothing about drug abuse and cared less; that the authorities hoped that by ignoring the urgency of the problem it would go away.[16]

Although he was influential, particularly in relation to the introduction of new regulations governing amphetamines and barbiturates and the holding of drugs in chemist shops and dispensaries, Christy O'Connor did not appear to have the same communications skills as Denis Mullins, who seemed to be uniquely capable of saying difficult and challenging things without creating antagonism. Towards the end of 1968, when a critical mass of popular opinion for the review of drug policy had been achieved through lobbying and the use of the media, the Minister for Health conceded and set up the Working Party. Denis Mullins was appointed to this committee and, perhaps because the Garda Síochána were somewhat

puzzled that such a junior officer would be appointed to an intersectoral governmental committee, so too was an Inspector from the Special Branch. Christy O'Connor of the College of Pharmacy was not, however, appointed to the committee.[17]

The Working Party was based within and serviced from the Department of Health, and it is worth noting that within the Department of Health responsibility for drug issues was allocated to the Food and Drugs Section (subsequently renamed the Public Health Division) rather than to the Mental Health Section. The relevance of this allocation is that it signified that drug control systems were being seen as more important than treatment systems.[18] Nonetheless, in his address to the first meeting of the Working Party, the Minister for Health pointed out that while the Government was considering legislative action to strengthen its drug control systems, it did not see criminal justice sanctions as the primary or most useful way to tackle drug problems. In addition to emphasising the importance of educating young people about the risks involved in drug use, the Minister suggested that those who developed a dependency on drugs were 'more to be pitied than punished, and should be regarded as sick people in need of medical care to be treated with sympathy and understanding and to be helped in every way possible to overcome their dependency on drugs'.[19] In short, the Ministerial view as the Working Party began its work was that Irish drug policy should combine treatment and rehabilitation activities with control measures.

Before discussing the conclusions and recommendations of the Working Party, it is important to comment briefly on what it did *not* do. The committee accepted, seemingly without question, the assumptions implicit in the phrase 'drug abuse' and in the terms of reference given to it, and did

not indulge itself in any philosophical or sociological debate as to the scientific status of this category or the apparent inevitability of prohibitionist policies.[20] It is understandable that the Working Party should have opted to ignore fundamental debate of this kind, since to do otherwise would have made it virtually impossible to accomplish the common-sense, administrative tasks expected of it. The Working Party was aware of and referred to the 'Wooton' Report 1968, a British report on cannabis which had been chaired by the social scientist, Baroness Barbara Wooton.[21] It is reasonable to assume that the Working Party was also aware of the opprobrium heaped upon Wooton because of her relatively moderate proposals to reduce the penalties for cannabis convictions; these intemperate and misinformed attacks on Wooton were not just a feature of the tabloid and more conservative broadsheet newspapers in Britain, but also involved the Home Secretary of the day, James Callaghan. The Irish policy climate at this time would have probably been equally, if not more, hostile to even mildly liberal proposals on drug use, and the terms of reference of the Working Party clearly pointed it in the rather conventional direction which the Minister for Health and his department wished it to go. There were, however, areas of discussion - such as the question of drug education, which will be considered later in this chapter - where critical debate could not be avoided. Finally, it is worth noting that members of the Working Party were not lacking a sense of either humour or irony; three different members of the committee told this writer that, as a team-building exercise, they had enjoyed a memorable drinks party during the early period of their deliberations, and also that the meal to mark the completion and signing of the final report became rather bibulous - with the conviction that drug abuse in Ireland had been dealt a serious blow strengthening in direct relation to the amount of alcohol consumed!

The Working Party held its first meeting in January 1969, submitted an interim report in September of that year, and completed its final report in February 1971. Viewed from a health promotional perspective, the membership of the committee was impressive, with representation from various medical specialties, pharmacy, social services, education, the criminal justice system and student involvement. The choice of Dr Karl Mullen, a well-known obstetrician and gynaecologist, as chairman of the committee was unusual, given that he had no experience of drug problems and their treatment, and it might have been expected that a psychiatrist would take on this role because of the tradition of treating addictions within the mental health system. Dr Mullen himself suggested that he had been selected for this task because of his association with sport - he had played on the Irish rugby team for a number of years and had won two Triple Crowns - which might have been seen as making him an appropriate role model for young people.[22] A number of members of the committee have suggested, rather more cynically, that the choice of chairman was influenced by those civil servants who were unconvinced of the necessity of the Working Party in the first instance and who were anxious to avoid having a psychiatrist - who might use the high-profile nature of the exercise to build a personal career or empire in drugs - in this position.

The recommendations of the Working Party were largely predictable given its terms of reference; but they were, even from the perspective of almost thirty years later, well argued and clearly presented. The recommendations were balanced evenly between treatment and prevention.[23] The whole question of treatment and rehabilitation will be dealt with in more detail later in this chapter, but it should be pointed out here that the Department of Health had to some extent pre-empted the Working Party by setting up treatment services in the Dublin area during the period of the Working

Party's deliberations. Recommendations for prevention included both proposals for new legislative control measures, to be backed up by tough penalties, and proposals for education and publicity aimed primarily at young people with a view to dissuading them from using drugs. The recommendations for new statutory controls were moderate and carefully considered. It was specifically argued that increased police powers should lead to 'no undue interference with the freedom of the individual';[24]; that a distinction should be made between 'simple' possession and possession for the purpose of sale or supply to others; that penalties should be scaled on the basis of the kind of drug involved, and that cannabis offences should be treated in a somewhat more lenient manner. The report of the Working Party also contained the first published statistics on the prevalence of drug abuse in Dublin at this time, drawing its data mainly from Garda sources since healthcare and other data were not routinely available at this time. At the time of the Interim Report, in September 1969, there were approximately 350 persons known to the Gardaí as drug abusers in Dublin; by December 1970 this figure had grown to 940, and it was believed that this was a real increase rather than merely a reflection of increased Garda activity. The most commonly abused drugs at this time were cannabis and LSD; neither heroin nor any of the synthetic opiates were in common use and there was no evidence of large-scale commercial drug dealing.[25]

It should be pointed out in concluding this account of the Working Party on Drug Abuse that the committee viewed its brief in terms which clearly and explicitly reflected what would later come to be known as an intersectoral health promotion perspective. This perspective is expressed most succinctly in Chapter X, a short chapter towards the end of the report in which the committee states:

> We were asked by the Minister for Health to examine the problem of drug abuse but it will be clear from the wide field

> covered by our recommendations that the problem is far more than a "health" matter. Thus responsibility for dealing with the problem and for implementing the various measures referred to in our report rests with a number of Government Departments, other public bodies and interested groups ... the Department of Health is essentially concerned with problems relating to treatment and epidemiological aspects of drug abuse as well as with certain aspects of the statutory controls over the availability and distribution of drugs, the Department of Justice has direct responsibility for the enforcement of these controls and for the criminal law. ... The Department of Education is vitally concerned in the matters contained in our Chapter on Education and Publicity ... The Revenue Commissioners and the Department of Posts and Telegraphs have responsibilities in relation to the smuggling of drugs ...[26]

The Working Party went on, therefore to recommend that there should be close and continuing liaison on drug issues between all Government departments, and also that a permanent advisory body on drugs, with a membership broadly similar to that of the Working Party, should be established to monitor what promised to be a changing drug scene.[27]

What was intended to be a permanent advisory body, described as the Inter-Departmental Committee on Drug Abuse, was in fact established in 1972 in line with this latter recommendation; it was, however, a relatively informal body, serviced by the Department of Health but with no statutory basis.[28] From a health promotion perspective, the key question to ask about this committee concerns the enthusiasm and energy which the Department of Health might display in coordinating this drugs network. The Working Party had been set up by ministerial decree, following the publicity which had been largely the product of the Denis Mullins network; the Department of Health had shown no evidence of urgency or conviction concerning the need for policy development in the drugs field and - as was shown in the earlier chapters of this thesis on the topic of alcohol-related problems - neither did it find the networking role comfortable or congruent with its own internal organisational culture. On the whole, the answer to this key

question is that the Department of Health demonstrated little commitment to managing the network of individuals and institutions represented on the Inter-Departmental Committee on Drug Abuse; however, since this was only to become evident in the early 1980s its discussion and consideration will be kept for Chapter Seven.

Education and Prevention

The idea of using education about drugs as a means of problem prevention was, as described above, amongst the topics included in the terms of reference of the Working Party on Drug Abuse. Attitudes towards drug education were at this time simplistic in the extreme, as exemplified in the comments of the Minister for Health during his opening address to the Working Party, when he suggested that:

> [M]any of the people taking drugs are young persons with no evil intent, taking them occasionally "for kicks" or to be "with it" who would, I should think, have nothing to do with drugs if they were properly advised and informed of the harmful consequences of continuing to take them.[29]

However, once it began its study of preventive drug education the Working Party began to discover how complex and potentially contentious this subject was.[30] Initially, the assumption was that factual drug education could function as a form of cognitive immunisation more or less as the Minister had suggested. It was envisaged that outside experts would address captive audiences of young people, most commonly in schools, to explain the risks inherent in drug use and to advise them to reject illicit drugs should they be offered them; it was presumed that information and admonition of this kind would be sufficient to deter most young people from experimenting with drugs. Educational tactics of this kind would, of course, be somewhat similar to what the Irish National Council on Alcoholism had been doing since its inception in 1966 – in the case of alcoholism education the outside experts tended to be either treatment

specialists or recovering alcoholics. The Working Party also contemplated using a broadly similar philosophy for the proposed publicity campaign aimed at the general public, where it was intended to use the mass media for communicating an anti-drugs message.

Underlying these proposals was an implicit belief that drug abuse was a self-evident, discrete pathological entity which could be defined in objective scientific terms. Accordingly, it was assumed that scientists could provide an authoritative, value-free legitimation of drug control systems, and that this legitimation could then be used to underpin all drug education programmes. Beliefs of this kind did not survive for long, however, once the Working Party immersed itself in the details of drug education. It became apparent that there was no scientific consensus on either what constituted 'drug abuse' or on the effectiveness of the simple information-giving approach to drug education originally envisaged. A study by a British psychologist (Wiener, 1970) which was consulted by the Working Party and cited in its final report, raised a number of these difficulties; one concerned cannabis specifically and suggested that giving honest information to school-children about this drug was likely to have the opposite effect to that desired, while another was that a universalist implementation of drug education programmes was likely to arouse interest in large numbers of children who had previously not considered using drugs.[31]

Draft proposals on drug education, based on simple information-giving, were circulated by the Working Party to a number of psychologists and youth workers, but generally the response from these parties was critical. For example, E. F. O'Doherty, who was Professor of Psychology at University College Dublin, while aware that he was 'being negative, but I

hope not unhelpful', made a number of fundamental criticisms of the draft document on drug education which he had been sent. He argued that:

' "Straightforward information-giving" is likely to arouse experimental approach in the young rather than deter. There is considerable evidence that this is so'.[32] On the question of mass media campaigns, he was equally critical of what was proposed:

> With regard to the content of page 4: "Publicity and adult education", it seems to me that instead of such massive use of communications media, public agencies etc., I would strongly suggest a cool playing down of the problem. I strongly believe, and I think it could be shown that the very devices suggested on this page are calculated to create problems rather than solve them.[33]

Another critical response came from the Rev. Patrick McDermott, who was Secretary of the Youth Welfare Section of the Catholic Social Welfare Bureau; he questioned the logical consistency of trying to persuade young people on moral and health grounds not to use drugs when the use of alcohol and nicotine did not seem so radically different. 'Why is alcohol in moderation socially acceptable but marjuana *[sic]* in moderation not?'[34]

What was by far the most radical critique of the draft proposals on education came, however, from two clinical psychologists in the Dublin Health Authority, Ingo Fischer and Brian Glanville. They wrote a lengthy and thoughtful response to the document they had been sent, in which they rejected the validity of the individualism which was implicit in all of the Working Party's proposals for preventive drug education.[35] The concept of individualism in this context refers to the ideological presumption, which was common to much of health education and still has its adherents, that the health status of an individual can be viewed solely as the product of that individual's behavioural choices or lifestyle, with little or no significance being attached to social circumstances or environmental factors. Naidoo (1986), in a later theoretical critique of individualism in health education,

argued succinctly that 'Three major criticisms can be leveled against individualistic health education: first, it denies that health is a social product; second, it assumes free choice exists; third; it is not effective within its own terms of reference'.[36] Fischer and Glanville argued along similar lines in 1970, when they suggested that the focus on individual decision-making being recommended by the Working Party was seriously flawed since it ignored the social circumstances which they predicted would constitute 'the major growth area for drug addicts'.[37] If the individualistic approach to drug education is, broadly speaking, what the Ottawa Charter refers to as the task of *Developing Personal Skills,* then the recommendations of Fisher and Glanville were broader and more politically radical and would, in terms of the Ottawa Charter, be categorised as *Creating Supportive Environments* and/or *Strengthening Community Action.*[38]

In brief, Fischer and Glanville predicted that the growth of serious drug problems in Dublin would be a feature of deprived neighbourhoods and would correlate with delinquency and a host of other social problems, rather than being primarily a phenomenon which would be randomly spread and largely explicable in terms of individual psychopathology. Their prediction concerning this new group of problem drug users in Dublin read, in part, as follows:

> Typically, a member of this group is likely to come for *[sic]* a Corporation Housing Estate and to have little parental control and harmony in his home, to be part of a school system which is inadequate in many respects ... the area is likely to have poor recreational facilities and the child is likely to suffer from overcrowding in his environment ...[39]

This prediction, as will be seen in Chapter Seven, was to prove remarkably accurate, but the Working Party balked at endorsing (or even discussing) the preventive measures suggested by Fisher and Glanville, presumably because they involved such radical structural changes as 'a fairly drastic re-

organization of the social structure of the municipal housing estates' and 'a redesign of both the physical and psychological environment.' [40]

The Working Party was obviously thrown by the unexpected complexity of the drug prevention debate, and appears to have vacillated between recommending that Ireland should have no drug education programmes at all and recommending forms of drug education which at least seemed to do no harm. This ambivalence is nicely illustrated in the minutes of the committee for June 23, 1970:

> Copies of the draft report prepared by the sub-committee [Education and Publicity] had been circulated. The report in general was agreed to but it was felt that the first section of the report should be re-drafted so as to avoid the impression of an apparent contradiction as between the introductory portion which stressed that there should be no educational programme and the later section which recommended the kind of programme which should be implemented. It was felt that the introduction should omit the references to opposing view points.[41]

Ultimately, the brief chapter on drug education (Chapter VII) which appeared in the Committee's final report was a compromise. It pointed out the complexities and what appeared, at least on occasion, to be the counterproductive aspects of drug education; but it also recommended drug education for those already known to be abusing drugs or deemed to be particularly at risk. The committee's unease with this aspect of its brief is reflected explicitly in its recommendation that another committee should be established:

> A group representing the Departments of Health and Education, the schools, the university departments, and professional bodies concerned should investigate the general question of communicating information on drugs to young persons, should provide guidance for school authorities and indicate areas where research is needed. This group should include specialists who advise on medical, psychological and social aspects.[42]

The result of this recommendation was the appointment of the *Committee on Drug Education* by Erskine Childers, Minister for Health, in October 1972

under the chairmanship of Bunny Carr, a broadcaster and communications consultant. The terms of reference of this new committee were precisely those contained in the above recommendation of the Working Party, and its membership consisted of fourteen people from varied backgrounds.[43]

The Committee on Drug Education submitted a brief interim report to the Minister for Health in February 1973, the most notable aspect of which was the suggestion that there should be a moratorium 'on all lectures and film shows on drug abuse in schools until such time as the Committee is in a position to give guidelines in the matter to school authorities.' [44] The reason for this suggested moratorium was the evidence available to the committee that drug education was becoming increasingly popular, particularly in secondary schools, but that much of this education was of a type which was likely to do no good - it tended to consist of one-off teaching sessions, usually delivered by outside speakers, and its content was sensational and exaggerated. In 1972, yet another committee - this one appointed by the Irish Council of Churches / Roman Catholic Joint Group on the Role of the Churches in Irish Society - had looked at drug issues in Ireland and, on the subject of education, had reached similar conclusions, referring not merely to exaggerated denunciations of drugs and drug use but also to: 'another hazard [which] comes from elevating drugs to a position of supreme importance by arranging talks from 'star turns', particularly ex-addicts'.[45]

This latter opinion of the inter-churches group, particularly in conjunction with the proposed moratorium on schools talks, highlights the conflict between attempts to conduct rational - or what would latterly be called 'evidence-based' - drug education programmes in schools and the more popular approach to such activity. Research evidence, by and large, suggested that drug education should be low-key, conducted by teachers

and aimed at developing life-skills if it were to have a positive outcome, or at least if it were to avoid being counter-productive. On the other hand, the prohibitionist nature of public policy on drugs, the harshness of the criminal justice sanctions involved and the sensationalist style of popular cultural representations of drugs all conspired to create and sustain the image of illicit drugs as being unspeakably evil. It was understandable, therefore, that school children, their parents, school management committees and perhaps the public generally should expect drug education to reflect this unambiguous and exciting truth. Teachers whose competence to teach academic subjects was unquestioned seemed to lack the credibility and verve expected of drug educators, and there was considerable demand for outside 'experts' to come into schools and tell it like it really was. This was not just an Irish phenomenon, as will be clear from the following remarks of Halleck (1970), one of the early American critics of drug education:

> Too often the program consists of one or more meetings at which a local physician, a law enforcement officer and perhaps a former addict will endlessly catalogue the horrible outcome of drug usage. The physician will exaggerate the degree to which drugs can produce bodily damage. The law enforcement officer will gravely talk about the increasing flow of drugs into the community and will throw in a few anecdotes about young people he has seen ruined by drugs. Sometimes he will even bring in displays of confiscated drugs to show his presumably horrified audience. The former addict, who is usually the star performer, will recount his sordid experiences as a drug user and will glowingly report the salutary effects of his reformation. It is an interesting show which has much of the glamour of an old-fashioned revival meeting.[46]

In its final report, which was presented to the Minister for Health in April 1974, the Committee on Drug Education recommended that school children *should* be given education on drug use and drug problems. The committee, like the Working Party which had preceded it, favoured an individualistic model and made no reference to structural factors which might predispose some young people to having far more negative drug experiences than others. Within the confines of this individualistic approach, however, the

committee resisted the pressure to succumb to the populist and propagandistic style of drug education discussed above; it recommended that drug education should not be delivered in isolation but as part of a broader health education curriculum and also that it should, as a rule, be carried out by ordinary teachers rather than outside experts. The style and content of school drug programmes favoured by the committee was also radically different from what was popularly expected; it was recommended of school programmes that:

> They should avoid becoming a mere set of rules and, more especially, a set of prohibitions. Obviously such programmes would include inter-personal relationships, personal responsibility, dignity of the individual and maturity. Within this broad context, it is felt that direct drug education could be usefully given.[47]

This style of non-directive education, more akin to counselling than to traditional didactic practice, was a far cry from the 'old-fashioned revival meetings' referred to by Halleck, but it remained to be seen whether it would be implemented or what the ramifications of this broad approach to drug education might be in Ireland. The committee noted that statutory responsibility for health education lay with the health boards under Section 71 of the Health Act 1970, but that there was little evidence of such education being carried out in Irish schools.[48] To encourage and support the development of health education generally, the committee recommended that a national health education authority should be set up under the Health (Corporate Bodies) Act 1961. The Minister for Health, Brendan Corish, (by this time Fianna Fáil had been replaced by a Coalition Government of Fine Gael and Labour) accepted this recommendation immediately and in October 1974 announced the establishment of a *Health Education Bureau* (HEB) The work of the HEB and the political complexities of conducting drug education will feature in Chapter Seven and will constitute the sole subject of Chapter Eight.

Treatment and Rehabilitation

It will be recalled from the earlier chapters of this thesis that, in health promotional terms, the health service response to alcohol problems in Ireland during the post-war period had been excessively tilted in favour of treatment, to the detriment of preventive activities. The popularity of treatment services was explained primarily by reference to the general cultural acceptance of alcohol as a normal commodity and the skillful lobbying of groups, such as Alcoholics Anonymous and the Irish National Council on Alcoholism, rather than as a simple reflection of the scientific validity of the disease concept or the demonstrated efficacy of conventional alcoholism treatment. The aim of this section is to review the manner in which the statutory health services and the voluntary sector approached the question of setting up treatment and rehabilitation services for those dependent upon or having other difficulties with illicit drugs, during this early phase of the Irish drug experience. The data presented so far in this chapter suggest that from a health promotional perspective the early response had been quite impressive, with intersectoral cooperation being established early on as the norm for a coordinated policy response, and the promise of comprehensive new legislation in which the health interest would be supported by criminal justice measures. The question from a treatment perspective is whether any lobby group would emerge to champion the cause of treatment and rehabilitation for drug addicts as effectively as in the case of alcohol services.

It is clear from a study of this early period of Irish drug policy development that, rhetorically at least, nobody disputed the value or desirability of setting up treatment and rehabilitation services for dependent or other problem drug users. The comments of the Minister for Health to the Working Party on Drug Abuse, to the effect that people who were dependent on drugs were

deserving of medical care, have already been cited, and indeed the Working Party devoted two chapters of its final report to this topic. These two chapters cannot be considered as being of any real policy importance, however, because in 1969 - two years before the Working Party reported - the Department of Health had itself taken steps to set up a drug treatment system which was to remain in place, virtually unchanged, for the next twenty years. The motivation behind this pre-empting of the Working Party may well have been that the Department of Health was convinced of the necessity to take a speedy initiative on this issue, rather than await the recommendations of a committee which was moving at the customary pace of official committees. Equally, of course, it may have been that the Department of Health felt that it had been wrong-footed by the effective lobbying of Denis Mullins and his associates and took this opportunity to set up services as *it* saw fit, rather than leave this matter to the Working Party.

In any event, the Working Party was presented with a *fait accompli* in the matter of treatment services, and had little option but to endorse this departmental initiative, which it did in its interim report[49] of November 1969 as well as in its final report. It is important, therefore, to examine in detail this creation of the Jervis Street Hospital drug treatment service, which was carried out without public debate or scrutiny but which was to have such lasting effects.[50]

On May 2, 1969, a meeting took place between representatives of the Department of Health, the Dublin Health Authority and Jervis Street Hospital (a voluntary, city-centre hospital which closed in the mid 1980s). Subsequent to this meeting, Dr Joseph Woodcock, Honorary Secretary of Jervis Street Hospital Medical Board, Dr John Ryan, Consultant

Psychiatrist at Jervis Street, and Dr. R.D.Stevenson, Consultant Psychiatrist at St Brendan's Hospital - a Dublin Health Authority psychiatric hospital - visited a number of British drug dependency units and drew up a plan for the creation of treatment services for drug users in Dublin. Essentially, it was decided to set up an outpatient clinic for drug addicts at Jervis Street Hospital while simultaneously creating an inpatient unit for treatment and rehabilitation at St Brendan's Hospital. The thinking of these three doctors on this topic may be readily explained in the context of the new 'clinic' system which was now being established in Britain as a result of the Second Brain Committee, which was discussed earlier in this chapter. British drug policy at this time was changing from the liberal Rolleston system to the more controlling style of the Second Brain Committee, and it was this less liberal set of ideas and institutions which now recommended itself to the visiting Dublin doctors. Stated briefly and explicitly, the model of drug treatment and rehabilitation which was now favoured in Britain and which was being imported into Ireland was one which emphasised the value of centralised and specialist services, with practically no role for primary health care or localised service provision. It is probably as important to consider the policy process which led to the creation of the Dublin drug treatment system as it is to examine its content. The British had just changed from a policy which had been in place for forty years, following a study of the old system and a review of possible alternatives by a public committee. The Department of Health in Ireland, on the other hand, with no history of drug treatment provision prior to this, had accepted this recent revision of British policy more or less axiomatically, and had set up services along these lines without any public discussion or critical debate on this subject; in doing so it had pre-empted any views which the Working Party on Drug Abuse –its own expert group - might have had on this important topic.

The selection of Jervis Street Hospital as the site for the outpatient drug treatment centre was explained in the unpublished planning document in terms of the experience of the London clinics which the three Dublin doctors had visited. It was suggested that general hospitals were more acceptable for the provision of outpatient services to addicts and their families than psychiatric hospitals, and it was also seen as helpful that they offered emergency medical care and laboratory facilities for screening blood and urine - facilities usually not available in psychiatric hospitals. Jervis Street Hospital was seen to satisfy all of these criteria, and it was also seen as advantageous that it had an existing Poisons Information Centre and a city-centre location.

The thinking behind the location of the inpatient treatment centre was briefly presented as follows:

> We feel that in-patient facilities are best suited in a psychiatric hospital where they will have available to them the background system and expertise of residential psychiatric nursing and other ancillary facilities. St Brendan's Hospital appears to be the most suitable hospital to provide the in-patient service.[51]

While there was again only the briefest of discussions of treatment policy - and no attempt at setting the recent British policy changes within the context of the previous regime - it was conceded that, for the small number of opiate dependent persons for whom it appeared necessary, methadone maintenance should be available in Jervis Street. Given the nature of Irish drug treatment services as they were to evolve after 1969, there was also the rather provocative and disingenuous recommendation that 'The policy of Treatment Centres in Ireland should create conditions here which are less attractive than those in Great Britain and thus inhibit any possibility of a migration towards this country'.[52]

This latter comment gives some indication of the negative view of drug addicts contained in this planning document, a view which contrasts sharply with the conventional wisdom on alcoholism and alcoholics described in earlier chapters. If alcoholics were seen as innocent victims of a baffling disease, if not indeed as rather more noble and more sensitive than those who appeared to be able to drink with impunity, attitudes towards those dependent on illicit drugs were much less benign. Implicit in this document was the notion that drug addicts were behaviourally difficult and devious patients who would have to be monitored closely and kept at some remove from generic services and facilities. While it was argued on page one of the document that Jervis Street Hospital, as a general hospital, would be attractive to addicts, page three contained the following statement:

> We think that such a Clinic situated at Jervis Street Hospital should be separated from the other out-patient facilities and that the individuals attending should be isolated from the general hospital. This will be necessary because of the tendency of addicts to seek drugs and to interfere with the management of ordinary patients.[53]

Later in the document, it was also suggested that 'The services of a porter would also be a necessity on account of the character of the patients attending'.[54] It did not say what precisely this character was, but the implication seemed stereotypically negative.

The importance of this planning process which took place outside the ambit of the Working Party on Drug Abuse - which had *inter alia* been formally charged with the task of planning rehabilitation services - became even greater in the light of the decision not to confine the functions of the Jervis Street Centre to clinical matters. It was recommended that it should 'also serve as an advisory centre for parents, individuals concerned with social problems associated with addiction, consultation with the legal authorities, advice to schools and [that] in general it should take a leading role in the organisation of a system of prevention of spread of addiction'.[55] This was

a very ambitious agenda for a small centre which was to be staffed quite modestly[56] and which was clearly going to be peripheral to the activities of Jervis Street Hospital as a whole. When the centre opened in late 1969 it was based in a caravan in the hospital courtyard, where it remained for more than a year before moving to a pre-fabricated building alongside the hospital's outpatient department. In 1971 a full-time medical director, Dr Michael Kelly (a consultant psychiatrist), was appointed and at about this time the Jervis Street Centre was designated the *National Drug Advisory and Treatment Centre.* The role of this unit in the period following 1979, when there was a major increase in heroin use in Dublin, will be explored further in the next chapter.

It is instructive, however, to consider the fate of the inpatient addiction unit at St Brendan's Hospital which was intended to complement the Jervis Street service. In December 1969, the Minister for Health, Erskine Childers, officially opened this unit which was known as St Dymphna's.[57] Although it had been specifically established as a treatment centre for drug-related problems, its medical director, Dr Stevenson, opted from the start to make its facilities available to both alcoholics and drug addicts. This was an unusual decision, since the psychiatric services generally at this time were dealing with increasing numbers of alcoholics while showing little or no interest in drug addiction. Within a year of its opening, however, the Eastern Health Board (as the Dublin Health Authority had now become) decided that St Dymphna's would only be used for the treatment of alcoholics, and its effective closure as a drug treatment centre left Jervis Street with a monopoly in this field. It is a measure of the blandness of the Working Party's coverage of treatment issues that it merely reported that: 'A special unit for the treatment of drug abusers and alcoholics was subsequently established at St Brendan's Hospital, Dublin, but this joint

arrangement did not prove successful and the operation was discontinued for drug cases.'[58]

It seems unusual that a new unit which had been resourced and opened specifically for the treatment of drug addicts should abandon its task in such a peremptory way, and it seems even more unusual that neither the Department of Health nor the Eastern Health Board thought it necessary to question why this happened. In fact, the decision to stop treating drug addicts in St Dymphna's was the result of the difficulties which its staff experienced in running the unit as a joint response to alcohol and drug problems. The drug addicts and alcoholics appeared to feel a great mutual antipathy towards one another and the resulting conflict militated against the creation of a therapeutic milieu. In these circumstances, it might reasonably be expected that the staff of the St Dymphna's and the administrators of the Eastern Health Board would opt to exclude the alcoholics and continue to offer a service to drug addicts; instead, because alcoholics were more numerous and because they were more easily managed and less challenging of the treatment system, the decision was that the service to drug addicts should be discontinued. At one level, this abandonment of the St Dymphna's service to drug addicts within a year of its establishment appears to be explicable in terms of poor planning and inadequate staff training - rather than being the inevitable result of natural incompatibilities between two groups of patients. Drug addicts were generally younger than alcoholics and much less prepared to defer to the authority of the psychiatric system, but the successful management of alcoholics and drug addicts within a single facility is, of course, possible once clear treatment philosophies and definite institutional structures are in place.[59] At a more fundamental level, however, the closure of St Dymphna's as a drug treatment facility signalled what was to become a more enduring feature of

the Irish health service response to addicts and problem drug users, namely the tendency of mainstream health service systems and professionals to distance themselves from illicit drug users, whatever the rhetoric about creating a caring approach.

Two further services for drug addicts were established within the Eastern Health Board's psychiatric system, one a small, closed residential unit at the Central Mental Hospital in Dundrum and the other a day centre at Usher's Island, but a review of their activities suggests the same difficulty and discomfort in adapting to the needs of this new client population as was apparent in the brief history of St Dymphna's. The unit at the Central Mental Hospital was administratively located within the forensic psychiatric system and offered a therapeutic programme, based on behaviourist 'token economy' principles, to small numbers of addicts transferred from Mountjoy Prison.[60] The unit was staffed by male psychiatric nurses from St Brendan's Hospital, who had not been given any special training and who appear to have held extremely moralistic attitudes towards their charges. The inmates reciprocated by smuggling in large amounts of drugs through their weekend visitors and by generally challenging the legitimacy of the therapeutic system. The unit's medical director was quoted in 1975 as saying:

> We find that most of our patients, once they leave Dundrum, immediately take up their activities of abusing drugs again. In fact it seems to us that drug abusers in Dublin use all the treatment facilities more to avoid going to jail for their offences, or else to get lighter sentences in court, if they say they are undergoing treatment in Jervis Street, Usher's Island or Dundrum.[61]

The Usher's Island unit was opened in 1972 as an outpatient facility for young addicts.[62] It was a well-staffed unit with a psychologist, a social worker and an occupational therapist as well as medical and nursing staff. As with the Dundrum unit, however, its staff appeared to become

pessimistic quickly about its value and efficacy, and its psychologist was quoted in 1975 as saying that professional services, delivered in clinical surroundings, were less likely to be acceptable to young users than voluntary services staffed by young workers.[63]

By 1977, the year in which new comprehensive drugs legislation was enacted, both the Dundrum and Usher's Island services had been closed by the Eastern Health Board, leaving the Jervis Street service in a virtual monopoly situation. This failure of the Eastern Health Board to create and sustain a therapeutic response to illicit drug use and addiction within its psychiatric system was, of course, in marked contrast to the growing enthusiasm for alcoholism treatment which was evident, not just in the Dublin area but throughout the country, at this time. The reasons why there should be such a disparity between the development of alcoholism services and drug addiction services are worth exploring again before ending this section on treatment services. A study of the social and psychological characteristics of treated drug addicts in Dublin,[64] which was published in 1971, confirmed the accuracy of Fischer and Glanville's prediction that drug addicts would predominantly come from deprived urban areas, where drug use was part of a wider package of psycho-social problems, rather than being distributed randomly across socio-economic and geographic boundaries. As a patient group they appeared to have little to recommend them to the psychiatric services: they were truculent, uncooperative, and openly sceptical of the fundamental tenets of the psychiatric model of treatment; and, because of their poverty, they lacked the purchasing power to generate private treatment developments. No psychiatrist emerged to champion the cause of drug addicts and no national organisation comparable to INCA was formed to lend respectability to their cause. Perhaps the clearest and most explicit statement of disavowal on the part of the medical

establishment was that contained in an editorial of the *Irish Medical Journal* in 1971, which said:

> The treatment of the established drug taker is extremely frustrating and therapeutically unrewarding. The task is usually given to our psychiatric colleagues. They can get patients successfully through the acute withdrawal phase which follows their admission to hospital and get them back to reasonable physical health. Subsequent management varies but psycho-therapy has not been demonstrably successful and psychiatrists are not willing to claim more than a very small percentage of cures ... One of the most heartening features of health care in Ireland over the last twenty years has been the great revival of voluntary effort in dealing with the handicapped members of society.[65]

The first, and for almost a decade the only, voluntary body concerned with the treatment of addicts in Dublin, was Coolemine Therapeutic Community which was set up in 1973.[66] The initiative for this development came from Lord Paddy Rossmore, an Anglo-Irish peer who apparently had become interested in drug problems as a result of seeing friends develop such problems; financial support for the establishment of the Coolemine residential facility came from the Eastern Health Board, from a range of other statutory sources and from voluntary fund-raising. The concept of a 'therapeutic community' essentially consisted of utilising the entire social milieu of residential facilities for the enhancement of the psychosocial functioning of residents, rather than relying on the brief interventions of psychiatrists or other professional therapists. The original therapeutic community concept was the inspiration of a British psychiatrist, Maxwell Jones, who experimented with this model of care for psychiatric patients, starting in the late 1940s.[67] The therapeutic community (commonly referred to in drug treatment circles as the TC) model as applied to addiction originated in the work of Charles Dederich, a recovering alcoholic who set up a self-help foundation known as *Synanon* in 1958 at Santa Monica, California.[68]

Unlike its British predecessor, the American TC for drug addicts was based on a rigid hierarchical structure, with inmates moving up and down the hierarchy as reward or punishment for their behaviour. The system as a whole was based on the belief that addicts were immature, and the treatment largely consisted of ritualised confrontation of this immaturity.[69] The Coolemine TC was introduced to Dublin through Phoenix House, London, which was itself a creature of Phoenix House, New York. Ideologically, the Coolemine programme was compatible with the general rhetoric of drug treatment in Dublin during this period; it was assumed that addicts had developed their drug habits because of individual personality defects or deficits, and no causal significance was attributed to social structural factors, such as unemployment, low income, poor housing or communal demoralisation. The Coolemine programme consisted largely of a self-help approach, and even its paid staff members tended to be recovering addicts; this undoubtedly contributed to the credibility and popularity of the service since - as in the case of Alcoholics Anonymous - it was popularly believed that such personal experience of a drug problem created a therapeutic advantage which professional training could not match. For the first seven years of its existence, the Coolemine service was very small, accommodating no more than nine clients in its residential centre, and it was not until the major growth in prevalence of heroin use in Dublin - from 1980 onwards - that it entered an expansionist phase.

In summary, it is clear that despite ministerial and other pronouncements as to the value and desirability of providing treatment and rehabilitation services for drug addicts, no service development comparable to that which had occurred in the alcoholism field took place during this early period of Irish drug policy. In the Dublin area, which is where drug problems appeared to be most prevalent, the public psychiatric services displayed no

interest in working with drug users and addicts, and instead one centralised service was developed at Jervis Street Hospital. The National Drug Advisory and Treatment Centre at Jervis Street received its funding directly from the Department of Health and, despite being based in Dublin and having a preponderance of Dublin patients, operated independently of the Eastern Health Board which was the statutory health authority for the Dublin area. Implicit in the overall pattern of treatment service development was the view that illicit drug users constituted a more deviant and behaviourally difficult client group than alcoholics; furthermore, it was assumed that the knowledge and skill base necessary for working therapeutically with these patients was highly specialised, so much so that it was pointless and possibly counterproductive to involve primary health care personnel in their treatment.

Misuse of Drugs Act 1977

The Misuse of Drugs Bill 1973 was published by the Minister for Health, Erskine Childers, in January 1973, only weeks before the Taoiseach, Jack Lynch, called a general election; Fianna Fáil, having been in government for the previous sixteen years, lost this election and were replaced by a coalition of Fine Gael and Labour. The change of government obviously complicated and delayed the debate on these legislative proposals, because it could not be presumed that the incoming Government would retain in its entirety the legislative proposals of its predecessor. However, some debate on the 1973 bill did take place; for instance , the Irish Association of Social Workers[70] pointed out that no provision had been made for the judiciary to commit convicted addicts to custodial treatment centres rather than conventional prisons, and it also offered criticism of the proposed Schedule or system for classifying drugs on the basis of their estimated harmfulness.[71]

It was not, however, until February 1975 that the new Minister for Health, Brendan Corish, leader of the Labour Party, took a somewhat amended version of the Misuse of Drugs Bill 1973 into Dáil Eireann for its second reading. In his detailed introduction of the bill the Minister made what were coming to be customary remarks on the necessity to balance tough control systems with caring and humane treatment services:

> This is a complex bill which attempts to deal in a balanced way with a very complex problem. A tough approach on the question of criminality and unethical behaviour has been adopted, while at the same time I have attempted to meet the treatment and rehabilitation needs of drug abusers in a humane and enlightened manner.[72]

It would be untrue to say that in the ensuing debate nobody commented on the failure to develop treatment services; Charles Haughey, the Fianna Fáil spokesperson on health, wondered what progress was being made in setting up a residential detoxification unit at Jervis Street,[73] and Dr Hugh Byrne of Fine Gael expressed reservations about the Dundrum and Usher's Island facilities, besides commenting generally that 'people in the psychiatric services do not always percolate towards a fringe ailment like this'.[74] However, it would be equally untrue to say that the issue of treatment and rehabilitation became contentious or high-profile in this debate, or at any subsequent time during the passage of the bill through the Oireachtas.

The major Corish amendment to the earlier bill was contained in a new Section 28, which obliged the courts to defer sentencing of persons convicted under the main sections of the bill until medical and social reports were completed, and which also permitted the courts to commit such persons to a designated custodial treatment centre. The effectiveness of this latter amendment would, of course, be contingent upon the creation of one or more such centres.

In general, however, the Misuse of Drugs Bill gave wide powers to the Garda Síochána to detain and search any person for whom there was 'reasonable cause' to suspect possession of the wide range of controlled drugs specified in the Schedule, and penalties for infringements of the bill - particularly for drug dealing - were tough The second stage debate was lively and well-informed. Mr Haughey argued for the necessity to distinguish between 'hard' and 'soft' drugs, worried that increased police powers might erode civil liberties and wondered about the credibility of anti-drug legislation in a society which was so tolerant of alcohol and tobacco. Dr John O'Connell, a Labour T.D. at this time, also spoke at length; he disagreed with the presumption that cannabis was a dangerous drug which should be criminalised as it was in this bill, arguing that it was 'no more dangerous than a glass of beer.[75] Significantly, most of the debate dwelt on the dangers which were assumed to be inherent in the drugs themselves and none of the speakers adverted to the causal link which might exist between socio-economic disadvantage and vulnerability to drug problems. There was, however, no evidence that the xenophobic view of Dr Hugh Byrne that all of Dublin's drug problems had their origins amongst foreign students at Trinity College Dublin was shared by other politicians.[76]

While the debate was lively, its tone was generally constructive and good-humoured, in sharp contrast with many parliamentary debates which are characterised by acrimony and political point-scoring. This is understandable because the topic was not one which readily lent itself to party political differences, and the bill being taken through the second stage by Mr Corish was essentially that which had been drafted by his Fianna Fáil predecessor. It was on this basis that the Minister for Health suggested that the third or committee stage of the Misuse of Drugs Bill 1973 might be handled by a *real* committee, not the whole Dáil acting in committee as was

the norm at this time.[77] Mr Corish had been at pains throughout to emphasise that he was open to all suggestions for improving the bill, and told the Dáil that he had 'asked Deputy Haughey if he would be agreeable to have it [the bill] sent to a special committee of the House where we could have a better discussion. There is no controversy about this Bill'.[78] Accordingly, a special committee consisting of fifteen Dáil deputies, and including three medical practitioners, was set up under the chairmanship of Barry Desmond of the Labour Party.

This committee met on fourteen occasions between October 1975 and June 1976 when it reported to Dáil Eireann on its proposals for amending the bill. The most significant change made by the committee was the abandonment of the Schedule system for categorising drugs, with cannabis being recognised uniquely as being less harmful by having lesser penalties attached for 'simple' possession. The debate at this committee in many ways reflected the earlier, second stage debate, with Dr Hugh Byrne protesting at what he saw as the folly of being soft on cannabis and Charles Haughey, in total disagreement, describing himself as 'reluctant to have any penalties for young people who fall into this particular social trap'.[79]

The report stage of the Misuse of Drugs Bill 1973 did not take place until March 1977 and the bill then went to the Seanad in early May of that year, eventually becoming the Misuse of Drugs Act 1977. It is tempting, in conclusion, to compare the exaggerated and rather stereotypical contributions of Dr Hugh Byrne with those of Oliver Flanagan - in relation to previously discussed alcohol licensing legislation - since each by virtue of their hard-line attitudes served to accentuate the 'balance' and 'moderation' of the majority view. The overall impression to be gained from reading the parliamentary debates on this piece of legislation is that the legislature was

convinced that it had handled this subject in a reasonable and efficient manner; Ireland could now ratify the Single Convention on Narcotic Drugs 1961 and the Convention on Psychotropic Substances 1971, two United Nations conventions, and yet the legislature had avoided the worst excesses of societal over-reaction to this new and controversial social problem. The self-congratulatory tone of the legislature is succinctly captured in the words of Michael D. Higgins, then a Labour senator, who commented that:

> The point that has struck me most forcibly listening to this debate has been the difference between the debate in the Dáil and Seanad and the usual debate which takes place among the public on the subject of drugs and drug abuse. The public discussion is often insensitive and crude in a number of important ways.[80]

Conclusion

Whether or not such satisfaction with the state of Irish drug policy, and particularly with this legislation, was justified will become clearer over the next three chapters. Having achieved an early victory, in terms of securing the establishment of the Working Party on Drug Abuse, the informal networking activities of those closest to drug problems had to some extent been routinised through their incorporation into formal official structures, and it remained to be seen how effective this network could now be. The Department of Health now occupied the key role as coordinator of Irish drug policy and, as convenor and facilitator of the Inter-Departmental Committee on Drug Abuse (which included voluntary, statutory and professional interest groups), was expected to monitor the changing drug scene and plan for appropriate policy responses. An important, if somewhat unclear, role in the coordination of treatment services and the formulation of policy was also expected of the national Drug Advisory and Treatment Centre at Jervis Street Hospital, but the burden of direct service

provision and the meagre resource allocation for this centre obviously raised questions as to the realism of these expectations.

By 1979, when the Misuse of Drugs Act 1977 was brought into operation, there were already grounds for believing that the much vaunted balance between treatment and control was illusory; treatment services had not been developed and sustained within the Eastern Health Board service structures, and the liberal promise of Section 28 of the Misuse of Drugs Act 1977 seemed doomed to failure because of the paucity of treatment and rehabilitation services. While it was asserted that drug issues represented the classic health promotional situation, where all sectors of government collaborated in a coordinated response, it also could be argued that the allocation of these issues to the Public Health Division of the Department of Health, rather than the Mental Health Division which ostensibly had responsibility for addiction treatment services, meant that even within the Department of Health there was no guarantee of balance or clear coordination on this subject.

Perhaps the most obvious and explicit policy complication which had arisen up to 1979 was that which concerned preventive drug education, yet it would have to be admitted that both the Working Party on Drug Abuse and the Committee on Drug Education handled the unexpected difficulties in this domain in a relatively sophisticated and efficient way. It was accepted that information giving or admonitions not to use drugs - because drug use did not conform to our collective value systems - were unhelpful, and lifeskills approaches to health education were approved of as being most likely to succeed. However, the establishment of the Health Education Bureau as the agency to promote such lifeskills approaches meant that the Department of Health was no longer directly involved in this activity. There were valid

reasons why the Department of Health, a policy-making body or *aireacht,* should not become directly involved in the implementation of drug education programmes, but equally there were risks involved in assigning this task to a new and inexperienced agency should this policy become contentious.

Finally, of course, no policy work was done on the possibility that the thesis put forward by Fischer and Glanville (in their response to the draft education proposals of the Working Party on Drug Abuse) was correct, and that the major predictive factors in the Dublin drug scene would be socio-economic factors. Irish drug policy, both in relation to drug education and treatment responses, remained resolutely individualistic, and the validity of this individualistic perspective was also to come under scrutiny in the period from 1980 onwards.

Chapter Six: Footnotes

[1] For a recent brief summary of these control systems and their evolution see: H. Ghodse, 'International Policies on Addiction: Strategy development and cooperation', *British Journal of Psychiatry* 166 (1995), pp 14-18. For a more critical analytical review of this topic see: K. Bruun, L. Pan and I. Rexed, *The Gentleman's Club: International Control of Drugs and Alcohol.* (University of Chicago Press, 1975) or E. Nadelmann, 'Global Prohibition Regimes: the evolution of norms in international society', *International Organization* 44 (1990), pp 479-526.

[2] Dáil Debates (Vol.50), Column 423.

[3] The distinction between *maintenance* and *detoxification* should be clarified here. Detoxification refers to the process whereby an individual who is physiologically dependent on a drug is gradually weaned off this drug through the prescribing of a reducing dosage of this drug or pharmacologically appropriate substitutes. Maintenance, on the other hand, refers to the indefinite prescribing of an addictive drug, where the prescriber is satisfied that the patient cannot or will not remain drug free; the advantage claimed for maintenance is, firstly, that it ensures that the patient is on a clean and standardised pharmaceutical product and, secondly, that it offers an opportunity for a more stable and crime-free life.

[4] For examples of American literature which more or less eulogises the British system see:
A. Lindesmith, *Opiate Addiction.* (Bloomington Indiana: Principia Press, 1947);
E. Schur, *Narcotic Addiction in Britain and America: the impact of public policy.* (London: Associated Book Publishers, 1966);
H.Judson, *Heroin Addiction in Britain: What Americans Can Learn from the English Experience.* (New York: Harcourt Brace Jovanovich, 1974);
A. Trebach, *The Heroin Solution.* (Yale University Press, 1982).

[5] These radical changes in British drug policy are described succinctly in: J. Strang, '"The British System": past, present and future', *International Review of Psychiatry,* 1 (1989), pp 109-120.

[6] G. Stimson and R. Lart, 'The relationship between the State and local practice in the development of national policy on drugs between 1920 and 1990', in J. Strang and M. Gossop (eds), *Heroin Addiction and Drug Policy: The British System.* (Oxford University Press, 1994), pp 331-341.

[7] For a summary of the work of Dole and Nyswander, complete with references to their 1960s research, see 'Conversation with Vincent Dole', *Addiction 89* (1994), pp 23-29.

For an interesting historical study of Marie Nyswander which describes her disenchantment with psychiatry and her 'conversion' to methadone see D. Courtwright, 'The prepared mind: Marie

Nyswander, methadone maintenance, and the metabolic theory of addiction', *Addiction 92* (1997), pp 257-265.

[8] The suggestion that there is an absolute consensus on societal values concerning the use of illicit psychoactive drugs has long been challenged by sociologists, particularly those who subscribe to new deviancy theory. A longitudinal study by Howard Parker and his colleagues in the North-West of England has concluded that drug use amongst young people in the 1990s is best regarded as normative within youth culture. H. Parker, J. Aldridge and F.Measham, *Illegal Leisure: The normalization of adolescent of recreational drug use.* (London: Routledge, 1998).

[9] Perhaps the most obvious example of disagreement as to what constitutes legitimate medical practice in an Irish social policy context involves contraception. To the majority of Irish family doctors the prescription of oral contraceptives to fertile young women is a routine professional activity, while to a minority it is morally reprehensible and a betrayal of the healing tradition.

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

[11] Ibid, p.9.

[12] *Report of the Commission of Inquiry on Mental Illness.* (Dublin: Stationery Office, 1966), p.84.

[13] The following account of the activities of Denis Mullins is based on a number of discussions with Denis Mullins himself (particularly one formal interview with him on September 6, 1997), as well as with several members of the Working Party (Noreen Kearney, R.D. Stevenson and Mary Whelan), and it also draws on journalistic sources, particularly: U. Macken, *Drug Abuse in Ireland* (Cork: Mercier Press, 1975) and S. Flynn and P. Yeates, *Smack: The Criminal Drugs Racket in Ireland.* (Dublin: Gill and Macmillan, 1985).

[14] *Dáil Debates* (Vol. 243), Column 326. Dr Browne was working as a Consultant Psychiatrist in St Brendan's Hospital, Dublin, at this time.

[15] Dr Des Corrigan of the School of Pharmacy, Trinity College Dublin, a colleague of Mr O'Connor, who is now deceased, discussed Mr O'Connor's work in this field with this researcher.

[16] This lengthy quote is from Macken, op. cit., p. 84; it simply refers to a 'lecturer in the College of Pharmacy in Dublin', but it is clear that it refers to Mr O'Connor.

[17] The membership of the Working Party on Drug Abuse was as follows:

Dr Karl Mullen (Chairman):	Consultant Obstetrician and Gynaecologist;
Mr A. Bourke:	Student Representative, Trinity College Dublin;

Dr W. Boles:	Practising pharmacist and member of the Council of the Pharmaceutical Society of Ireland;
Mr A. Chard:	Student representative, Trinity College Dublin;
Dr F. Campbell:	Assistant Inspector of Mental Hospitals, Department of Health;
Mr S. Hensey:	Principal Officer, Department of Health;
Dr P. A. Jennings:	G.P., Dublin;
Ms N. Kearney:	Social Worker, Dublin Health Authority;
Dr G. Lawler:	Consultant Psychiatrist, Longford/ Meath/Westmeath Mental Health Board;
Ms M. Whelan:	Lecturer in Social Science, University College Dublin;
Dr P. Melia:	Consultant Psychiatrist, St Patrick's Hospital and Student Health Service, Trinity College Dublin;
Mr D. Mullins:	Detective Sergeant, Garda Síochána;
Mr B. O'Callaghan:	Student Representative, University College Dublin;
Mr E. O'Dea:	Detective Inspector, Garda Síochána;
Mr A. O'Gormáin:	Senior Psychologist, Department of Education;
Dr R.D. Stevenson:	Consultant Psychiatrist, Dublin Health Authority.

[18] Mr Joe O'Rourke, who was Assistant Secretary at the Department of Health with responsibility for drug issues during the 1980s, provided information on this matter of allocating drugs to a specific section of the department at the time the Working Party was set up. He also checked his memory of events with a former colleague, Sean Hensey - a member of the Working Party. Their recollection was that no great debate took place within the Department on this topic; it was apparently assumed that the Food and Drugs Section was the logical place for this responsibility because the priority was seen to be the creation of new drug control systems. (Interview with Joe O'Rourke, 30th November, 1988).

[19] *Report of the Working Party on Drug Abuse,* cit. sup., p.59.

[20] Even at this time in 1968 the sociological literature, particularly from writers on deviancy, was questioning most of the allegedly scientific principles underlying international drug policy. A good example of this early critical literature is: H. Becker, *Outsiders.* (New York: The Free Press, 1963).

[21] Advisory Committee on Drug Dependence, *Cannabis.* (London: HMSO, 1968).

For an interesting account of media and political responses to this report see: J. Young, *The drugtakers: The Social Meaning of Drug Use.* (London: Paladin, 1971), Ch. 10.

[22] Dr Mullen offered this explanation to this writer in a letter dated 17th April 1990. Following the completion of the *Report of the Working Party on Drug Abuse*, he returned to his previous work and interests and played no further role in the drug policy field.

[23] These recommendations are summarised in Chapter XII of the *Report of the Working Party on Drug Abuse,* cit.sup.

[24] *Report of the Working Party on Drug Abuse,* cit.sup., p.19.

[25] Ibid., pp 14-15.

[26] Ibid., p.52.

[27] Ibid., p.52.

[28] There are no real written sources of information on this committee since it produced no reports during the ten or so years of its existence. The *Draft Report of the Special Governmental Task Force on Drug Abuse* (1983 p.18) confirms its establishment and continued existence, but this researcher's information on the Committee's activities was gleaned solely from interviews with members of the committee.

[29] *Report of the Working Party on Drug Abuse,* cit.sup., p.59.

[30] This account of how the Working Party handled the topic of preventive drug education is taken not just from the final report of this committee but also from a study of the working papers of the committee which one of its members passed on to this researcher. The Working Party had five sub-committees, one of which was concerned solely with Education and Publicity.

[31] R. Wiener, *Drugs and Schoolchildren.* (London: Longman, 1970).

[32] Letter from Professor E. F. O'Doherty to Tony O'Gorman (member of Working Party), dated 5th June, 1970.

[33] Ibid.

[34] Letter from Rev. Patrick McDermott to Mary Whelan (member of Working Party), dated April 30, 1970.

[35] 'Comments on "Education and Publicity on the Use and Abuse of Drugs. ' - undated submission to the Working Party on Drug Abuse from Ingo Fischer and Brian Glanville, Department of Psychology, St Brendan's Hospital, Dublin.

[36] J. Naidoo, 'Limits to Individualism' in S. Rodmell and A. Watts (eds), *The Politics of Health Education: Raising the Issues.* (London: Routledge & Kegan Paul, 1986), p.17.

[37] I. Fischer and B. Glanville, cit.sup., p.1.

[38] For a discussion of the *Ottawa Charter for Health promotion* see Chapter One of this thesis.

[39] I. Fischer and B. Glanville, cit. sup., p.1.

[40] Ibid., p.3.

[41] Minutes of the 33rd Meeting of the Working Party on Drug Abuse held in the Conference Room (Department of Social Welfare) on Tuesday, June, 23, 1970.

[42] *Report of the Working Party on Drug Abuse,* cit. sup., p.39.

[43] The membership of the Committee on Drug Education as follows:

Mr Bunny Carr (Chairman):	Broadcaster;
Dr J. Corridan:	Lecturer in Social Medicine, University College Cork;
Mr L. Dáibhís:	Assistant Principal Officer, Department of Education;
Dr T. Fitzgerald:	Medical Officer, Department of Health;
Mr P. Grant:	Assistant Principal Officer Department of Health;
Mr D. Hayes:	Secondary Teacher, Bangor, Co. Down;
Rev. A. Jones	Ferns Diocesan Youth Service;
Ms N. Kearney:	Department of Social Studies, Trinity College Dublin;
Dr M. Kelly:	Medical Director, Drug Advisory and Treatment Centre, Jervis Street Hospital;
Mr J. McKeever:	Vocational Teacher, Dun Laoghaire;
Dr E. Meenan:	Consultant Psychiatrist, Eastern Health Board;
Mr A. O'Gorman:	Senior Psychologist, Department of Education;
Mr R. Power:	Community Pharmacist, Newtownmountkennedy, Co. Wicklow;
Dr M. Webb:	Department of Psychiatry, Trinity College Dublin.

[44] *Report of the Committee on Drug Education.* (Dublin: Stationery Office, 1974), p.30.

[45] Irish Council of Churches / Roman Catholic Joint Group on the Role of the Churches in Irish Society, *Report of the Working Party on the Abuse of Drugs* (1972), p.20.

[46] S. Halleck, 'The great drug education hoax', *The Progressive, 34* (1970), pp 1-7, cited in J. Swisher, 'Addiction Prevention - Future Directions', *Proceedings of Health Education Bureau Conference Education Against Addiction, 1979,* p.68.

For an example of the enduring but somewhat naive acceptance of the value of having former addicts play a major role in drug education see P. Charleton, 'Drugs and Crime - Making the Connection', *Irish Criminal Law Journal, 5* (1995), pp 220-240. Charleton, a practising barrister from a middle-class background recalls the salutary effects

for his own life of hearing a member of Alcoholics Anonymous tell his story during a school talk, when he was fifteen. From this experience he goes on to ask: 'Would it not be possible to engage former addicts, who have been rehabilitated in one form or another, to speak in our schools, to speak on the radio, to speak on television? (p.238).

47 *Report of the Committee on Drug Education,* cit. sup., p.14.

48 Ibid., p.21.

49 The interim report is summarised in the final report: pp 75-78.

50 The following account draws primarily from: *Report on the Proposed Drug Addiction Clinic Sited at Jervis Street Hospital,* an unpublished planning document dawn up by Dr Joseph Woodcock, Honorary Secretary, Jervis Street Hospital Medical Board, Dr John Ryan, Consultant Psychiatrist, Jervis Street Hospital, and Dr R. D. Stevenson, Consultant Psychiatrist, Dublin Health Authority. This writer also draws on many discussions of these events with Dr R. D. Stevenson.

51 *Report on the Proposed Drug Addiction Clinic Sited at Jervis Street Hospital,* cit. sup., p.2.

52 Ibid., p.5. This recommendation is regarded as provocative and disingenuous because it seemed highly unlikely that the Irish authorities would create a liberal drug treatment regime which would attract an influx of British addicts; up until this time in the late 1960s it was Britain which attracted foreign – particularly American and Canadian – addicts. As will become clear in Chapters Seven and Nine, the British drug treatment continued to be seen by Irish addicts as more liberal and welcoming; it could be argued that the Irish authorities were intent on encouraging Irish addicts to go to Britain for treatment, as much as they were intent on discouraging British addicts travelling in the opposite direction.

53 Ibid., p.3.

54 Ibid., p.4.

55 Ibid., p.1.

56 The proposal was to staff the Jervis Street Centre with one psychiatrist, two nurses and a social worker (*Report of the Proposed Drug Addiction Clinic Sited at Jervis Street Hospital,* cit. sup. 3).

57 The Minister referred to this official opening in his address to the Working Party on Drug Abuse on March 2, 1970. He described the work of both St Dymphna's and Jervis Street as follows: 'I understand that both units are now functioning along the lines generally recommended by the Working Party. The facilities which are now available through this combined service fulfil a long-felt need' (*Report of the Working Party on Drug Abuse,* cit. sup., p.63).

58 *Report of the Working Party on Drug Abuse,* cit. sup., p.41.

[59] For example, the Rutland Centre is one Dublin treatment centre which has always treated both alcoholics and drug addicts in one centre; the routine manner in which it does so is attributable to its definite treatment philosophy and structures. This author's understanding of the stated reasons for closing St Dymphna's as a drug treatment centre is based upon numerous conversations with his clinical director, Dr R. D. Stevenson.

[60] The unit at Dundrum operated from 1971 to 1977. It was never formally evaluated and this researcher's information on its functioning is derived from several discussions with a former member of its nursing staff and a former patient - both of whom have requested anonymity. Dr John McCormack, a Consultant Psychiatrist who worked for some time in the unit, also spoke to this researcher about his memory of it (Interview - October 25, 1988).

[61] Cited in U. Macken, op. cit., p.100.

[62] Information on this service was provided by Dr McCormack (see note 61); and an Eastern Health Board planning document - *Proposed Intermediate Hospitalisation Programme For Young Drug Abusers* (undated) - was also used.

[63] Cited in U. Macken, op. cit., p.103.

[64] R. Stevenson and A. Carney, 'Social and Psychological Characteristics of Drug Addicts Interviewed in Dublin', *Irish Medical Journal,* 4, (1971), pp 372-375.

[65] 'Care of the Drug Addict' (Editorial), *Journal of the Irish Medical Association, 64* (1971), p.148.

[66] Information on Coolemine Therapeutic Community and its origins is based on this researcher's experience of the service over many years, as well as on the following written sources: U. Macken, op.cit.; J. Comberton, *Drugs and Young People.* (Dublin: Ward River Pess, 1982).

[67] M. Jones, *The Therapeutic Community: A New Treatment Method in Psychiatry.* (New York: Basic Books, 1953).

[68] For an interesting, detailed - but extremely uncritical - study of the early years of this model see L. Yablonsky, *The Tunnel Back: Synanon* (New York: Macmillan, 1965). For a more critical review of the controversial history of the TC system see T. Bratter, E. Bratter and J. Heinberg, 'Uses and Abuses of Power and Authority Within the American Self-Help Residential Therapeutic Community', in G. De Leon and J. Ziegenfuss (eds), *Therapeutic Communities for Addictions: Readings in Theory, Research and Practice.* (Springfield, Illinois: Charles C. Thomas, 1986), pp 191-207.

[69] The full extent of this confrontation does not appear to have been known to those who referred clients to the TC, or to the general public, at this early period, but it was occasionally referred to later, as in P. O'Mahony and T. Gilmore, *Drug Abusers in the Dublin Committal Prisons: A Survey.* (Dublin; Stationery Office, 1982).

[70] *Submission from a Special Interest Group of the Irish Association of Social Workers to the Minister for Health in the Misuse of Drugs Bill 1973.* (Undated document).

[71] The Misuse of Drugs Bill 1973 was criticised by the IASW specifically because it categorised cannabis as being more dangerous than would generally be accepted; cannabis was placed in Category II while the barbiturates (which have a considerable overdose potential) were in the less harmful Category III.

[72] *Dáil Debates* (Vol. 278), Column 918.

[73] Ibid., Column 933.

[74] Ibid., Columns 950-951.

[75] Ibid., Column 967.

[76] Ibid., Column 938

[77] The tradition in the Irish political system until recent years had been for the parliament to play a rather subordinate role to the executive, so that at the committee stage the scale and character of the debate militated against real exchanges. In these circumstances, opposition deputies appeared to oppose government legislative proposals almost ritualistically, while government deputies supported them in an equally ritualistic way. There is much more opportunity for real debate on legislation where a select committee of the Dáil meets outside the parliamentary chamber to discuss the detail of a particular bill. Chubb (1982) pointed out that between 1965 and 1973 only one bill was handled by special committee, but between 1973 and 1977 six bills were handled in this way (B. Chubb, *The Government and Politics of Ieland (2nd).* (London: Longman, 1982), p.209. Over the last decade of the twentieth century, however, the committee system has become much more developed.

[78] *Dáil Debates* (Vol. 282), Column 375.

[79] *Special Committee on the Misuse of Drugs Bill 1973* (Minutes of Meeting of December 10, 1975), p.50.

[80] Seanad Debates (Vol. 86), Column 742.

CHAPTER SEVEN

POLICY RESPONSES TO DUBLIN'S OPIATE EPIDEMIC 1980-1985

Introduction

It was suggested in Chapter Six that by the late 1970s there was a general sense of accomplishment, if not indeed complacency, on the part of those concerned with the formulation and implementation of drug policy in Ireland. Legislation had been enacted; treatment services had been established; the Garda Drug Squad enjoyed an exceptionally good public reputation; and the Health Education Bureau was embarking on what appeared to be a thoughtful and well-planned anti-drugs educational programme. This seemed to represent a solid list of achievements, marked by intersectoral cooperation, commonsense and balance, and devoid of the excessive moralism and hysteria which characterised public policy responses to illicit drugs in some other countries. As will be shown in this chapter, however, satisfaction with these achievements was premature and came to be seen as primarily reflecting the fact that, throughout the 1970s, drug problems in Ireland had remained at a relatively low level and could not really be described as constituting a crisis for either the health care or criminal justice systems. There was, however, to be a dramatic change in the drug scene in Dublin commencing in 1979/80, and this chapter will assess how the policies and structures set in place during this earlier period withstood the test imposed upon them by what came to be known as the 'opiate epidemic'.

A new style of drug use was first introduced into Dublin during the summer of 1970, consisting of the use of synthetic opiates which were ground down, mixed with a liquid and injected intravenously. The drug most commonly used in this way was dipipanone (better known by its trade name *Diconal* or street name *dike*), a morphine alternative used conventionally for analgesic purposes; apart from the risk of overdose associated with the use of this drug, there were the additional health risks associated with the

introduction of contaminants into the bloodstream and with the sharing of unsterilised needles and syringes.[1] While the practice of using this and other synthetic opiates in this way persisted, it did not apparently involve large numbers of drug users, nor did it lead to large-scale social and behavioural problems.[2] A study of the statistics referring to those charged with drug offences, contained in the Garda Commissioner's Annual Reports on Crime, does not suggest any real change in the pattern of illicit drug use during the 1970s, and it was ritually reported that 'cannabis continues to be the most widely used drug'.[3]

There was, however, a radical change in the Dublin drug scene from 1979/80 onwards; this change involved the increased availability of heroin, which was now being 'pushed' for the first time on a commercial scale and was being used intravenously by increasing numbers of young people in some of the most disadvantaged inner-city and peripheral working-class neighbourhoods. In retrospect, it became apparent that the influx of relatively pure and cheap heroin into Ireland at this time was part of an international change in the pattern of drug trafficking, in which - for a variety of both political and climatic reasons - the 'Golden Triangle' area of South East Asia was replaced as the major exporter of natural opiates by the 'Golden Crescent' of Iran, Afghanistan and North-West Pakistan.[4]

There are two major sources of official statistics which confirm this emergence of a heroin problem in Dublin, and the first of these, the Garda Commissioner's Crime Reports which have already been referred to, provides the data presented in Table Ten.

TABLE 10:

Heroin Use As Reflected By Garda Crime Statistics

Year	Total Numbers of Persons Charged with Drug Offences	Number of Persons Charged with Heroin Offences	Quantities of Heroin Seized by the Gardai (Grammes)
1975	333	3	14 (+ 150 tablets) *
1976	289	-	1.6
1977	381	2	40 tablets *
1978	501	5	27.0
1979	594	5	5.0
1980	991	47	105.25
1981	1,256	177	170.134
1982	1,593	208	1,264.35
1983	1,822	449	1,279.04
1984	1,369	340	525.14
1985	1,270	359	1,220.0
1986	1,163	341	1,895.79
1987	1,196	256	51.56

* Information provided by Dr Desmond Corrigan of the School of Pharmacy, Trinity College Dublin, suggests that these heroin tablets would contain 20 milligrammes of heroin. Thus 150 tablets would be the equivalent of 3 grammes of heroin, and 40 tablets the equivalent of 0.8 grammes of heroin. Although the Garda Crime Statistics do not make it clear, it is safe to assume that these quantities of heroin do not refer to pure heroin, but to the adulterated street drug which is of varying purity.

Source: Annual Reports on Crime by the Commissioner of the Garda Síochána to the Minister for Justice

Crime statistics must be interpreted with caution, since they may reflect changes in police activity or efficiency as much as objective changes in criminal behaviour. The statistics referring to annual heroin seizures are a particularly good example of this need for cautious interpretation, since one or two big seizures will obviously have a major influence on the final annual statistic and yet may not be an accurate reflection of what is happening at street level. In 1986, for example, the total heroin seizure of 1,895.79 grammes was inflated by a single seizure of 1,311.60 grammes, involving an Italian national who was using Ireland as a transit point to her own

country.[5] Conversely, low heroin seizures by the police may sometimes conceal a flourishing street scene, albeit one which is fed by many couriers with small amounts of heroin rather than a few couriers with large consignments. Notwithstanding this *caveat,* it seems reasonable to infer from the data presented in Table Ten that there had been a major increase in the use of heroin and other drugs in the years following 1979. The Garda Drug Squad, which was still directed by Denis Mullins, fought its own battle for increased resources and in 1981 succeeded in having its numbers more than doubled.[6] The health care response was somewhat slower to materialise although, as Table Eleven shows, the National Drug Advisory and Treatment Centre was treating significantly more drug users and particularly more heroin users.

Table 11

Numbers Presenting for Treatment at the National Drug Advisory and Treatment Centre, Jervis Street

Year	Total Numbers of Drug Users	Numbers of Heroin Users (as % of all users)
1979	319	55 (17%)
1980	554	213 (38%)
1981	800	427 (53%)
1982	1,307	772 (59%)
1983	1,515	1,006 (66%)
1984	1,454	969 (67%)
1985	1,427	798 (56%)
1986	1,331	646 (48%)
1987	1,224	579 (47%)

Source: National Drug Advisory and Treatment Centre, Jervis Street.

A number of local community groups also began to emerge in neighbourhoods where heroin use was perceived to be problematic; as part of their campaign for local prevention and treatment responses, these groups

sometimes documented the scale of the heroin problem in their areas, and this community activism will be looked at later in this chapter. In general, the remainder of the chapter will assess the policy response to the so-called opiate epidemic from a health promotional perspective. It will ask whether the ongoing coordinated, inter-sectoral policy responses envisaged in Chapter Six proved to be a reality, and will also study the extent to which the health care authorities demonstrated a willingness and capacity to allow local communities to participate in defining the problem and developing preventive and therapeutic initiatives.

Coordinating a National Response

Perhaps the first question that springs to mind when one studies the policy response to the opiate epidemic is whether the Inter-Departmental Committee on Drug Abuse which had been set up in 1972 functioned effectively. This committee, it will be recalled, had been set up on the recommendation of the Working Party on Drug Abuse, precisely because it was recognised that the drug scene was prone to change, and because it was felt that such a committee would be the ideal vehicle for monitoring change and devising swift and appropriate policy responses. The Interdepartmental Committee on Drug Abuse, in some ways, can be seen as institutionalising and replacing the informal network of lobbyists and activists which Denis Mullins, the founder of the Garda Drug Squad, had coordinated so effectively in the late 1960s and early 1970s.

The short answer to this question is that the Interdepartmental Committee failed to function effectively and to orchestrate a speedy response to the heroin problem; as will be described later in detail, there was no serious policy response to this changed situation until 1983. Why this should have happened will also be explored.[7] Because the Interdepartmental Committee

had no formal terms of reference, it was not obliged to meet on a regular basis to prepare reports for the Minister for Health, and it appears to have drifted into a pattern of sporadic meetings, with no coherent programme of work. When its abolition was mooted in 1983,[8] it was suggested that it was this informal constitution and lack of terms of reference which had militated against the committee's effectiveness. However, as will be detailed below, some of its members have argued that the committee was never taken seriously by the Department of Health and was, in fact, thwarted by departmental officials.

By the time that heroin began to be easily available in 1979/80, Dinny Mullins had been replaced on the Interdepartmental Committee by a senior officer of the Garda Síochána who was only indirectly involved with drugs and who was unlikely to have had the same personal commitment to this area of police work. However, three members of the committee (Martin Tansey, Joe Power and Jim Comberton) to whom this researcher has spoken have insisted that the committee as a whole had fed detailed information on the changing drug scene and on the need for a vigorous policy response into the Department of Health. Joe Power, a practising community pharmacist, was emphatic that the committee was never taken seriously by the civil service which, in his view, was unconvinced that drugs were an important issue for health policy and which tended to the view that reports of heroin problems were greatly exaggerated. In many ways, Joe Power's perception of civil servants in the Department of Health was similar to that which his colleague, Christy O'Connor, had described a decade earlier (as discussed in Chapter Six); both of these pharmacists were strongly of the opinion that the Department of Health had no interest in looking in an open-minded way at the prevalence or gravity of illicit drug problems, regarding it as more important to avoid over-reaction.

Joe O'Rourke, who was the Assistant Secretary at the Department of Health's Public Health Division (which was the section which then had responsibility for drug issues) throughout the period described in this chapter, was at a loss to account for the failure of the Interdepartmental Committee to mobilise a more speedy response, when questioned by this writer. Mr O'Rourke said that he himself did not attend meetings of the Interdepartmental Committee, which perhaps confirms the belief of Joe Power that the attendance of relatively junior civil servants at this committee reflected its unimportance in the eyes of senior departmental officials.

By the end of 1981, the Department of Health had still not publicly acknowledged that any change had occurred in the Dublin drug scene, nor had it attempted to introduce any new treatment or preventive measures. Media and political comment on the growth of a heroin scene had however begun to increase, and in November 1981 the Fianna Fáil spokesman on Justice, Gerry Collins, spoke at length on this topic in Dáil Eireann, concluding that 'Anybody who does not believe that the usage of heroin is growing has his head in the sand'.[9] Two weeks later it was reported in *The Irish Times* that the Pompidou Group of the Council of Europe had been told by Donal Creed, Minister of State at the Department of Health, and by Joe O'Rourke that the heroin problem in Ireland had 'stabilised'.[10] In view of its previous failure to acknowledge that such a problem existed, this statement was greeted with anger and disbelief by some who were already involved in constructing 'bottom-up' responses to the heroin situation. Typical of these angry responses was a letter to the *Irish Times* from Barry Cullen, a community worker in the south inner-city, who argued that there were 'some communities in the Dublin area where even with the assistance of comprehensive treatment and rehabilitation resources, problems leading

to and resulting from heroin dependency will now remain unsolved for decades'.[11]

This failure of the Department of Health to coordinate a speedy and appropriate response to the evolving Dublin heroin problem from 1979 onwards is in some ways comparable to its performance in the alcohol policy field, which was the subject of Chapter Five. In analysing the delay of the Department in reacting to this changed drug scene, it is again difficult to resist the conclusion that departmental officials were poor 'networkers'; they found it difficult to consult outside their own immediate circle or to take seriously the views of those close to the drug scene, particularly when these views differed from some existing departmental view of their own. Ultimately the Interdepartmental Committee appeared to become, in the words of Joe Power, just a 'talking shop' which met infrequently and had a mere token existence.

Barry Desmond, who was Minister for Health from November 1982 until January 1987, has argued retrospectively that departmental officials had no coherent view on this upsurge of heroin use, or on drug use generally, and that the Department of Health simply lacked the expertise and openness to analyse and respond to this new and complex medico-social problem.[12] He also suggested that this administrative inertia was compounded by the political instability of this period, during which there were frequent changes of minister, thus strengthening the power of departmental officials. The position of Minister for Health was subject to the following changes during these early years of the opiate epidemic:

- Charles Haughey was replaced by Michael Woods in December 1979;
- Michael Woods was replaced by Eileen Desmond in June 1981;

- Eileen Desmond was replaced by Michael Woods in March 1982;
- Michael Woods was replaced by Barry Desmond in November 1982.

It seems reasonable to conclude that a recognition of the need to develop some new policy initiative in response to heroin use was delayed by this inordinate turnover of Ministers for Health. It is also significant that this was a time of national economic difficulties, when increased health spending on drug prevention or rehabilitation would most likely be expected to come from the existing health budget rather than from additional funding; this economic reality would also have dampened the enthusiasm of Departmental officials for radical policy initiatives in this area.

In any event, while civil servants may have been reluctant to acknowledge that heroin use had become commonplace in some Dublin areas, it could reasonably be expected that local community activists would, sooner or later, make contact with and seek to persuade the Minister for Health of the necessity for taking action on this matter. As will now be discussed, intensive lobbying of this kind became the norm from mid -1982 onwards.

The period from June 1981 to November 1982 was, as already stated, one of great political instability, involving three general elections. The short-lived Fianna Fáil Government of March to November 1982 was reliant on the electoral support of Tony Gregory, an independent T.D. from the north inner-city of Dublin, and amongst the various political favours and advantages which he sought for his constituency was a response to the heroin problem in this area.[13] In general, local service providers and community activists from the north inner-city were greatly angered at the scepticism of Department of Health officials; the Department of Health was based in the Custom House at this time, so that civil servants were seen by

people from the north inner-city as ignoring a reality which was just outside their back door.[14]

One of the initiatives taken by Michael Woods as Minister for Health was to commission a prevalence study of drug use in the north inner-city. Although this study, which was started in September 1982 and finished in April 1983, could in many ways be seen as simply giving a scientific gloss to the statistics which local activists had already compiled, its findings and the publicity attaching to their presentation effectively led to drug issues being finally placed on the national policy agenda. The research was under the overall direction of Dr Geoffrey Dean, Director of the Medico-Social Research Board (MSRB); the senior researcher and author of the report was Dr John Bradshaw, and the field investigator was Fr Paul Lavelle who had served as Catholic Curate in the Seán MacDermott Street parish of the north inner-city.

The study, popularly referred to as the 'Bradshaw Report',[15] concluded that there was a ten per cent prevalence rate of heroin use in the 15-24 age group for the year prior to survey, while the rate was twelve per cent for the 15-19 age group and for girls in the 15-19 age group it was thirteen per cent. The study also showed that:

- 84 of the 88 heroin users (95%) identified in the area were less than 24 years of age;
- 82 (93%) users said that they had been taking heroin at least once a day, and 65 (74%) said that intravenous use was their preferred mode of use;
- only 4 (4%) identified users had any kind of educational certificate, while 10 (11%) were illiterate;
- just 4 (4%) identified users were employed, while 64 (73%) were described as compulsorily unemployed.[16]

Understandably, these statistics were taken up and widely publicised by the media, as was the report's conclusion that the Mountjoy A electoral area had a prevalence of narcotics use that was comparable with, and in some cases worse than, some of the more notorious drugs ghettoes in the United States. The media did not, on the whole, pick up on the fact that the report had not 'demonised' heroin; that is, it had not portrayed heroin as being the sole or primary corruptor of an otherwise functional social system. In fact, Bradshaw discussed heroin use in this neighbourhood from a classic public health perspective, seeing it not so much in terms of individual pathology, but rather as being largely explicable in terms of adverse environmental factors which struck him as self-evident. He expressed this conclusion in stark terms:

> Finally, it is difficult not to think that these young people in North Central Dublin are the victims of society. They live in a dirty, squalid, architecturally dispiriting area; education seems to provide no mode of escape; unemployment is to be their almost inevitable lot; their parents are quite often separated or dead; abuse of alcohol is a common problem; crime the societal norm; imprisonment more likely than not; heroin taking is regarded as commonplace by quite young children; current treatment and rehabilitation facilities seem to hold little in the way of answers to their heroin abuse.[17]

The response of the Minister for Health, Barry Desmond, in the immediate aftermath of the Bradshaw Report was to appoint a committee of six Ministers of State under the chairmanship of Fergus O'Brien, Minister of State at the Department of Health, to 'review and report on the question of drug abuse, with particular reference to the Dublin inner-city area'.[18] This committee, which was described as the *Special Governmental Task Force on Drug Abuse,* had its first meeting on April 28, 1983, and submitted a report to Government during August of that year. The full report of this Task Force was never published but most of its recommendations were accepted by Cabinet and made public through a number of press releases from the Department of Health on September 20, 1983.

The decision to set up this committee of junior ministers, rather than a more conventional expert committee, obviously reflected the Government's sense of urgency as well perhaps as a fear that, in the absence of direct political involvement, Department of Health officials might continue to delay the formulation of new policy responses.[19]

> **Law Enforcement:** The Misuse of Drugs Act 1977 was to be amended to take account of the changed situation; there were also recommendations for improved policing and for streamlining judicial procedures in this area;
>
> **Treatment Facilities:** It was recommended that the Jervis Street centre be replaced by a purpose-built unit on the same site, and that in addition to having an in-patient detoxification unit at Beaumont Hospital (to replace the Jervis Street beds when Jervis Street Hospital closed, as it did in 1987), there should be a southside unit at St James's Hospital;
>
> **Education and Research;** It was recommended that the MSRB should conduct further research into the prevalence of drug use and its social correlates, and that educational activities aimed at preventing drug use should be carried out both in high-risk areas and throughout society;
>
> **Community and Youth Development:** The Government recognised that drug abuse was both a 'youth problem' and one that was particularly common in deprived urban communities; it proposed, within existing budgets, to develop and coordinate a range of youth work and community development projects within the most vulnerable areas.

Collectively, these policy recommendations could be seen as incorporating all the main health promotion strategies, but it was the latter recommendation - on developments in community and youth work - which was potentially the most radical in its promise to recognise the causal importance of environmental factors. However, a careful reading of the full report of the Special Governmental Task Force on Drug Abuse *vis à vis* the various press releases on the unpublished report suggests considerable Governmental ambivalence on this topic, rather than an unequivocal abandonment of the traditional policy emphasis on individual pathology and individual vulnerability.

Section Four of the full report (which remained unpublished and which only became available to this writer in a leaked version during 1988) contains a clear and explicit argument by its authors that the epidemic of drug abuse then being experienced in Dublin could be validly explained in terms of the poverty and powerlessness of the neighbourhoods concerned, rather than in terms of individual risk factors. The Task Force recommended that through the use of a number of indicators - prevalence of drug abuse, the crime rate, levels of educational attainment, the unemployment rate and the general state of social and recreational amenities - certain areas should be identified and designated as *Community Priority Areas* (CPAs). This designation would warrant the allocation of special, additional resources for job creation and training schemes, as well as the creation of new programmes designed to co-ordinate all existing statutory and voluntary social services in these areas. It was recommended specifically that each CPA should have within it a new body, to be called a 'Youth and Community Development Forum', which 'would draw up integrated plans for the provision and delivery of services and facilitate community responsibility for development'.[20]

The Task Force also recommended special funding for these CPAs: £500,000 to be allocated annually for all the CPAs, with a further £80,000 for the development of social and health education within the youth service sector, and a new 'Capital Grants Scheme for Community Facilities' which would have a budget of £500,000 for 1984.[21]

These detailed recommendations for youth and community development as a means of drug abuse prevention never became known to the public because they were rejected at Cabinet and did not, therefore, feature in the press releases on the work of the Task Force issued on behalf of the Department of Health. No additional funding was provided and no new administrative

structures were established to implement the summarised and by-now vague and aspirational recommendations on youth and community work contained in the press releases. It is difficult to know to what extent or how explicitly the Government considered this environmental or public health model of drug problems. The fact that youth and community issues were retained at all in the press releases suggests that this model was given some credence, but the traditional rhetoric of individualism was equally reflected in the Department of Health press releases. It was argued, for instance, that:

> The drug problem, which is mainly confined to the greater Dublin area, now affects young people particularly, without any reference to intellectual or educational attainment. No social class and no district in this area is exempt ... It cannot, however, be too strongly stressed that in this area, above all others, it is the individual decision which counts most.[22]

Barry Desmond told this researcher that the decision to reject the Task Force's detailed recommendations on Community Priority Areas was based both on financial considerations and on the belief that the Eastern Health Board and the other relevant local authorities did not have the competence or capacity to successfully implement these recommendations.[23]

Of the various recommendations made by the Special Governmental Task Force on Drug Abuse, it was those relating to law enforcement which were implemented most speedily and decisively, suggesting that supply reduction by vigorous enforcement of the criminal law continued to be the most uncomplicated and least uncomfortable policy response as far as the Government was concerned. Amended Misuse of Drugs legislation was introduced to the Oireachtas by Barry Desmond in early June 1984, and by August of that same year it had passed all stages, been signed by the President, and the commencement order for its implementation had been made. The major changes introduced by the Misuse of Drugs Act 1984 may be summarised as follows:

- penalties for drug offences were generally increased and the maximum sentence for drug trafficking was increased from fourteen years to life imprisonment;

- the mandatory requirement that judges should defer sentencing convicted drug offenders pending completion of medical and social reports (Section 28 of the Misuse of Drugs Act 1977) was dropped;

- the definition of cannabis was altered to close off a legal loop-hole in the 1977 legislation;

- drivers of motor vehicles and people in charge of boats or aircraft being searched for controlled drugs were compelled to remain with their vehicles for the duration of the search;

- it became an offence to publish, sell or distribute literature which advocated the use of controlled drugs.

If the parliamentary debate on the Misuse of Drugs Act 1977 had been relatively liberal, reflecting perhaps the fact that Ireland had no serious drug problem at this time, the debate in 1984 was considerably less so. Politicians now seemed anxious to persuade the electorate that on the whole question of drug use and drug problems they were unequivocal and resolute, and despite the fact that it was the use of heroin which had necessitated this new legislation, a considerable part of the parliamentary debate was taken up with discussion of cannabis.[24] Among the sources referred to by the Minister for State at the Department of Justice, Nuala Fennell, was a paper by Inspector John McGroarty of the Drug Squad entitled 'Cannabis: A Cultural Poison'[25]; and in general the legislators concentrated on the evil which was deemed to be inherent in all illicit drugs, rather than on the socio-economic and other environmental factors which seemed to create vulnerability to serious drug problems among specific sub-groups of the population. Understandably perhaps, it appeared to be easier for the legislators to condemn the discrete evil of drugs, and the even more unspeakable evil of drug pushers, than to acknowledge the role played by structural factors in the creation of Dublin's opiate epidemic. While the language of Deputy Brendan McGahon was somewhat more extreme than

that of most of his colleagues in the Oireachtas, his general views on this topic were not radically different from those of the majority of legislators. In the course of his contribution to the debate on the Misuse of Drugs Bill 1984, Brendan McGahon said:

> Dependency on heroin is living death and the most extreme measures should be introduced to counteract it. Unfortunately, one of the drawbacks of a democracy is that it allows liberalism to flourish ... As far as drugs are concerned, liberals should not be allowed to be heard because surely nobody in his right senses can condone the taking of drugs, soft or hard. In other countries, drug pushers are dealt with summarily by being shot, and there is little or no drug pushing. I am not advocating that penalty here because it would not be accepted but, unfortunately, there will be commissions and inquiries and the problem will worsen and get out of control, as in the case of law and order.[26]

In Dáil Eireann, an alternative perspective on heroin problems was presented most explicitly by Deputies Tony Gregory and Proinsias De Rossa,[27] while, in Seanad Eireann, the policy thrust of the 1984 legislation was questioned most sharply and coherently by Senator Brendan Ryan. Among the issues which Brendan Ryan addressed was the alleged causal link between cannabis use and hard drug use; his view on this was that, 'You have to do a little more than say because a person does two things, one follows from the other'.[28] He also quoted at length from a statement on the Misuse of Drugs Bill 1984 which had been issued by the Irish Council for Civil Liberties (ICCL), which *inter alia* was critical of the proposals to make pre-sentencing medical and social reports discretionary. The ICCL also expressed concern that the new 'advocacy' offences, which prohibited publications which could be interpreted as promoting illegal drug use, might have the effect of stifling public debate on drug policy or might question the legality of any educational programme 'which admits as a matter of fact that pleasurable experiences can be obtained by the use of illegal substances'.[29] Finally, in his contribution to the debate on the Misuse of Drugs Bill 1984, Brendan Ryan reiterated the views of Tony

Gregory and Prionsias De Rossa concerning the causal link between heroin problems and social deprivation; as Brendan Ryan saw it, it would not be 'possible to deal with drug abuse on a universal scale or completely, if we leave areas of this city with dreadful housing, poor education and virtually no employment prospects'.[30]

In summarising this section, which has examined the way in which the Government co-ordinated a national response to the upsurge of heroin use in Dublin from 1979/80 onwards, it must be concluded that the response was slow and, from a health promotional perspective, obviously unsatisfactory. The informal lobbying and networking activities which had been orchestrated by Denis Mullins in the late 1960s had been institutionalised by the establishment of the Inter-Departmental Co-ordinating Committee on Drug Abuse in 1972; much was expected of this latter committee but these expectations were largely disappointed. In its 1983 report, the Special Governmental Task Force on Drug Abuse accepted that the Inter-Departmental Committee had failed, and commented as follows:

> This Committee was established in 1972 so that those represented on it might exchange available information in relation to drug abuse which would enable deficiencies to be identified and effective action to be decided upon. However, it has been apparent for some time, particularly since the sudden dramatic rise in the incidence of heroin abuse in 1981, that the present Committee is not operating effectively. There are various reasons for this among which is the fact that the Committee was established on an informal basis without specific Terms of Reference. The members of the Committee are aware of these limitations and have been seeking additional powers for some time to enable them to exercise their functions effectively.[31]

This suggestion that the Committee's failure was attributable to its informal status and lack of specific terms of reference reflects a rather more disingenuous bureaucratic explanation than that which was advanced earlier in this section. Members of the Committee, and indeed the Minister

himself, had suggested as an alternative explanation that the Department of Health had neither the will nor the capacity to coordinate policy development in relation to drug problems. The Inter-Departmental Committee, by virtue of its informal status, was almost totally dependent on the Department of Health and, it was argued, departmental officials took advantage of this situation to keep the Committee in an administrative limbo - much as they had done with the Working Group on the National Alcohol Policy, discussed in Chapter Five of this thesis. Looked at from a health promotional perspective, or particularly from an organisational networks framework, it seems as though the culture of the Department of Health encouraged its officials to look inwards and to treat with scepticism any externally-generated information, ideas or policy recommendations which did not coincidence with their own conventional wisdom on drug problems. Members of the Committee who tried to persuade the Department of Health that a major change had occurred in the Dublin drug scene, reported that this message was treated with polite disbelief: the Department was unconvinced that any serious change had occurred and appeared to believe that its main duty was to prevent any policy over-reaction in this area. The recommendation of the Special Governmental Task Force on Drug Abuse on this matter was that a new National Coordinating Committee on Drug Abuse, with specific terms of reference, should be established to replace the Inter-Departmental Committee which had been in existence since 1972. The new committee did not come into being until 1985 but by tracking its progress (this will be done in Chapter Nine) thereafter it should be possible to throw further light on these alternative explanations as to why the coordinating structure - of which there were such high hopes - failed to live up to expectations.

Prevention and Treatment - Collaboration Between Local Communities and Statutory Services

The fact that at national level the established policy coordination system had failed to operate as quickly or as effectively as it might have does not necessarily mean that local health responses were equally poor, and this section is solely concerned with local health service responses to the upsurge of heroin use in Dublin between 1980 and 1985. In the main, this involves looking at how the Eastern Health Board - the statutory authority for the provision of health and social services in Dublin - responded to this situation; some attention will also be paid, however, to the National Drug Advisory and Treatment Centre at Jervis Street Hospital, particularly with a view to seeing whether this service altered its philosophy and *modus operandi* to accommodate the localised nature of the heroin problem in Dublin.

The events and issues to be discussed here are, potentially at least, the very stuff of health promotion. A serious heroin problem was emerging in Dublin, and there was evidence that it was not distributed randomly but that it was linked to socio-economic deprivation and was confined to identifiable communities; the question for health authorities was whether they would acknowledge the importance of these environmental factors and work collaboratively with the communities most affected, or whether they would persist with a more traditional biomedical approach to heroin use and heroin addiction. Such a biomedical approach would involve the provision of treatment and rehabilitation by professional health-care workers, based on an individualistic model, and probably delivered from central rather than local services and facilities. A health promotional or public health response, on the other hand, would consist of close collaboration between health authorities and affected communities, based on an acceptance of the causal importance of social environmental factors, and involving members of the

community and primary care personnel in the delivery of locally-based services. Referring back to the Ottawa Charter which has identified five main tasks considered essential to the realisation of health promotion, the following three tasks are particularly relevant to the analysis of health service responses to the opiate epidemic:

> **Creating Supportive Environments** - this would involve the health authorities in recognising that both the physical and social environments of some Dublin neighbourhoods were generally inimical to good health and were specifically contributing to a high incidence and prevalence of heroin problems;
>
> **Strengthening Community Action** - this would involve the health authorities in the creation of participative structures and processes whereby local residents were actively collaborating in defining the problems of their communities and putting together both preventative and therapeutic responses to these problems;
>
> **Reorienting Health Services** - this is little more than a summarised statement of the necessity for health authorities and professionals to move from their previous preoccupation with curative matters to a holistic approach which would recognise the importance of environmental factors, accept the validity of lay knowledge and lay participation in health-care matters, and acknowledge the valuable role of primary care health care workers.

It will be recalled from Chapter Six that during the period from the mid-1960s to the late-1970s the Dublin Health Authority and its successor the Eastern Health Board had not developed any real treatment system for those using or dependent upon illicit drugs. No independent lobby group had emerged to argue the case for such treatment systems and, unlike the situation pertaining to alcohol problems, there appeared to be no enthusiasm on the part of psychiatrists to become involved with the treatment and rehabilitation of illicit drug users. Furthermore, the creation of the National Drug Advisory and Treatment Centre at Jervis Street Hospital had made it unclear whether there was any necessity for the Eastern Health Board to develop its own services for drug users, since the relationship between Jervis Street and the Eastern Health Board was never clarified.

In 1979, however, the Eastern Health Board made an internal management decision which, on the face of it, had interesting and important implications for its future management of illicit drug problems: this was the decision to transfer responsibility for drug problems from the Board's Special Hospital (Mental Health) to its Community Care Programme.[32] This transfer of responsibility might have been interpreted as signalling a new policy orientation, acknowledging the reluctance of the psychiatric services to become involved with drug users and the perceived desirability of developing localised prevention and treatment initiatives. McKinsey, the management consultants who had designed the management structures of the health boards following the Health Act 1970, had argued that the Community Care Programme could be expected to deliver services which were 'community based, where local knowledge and insight is of great assistance to their efficient administration and where constant communication and contact with the local population is essential'.[33] If the transfer of drug problems into the administrative sphere of Community Care resulted in the application of this philosophy to drug problems, then it could certainly be said that health promotion was being taken seriously in this field.

The truth of the matter, however, was that the motivation underlying this change was rather more mundane and, from a policy perspective, disappointing than this. What happened, quite simply, was that Áine Flanagan, a Senior Administrative Officer in the Board's Special Hospital Programme, transferred as a personal career move to Community Care and it was decided that 'she should take drugs with her'.[34] At the time of Ms Flanagan's transfer, it became apparent to senior management in the Eastern Health Board that she was - by virtue of almost ten years experience of dealing with drug issues - the only senior administrator in the organisation

who could be regarded as being in any way conversant with them. The Board could have decided to take this opportunity to insist that the psychiatric services take a more active and responsible role in relation to illicit drugs, or it could, alternatively, have reviewed the whole topic from a Community Care perspective and set up formal management or policy-making structures to incorporate drug services into Community Care. It did neither in fact, but, without any public debate or announcement, it opted to regard drug problems as a discrete and uncomplicated administrative matter which was best left with Ms Flanagan, rather than seeing this as a question that involved policy formulation.

Even nine years after this event, when this writer discussed the transfer of drugs to Community Care with Michael Walsh, then Programme Manager for the Special Hospital Programme, Mr Walsh did not see this event as unusual or questionable.[35] At this same time, however, Ms Flanagan (who still was carrying almost total responsibility for drug matters in the Eastern Health Board) was disparaging about the logic and general wisdom of the transfer. She was reluctant to speak at length on this subject, other than to reject the suggestion that the Board's transfer of drug issues to Community Care reflected any policy view on this matter; it was, she suggested derisively, just another example of what she termed Health Board 'ad hoccery'.[36]

The significance of all this is that, just as Dublin was about to experience a dramatic increase in opiate use, the Eastern Health Board had neither a formal management structure to deal with this problem nor any coherent view as to what its role should be in relation to this problem. It displayed no self-critical or reflective capacity in this regard, seeing the drugs issue as one which could reasonably be left to the discretion of a single administrator

rather than one which called for on-going policy formulation. This placed Áine Flanagan in an invidious position; she was, it would generally be agreed, an intelligent, formidable and hard-working administrator but, lacking either professional training or a clear policy line to guide her in the complex arena of Dublin's heroin problem, she was largely reliant on her own instincts as to how best to respond. These instincts, it should be remembered, had been developed and honed in a traditional clinical model of service provision, where the 'authorities' set up systems for healthcare professionals to treat a relatively passive laity, rather than in any form of participative community work.

Before looking in some detail at a number of case-studies of community responses to the heroin problem, reference will first be made to the *Task Force on Drug Abuse* which was set up in the late summer of 1982 within the Eastern Health Board, and which represented the Board's only formal attempt at policy making on this topic during this period.[37] This Task Force was set up by the Chief Executive Officer of the Eastern Health Board with the following terms of reference:

> To examine and quantify the extent of drug abuse in the Eastern Health Board area, to recommend appropriate action in the prevention and treatment area to deal with the problem and to co-ordinate such activity within the Eastern Health Board area.[38]

This Task Force was chaired by the Director of the Eastern Health Board's Forensic Psychiatric Service, Dr Liam Daly, and in addition to other representation from the Board, its members included personnel from Jervis Street, the Departments of Health, Education and Justice, the Health Education Bureau, Coolemine Therapeutic Community and the Garda Drug Squad (which was still represented by Denis Mullins).

The decision of the Board's Chief Executive Officer to appoint Dr Daly as chairman of this Task Force may, in view of the reluctance of Eastern Health Board psychiatrists to become involved with drug users, be seen as indicative of the vague and confused approach which its management generally had towards drug issues, and it appears that practically all responsibility for managing the Task Force and producing a report fell upon Áine Flanagan. Ms Flanagan herself described the workings of the Task Force as 'half-hearted', with very few of its members pulling their weight, and claimed that in the circumstances she felt obliged to take a leadership role. Her behaviour in doing so left her open to criticism, however, with Jim Comberton of Coolemine Therapeutic Community suggesting that she monopolised the proceedings and refused to countenance views contrary to her own.[39] A further example of criticism of Áine Flanagan's direction of the Task Force is that expressed by Paul Harrison, an Eastern Health Board social worker, who at this time was working as Project Leader of the Seán McDermott Street Youth Development Programme (a specific drug project in the north inner-city). Mr Harrison maintained that he was under the impression that he had been summoned to a personal discussion with Áine Flanagan, only to discover that he was expected to make an oral submission to a formal meeting of the Task Force. Ms Flanagan, he said, was chairing this meeting but, when he expressed critical views on the way in which the Eastern Health Board was responding to Dublin's heroin problem, she abandoned all pretence of neutrality and subjected him to a 'browbeating' for having the temerity to criticise their mutual employer.[40]

Apart from the rather unconventional way in which the Task Force conducted its business, its report offered little by way of comfort for those who might have hoped for evidence of a clear strategy on drugs on the part of the Eastern Health Board.[41] The report itself is a poorly written and

confused document, consisting of five pages of discussion and recommendation, followed by *fifty* pages of appendices. The recommendations are not spelt out clearly, do not flow logically from the preceding text and do not focus on activities which were specifically within the remit of the Eastern Health Board.[42] The report is best regarded as a non-event, and from a policy analysis perspective it is perhaps more illuminating to point out what it did *not* do. It did not:

- focus upon the almost total abdication by the public mental health services in Dublin of all responsibility for drug problems;
- attempt to clarify the working relationships, or division of labour, between the National Drug Advisory and Treatment Centre (Jervis Street) and the Eastern Health Board;
- clearly identify heroin as the drug which was causing the most social and behavioural disruption in Dublin at this time;
- acknowledge the localised nature of heroin problems in specific neighbourhoods, or attempt to produce policy guidelines for collaborative work with the residents and primary care personnel of these areas.

It was pointed out in Chapter Six that the establishment of the National Drug Advisory and Treatment Centre at Jervis Street Hospital had been modelled on the British policy decision (contained in the second report of the Brain Committee) to locate drug treatment services in centralised facilities, which were colloquially referred to as 'the clinics', run by specialist staff. The wisdom and practicality of this policy came under scrutiny in the early 1980s when Britain, like Ireland, experienced a dramatic increase in opiate use. In December 1982, the Advisory Council on the Misuse of Drugs, Britain's statutory drugs advisory body, published its *Treatment and Rehabilitation* report which argued that it was no longer practicable to expect all problem drug takers to be treated by specialist staff in centralised clinics; instead, it recommended that local drug services should be established which would largely be reliant on the contribution of generic

primary health and social service personnel.[43] It would be unfair to suggest that the Eastern Health Board's Task Force should have considered this influential British report, because *Treatment and Rehabilitation* was published just as the Task Force was completing its own report. It would not be unfair, however, to say that the issues involved - the relative merits of centralised and local services - were reasonably obvious, and that its failure to address them showed that the Task Force lacked analytic capacity.

While it is difficult to draw definite conclusions from the brief and meandering text of the Task Force report, what appears to come across is that its authors (if indeed it had multiple authors) were unconvinced about the gravity of this upsurge in heroin use. Specifically, it appears that the Task Force was insensitive to the needs of those neighbourhoods where heroin use was creating new and seriously disruptive social problems, directly involving very young drug users and indirectly involving entire communities. It was argued that 'The problem, in terms of damage to the region's health, from the "Abuse of Drugs" is still relatively small, particularly when it is compared with the wider effects of cigarette smoking and alcoholism'.[44] This point is valid only in terms of crude, total population indicators, but, as the Bradshaw Report was confirming at this time, more specific indicators based on the study of cohorts of young people in inner-city neighbourhoods showed a very different picture for those who lived in these neighbourhoods.

The next section will consist of a detailed review of how the Eastern Health Board (and to a lesser though important extent the National Drug Advisory and Treatment Centre at Jervis Street) collaborated with local community drug activists in three particular areas. In view of the material presented in this section, however, it has to be concluded that the Health Board - even

following the transfer of drugs issues to the Community Care Programme - did not display any great health promotional tendencies, and so it was not to be expected that the collaborative relationships between Health Board and local groups would run smoothly.

Health Board - Community Collaboration: Three Case-Studies

The material considered in this section refers to three working-class areas of Dublin which were particularly affected by the opiate epidemic: the areas in question are St Teresa's Gardens in the south inner-city, the Seán MacDermott Street area of the north inner-city and Ballymun, a peripheral high-rise development to the north of the city which had been built in the 1960s. It will be shown that what happened in each of these areas by way of response to heroin problems can be seen as approximating to the *organisational networks* style of policy making discussed in Chapter One. In other words, this response to heroin problems was neither of the *rational - comprehensive* type, involving the State in a top-down and co-ordinated plan, nor of the *partisan mutual adjustment* type, consisting of an incremental process of bargaining and compromise between all the interest groups involved; instead, the response to heroin problems in these three communities evolved from the on-going relationships between local representatives of various human service organisations and indigenous community leaders.

In view of the controversy and the allegations of violence, vigilantism and political subversion which were to be made against some of the later anti-drugs groups, it is important to emphasise how 'respectable' and mainstream these original community networks were.[45] In the Ballymun area, for example, a local resident, Queenie Barnes, became concerned in late 1980 at the prevalence of heroin use and, following the deaths of three

young people from drug-related causes, she approached Ineke Durville, an Eastern Health Board Community Care social worker for the area; the groundwork for the establishment of the Youth Action Project was carried out in early 1981 by these two people and by Frank Deasy, a social work student on placement with Ineke Durville from Trinity College Dublin.[46] In the Seán MacDermott Street area, similarly, the initiative for developing specific anti-drug measures in the area came in 1981 from an informal social service group, the 'V & S', so-called because it was made up of both voluntary and statutory social service personnel. This group involved, for example, Paul Harrison, a Community Care social worker with the Eastern Health Board, and Fr Paul Lavelle, the local Catholic Curate. In St Teresa's Gardens the anti-drugs initiative stemmed largely from the Eastern Health Board's community care social work post which had been in existence since 1972 and which had - through a succession of holders of this post - created a good working relationship with a local residents' group, the St Teresa's Gardens Development Committee.[47] As early as 1980, this group was convinced of the necessity to provide a local response to the growing use of heroin, and in 1981 a specific community group called the Youth Development Project (YDP) was established to combat the heroin problem. At the end of 1981 the committee of the YDP consisted of the following:

> Dr Fergus O'Kelly, General Medical Practitioner
> Fr Seán McArdle, Catholic Curate
> Patricia Smith, Probation and Welfare Officer
> Matt Bowden, Secretary of the St Teresa's Gardens Development Committee
> Michael King, Principal of Liberties Vocational School
> Barry Cullen, Social Worker, Eastern Health Board
> Paul Humphrey, Chairperson of the St Teresa's Gardens Development Committee
> Ray Kavanagh, Assistant Sector Officer, Community Care Programme, Eastern Health Board
> Sam Anglin, Coolemine Therapeutic Community

It is clear that this committee was almost entirely made up of conventional caring service personnel rather than of political subversives eager to exploit the emerging heroin crisis in St Teresa's Gardens; indeed if any criticism

were to be made of its make-up it would probably be that local residents were under-represented on it.

Having established who was involved in these local networks, it is obviously important to clarify what their views were and what vision they had for the eradication of heroin problems from their areas. While there may have been minor differences of opinion between the three groups being considered here, they developed a common vision which may be described as health promotional in its essence. In summary, these local networks may be seen as making three points:

- that there was a big increase in heroin use amongst the young people in these areas and that this new form of drug use was leading to unprecedented health and social problems;

- that this prevalence of heroin use was causally linked to the poverty and the communal demoralisation which characterised these areas;

- that treatment and preventive measures could not be delivered in a traditional biomedical way, with an emphasis on expert therapists treating pathological individuals, but that a social and participative model must be established at local community level.

This vision was expressed with varying degrees of clarity and conviction to the Eastern Health Board, the Department of Health and Dublin Corporation. Some of the analysis was extremely detailed and explicit, as, for example, in the submission of Barry Cullen to the Lord Mayor of Dublin in October 1981; it had been proposed to establish a working party on drug use within Dublin Corporation and with the agreement of his Director of Community Care Barry Cullen submitted a document to the Lord Mayor, setting out the agenda and philosophy of the group then working in St Teresa's Gardens. Having made the point that it was heroin use which had caused this group to come into existence, Barry Cullen went on:

> People from all backgrounds, experiences and situations will come in contact with drugs, some will use and become addicted to them. This is a human reality. However, and

> this point is fundamental to understanding Dublin's drug problem, the widescale use of hard drugs can only be a major problem for a particular community, it can only be endemic to that community, when the social, economic and environmental conditions allow it ... When social and economic planners deny urban communities a role in planning their own development, they are predisposing such vulnerable communities to a hard drug problem.[48]

This perspective on drug problems is, of course, similar to that enunciated by Fischer and Glanville in their submission to the Working Party on Drug Abuse (discussed in Chapter Six) but its implications for prevention and treatment were profoundly at odds with the biomedical perspective which had implicitly underpinned all drug treatment and rehabilitation in Dublin up to this point. At its most radical, this bottom-up model of drug problems called for major restructuring of local governmental systems in the areas in question, with local residents being afforded a much greater opportunity to participate in housing policy and in other social and environmental services, as well as in training and job creation schemes. At a less radical level, this new vision of drug problems insisted that it was no longer acceptable that treatment service provision should be located in centralised facilities - at a geographic remove from the communities most afflicted - dominated by healthcare professionals. Two years after its foundation, the Ballymun Youth Action Project summarised its philosophy in the following way:

> In this approach, we see the primary problem facing the individual abuser and his/her family as one of addiction and seek to develop community based supports. In terms of the wider community we seek to develop the awareness, skills and resources necessary to cope with and prevent the escalation of drug abuse as a community problem.[49]

In terms of practical politics, the main demand being made of the Eastern Health Board, therefore, was for the establishment of community based counselling and rehabilitation facilities and youth work services, in which local residents and locally-based professionals could work collaboratively with the Health Board. The most fundamental difficulty which the Health Board had with this demand was that, as discussed in relation to its Task

Force on Drug Abuse, it appeared to be unconvinced that a serious drug problem existed and therefore did not accept the necessity for reviewing or changing existing service provision. The first task of the local drugs groups was, therefore, to persuade the Eastern Health Board that a heroin problem actually existed, and this will now be looked at in some detail.

To illustrate the frustration and anger of local community activists at this official scepticism, it is worth quoting from a paper written by Willie Martin, a voluntary community worker in St Teresa's Gardens during this period. He wrote:

> By that summer of 1983, the use of heroin had reached epidemic proportion in the city of Dublin. St Teresa's Gardens was one of the worst affected areas. It was estimated that over 200 junkies a week were getting their supply of heroin in St Teresa's Gardens. The flats were in a constant upheaval of vomit, urine, blood and overdoses. Many of the junkies were so badly in need of a vein to fix into that they pulled down their pants and searched their lower parts, not giving a damn about the children who would be passing up and down the stairs ... For years we had been struggling to alleviate the problem but with little success. It was not our fault. We had approached all the right people - Ministers for Health, T.D.'s, Corporation officials and the police. Nobody took us seriously. They implied that if there was a drug problem wouldn't they be the first to know about it.[50]

In St Teresa's Gardens and in Seán MacDermott Street the local anti-drugs groups had engaged in what may be conceptualised as 'popular epidemiology' in an attempt to persuade the Department of Health and the Eastern Health Board that their communities were experiencing a new and unprecedented wave of heroin use. Popular epidemiology is is an American concept which refers to the way in which local residents and primary care personnel gather data and present the authorities with their findings in support of their convictions that their communities are experiencing environmental health problems.[51] The 'experts', in this case the Department of Health, the Eastern Health Board and the National Drug Advisory and Treatment Centre at Jervis Street, had not accepted that heroin

use had increased as radically or as destructively as the local groups perceived it to have, so the local groups set about researching and documenting their case as systematically as they could.

The first research of this kind was that carried out in October 1981 by the St Teresa's Gardens group and later submitted to the Eastern Health Board.[52] The main findings were that:

- of 350 families in the target area, 40 had at least one member who was a heroin user;
- 57 heroin users were identified in this community, 39 of whom were over the age of 18, and 18 of whom were in the 12-18 age group;
- the number of children deemed to be 'at risk' by virtue of residence with a heroin user was 35;
- the youngest heroin user identified by the researchers was 12 years old and it was estimated that he had been using heroin for two years at the time of the survey.[53]

The Seán MacDermott group used a similar methodology during 1982 to calculate the prevalence of heroin use in its own area, and when some of its members met the Minister for Health in May 1982 they reported that in their area there were 50-60 heroin users between 12 and 18 years of age.[54] It is at this point that the political issues surrounding this form of popular epidemiology become obviously pointed. It appears that Department of Health officials remained unconvinced about the validity of these prevalence figures and of the necessity for taking decisive action in relation to heroin; the Minister (Dr Michael Woods), while personally persuaded that the inner-city really had a serious drug problem, decided that the health care system would only respond when there was 'scientific' evidence to this effect, and he accordingly commissioned prevalence studies from the Medico-Social Research Board.[55] This led to the completion and publication of the Bradshaw Report, referred to earlier in this chapter. The Seán MacDermott group cooperated fully with the Medico-Social Research Board, and the

main investigator in their area was, as previously mentioned, the local curate Fr Paul Lavelle. The YDP Committee of St Teresa's Gardens met Dr Bradshaw but refused to cooperate with the research which he and Dr Geoffrey Dean of the Medico-Social Research Board proposed to carry out in their area. Cullen, in discussing the YDP's motives for not cooperating with Bradshaw, has said:

> The committee discussed this matter and having considered what were now obvious political dimensions to Bradshaw's second phase study, and for other reasons - particularly their concern that a comprehensive survey would raise local expectations that an official response was imminent - refused to participate any further in the study. Furthermore, members of the committee expressed strong views that the information collected to date, and submitted already to the health board was sufficient to warrant a substantial official response and that little was to be gained, at this stage, by participating in further research.[56]

The publication of the Bradshaw Report received great publicity, and some at least in the north-inner city were unhappy with this publicity which, they claimed, merely gave the area an even worse name than it already had.[57] While it may have led directly to the setting up of the Special Governmental Task Force and indirectly to the enactment of the Misuse of Drugs Act 1984, the Bradshaw Report did not lead to clearer or more harmonious relationships between the Eastern Health Board and the local groups which were concerned with heroin problems in these areas.

At their meeting with the Minister for Health in May 1982 the Seán MacDermott group had presented the Minister with detailed plans for a local service. It was reported to the Eastern Health Board that 'The delegation said they already have a site - the Youth and Community Centre - which could be used as a walk-in treatment centre for young addicts. They need professional staff. They also want to be involved themselves in the centre to encourage young people to come in.'[58] Following this meeting the Minister approved a grant of £20,000 towards the cost of setting up this

local centre, and in August 1982 Paul Harrison, an Eastern Health Board Community Care social worker, was appointed as Project Leader to the centre.[59] However, the working relationship between the local group and the Eastern Health Board quickly became strained and acrimonious, and there appeared to be a particularly conflictual relationship between Ms Flanagan and Fr Paul Lavelle, the local priest who had been involved in campaigning for a local treatment service for several years and who had been the principal investigator for the Bradshaw Report.[60] The perception of the local group was that the Eastern Health Board did not want to develop any drug project in which it had to share power with local residents and locally-based professionals, but that it was only comfortable with a conventional treatment model – namely one which was run by professionals and managed by the Health Board. After five months in his post as Project Leader, convinced that his own employing organisation (the Eastern Health Board) would commit itself neither philosophically nor financially to the proposed new service, Paul Harrison resigned from his post and went back to Community Care social work.[61] A treatment centre for young drug users was in fact established in the north inner-city during 1983, but it was directed by a social worker who had previously worked in the National Drug Advisory and Treatment Centre, Jervis Street, and it developed as a professionally-run service which almost immediately lost its local community connections.

A very similar set of events took place in St Teresa's Gardens where the local YDP had developed detailed and elaborate proposals for a locally-based treatment centre for young drug users.[62] The Eastern Health Board initially agreed to collaborate with the YDP in the establishment of this centre but, as in the case of the Seán MacDermott project, this agreement was followed by increasingly bitter exchanges between the two parties. The

first Project Leader appointed to the St Teresa's Gardens venture, Helen Walker, also resigned after a short period in office, precisely mirroring the motivation and actions of Paul Harrison in the north inner-city. She was replaced by Barry Cullen, another Health Board social worker, but, after what resembled a war of attrition, it became clear that the Eastern Health Board would not participate in the proposed new centre and the plan came to nothing.

In Ballymun, the YAP had evolved slowly and had not produced detailed proposals for a new treatment centre or made serious financial demands on the Health Board.[63] In 1983 it employed Mary Ellen McCann, an experienced addiction counsellor, to work for it on a half-time basis; she was the organisation's first paid worker, and it was not until late 1984 that a grant from the Youth Affairs Section of the Department of Labour allowed it to advertise for its first full-time post. Within days of this post being advertised, however, the YAP discovered that the Eastern Health Board had appointed an addiction counsellor to work in Ballymun; this appointment caused great annoyance to YAP which believed that it should have been consulted, or at least informed, about this development. The ensuing row, in early 1985, received considerable newspaper coverage which publicly and explicitly highlighted the disagreements between the Health Board and local groups as to what constituted 'community care' for young drug users. In the course of a long letter to the *Irish Times,* members of YAP said:

> The [Eastern Health] Board's statement that they are interested in working together would be more credible if this had been a joint decision. Far from helping our project to develop, this leaves us with a new set of circumstances to deal with - what are the Health Board plans for the area? Are local people to be totally excluded from those plans? *How* are we supposed to work together? ... It would seem there are perceptions of what constitutes resources being 'community-based'. Those caught in the middle of those differences are those most in need of help - addicts and their families.[64]
> (Italics as in original)

A fuller account of this debacle is contained in *Ten Years On,*[65] the history of the YAP which was written when the project was ten years old, but the YAP perception of these events essentially corresponds to that of the St Teresa's Garden's and Seán MacDermott Street groups: the Health Board was seen as being unwilling or unable to share power with local groups in creating a response to drug problems.

The World Health Organisation, as described in Chapter One, had published its *Strategy for Health for All by the Year 2000* in 1978 and had continued to develop these health promotional ideas thereafter. A 1985 WHO publication which sought to define specific targets for its *Health for All* programme argued that:

> It is a basic tenet of the health for all philosophy that people must be given the knowledge and influence to ensure that health developments in communities are made not only for but also with and by the people.[66]

The anti-drug activities described in this section could be seen as exemplary models of health promotion at community level, yet the Eastern Health Board consistently appeared to resent and thwart these developments. In seeking to understand this, there are a number of plausible explanatory factors which suggest themselves. The first such explanation, which has already been touched upon, concerns the lack of policy discussion of any issues at both Department of Health and Health Board levels. While there may have been conflicting views articulated as to the nature of alcohol problems (as discussed in the first half of this thesis), this could be seen in a positive light as contributing to an informed policy debate and a raising of relevant questions and possible answers. No real debate had taken place at a high policy level in relation to illicit drugs, however, and the only ideas which guided Irish policy in this area were the minimalist and rather superficial ideas contained in the *Report of the Working Party on Drug Abuse* (1971). Had this committee given credence to the Fischer and

Glanville submission on the importance of socio-economic factors in the causation of drug problems, this might have facilitated the Eastern Health Board in linking abstract ideas about health promotion and community care to the concrete bottom-up initiatives in working-class communities described here.

In the absence of formal debate on drug issues at Departmental or Health Board levels, a great deal of discretion lay with Áine Flanagan who, as the senior administrator dealing with drug issues within the Eastern Health Board, carried almost total responsibility for the Board's response to the opiate epidemic. It has already been acknowledged that Ms Flanagan was in an unusual and invidious position, and it is important in discussing these events that she should not be personally demonised in any way, but rather seen as representing the administrative system of the time to which she belonged. It is relatively easy to understand Áine Flanagan's motives and intentions in this matter, however, since she was always quite forthright in explaining and defending Health Board activities.[67]

Stated simply, Áine Flanagan did not subscribe to the concept of community work or community development in the sense that this implied a participative element to health and social service provision as reflected, for example, in the WHO statement quoted above. Instead, her vision consisted of a traditional approach to service delivery, in which the planning and administration of services were carried out by health authorities (such as the Health Board) with the services then being delivered by professionals; the role of service consumers in this traditional view was, of course, a relatively passive one, with little or no credence being given to the idea that lay people had any wisdom to contribute to service planning or delivery. Ms Flanagan was critical of Health Board employees who became integrated

into local networks, and found it difficult to understand how such people would not unequivocally support the Health Board when power struggles arose between it and local community groups. In commenting critically on Barry Cullen's work as a member of the St Teresa's Gardens YDP while he was also an Eastern Health Board employee, she described him as being 'disloyal' to the Health Board.[68] Insofar as she understood the WHO concept of community empowerment she disapproved of it, because implicitly her own view of power was of the zero-sum type: the more power a local community group acquired, the less power was left for the Health Board.

Ms Flanagan was also sceptical about the value of or necessity for formal planning, and tended to see policy discussion papers or formal plans produced by community groups as consisting of 'silly ideas'.[69] Her own beliefs and those of her administrative colleagues, on the other hand, were seen as reflecting their hard-won experience and administrative commonsense; such beliefs tended not to be recorded in written form but to be retained and passed on within the Health Board as part an oral tradition. No mechanisms existed whereby the policy statements and plans of community groups could be considered as part of a formal planning process within the Health Board, and Ms Flanagan did not appear to see how difficult it was for outside bodies to understand the Health Board's position in the absence of clearly written policy statements.

Áine Flanagan was, however, comfortable with traditional treatment services and, from 1983 onwards, she gradually built up within the Health Board a network of community-based addiction counsellors who were expected to undertake therapeutic work with addicts and their families. This addiction counselling was organised along conventional therapeutic lines - it

was almost entirely individualistic in orientation and took little or no account of the wider socio-economic environment - and the intention was that it would be supervised from Jervis Street.[70] In discussing this scheme for allocating addiction counsellors to various parts of Dublin, Ms Flanagan was fulsome in her praise of these counsellors; they were, from her point of view, sensible people with visible caseloads rather than naive community workers whose activities seemed so intangible but which left the Health Board open to political manipulation.[71]

Throughout this period, the National Drug Advisory and Treatment Centre at Jervis Street continued to have a monopoly in terms of the medical assessment, detoxification and rehabilitation of drug users. Since the Eastern Health Board psychiatric services had almost completely abdicated responsibility for illicit drug users and their problems, it was to Jervis Street that Áine Flanagan turned for advice and support in carrying out her work for the Health Board. Neither the Eastern Health Board Task Force nor the Special Governmental Task Force had questioned the policy of confining the medical treatment of drug users to a single centralised clinic, and Ms Flanagan professed herself happy with this system and unconvinced that any alternative system was feasible.[72] Media and public opinion of Jervis Street throughout the period of the opiate epidemic appears to have been uniformly positive, with much sympathy being expressed for the poor facilities and general lack of resources which were the lot of the centre's staff.

In 1983, the year during which attendance figures at Jervis Street peaked, Peter Murtagh of the *Irish Times* described the Jervis Street premises as an 'undercapitalised slum', and quoted the centre's director, Dr Michael Kelly, as follows:

> 'It is virtually impossible to deal with the volume of addicts we are now getting', Dr Kelly says. 'We are facing a very acute situation. We can't wait for a custom-built unit to be put up. We are already choked with a motley crew of schoolchildren, hardened addicts and criminals coming in through that waiting room.' [73]

Although it had been envisaged at the time of its establishment that the Jervis Street centre would play a lead role in preventive work and in the general policy advisory area, in practice it had confined its activities almost entirely to the treatment scene; this is at least partly explicable in terms of the huge pressure of day-to-day clinical work which militated against the development of a reflective, analytical approach to policy issues. Not only did the Jervis Street centre fail to play a major role in alerting the Department of Health to the full significance of the rise in heroin use, but it also failed to capitalise upon its unique position in the treatment scene by securing the greatly enhanced resources it would have needed to fulfill all that was expected of it.[74]

Given that the major increase in drug use involved heroin, the question of introducing methadone maintenance - as opposed to detoxification and drug-free rehabilitation - now had become practically relevant. Jervis Street, however, drifted without public debate into a policy of detoxification and abstinence during this period.[75] The Coolemine Therapeutic Community expanded greatly in the early 1980s, particularly in 1983 when it acquired a new residential centre at Navan, Co. Meath, which was capable of holding up to a hundred residents. Cooperation between Jervis Street and Coolemine was close, both philosophically and practically, and between them they reinforced the most basic of the assumptions inherent in the Eastern Health Board's response to the opiate epidemic: drug addiction was largely explicable by reference to individual psychopathological characteristics; treatment was best delivered by professionals in specialist services; and the only valid outcome of treatment was total abstinence from

mood-altering drugs. All of these assumptions were, to some extent at least, antipathetic towards the broad thrust of health promotion and to the specific community activities discussed in this section.

Finally, in concluding this account of the conflictual relationship between locally-based activists and statutory authorities, some reference must be made to the emergence of other forms of local community responses to drug problems in Dublin, which began in 1983 and which were frequently characterised as constituting a form of aggressive vigilantism. An umbrella body known as *Concerned Parents Against Drugs* (CPAD) sporadically provided a degree of centralised organisation for local groups who attempted to set up informal policing of their areas, and whose activities included evictions of residents judged to be drug dealers. CPAD was primarily representative of residents of working-class areas, with little or no involvement of locally-based professionals, and was controversial not just for its vigilantism but because of the allegations of the authorities that it was a front for Sinn Fein. Specifically on this latter point, it was suggested that Sinn Fein was making cynical use of the heroin problem to advance its own republican political agenda. It could be argued that it was the failure of statutory bodies to collaborate and share power with more responsible and representative bodies, such as those discussed in this section, that created the conditions for the emergence of CPAD. Equally, it could be argued that the reluctance of the statutory authorities to share power was vindicated by the nature of the vigilante activities espoused by CPAD: that the Eastern Health Board, in particular, had been astute in recognising that community responses to drug users would not always be benign and that professionalism remained the best option. This is an issue which will be returned to in Chapter Nine when the question of local drug treatment services is again considered.[76]

The Health Education Bureau and the Opiate Epidemic

Although it had a broad health education brief, the HEB had (as discussed in Chapter Six) been set up specifically as a result of public concern about drug problems. For the first two years of its existence it had been a rather modest affair, effectively little more than an off-shoot of the Department of Health run by a few civil servants on a small budget. During the period that Charles Haughey was Minister for Health, from July 1977 until December 1979, the fortunes of the HEB were transformed dramatically: a full-time director (Dr Harry Crawley, a consultant psychiatrist) and professional staff were appointed; a substantial budget was allocated; and a large and munificent building at Upper Mount Street in Dublin purchased as a corporate headquarters.

Despite this apparent good fortune, the environment in which the HEB was expected to operate was not entirely hospitable or uncomplicated, and it will be argued here that any analysis of the Bureau's performance must inevitably include an evaluation of its 'networking' skills or political abilities in this environment.

Paradoxically, the generosity of Charles Haughey towards the HEB may be seen as constituting a mixed blessing for the organisation. It was generally believed and quickly confirmed that Mr Haughey was intent on using his time in the Department of Health to complete the process of political rehabilitation, necessitated by his involvement in the Arms Trial of 1970, and to position himself as successor to his Party Leader and Taoiseach, Jack Lynch.[77] It was not uncommon then for people at this time to view Mr Haughey's commitment to health education as a cynical political exercise and, fairly or otherwise, to transfer these negative attitudes onto the HEB. The apparent wealth of the HEB also generated some resentment on the part

of those already involved in health and social services who saw themselves as carrying out equally, if not more, important work in straitened circumstances. Civil servants in the Department of Health, for example, were at this time in transition from the overcrowded grandeur of the Custom House to the less salubrious conditions of Hawkins House, one of Dublin's more reviled modern buildings. Statutory health and social service workers saw themselves, as perhaps they invariably do, as operating with less than adequate resources; and existing voluntary bodies, whose work had often included educational and preventive aspects, looked with a somewhat jaundiced eye at the newly acquired affluence and dominance of the HEB.

The first major initiative taken by the HEB in relation to drugs, following its transformation by Mr Haughey, was the holding of a conference on the theme of 'Education Against Addiction' in Killarney in November 1979. This conference was attended by more than three hundred delegates, from health, educational and social service backgrounds, and the speakers included national and international specialists in the addictions field.[78] The content of the conference papers and the ensuing discussion encompassed all addictive substances - whether licit, illicit or prescribed - and the proposals which arose from the discussion referred to a wide range of public policy initiatives which, it was argued, could reduce the societal damage caused by psychoactive drug use. The final task of summarising the conference themes and recommendations fell to Jerry O'Dwyer of the Department of Health who referred in his summary to the 'many calls [which] were made highlighting the need for a national policy in relation to addiction'.[79] He referred specifically to two fundamental ideas which had emerged concerning:

> (i) The lack of co-ordination which was seen to exist between the many agencies who are in a position to bring resources to bear on the problem at present, and

(ii) The need to develop and implement a consistent set of attitudes and values in relation to addictions.[80]

The model of policy making implicit in these conference recommendations was the rational-comprehensive one, and the recommendations, taken as a whole, could validly be seen as health promotional. There are, however, great differences between the aspirations which delegates express at conferences and the political realities which surround their implementation. Jerry O'Dwyer, despite the clarity of his summary, must have been aware of these political difficulties, and there may have been a slight touch of mockery in his concluding wish that 'When Killarney will be but a pleasant memory for us, I hope that the bureau will publish in suitably psychedelic form the authorised version of the proceedings of the Conference and circulate it to a very wide audience'.[81]

In studying the activities of the HEB following this conference, it could be concluded that the Bureau was realistic and politically prudent in selectively pursuing conference recommendations. It did not, for example, pursue the notion of a single national addiction policy by developing a more active role for itself in relation to alcohol; and it seems reasonable to presume that its decision not to do so was motivated not just by a general appreciation of the difficulties inherent in bringing about a root and branch change in alcohol policy, but by a more specific and mundane desire to avoid an unseemly 'turf war' with the Irish National Council on Alcoholism.[82]

What the HEB mainly took from this 'Education Against Addiction' conference was a renewed conviction of the validity of its original position on drug education, which had been laid down by the Committee on Drug Education in 1974. This meant that it would not engage in mass media campaigns which presented the negative effects of drugs such as heroin in a

sensationalist way, nor would it assist in the creation of school programmes which adopted such tactics. The Bureau was satisfied that there was no scientific justification for drug education of this kind; not only did the research fail to show that explicit anti-drug messages delayed or prevented initiation into drug use by young people, but it also suggested that this kind of education often generated oppositional responses in its audience and ultimately could be counterproductive. The policy on drug education adopted by the HEB, therefore, was one which was low-key and non-specific; its focus was on the development of individual life-skills or decision making skills for young people, to be achieved indirectly through training teachers, youth leaders and others who could be regarded as 'primary influencers'.[83]

The HEB policy on drug education was for all practical purposes identical to that recommended in Britain by the Advisory Council on the Misuse of Drugs in its *Prevention* report of 1984,[84] but it is important to note that the Thatcher Government totally ignored this advice and went ahead with a large-scale advertising campaign aimed specifically at fighting heroin.[85] In Ireland, too, it began to appear as though political leaders would prefer drug education which was more explicit, high-profile and generally propagandist, whatever the results of scientific research in this field. There emerged, therefore, an ongoing tension between the HEB's commitment to subtle educational programmes, which at least promised to do no harm, and the desires of politicians and others for a more public, full-frontal attack on heroin, symbolising society's repugnance for this drug. In a subsequent discussion of this period, Eugene Donoghue, Head of Training and Education at the Bureau, referred to the Bureau's attempts to achieve a 'fine balance between responding to public demands and conducting quality drug education'.[86]

The contrast between the measured, low-key approach of the HEB and the emerging political rhetoric of this period in the early 1980s is reflected in the words of Dr Michael Woods, Minister for Health, from a speech he made in October 1982 at the start of a seminar for school principals run by the HEB. The Minister declared dramatically that:

> The Government has declared war on drug abuse. We are determined to attack and root out this new cancer which is eating into our community. Although we were sheltered from the waves of harmful drugs which flooded Europe in the last decade, we are no longer exempt from their insidious influence.[87]

In April 1982, the Minister for Health allocated an additional £250,000 to the HEB for its drug education activities; the extra funding had not been sought and, given the implicit expectation that it would be used to conduct a more overt attack on heroin, it was regarded with some ambivalence by its recipients.[88] Amongst those concerned with drug problems, and to some extent amongst the general public, the HEB was not viewed as an entirely credible institution, as evidenced by an *Irish Times* editorial on the subject of the extra funding, in which the wisdom of the Minister's decision was commented upon in the following way:

> Maybe he is right to increase the funding of the Health Education Bureau. Maybe their new programme will do better than those that have gone before it - although such organisations as the Coolemine Therapeutic Community (which has a proven track record in the salvage of young drug abusers) is already active in this field and is on record as being in need of further funds.[89]

This editorial comment is particularly interesting in that it shows that, amongst organisations working in the drugs field, there is no necessary correlation between attention to scientific research and public credibility. The activities of the HEB, as already discussed, were carefully and conscientiously based on research findings but to the public they seemed equivocal and half-hearted. Coolemine, on the other hand, was unequivocally and whole-heartedly opposed to drugs, and to politicians and to the general public it seemed not to matter a whit that its approach to drug

rehabilitation was not well supported by research evidence.[90] The HEB did not change its policy on drug education in any way as a result of receiving this extra money from the Minister for Health, and its decision to use the money to run another international conference on drug education (which was held in the Shelbourne Hotel Dublin in November 1982) can hardly have been pleasing to the Minister and to all those who would have preferred to see it spent on something with more mass appeal.

Viewed in terms of the Ottawa Charter, the HEB's approach to drug prevention is most aptly described as 'Developing Personal Skills', an approach which is almost entirely individualistic. However, if the HEB wished to establish a popular support base for its activities, then it seemed imperative that it should complement its work on individual life-skills with programmes and policies that took account of socio-economic and other environmental factors. Specifically, what would have helped the Bureau's public image and general credibility would have been the establishment of close links with the community-based groups which were attempting to deal with heroin problems in working-class areas of Dublin. Had the Bureau established such links, it would effectively have made the point that individuals do not exist in a social vacuum and that human health cannot be entirely explained in terms of personal choice. The community groups were all, with varying degrees of explicitness and coherence, working out ecological models of health which referred to their experience with heroin, and the support of the HEB might have been helpful in all kinds of ways to these groups.

There was, however, to be no real collaboration between the HEB and these community groups, a failure which can be explained in both ideological and structural/administrative terms. Ideologically, it appeared that the Bureau's

view of drug problems at this time, as indeed of all health matters, was one which was completely blind to social class; as a consequence of this it concentrated exclusively on individual decision-making, ignoring social class influences and presenting all of its educational materials in a language and style which was middle class in its orientation. Dr Fergus O'Kelly, a G.P. who worked in the St Teresa's Gardens area of the south inner-city of Dublin and who as an active member of the Youth Development Project there, had done pioneering epidemiological work on drug problems in his practice during the early 1980s. He was, therefore, personally and professionally well placed to comment on these issues, and described his disbelief on attending an HEB seminar for doctors in 1982, at which one of the main speakers argued that drug problems were 'classless'.[91] Similarly, Dr John Bradshaw, who had carried out epidemiological research in the north inner-city of Dublin, responded critically to the Bureau's 1983 booklet *Open Your Minds to the Facts,* arguing that it was 'totally unsuited in length and tone to the parents of central Dublin and other deprived districts where drug abuse is certainly or probably rampant'.[92]

It is difficult to know why the HEB should have adopted such an individualistic stance on drug problems, given the central importance of environment in traditional public health. It is tempting, however, to conclude that it was aware of the reluctance of Government to acknowledge the link between poverty and serious drug problems, and that in opting to turn a blind eye to this link the Bureau itself was primarily motivated by a desire to avoid involvement in damaging political controversy. There was nothing unique about this determination to see drug use purely as a personal choice, and through the mid 1980s the slogan 'Just Say No' (popularised by Nancy Reagan, wife of the U.S. President, Ronald Reagan) gained much currency internationally.

Even if it had been so minded, however, it appears that the HEB was greatly constrained by its own statutory nature when it came to working with community groups. The Bureau had been set up by the Minister for Health under the Health (Corporate Bodies) Act 1961, a statute which allowed the Minister to establish corporate bodies to carry out health functions inappropriate to local health authorities. Both the north and south inner-city groups had sought the assistance of the HEB in their anti-drugs campaigns, but the Bureau's understanding was that it could not become involved with these groups unless permitted, if not indeed specifically requested, to do so by the statutory health authority for the area, the Eastern Health Board.[93] In view of the on-going antagonism between the Health Board and the community groups, the Health Board demurred and so the HEB was not drawn into the picture.[94]

It seems, in conclusion, that despite its new-found affluence the HEB played a relatively limited role in the overall health and social service response to the opiate epidemic between 1980 and 1985. Its refusal to create sensationalist and explicit advertising campaigns did not endear it to politicians who liked the public drama and symbolism of such campaigns, and its individualistic life-skills emphasis and failure to become involved with community drugs activists lost it grassroots support and credibility. Above all perhaps, it appeared to lack the common touch when it came to networking; none of its staff developed to any great extent the communication and lobbying skills which might have served the Bureau in good stead through what was undoubtedly a difficult era. Instead, a negative perception of the HEB was allowed to develop, which included jokes about the 'lifestyle' of its personnel, referring, for example, to the grandeur of their building and the depth of their carpets, as well as their penchant for international conferences. The Bureau moved towards a more

explicit use of health promotion concepts in the mid 1980s but, despite the apparent popularity and official acceptance of such concepts, continued to be involved in public controversy. This controversy and the ultimate closure of the HEB in 1988 will be the subject of Chapter Eight.

Conclusion

The most obvious conclusion that can be drawn from the material presented in this chapter is that the various policies and institutions which had been established prior to 1980 failed to provide a speedy and effective response to the heroin problems which grew quite dramatically from this year onwards. There had been no large-scale use of opiates in Ireland prior to this time, nor had there been a culture of needle use amongst illicit drug users, and this new style of drug use brought with it a wide range of medico-social problems. Perhaps those most commented upon publicly were the risk of overdose and the drug's obvious capacity to create physical dependency, but there were also serious indirect health problems associated with needle use and needle sharing, such as hepatitis, abscesses and toxaemia. There were also behavioural problems associated with heroin use, mainly consisting of crime of an acquisitive kind aimed at raising the money necessary to sustain an illicit and expensive dependency, but prostitution as a means to 'feed a drug habit ' also became more common as heroin became the primary drug of choice of illicit drug users. Such medico-social problems were of concern to Irish society as a whole but, as explained in this chapter, they particularly appeared to engulf those already deprived urban areas in which they were disproportionately prevalent.

Two bodies of which there were clear policy-making expectations - the Inter-Departmental Committee and the National Drug Advisory and Treatment Centre at Jervis Street Hospital - failed signally to meet these

expectations. In the case of the former, the official explanation for its tardiness and inefficiency was couched in disingenuous bureaucratic terms: the Inter-Departmental Committee on Drug Abuse, it was suggested, did not perform well because its terms of reference were not sufficiently formal. Had it succeeded, this Inter-Departmental Committee could have been a good example of the inter-sectoral collaboration and co-ordination that is described under the health promotion label of 'Healthy Public Policy'. The evidence presented in this chapter, however, argues for an alternative explanation of why this committee was so slow to respond to the upsurge in heroin use, attributing this delay to the conservative 'territorial' instincts of Department of Health officials, who found it difficult to share administrative power or accept a policy perspective which differed from their own.

The Jervis Street centre operated solely as a clinical agency, demonstrating no interest in or aptitude for policy debate. It was telling that up to the beginning of the opiate epidemic this centre did not even compile and publish annual statistics describing its own workload. Neither, as the use of heroin increased and as its localised geographical nature became clear, did Jervis Street foster any policy debate on the merits of decentralising treatment service provision. Finally, it was significant that it adopted an abstinence model of treatment and rehabilitation, without any discussion of the other option, methadone maintenance, which was commonly used internationally for the treatment of heroin dependency.

The failure of these policy-making institutions meant that the kind of balanced, inter-sectoral debate envisaged in 'health public policy' did not occur in Ireland during this period of the opiate epidemic; as a consequence, the most visible and unequivocal policy development between 1980 and 1985 was the enactment of the Misuse of Drugs Act 1984, which was aimed

primarily at controlling the supply of illicit drugs. This legislation was, of course, broadly comparable to that being enacted internationally, but the prospect of cutting off the supply of illicit drugs through the use of criminal justice sanctions was slight; in many ways, the legislation may be considered more in terms of its symbolic importance, rather than from an instrumental perspective.

If there is any single concept which comprehensively captures the essence of the official health service response to Dublin's opiate epidemic between 1980 and 1985 it is that of *individualism*. since, both in terms of treatment service provision and health educational programmes aimed at prevention, the unit of analysis was always the individual. All of the public health or health promotional frameworks which argued that environmental factors should be considered were ignored, and a traditional biomedical model implicitly - and sometimes explicitly - underpinned all health service activities in this sphere. The 'disease' of drug dependency was seen to exist within individual sufferers and, therefore, it was in order that they should be plucked from their everyday environment and taken to a centralised treatment system, where they could be subject to the ministrations of technical experts in this condition. Health authorities seemed satisfied with this biomedical model, not so much perhaps because they were convinced of its logic or its technical efficacy but because it was familiar to them and spared them from the distasteful business of sharing power with lay people and working class communities. For politicians, the attraction of individualism almost certainly was that it distracted public attention from the links between heroin problems and poverty; it was more comforting to conceptualise drug use in terms of the poor decision-making and defective lifestyles of individuals than to acknowledge that health is also a social product. The situation in Britain was somewhat similar, as may be gleaned

from these 1984 remarks of Griffith Edwards, a psychiatrist who was recognised as one of the world's leading experts on drug problems:

> The Minister of Health will look bored if he asks us for recommendations on how to curtail the drug epidemic and we come back only with the answer that, if he does not want Brixton to go the way of Harlem he had better do something about Brixton. But if he gets the social and political job wrong, no amount of committee reports, customs officers, sniffer dogs, life sentences, consultant sessions or lecturing to school children will be able to pick up the broken pieces.[95]

These remarks apply *a fortiori* to Ireland, and in Chapter Nine (following a specific study of the Health Education Bureau which is presented in Chapter Eight and which demonstrates that individualistic health education strategies could also prove politically contentious) the period from 1986 to 1996 will be studied to see to what extent it proved possible for Irish drug policies to move beyond the conventional biomedical perspective which has been described here.

Chapter Seven: Footnotes

[1] A study of this new practice reported that there had been five deaths among *Diconal* users between the early summer of 1970 and end of 1971: - M. Kelly, 'Misuse of a Morphine Alternative (Diconal)',*Journal of the Irish Medical Association, 65* (1972), pp 414-415.

[2] It is perhaps a measure of how calm and unimportant the drug scene was during these years that the national Drug Advisory and Treatment Centre at Jervis Street was not required to compile and return annual statistics on its activities. Annual data from this centre are available only from 1979 onwards.

[3] These reports are published annually by the Stationery Office under the title *Annual Report on Crime by the Commissioner of the Garda Síochána to the Minister for Justice.*

[4] For an interesting journalistic account of this changed pattern of heroin trafficking see J. Picardie and J. Wade, *Heroin: Chasing the Dragon.* Penguin Books, 1985).

[5] *1986 Annual Report on Crime by the Commissioner of the Garda Síochána to the Minister for Justice.* (Dublin; Stationery Office, 1987), p.30.

[6] *1981 Annual Report on Crime,* p.29.

[7] There are no Department of Health Reports, or documents of any kind, relating to the Interdepartmental Committee on Drug Abuse, in the public domain. The information on this committee presented here is drawn from interviews with the following:
Denis Mullins of the Garda Drug Squad and member of the committee during the 1970s;
Joe O'Rourke, who was Assistant Secretary at the Department of Health and who was involved with this committee from about 1978/79;
Joe Power, representative of the Pharmaceutical Society of Ireland on this committee;
Martin Tansey, Principal Probation and Welfare Officer, Department of Justice and member of this committee in the late 1970s and early 1980s;
Jim Comberton, Executive Director of Coolemine Therapeutic Community and member of this committee.

[8] This was one of the recommendations of the Special Governmental Task Force on Drug Abuse (1983) which will be discussed later in this section.

[9] Dáil Debates (Vol.330), Column 1384.

[10] *The Irish Times,* November 18, 1981. Joe O'Rourke insisted to this researcher that he had been misquoted by the newspaper, and that he had said that 'it was hoped' that the problem had stabilised. He did not seek to correct this in the paper, however, and it seems of little

importance since the Department of Health had not previously accepted in any public way that a heroin problem existed.

[11] *The Irish Times,* December 7, 1981.

[12] Interview with Barry Desmond (November 28, 1988).

[13] Community activism in response to heroin use in various areas of Dublin will be discussed in more detail later in this chapter. A letter from a departmental official to the Eastern Health Board (dated May 25, 1982) describes 'a meeting which took place on 20th inst. between the Minister and representatives of Seán MacDermott Street parish to discuss the growing problem of drug abuse in their area ... The delegation consisted of Deputy Tony Gregory, Fr Paul Lavelle, a teacher, an E.H.B. Community Officer, a Department of Justice Welfare officer and three parents from the parish.' (Letter to Tom Harty, Eastern Health Board from Mary Alyward, Department of Health).

[14] This account of activism in the north inner-city is based on the researcher's memory of this period and on interviews with Barry Desmond, Paul Lavelle (the local priest) and Paul Harrison, social worker with the Eastern Health Board. It will be discussed in more detail later in this chapter.

[15] The formal reference for this report is: G. Dean, J. Bradshaw and P. Lavelle, *Drug Misuse in Dublin 1982-1983: Investigation in a North Central Dublin Area and in Galway, Sligo and Cork.* (Dublin: Medico-Social Research Board, 1983). The title is misleading since the only research of significance reported is that in the north inner city.

[16] This phrase 'compulsorily unemployed' was used to distinguish those who would work if work were available from those who apparently were not interested in work.

[17] Dean, Bradshaw and Lavelle, op. cit., pp 20-21.

[18] *Unpublished Report of the Special Governmental Task Force on Drug Abuse, 1983*, p.1.
(This researcher was given a copy of this unpublished report by a public servant who wished to remain anonymous. The authenticity of the document was confirmed, with regret, by Joe O'Rourke of the Department of Health).

[19] This conclusion is primarily based on this researcher's interviews with Barry Desmond and Joe O'Rourke. At the time of the Special Governmental Task Force on Drug Abuse in 1983, Barry Desmond was Minister for Health and Joe O'Rourke was Assistant Secretary in his department with senior responsibility for drug issues. The differing views of these two men on the Task Force are interesting and illustrative of general tensions between ministers and civil servants. Barry Desmond was convinced that a committee of this sort, comprised of junior ministers rather than civil servants or outside experts, was necessary to tackle the heroin problem quickly and effectively; his view was that the civil servants in his department were neither able nor willing to produce a coherent response to this

problem. For his part, Joe O'Rourke thought that the Task Force, made up entirely of politicians under pressure to produce a quick report, was a higher-risk strategy which could lead to precipitate policy responses. Joe O'Rourke was ultimately satisfied with the report of the Task Force and attributed the success of the committee, partially at least, to the fact that he had invited a guest speaker from the Pompidou Group (a Council of Europe drugs policy group) to address the Task Force, thus reassuring them that in a European context drug problems were normal, and that political over-reaction was to be avoided.

20 *Unpublished Report of the Special Governmental Task Force on Drug Abuse, 1983,* p.10.

21 Ibid.

22 'Drug Abuse and the Task Force' (Press Release issued by the Government Information Services on behalf of the Department of Health, 22 September, 1983).

23 Interview with Barry Desmond (November 28, 1988). It is also worth noting that in a reply to Proinsias De Rossa, T.D. (then a member of the Workers' Party), Barry Desmond appeared somewhat uncomfortable about the fact that the Task Force report was never published. He argued initially that it was merely a Cabinet sub-committee report, and, as such, would not normally be published. He later shifted his ground to argue that security considerations prevented its full publication, since it 'would alert criminal elements to what we might intend doing'. [Dáil Debates (Vol. 346), Column 689].
A close reading of the full report does not provide any justification for this latter suggestion. The most plausible explanation is that the report was not published to avoid the embarrassing debate that might ensue when it emerged that the Task Force (which consisted of five Fine Gael deputies and one Labour deputy) had recommended increased and selective spending in areas of high social deprivation, and that this recommendation was rejected by a Cabinet which included four Labour ministers, including the Minister for Health.

24 Underlying this discussion of cannabis was the idea that it served as a 'gateway' drug, leading on to the use of harder drugs. In strictly logical terms, no causal connection has ever been established between cannabis use and heroin use; the vast majority of cannabis users do not go on to use heroin, and the Bradshaw Report had shown that in the case of heroin users in the north inner-city many had never used any other illicit drug.

25 *Dáil Debates* (Vol. 351), Column 1142. It is worth noting that ten years later John McGroarty published an article in *The Irish Times* (June 23, 1994) entitled 'The Cannabis Debate'; in this later piece, written as serving Garda Drugs National Liaison Officer, Superintendent McGroarty was somewhat less definitive in his condemnation of cannabis.

26 *Dáil Debates* (Vol. 351), Column 1146.

[27] The amended Misuse of Drugs legislation was debated in Seanad Eireann on July 10 and 11, 184. (*Seanad Debates,* Vol.104).

[28] *Seanad Debates* (Vol.104), Column 1115.

[29] *Irish Council for Civil Liberties Press Release,* June 22, 1984.

[30] *Seanad Debates* (Vol. 104), Column 1119.

[31] *Unpublished Report of the Special Governmental Task Force on Drug Abuse, 1983,* p.18.

[32] This researcher was an employee of the Eastern Health Board at the time of this transfer of drug responsibilities to Community Care, and has some memory of the low level of discussion or debate surrounding Ms Flanagan's transfer. The motivation behind the transfer and its policy implications were subsequently discussed by him with Áine Flanagan, Senior Administrative Officer in the Eastern Health Board (interview November 29, 1988) and with Michael Walsh, Programme Manager, Special Hospital Programme, Eastern Health Board (telephone discussion December 19, 1988).

[33] McKinsey and Co., *Towards Better Health Care Management in the Health Boards* (Vol. 1). (Dublin: Department of Health, 1970), p.34.

[34] This was the phrase used by Michael Walsh in discussing the transfer of responsibility with this writer (see note 32 above).

[35] Telephone interview with Michael Walsh, December 19, 1988.

[36] Personal interview with Áine Flanagan, November 29, 1988.

[37] This account of the Eastern Health Board's Task Force on Drug Abuse (1983) is based on a reading of its unpublished report and on interviews with the following: Áine Flanagan (Eastern Health Board); Barry Desmond (Minister for Health from November 1982 to January 1987); Paul Harrison (Social Worker, Eastern Health Board) and Jim Comberton (Coolemine Therapeutic Community and member of the Eastern Health Board Task Force).

[38] *Eastern Health Board Task Force on Drug Abuse.* (Unpublished report, 1983), p.1.

[39] Interview with Jim Comberton, October 10, 1988.
Mr Comberton was extremely critical of Áine Flanagan's handling of the Task Force, even to the point of saying that she had refused to give him a copy of its report - despite the fact that he was a member of the Task Force.

[40] Interview with Paul Harrison, November 11, 1988.

[41] Barry Desmond, who received a copy of the report soon after becoming Minister for Health in late 1982, said that it confirmed for him his most pessimistic views about the capacity of the Eastern Health Board to deal with the opiate epidemic. Ms Flanagan conceded

that the report had been generally criticised, especially by board members of the Eastern Health Board.

42 The recommendations (from page 6 of the unpublished report) are as follows:

"1. To provide a service for hepatitis cases
2. N.D.A.C. [Jervis Street] premises should be enlarged.
3. Legislation review: (a) Closed Unit
(b) Court Witnesses
(c) Special Court Systems
4. Monitoring Committee to be established
5. Education: (a) Use of Health Education Bureau to provide courses for G.P.s, Psychiatrists, Preventive Medicine.
(b) Continue to provide for teachers and parents
(c) Training for Counsellors.
(d) Clarification on role of educators towards potential abusers."

43 Advisory Council on the Misuse of Drugs, *Treatment and Rehabilitation* (London: HMSO, 1982).
For an interesting account of the type of treatment services which were proposed under this new policy dispensation see: J. Strang, 'A model service: turning the generalist on to drugs' in S. MacGregor (ed.), *Drugs and British Society: Responses to a social problem in the eighties.* (London: Routledge, 1989), pp 143-169.

44 *Eastern Health Board Task Force on Drug Abuse,* cit. sup., p.3.

45 The following are the main written sources for this section:
M.E. McCann, *Ten Years On: A history of the Ballymun Youth Action Project, a community response to drug and alcohol abuse.* (Ballymun Youth Action Project, 1991);
N. O'Donohue and S. Richardson (eds), *Pure Murder: A Book about Drug Use* (Dublin: Women's Community Press, 1984);
B. Cullen, *Community and Drugs: A case study in community conflict in the inner city of Dublin.* (Unpublished M.Litt. Thesis, Trinity College Dublin, 1992).
The section draws on previously cited research interviews with: Áine Flanagan, Eastern Health Board; Paul Harrison, Eastern Health Board, and Barry Desmond, former Minister for Health.
It also makes use of a telephone interview with Fr Paul Lavelle, Catholic Curate in Seán MacDermott Street during the early 1980s (January 25, 1989) and a research interview with Barbara Law, social worker at Jervis Street and subsequently at the National Drug Treatment Centre Board, Pearse Street (October 26, 1988).
This writer also draws on his own memory of this period and on numerous discussions of these times and events with Mary Ellen McCann of the Ballymun Youth Action Project, and Barry Cullen and Matt Bowden, both of whom were involved in the St Teresa's Gardens Youth Development Project.

46 M. E. McCann, op.cit., p.5.

47 There is a detailed account of this evolution of the St Teresa's Gardens anti-drugs activities in B. Cullen, op. cit., Chapter Five.

[48] *Submission to City Council Proposed Working Party on Drug Abuse in Dublin* (from Barry Cullen, Social Worker, Eastern Health Board, Community Care Area Three, October 29, 1981).

It was perhaps a sign of the conflict which was to surround later developments in the drugs area that, while the Lord Mayor of Dublin wrote to thank Barry Cullen for this submission, the Director of Community Care was rebuked by Health Board management for allowing the document to be sent to the Corporation without first having it cleared by the Board. (Cullen, op. cit., p.58).

[49] M. E. McCann, op. cit., p.11.

[50] W. Martin, 'Concerned Parents Against Drugs Action Group', in N. O'Donohue and S. Richardson, op. cit., pp 71-72.

[51] Most popular epidemiology involves the physical environment and associated claims that toxic materials of one kind or another have led to a demonstrable increase in the incidence of specific illnesses. In Ireland the best known example of popular epidemiology is probably that which has gone on in the Louth area over many years, arguing that the area has an increased incidence of illnesses and congenital abnormalities which is causally related to an explosion at the Sellafield Nuclear Plant in Cumbria in the late 1950s.

For an analysis of a specific example of popular epidemiology see P. Brown, 'Popular epidemiology : community response to toxic-waste induced disease in Woburn, Massachusetts', *Science, Technology and Human Values, 12* (1987), pp 78-85.

For a general discussion of this concept and its relationship to health promotion see G. Williams and J. Poppay, 'Lay knowledge and the privilege of experience' in J. Gabe, D. Kelleher and G. Williams (eds), *Challenging Medicine* (London: Routledge, 1994), pp 118-134).

[52] A summary of the St. Teresa's Gardens research was included in the appendices to the *Eastern Health Board Task Force on Drug Abuse,* cit. sup., p.19.

[53] Because of the relatively small and geographically well defined nature of the area, it was possible for the committee of the Youth Development Project to go through St Teresa's Gardens flat-by-flat (this was a paper exercise rather than a literal walkabout) and through a pooling of local residents' and professionals' knowledge to identify known heroin users. It was accepted by the committee that this exercise might result in an underestimate of the true prevalence of heroin use, and a few years later it was concluded that the actual number of heroin users resident in St Teresa's Gardens during 1981 was 68, not 57. The revised age-specific rate for heroin use amongst people in the 15-24 age group during 1981 in St Teresa's Gardens was 9.3%; these revisions of the original 1981 study are contained in: F. O'Kelly, G. Bury, B. Cullen and G. Dean, 'The Rise and Fall of Heroin Use in an Inner City Area of Dublin', *Irish Journal of Medical Science,* 157 (1988), pp 35-38.

[54] See footnote 13 above.

[55] See Cullen (1992), cit.sup., p.63.

[56] Cullen (1992), cit.sup., p.63.
The reference to Bradshaw's 'second phase study' concerns the intention to do direct research interviews with drug users rather rely solely on the information supplied by professional and local informants.

[57] See, for instance, P. Malone, 'Community Action in the North Inner City', in N. O'Donohue and S. Richardson, op. cit., pp 75-81.

[58] See note 13 above.

[59] Interview with Paul Harrison (November 1988).

[60] Confirmed by Fr Lavelle (Telephone conversation, January 25, 1989).

[61] Interview with Paul Harrison.

[62] The main source for this material is B. Cullen, op. cit.

[63] See M.E. McCann, op. cit.

[64] *The Irish Times,* February 4, 1985.

[65] See M. E. McCann, op. cit.

[66] World Health Organisation, *Targets for Health for All.* (Copenhagen: WH. Regional Office for Europe, 1985). It is worth noting that this WHO publication had considerable currency in Irish health policy circles and was an influence on two policy documents. - *Health: The Wider Dimensions* (1986) and *Promoting Health Through Public Policy* (1987).

[67] This account is based on numerous dealings which this writer had with Áine Flanagan in relation to alcohol and drug services between 1977 and 1991, and on a research interview with her on November 28, 1988.

[68] In fairness, Ms Flanagan did attribute many positive characteristics to Barry Cullen also, but these positive attributes were outweighed in Ms Flanagan's mind by his disloyalty to 'the Board'.

[69] In his research interview with this writer, Paul Harrison commented humorously that, in terms of the Health Board culture of this period, 'planning was for sissies'; and the former Minister for Health, Barry Desmond, complained bitterly that any attempt to discuss drug policy issues with Fred Donohue (Programme Manager for Community Care and Áine Flanagan's immediate superior) quickly degenerated into farce as Mr Donohue overwhelmed him with personal anecdotes.

[70] The development of addiction counselling will be looked at in more detail in Chapter Nine.

[71] Interview with Áine Flanagan, November 28, 1988.

[72] On a number of occasions, this writer suggested to Áine Flanagan that the existing network of Eastern Health Board mental health services might be utilised in the treatment of drug users, but she did not see any practical merit in this suggestion. The motivation behind the suggestion was the belief that services should be 'normalised' and that drug treatment was not a particularly specialist or 'high-tech' enterprise.

[73] *The Irish Times* , November 23, 1983.

[74] It seems surprising that Jervis street did not lobby more vociferously and effectively for much greater resources. The former Minister for Health, Barry Desmond, confirmed that no such lobbying had taken place in his time in this ministry. One possible explanation is that within the Jervis Street centre it was deemed prudent to keep a low profile; heavy lobbying might have led to a fundamental review of the function of the centre and to a decision to diversify resources, thus ending the Jervis Street monopoly It is worth noting that the plan to establish a drug treatment centre at St James's Hospital, which was recommended in the *Report of the Special Governmental Task Force on Drug Abuse* (1983), appears to have fizzled out due to a lack of interest on the part of all concerned.

[75] The only exception to the rule of detoxification and drug-free rehabilitation was that allowed for women during pregnancy and for a limited period following childbirth, when maintenance was provided.

[76] For a succinct analysis of the origins of CPAD, in the broader context of community work in Ireland, see B.Cullen, 'Community Action in the Eighties: A Case Study' in *Community Work in Ireland: Trends in the 80s , Options for the 90s.* (Dublin: Combat Povery Agency, 1990), pp 271-294; for a sympathetic sociological discussion of CPAD as an informal policing system see D. Bennet, 'Are They Always Right? Investigation and proof in a citizen anti-heroin movement' in M. Tomlinson, T. Varley and C. McCullagh (eds), *Whose Law and Order? Aspects of crime and social control in Irish society.* (Sociological Association of Ireland, 1988), pp 21-40.

[77] For a discussion of this period of Ireland's and Fianna Fáil's history see J. Lee, *Ireland 1912-1985: Politics and Society.* (Cambridge University Press, 1989), Chapter 7.

[78] Among the international speakers was Marcus Grant of the Alcohol Education Centre in London, who was to move soon after this to the World Health Organisation at Geneva, and Michael Goodstadt of the Addictions Research Foundation of Ontario. Among the Irish speakers was Dermot Walsh, who introduced the public health perspective on alcohol to an audience which, it is fair to assume, may have been largely unaware of it prior to this.

[79] J. O'Dwyer, 'Conference Report and Recommendations', in *Proceedings of the Education Against Addiction (November 1979).* (Dublin: Health Education Bureau, no date), p.90.

[80] Ibid., p.90.

[81] Ibid., p.93.
At the time he made these remarks, Jerry O'Dwyer was a Principal Officer in the Department of Health; he was to become Secretary of the Department in 1994.

[82] See Chapter Four for references to INCA's views on its relationship with the HEB. The concern of the HEB to avoid encroaching on INCA's territory was also confirmed for this writer by Eugene Donoghue, Head of Education and Training at the HEB during the early 1980s (Interview with Eugene Donoghue, November 7, 1988).

[83] This HEB approach to drug education was described succinctly in E. Donoghue, 'Drug Education: Approaches in Ireland', *Paper read at International Symposium on the Health Promoting School at Peebles, Scotland, May 11-17, 1986.*

[84] Advisory Council on the Misuse of Drugs, *Prevention.* (London: HMSO, 1984).

[85] For an interesting discussion of the British anti-heroin campaign see R. Power, 'Drugs and the media: prevention campaigns and television' in S. MacGregor (ed.), *Drugs and British Society: Responses to a Social Problem in the 1980s.* (London: Routledge, 1989), pp 129-142.

[86] E. Donoghue, op. cit., p.10.

[87] *Press Release issued by the Government Information Services on behalf of the Department of Health, October 5, 1982.*

[88] This ambivalence was confirmed for this writer by Eugene Donoghue, and by Dr Des Corrigan who at this time was working on some of the HEB's drug education programmes.

[89] *Irish Times,* April 27, 1982.

[90] As far as this writer has been able to ascertain, Coolemine has never published an evaluative study of its own activities. It is essentially the same as the American therapeutic community from which it originated, and it seems reasonable to draw on the American evaluative literature of this period to illustrate its limitations. The major limitation is that its tough, confrontational approach and insistence on abstinence appears to be acceptable to only a small proportion of its potential customers. Of those who self-select to enter a TC, about 75-80% drop out before completing the programme (G. De Leon and S. Schwartz, 'Therapeutic Communities: What Are the Retention Rates?', *American Journal of Drug and Alcohol Abuse,* 10 (1984), pp 267-284. It is also interesting to note that in discussion with this writer both Barry Desmond and Áine Flanagan admitted that, despite

their support for Coolemine, they did not regard it as having the capacity to make a significant impact on Dublin's heroin problem.

[91] Cited in Cullen (1992), cit.sup., p.53.

[92] *Irish Times*, July 25, 1983.

[93] This is discussed in Cullen (1992), cit.sup., p.53; it was also confirmed for this writer by Eugene Donoghue of the HEB.

[94] In discussing the HEB with this writer, Áine Flanagan of the Eastern Health Board said that she was 'not an admirer' of the Bureau, and that she did not see it as having any useful role 'in my area' (which this writer took to mean the drugs field).

[95] G. Edwards, 'Addiction: A Challenge to Society', *New Society* (October 25, 1984), p.135.

CHAPTER EIGHT

THE HEALTH EDUCATION BUREAU AND THE LIFESKILLS CONTROVERSY: 1984-1987

Introduction

The broad thrust of the HEB's strategy for drug prevention was discussed previously in Chapters Six and Seven. To recapitulate, the HEB had resisted political pressure to produce publicity materials which largely consisted of explicit denunciation of illicit drugs and moralistic admonitions to young people to eschew all such drug use; the Bureau did this because it was clear from the research literature that drug education of this kind was ineffective if not actually counterproductive. Instead, it had opted to include drug prevention as part of its wider health education package and to do so indirectly through its *lifeskills* programmes, which it hoped would be implemented by 'primary influencers' - mainly teachers and youth leaders - in the lives of young people.

The principles involved in this form of lifeskills education were set out explicitly in the HEB's *Teacher Training Programme in Health Education*.[1] Generally, it was postulated that health was the product of personal choice: it was argued that people largely determined their health status through the lifestyle choices which they made, and that the function of health educators was to facilitate more skillful behavioural choices, which would lead in turn to healthier people. The teaching or 'facilitation' of lifeskills was quintessentially health promotional in its non-authoritarian or partnership approach to this enterprise; students were not instructed to make particular behavioural choices but, instead, were encouraged in a non-directive way to explore the scientific data on particular health risks, to consider the nature of peer and other pressures to make certain choices, and to clarify the value systems relevant to various aspects of lifestyle. The style of teaching and the choice of teaching methods which characterised lifeskills education reflected the non-authoritarian content of the curriculum, with a heavy

emphasis on interactive and student-centred work, such as group discussion, quizzes and role play.

As pointed out in Chapter Seven, the HEB had resolutely ignored the structural or environmental aspects of Dublin's drug problems, opting instead for an exclusive focus on individual decision-making. In choosing to avoid looking at the environmental factors which seemed to be so obviously central to the drug experience of many of Dublin's most deprived neighbourhoods, the HEB may have believed that it was steering clear of potentially stormy political waters. Ironically, its emphasis on individual lifeskills – which may be seen as corresponding to the Ottawa Charter's category of 'developing personal skills' - was to prove a great deal more controversial and politically contentious than anticipated, ultimately contributing to the Bureau's own demise. The aim of this relatively short chapter, therefore, is to discuss and analyse the controversy about lifeskills education, which drew the HEB into direct conflict with clerical authorities and conservative lay members of the Roman Catholic Church.

The Lifeskills Controversy

What happened was that from the mid-1980s a number of conservative Roman Catholic groupings began to develop a coherent, sustained and public critique of lifeskills education in general and of the HEB in particular. These groups argued that the HEB's lifeskills programme was secular, humanist and fundamentally antithetical to traditional Christian methods of religious and moral education. What its opponents found particularly objectionable was the application of the concept of *values clarification* in lifeskills education. Rather than teaching morality prescriptively, or arguing for the validity of particular value systems, as

traditional moral educators would have done, lifeskills facilitators encouraged their charges to discuss and clarify their own value systems in a non-directive way. This values clarification exercise then provided a moral context for the wider discussion of lifestyle choices, which included not just alcohol and drug use, but food consumption, physical exercise, personal relationships, and - most controversially in the Irish situation - sexuality. Lifeskills facilitators were not directive or didactic, but instead behaved like non-directive psychotherapists: they did not tell their students what to do or what not to do, nor did they express censure for lifestyle choices which might traditionally have been regarded as morally wrong.

This lifeskills approach to drug and alcohol education had much to recommend it from a technical perspective, since there was no evidence that it made matters worse and indeed there was modest evidence that it helped to defer initiation into drug and alcohol use by young people and to reduce the harm associated with such use. It appeared to have a good deal to commend it in a situation where experimental drug use seemed to be increasingly common, and where popular and simplistic slogans- such as the 1980s favourite , *Just say no* - were coming to be seen by researchers as of symbolic significance only. Its non-moralistic stance also seemed particularly suited to the complex situation which was emerging from the early to the mid-1980s, as the connection between between the transmission of the newly-identified *Human Immunodeficiency Virus* (HIV) and needle-sharing between injecting drug users became apparent. However, the HEB appeared to be completely unaware of how offensive this lifeskills approach might prove to traditionalist Roman Catholic sensibilities, or of the need to present it in a way which would disarm rather alarm potential objectors. Up to 2,000 secondary school teachers had completed lifeskills training

with the HEB[2] when objections began to be raised to this form of health education. From about 1984, the Bureau became the focus of critical scrutiny in the *Ballintrillick Review,* a publication which was produced six times a year and was sub-titled *A Magazine for Catholic Realists.* In 1986, Doris Manly, editor of this magazine edited a book called *The Facilitators* which was largely devoted to attacking the HEB, and a year later Joseph McCarroll (a regular contributor to the *Ballintrillick Review*) wrote a book called *Is the School Around the Corner Just the Same?* which was a critique of the HEB's teacher training programme.[3]

Those who objected to lifeskills education did so largely on the grounds of their belief in objective moral truth; they believed that most human behaviour or personal choices could be objectively deemed to be morally right or morally wrong, and that it was the function of educators to teach this morality. Doris Manly wrote that:

> Values clarification has *nothing whatever* to do with the recognition of objectively true values. Those who invented it do not believe that objective truth exists. They are total amoral and philosophical relativists; they are subjectivists and emotivists. And usually (outside of Ireland) they are quite frank about saying so [Italics in original].[4]

This same point was made by Joseph McCarroll who insisted that objective moral truth exists, that it is contained in the Roman Catholic tradition, and that failure to teach this truth to children was equivalent to leaving them 'to work out the elementary rules of mathematics on their own'.[5]

These attacks on the HEB were, at least in the first instance, confined to a relatively small circle of conservative Roman Catholic activists and were not treated with any great seriousness by the Bureau.[6] This, in retrospect, was

a tactical error since the groups involved, which included *Family Solidarity* and the *Responsible Society,* were well-organised and formidable opponents who had the experience of the two ('Pro-life' and divorce) Constitutional Referenda behind them. The media soon picked up on this controversy[7] and some of the more conservative members of Roman Catholic Hierarchy also began to take an interest in it. Dr Kevin McNamara, Archbishop of Dublin, delivered an address on this theme during 1986, which was later published in pamphlet form, arguing that:

> While appreciating the need for health education in our schools, and commending the effort to make it available, one may reasonably ask that programmes presented under the heading of 'health education' should, to avoid misunderstanding and confusion, confine themselves to what is normally understood by health, and not seek to gather into the net of health education practically the whole range of a pupil's personal and social life and how, in the wide range of a pupil's relationships with others, moral decision-making and moral behaviour should be guided.[8]

At about the same time, Dr Jeremiah Newman, Bishop of Limerick, published a book entitled *Puppets of Utopia: Can Irish democracy be taken for granted?* in which he argued that Ireland was in serious danger of becoming a state-dominated, totalitarian society.[9] The lifeskills programme of the HEB was cited specifically by Dr Newman as one example of manipulative interference by the state so as to produce a docile and easily-managed public, rather in the style of Orwell's *1984.*

While these attacks on the HEB's lifeskills programme seemed somewhat intemperate - and in the case of Dr Newman almost paranoid - what was most telling was that there was no rush on the part of any of its potential allies to defend the Bureau in this matter. Neither the Minister for Health nor the Minister for Education (or their respective departments) were prepared to become embroiled in public controversy on the subject of health

education and lifeskills. If drug use is taken as an example of the lifestyle behaviours included in the HEB's programme, it is relatively easy to offer a defence of the HEB's position. The scientific facts, if such are conceded to exist at all in an era of social constructionism or postmodernism, do not support absolute condemnation of illicit drug use, but rather paint a more subtle and qualified picture of what the health and other risks are in this area. Similarly, it could be said that moral condemnations of psychoactive drug use lack credibility in a society in which alcohol and tobacco (not to mention tea and coffee) are culturally normative. Finally, and very practically, it can be pointed out that denunciations of drug use and injunctions to young people not to initiate such use are, whatever their symbolic value, of no instrumental value and may instead prove counterproductive.

No such public defence of the HEB's lifeskills programme was mounted, however, by the central government departments most concerned with these issues, nor was the potential value of lifeskills in the era of HIV/AIDS highlighted by any other health sector representative. It was argued in Chapter Seven that the HEB had displayed little or no networking skill during the years of the upsurge in heroin use, at a time when its own resources had been greatly enhanced. It was suggested specifically that, by virtue of its decision to see drug use and drug problems solely in individualistic terms, the HEB had formed no alliances with working class areas where heroin problems were rampant. Not surprisingly, when the HEB's individualistic prevention programme came under attack, none of these working class communities rallied to its defence.

The Closure of the HEB

The position of the HEB was, therefore, one of unenviable isolation, and it came as no great surprise when in September 1987, the new Minister for Health, Dr Rory O'Hanlon, announced that it was to be abolished and that, as part of his commitment to health promotion generally, he was to establish a replacement *Health Promotion Unit* in the Department of Health. It would be wrong to suggest that ideological conflict concerning lifeskills education was the sole or primary factor which motivated Dr O'Hanlon in his decision to close the Bureau. Even its critics resisted the temptation to claim this as a success for themselves; Doris Manly wrote at this time:

> Why did the government axe the HEB? I don't know. Did our criticism play much of a part in the decision? Again, I don't know. I think it reasonable enough to assume that it may have played *some* part. But how large a one it's impossible even to speculate. The one safe conclusion, I suppose, is that our criticism didn't do the HEB any good.[10] [Italics in original]

There is no evidence that Department of Health officials were ideologically opposed to lifeskills; indeed the Health Promotion Unit which replaced the HEB, and which was an integral part of the Department of Health, made use of almost identical concepts and strategies over the succeeding decade, although it took care to avoid concepts and linguistic usages that might reopen old wounds.[11] The Minister for Health who took the decision to close the HEB, Dr Rory O'Hanlon, was generally regarded as a cautious and conservative politician, and if the HEB had ever imagined that Dr O'Hanlon would become a latter-day Noel Browne, in defence of the lifeskills programme, then it was greatly mistaken.

If health promotion is regarded as involving a large amount of networking or political lobbying skills, then the controversy over lifeskills demonstrates, as was argued in Chapter Seven, that the HEB was singularly lacking in these skills. It was not just that it appeared insensitive to orthodox religious sensibilities and blundered its way into conflict with religious traditionalists, but also that it had made no allies to support it in such a conflict. It is instructive to compare the lot of the HEB with that of the National Social Services Board (NSSB), the closure of which was announced by the Minister for Health at about the same time as that of the HEB. Fianna Fáil had won an overall majority in the general election of early 1987 and, contrary to its election promises, had introduced health cuts as part of its general policy of reducing public expenditure. The closure of the NSSB was to be such a cut, with its functions being taken over by the Department of Health and the regional health boards. Unlike the HEB, the NSSB did not passively accept its fate but instead embarked on a vigorous campaign to have this decision rescinded. One of the main functions of the NSSB over the previous decade had been the establishment and servicing of a network of *Community Information Centres* ; these centres were staffed by local volunteers, and now, in its hour of need, the NSSB was able to enlist these voluntary community workers in lobbying for the organisation's survival. The resulting campaign was well orchestrated, leaving national and local politicians in no doubt as to the high level of support for the NSSB, and consequently the decision to abolish the organisation was reversed. No such networking was undertaken by the HEB, however, and it was closed in early 1988.

It is worth reiterating that the Minister for Health justified the closure of the HEB and its replacement by a body located within his own department in

terms of his personal commitment to health promotion. Replying to questions in Dáil Eireann on the closure of the Bureau and its replacement by a Health Promotion Unit within the Department of Health, Dr O'Hanlon said:

> I am sure that Deputies will be familiar with the concept of health promotion. It requires that we not only concentrate on the health education of individuals but that we also develop health promotion policies in those social and economic sectors which influence the quality of our health. In order to initiate the actions required to bring about these board changes, it is obviously necessary that I and my Department should take the lead role. For that reason I have decided to establish a health promotion unit within the Department and to merge in it the present functions of the Health Education Bureau ... I shall be appointing shortly an advisory council on health promotion which will include persons selected from the major social and economic areas which influence the quality of our health. I might mention that the appointment of this council is based on a recommendation which the Health Education Bureau made earlier this year in their report Promoting Health Through Public Policy.[12]

This last reference to *Promoting Health Through Public Policy* could be interpreted as a jibe at the political ineptitude of the HEB, with the Minister and his department taking the Bureau at face value and using one of its own reports as policy justification for its closure. Following this reply in Dáil Eireann, Bernard Allen of Fine Gael asked him if he would agree that there had been friction between the Department of Health and the HEB, and if so whether this friction had contributed to the decision to close the Bureau. The Minister replied briefly and somewhat disingenuously that he was unaware of any such friction.[13] In any event, the HEB was closed in early 1988 and its functions were taken directly into the newly-created section of the Department of Health known as the *Health Promotion Unit* (HPU), which was discussed in detail in Chapter Five in relation to the national alcohol policy.

Conclusion

The closure of the HEB in the wake of public controversy about the morality of its lifeskills programme may be regarded as an indicator of the policy climate in which health policy makers were beginning to contemplate what were known as 'harm reduction strategies' for illicit drug use (strategies which will be examined in detail in Chapter Nine), and also as predictive of the style of policy making which could be expected in this area. The Department of Health was made aware of the fact that the morality of its policies could still become a matter of public controversy and that, notwithstanding the crisis nature of the newly-emerging HIV/AIDS situation, it could not assume that harm reduction strategies - including methadone maintenance, needle exchange schemes or free condom distribution amongst drug users - would automatically gain public acceptance. It is against this background then that the introduction of harm reduction will be explored.

Of equal importance, however, was the lesson which was there to be learnt concerning the style of policy making which might be deemed most suited to areas of potential public controversy. As mentioned above, there was no reason to believe that Department of Health officials had any ideological objections to the lifeskills method of health education, rather was its main concern to avoid unnecessary conflict or embarrassment to the Minister or the Department. From a civil service perspective, the HEB had displayed naivete and a lack of tact in its handling of this issue, and it could be expected that in its future policy activities in the drugs sphere – particularly in relation to the new public health risks involving injecting drug use and HIV/AIDS – the Department of Health would adopt a style which would be circumspect and aimed at the avoidance of major public controversy. It is

this topic, the drug policy response of the Irish healthcare system to the challenges posed by HIV/AIDS, which is the subject matter of Chapter Nine.

Chapter Eight: Footnotes

[1] Health Education Bureau, *Teacher Training Programme in Health Education.* (Dublin: HEB, no date).

[2] This is based on discussion with Eugene Donoghue, Head of Training at the HEB (November 7, 1988).

[3] D. Manly, L. Browne, G. Cox and P. Lowry, *The Facilitators.* (Dublin: Brandsma Books, 1986; J. McCarroll, *Is the School Around the Corner Just the Same?.* (Dublin: Brandsma Books, 1987).

[4] D. Manly et al, op.cit., p.55.

[5] J. McCarroll, op. cit., p.8.

[6] This is based on this writer's memory of this period, during which time he collaborated with the HEB on the development of a drugs training pack for community groups, and also on the above cited interview with Eugene Donoghue.

[7] For example, *Today Tonight,* RTE's main news features television programme covered this controversy during 1986 and included a studio debate between Eugene Donoghue of the HEB and Joseph McCarroll of Family Solidarity.

[8] K. McNamara, *Curriculum and Values in Education.* (Dublin: Veritas, 1987), p.15.

[9] J. Newman, *Puppets of Utopia: Can Irish democracy be taken for granted?* (Dublin: Four Courts Press, 1987).

This puppetry theme – with the HEB cast in the role of a devious puppet master manipulating a naïve public – seems to have been popular with opponents of the HEB; the cover of Doris Manly's book *The Facilitators* also depicted such a scene.

[10] *The Ballintrillick Review* (Autumn 1987), p.12.

[11] In 1994, for example, the Health Promotion Unit in collaboration with the Psychological Service of the Department of Education and the Mater Dei Counselling Service produced a new Substance Abuse Prevention Programme for secondry schools, *On My Own Two Feet,* which was essentially based on the lifeskills model which had been so controversial in the 1980s. The inclusion of the Mater Dei Counselling Service (an integral part of the Roman Catholic Archdiocesan institution in Dublin) in the process of producing this training pack considerably reduced the likelihood of its being attacked by official Church sources.

[12] *Dáil Debates* (Vol. 374[b]), Columns 1527-1528.

[13] Ibid., Column 1529.

CHAPTER NINE

COPING WITH THE 'VIRUS' 1986 - 1996: IRISH DRUG POLICY IN THE AGE OF HIV

Introduction

The period of the 'opiate epidemic', which was the subject of Chapter Seven, was for Irish drug policy makers a difficult one. The apparent consensus amongst all sectors of Government and amongst the general population on the evils of illicit drug use did not lead automatically to the formulation and implementation of clear and effective policy in this area; on the contrary, it can fairly be said that the sudden upsurge in heroin use from 1979 onwards appeared to take the authorities by surprise and that they struggled to come to terms with the complexities of this new situation. Policy making during the period 1986-1996, which is the subject of the present chapter, was to be an even more fraught affair; not only did Irish policy makers have to cope with all of the unresolved issues and dilemmas from the earlier period, but they were now compelled to review the most basic tenets of conventional drug policy in the light of the new public health crisis which accompanied the human immunodeficiency virus (HIV) and its associated acquired immune deficiency syndrome (AIDS).

This chapter will therefore describe and analyse the drug policy response in the era of what Dublin drug users tended to refer to simply as 'the virus'.[1] The focus here will again be on the way in which policy makers devised individualistic and environmental strategies, bearing in mind the radically changed policy climate engendered by HIV/AIDS, and on the way in which they handled the balance between these strategies. In addition to this, the policy process itself will be considered with a view to seeing which of the policy models used throughout this thesis corresponds most closely to the policy process during this period.

HIV/AIDS and Their Impact on Drug Policy

Prior to the advent of HIV/AIDS, it could be said that Irish drug policy was a seamless garment in which all sectors of government were agreed on the absolute evil of illicit drugs and on the necessity to work collaboratively for the attainment of a drug-free society. In *Health: The Wider Dimensions,* a consultative document on health promotion published by the Department of Health in 1986, there was a brief statement to the effect that: 'In Ireland the problem of drug abuse provides a good example of intersectoral collaboration working successfully in practice'.[2] This statement was by way of contrast with an immediately preceding discussion of the difficulties involved in fostering an intersectoral response to alcohol problems in Ireland. Sociologists have tended to view *health risk* as a social construct rather than as solely, or even primarily, the product of objective and value-free research;[3] what this means is that societal decisions about what are deemed to be hazards or dangers to human health are arrived at through social, cultural and political processes rather than always flowing rationally and directly from scientific research.

Applying this notion of health risk to what has been presented thus far in this thesis (particularly in Chapters Four and Five), it could be said that Irish society has demonstrated a marked reluctance to acknowledge alcohol consumption as an essentially risky activity - despite the best efforts of public health activists who argued for such a construction. On the other hand, it could be said that discourse on the health risks of illicit drug use was exaggerated, since there was virtually no voice to argue for a more subtle or discriminating analysis of how these drugs had an adverse impact on human health. It will be argued in this chapter, however, that in common with other countries, Ireland was compelled to question this absolutist or fundamentalist rejection of drugs, once the connection between HIV

transmission and needle sharing between intravenous drug users began to become clear in the mid-1980s. When drug use and HIV infection were viewed in relative public health terms, it began to seem as though drug use was the lesser of two evils; therefore newer approaches to drug policy, reflecting this conclusion, began to emerge. This abandonment of the absolutist rhetoric of the War on Drugs effectively constituted a rending of the previously seamless garment of Irish drug policy; the criminal justice system might continue to enforce prohibitionist laws, and the educational system might continue to exhort Irish young people to 'Just say no', but there could be no gainsaying the fact that, in response to the crisis of HIV/AIDS, Irish health policy was moving towards a position in which total abstinence was no longer seen as the only acceptable treatment outcome for illicit drug users.

Before looking in detail at how HIV/AIDS made an impact on drug policy in Ireland and elsewhere, it is necessary to have a short discussion of how medical scientists identified this new virus and discovered how it was transmitted.[4] The first indications of a new disease or syndrome came from clinical experience in New York where it was noted in 1981 that young, male homosexuals were beginning to show an unusually high incidence of opportunistic infections and cancers, which would previously have been associated with older people whose immune systems had been damaged. In 1983 the virus which was deemed to be the primary cause of these diseases was identified, more or less simultaneously, in France and in the USA; this virus was initially referred to in Europe as the *Lymphadenopathy Associated Virus* (LAV) and in the USA as the *Human T-Cell Lymphtrophic Virus III* (HTLV III), but within a few years it came to be known by international consensus as the *Human Immunodeficiency Virus* (HIV). It was discovered that the mode of action of HIV in an infected person was to attack

T4 and T-helper cells which play a crucial role in mobilising the body's immune system against attack by infectious agents. Thus an individual whose immune system has been compromised by HIV infection becomes vulnerable to infections and tumours which would be easily resisted by somebody with a normal immune system.[5]

Scientific consensus on the main modes of transmission of HIV also emerged relatively quickly, and it was concluded that the virus could only be passed from one person to another in a very limited number of ways, all of which involved an exchange of certain body fluids - notably blood, semen and vaginal fluids. The most common such body fluid exchanges were:

- sexual contact involving penile penetration of the vagina or anus;
- mother to child contact, either across the placenta, through the birth canal or in breast milk;
- blood transfusion or other medical treatments involving blood products;
- sharing of unsterilised needles and syringes between intravenous drug users.
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Since no vaccine against HIV seemed imminent and since there was no cure for AIDS, public health measures aimed at preventing transmission were largely concentrated on bringing about change in sexual behaviour and in drug use behaviour, as well of course as making blood transfusion systems safe.

The advent of HIV/AIDS was not just a cause for concern amongst health care professionals and health service authorities, but amongst the general populations of developed countries - more accustomed to news of therapeutic breakthroughs and the conquest of existing illnesses - it created an unprecedented sense of fear and crisis. At the level of popular cultural and media discourse, this new syndrome was often discussed in a way that

conjured up images of the fourteenth century Black Death; it was not simply seen as a new ailment to be tackled by biomedical researchers, but sometimes as a modern plague or form of divine retribution on a morally lax world. Because of its close association with male homosexuals, it was sometimes referred to as a 'gay plague' and gay activists argued that, at least until the full implications of HIV for society as a whole became apparent, health authorities were inclined to see AIDS as a self-inflicted condition which they were in no real hurry to address.[6] Almost from the outset, however, the importance of various social aspects of AIDS was recognised and, in addition to medical research on the virus and its effects, there emerged a thriving social science research and publications industry based on this topic.[7] A good deal of the research by sociologists and social psychologists was aimed at increasing knowledge of sexual behaviour and drug use behaviour, and applying this knowledge to HIV prevention; the research was also more broadly aimed at promoting policies which would be rational and humane and which would avoid the worst excesses of discrimination and stigma against those infected by HIV. The World Health Organisation, through its Global Programme on AIDS, also played a role in this latter activity; writing in 1988, Dr Jonathan Mann of the WHO argued that:

> For analytic purposes, it is useful to consider AIDS as three distinct yet intertwined global epidemics. The first is the epidemic of AIDS virus infection itself. The second epidemic, inexorably following the first, but with a delay of several years, is the epidemic of the disease AIDS ... Finally, the third epidemic - of social, cultural, economic and political reaction to AIDS - is also worldwide and is as central to the global AIDS challenge as the disease itself.[8]

From a policy perspective, the introduction of HIV prevention measures in Ireland was unusually complex. As would later become clear, the task of ensuring that blood and blood products were uncontaminated was far from simple; but it could at least be said that this was a task which was essentially technical and which was not complicated by moral debate. When the focus

is switched to HIV prevention amongst gay men and intravenous drug users, it becomes instantly clear that the policy process is greatly complicated by moral debate, because the behaviours involved were illegal and commonly regarded as morally reprehensible.[9] From the mid-1980s onwards, the Department of Health – with the technical assistance of the Virus Reference Laboratory at University College Dublin – monitored the incidence of HIV infection in Ireland, and this epidemiological research was intended to be used as a basis for planning preventive strategies.

TABLE 12

Antibody Positive Test Results In Selected Samples of At Risk Groups in Ireland (November, 1985)

At Risk Group	No. Tested	% Positive
Haemophiliacs	256	33
Intravenous Drug Abusers	240	30
Homosexuals	347	9

Source: Department of Health, 1986

Preliminary HIV testing, as can be seen from Table 12, revealed that haemophiliacs had indeed been badly affected by contaminated blood products used in the treatment of their illness; however, it also confirmed that gay men and intravenous drug users constituted important 'at risk' groups for whom the construction of prevention strategies was likely to be a complex and ongoing process. Prevention campaigns could of course have been confined to simple admonitions to these latter groups to stay within the law and desist from illicit sexual and drug use behaviours, which now carried an additional risk of exposure to HIV. Such preventive tactics were generally deemed futile, however, and policy makers in Ireland, as elsewhere, were led to a consideration of more pragmatic measures to deal

with this major public health problem. What gave further impetus to this switch towards pragmatism was the conclusion on the part of public health authorities that HIV/AIDS was unlikely to be confined to these 'deviant' sub-groups, but that these groups might act as a bridge for the transmission of HIV into the general population. Such transmission could occur, for instance, when drug users had sexual contacts with non-drug users, or when bisexual men became infected through homosexual contacts and then went on to infect their women partners.

Despite the fact that male homosexual behaviour was still illegal, the Health Education Bureau gave funding to a voluntary body known as the *Gay Health Action* group, which led to the production of the state's first information leaflets on AIDS, in 1985 and 1988.[10] These leaflets did not advocate sexual abstinence for gay people but instead recommended what came to be known as 'safer sex' practices - such as non-penetrative sex or the use of condoms - which minimised or eliminated the risk of HIV transmission. To put these Gay Health Action activities in context, it should be pointed out that the laws against male homosexual behaviour were by this time rarely enforced and that a legal and political campaign for the decriminalisation of male homosexuality was well under way.

There was, however, absolutely no suggestion from any quarter that the ideological basis of Irish drug policy and legislation was in need of revision; the legislation was of very recent origin and was strictly enforced, and, as discussed in Chapter Seven, Irish politicians tended to the view that their public pronouncements on drug issues should be unequivocally prohibitionist. Furthermore, illicit drug users were generally regarded as a disparate and disorganised collection of individuals, primarily to be categorised in pathological terms, rather than viewed as a coherent lobby

group like the 'gay community'. Nonetheless, for public health policy in Ireland an obvious dilemma had arisen: the prevention of HIV transmission had become imperative, but it was impossible to see how effective preventive measures could be introduced amongst intravenous drug users without apparently undermining the ideological commitment to a drug-free society as epitomised in the Misuse of Drugs Acts. Just as HIV prevention in the gay community revolved around safer sex rather than sexual abstinence, so too was it now mooted that amongst drug users it might consist of safer drug use rather than solely being confined to the traditional therapeutic goal of total abstinence. The phrase most commonly used to describe this emerging public health approach to drug use was 'harm reduction', and its meaning and implications will now be discussed in some detail.

Harm Reduction

It could, of course, be argued that traditional drug treatment and rehabilitation programmes which aim to make their clients drug free deserve the title *harm reduction* ; such programmes are, after all, concerned with reducing drug-related harm and do so in what is the most obvious way, which is to assist people to become and remain drug free. In the context of the public health crisis associated with HIV, however, harm reduction is invariably understood as referring to strategies which are aimed at reducing drug-related harm where the drug user is either unwilling or unable to stop using drugs.[11] The concept of harm reduction, when understood in this context, incorporated some strategies, such as methadone maintenance, which were not new, and some others, such as needle exchange schemes, which were devised specifically in response to HIV.[12]

While proponents of harm reduction tended to the view that such strategies were pragmatic responses, which were justified in the era of HIV/AIDS and were necessitated by the obvious failure of abstinence approaches, opposition to harm reduction was predictable. Essentially, the emergence and articulation of a harm reduction philosophy involved a fundamental reconstruction of drug-related health risk in a way which was ideologically undermining of the traditional prohibitionist position.[13] For example, in relation to heroin use, it was now being acknowledged that it was not heroin use *per se* which constituted the major health risk (although there were overdose risks associated with heroin), but rather the practice of administering the drug intravenously with non-sterile injecting equipment. This acknowledgement led on logically to a consideration of a *number* of HIV prevention strategies for heroin-users. Harm reduction and abstinence are not necessarily dichotomous categories, and in practice many (if not most) professionals would start by suggesting to their heroin using clients that they should detoxify and remain abstinent. Where clients were unable or unwilling to pursue the abstinence option, however, there were now several other harm reduction options which could be explored, including the following:

- the replacement of street heroin by a prescribed substitute drug such as methadone;
- the use of heroin through smoking rather than by injection;
- intravenous use by means of sterile, non-shared injecting equipment - made available through needle exchange schemes;
- intravenous use by means of shared equipment, where the user is given advice and assistance in the art of sterilising previously used needles and syringes.[14]

Individually and collectively these harm reduction options represented a new style of risk construction in terms of the health implications of illicit drug use; what they acknowledged explicitly was that it was not drug use

per se which constituted the sole or even the major risk to human health and that it should logically be possible to foster 'healthy' drug use, just as it was logically possible, for example, to foster 'sensible drinking'.

If the various harm reduction strategies are considered in more depth, it becomes clear that they differ from the traditional abstinence approach not just in that they tolerate continuing drug use, but also in that they involve a radical reconceptualisation of drug users. Prior to the advent of HIV the dominant conceptualisation of illicit drug users had been entirely grounded in ideas of pathology. Drug use was regarded as a self-evidently pathological and deviant activity; individual drug users were assumed to demonstrate high levels of individual psychopathology; and insofar as drug users were perceived to exist within their own sub-culture this too tended to be seen in sociopathological terms. The emergence of treatment and rehabilitation services for illicit drug users in Ireland, as discussed in Chapters Six and Seven, had been completely predicated upon such pathological conceptualisations of drug users. Implicit in the harm reduction approach to drug treatment services, however, was a very different view of illicit drug users, one which was more positive and more respectful.[15]

Essentially, the harm reduction philosophy reframed illicit drug use as a phenomenon which was just as intelligible as alcohol consumption; the decision of illicit drug users to seek gratification in this way was no longer regarded as inherently irrational or pathological. Furthermore, it came to be accepted that the process of maximising drug-related pleasure while minimising risk was just as amenable to health promotion interventions as any other aspect of lifestyle. Most important of all perhaps was the related acceptance of the view that health care professionals could no longer

assume a position of moral and cognitive superiority in their dealings with illicit drug users. Instead, in the new dispensation, it was argued in classic health promotional terms that professionals should respect and learn from the knowledge and wisdom of drug users, who, it was argued, knew more about drug use than anybody else. It was suggested, for instance, that current drug users could play a valuable role in health promotion as *peer workers* in their own drug-using communities. In a 1989 paper in which he attempted to summarise the shift towards harm reduction in the British treatment scene, Griffith Edwards suggested that:

> The central change is perhaps that the balance of power between treatment agency and person treated has been sharply re-adjusted. Agencies have less capacity than previously to demand, challenge, set contracts or exclude from treatment, while patients or clients are now likely to secure treatment (including prescribed opiates) much more on their own terms.[16]

Also implicit in this more positive and respectful vision of drug users was a conviction that services should be structured in such a way as to maximise their acceptability and accessibility to potential consumers; centralised services (such as those which had been set up in Dublin) to which drug users were expected to come as supplicants were no longer viewed as appropriate, and it came to be expected that services would be localised and that *outreach* systems would be set in place to make contact with hitherto untreated drug users.[17]

Given the vehemence of international condemnations of illicit drugs and the uncompromising nature of the rhetoric of the War on Drugs, it was obvious that the introduction of harm reduction policies would be difficult and contentious everywhere. Ideologically, harm reduction represented a softening of the anti-drugs stance which had previously been unchallenged; to those who remained fully committed to the prohibitionist stance, harm reduction was an unacceptable compromise which looked suspiciously like

the first steps towards decriminalisation, if not full legalisation, of previously prohibited substances.[18] From a comparative perspective, one could predict that some countries would have less difficulty than others in introducing harm reduction, depending not just on how particular countries had framed their own drug policy but also on their wider political cultures. For instance, in view of its previous history of the so-called 'British system' (which could be regarded as an early experiment with harm reduction), it could be predicted that Britain would experience far less problems in introducing harm reduction than would the USA, which had a long history of strict prohibition. Similarly it seemed clear that the Netherlands - with a political culture which was generally characterised by pragmatism - had already been introducing a harm reduction policy (although without naming it as such) for ten years prior to the identification of HIV.[19]

The problems which might attend any attempt to introduce harm reduction in Ireland are largely identifiable from the account of previous drug policy making contained in Chapters Six and Seven. One quite fundamental difficulty was the absence of an effective policy advisory body which could formally and publicly debate the issues, weigh up the pros and cons of the various options and make recommendations to Government. In Britain this role was carried out by the *Advisory Council on the Misuse of Drugs,* a statutory body which had been established in accordance with Section One of the Misuse of Drugs Act 1971; in Ireland, as discussed in Chapters Six and Seven, no such body existed and it appeared to be taken for granted that the policy issues were so clear-cut that debate was unnecessary. It was pointed out in Chapter Seven, for instance, that even at the height of the 'opiate epidemic' there had been no policy debate on the merits or otherwise of methadone maintenance.

The total reorientation of health services for drug users which was implicit in harm reduction would obviously prove difficult. The Dublin services had been entirely centralised, insistent on abstinence as the only acceptable treatment goal and unwilling to share power with local community groups. It was hard to see how these services could be easily decentralised, how methadone maintenance or needle and syringe exchange schemes could be widely introduced, and how power could be shared with drug users in outreach and peer-led service initiatives.

Even if political leaders were personally inclined to advocate the introduction of harm reduction strategies - and it has to be said that during the mid 1980s there was little evidence of such inclination - the political climate at this time could hardly have been less favourable to such a liberal-seeming enterprise. The success of conservative religious groups in the 1983 'pro-life' Constitutional Referendum and in the 1986 divorce Referendum had created unprecedented social divisions[20] and must surely have convinced politicians that this was not an opportune time for the introduction of what would generally be seen as liberalised drug policies. The controversy which had surrounded the Health Education Bureau's lifeskills programmes and the ultimate fate of the Bureau itself, which was the subject of Chapter Eight, must also have raised questions for Irish policy makers about the wisdom of publicly espousing harm reduction policies and strategies.

The remainder of this chapter will look in detail at this dilemma for Irish policy makers and service providers: the threat to public health posed by HIV made it imperative that harm reduction policies for drug users should be given serious consideration, yet harm reduction appeared to be

ideologically incompatible with previous Irish policy on this subject, which generally reflected the broad thrust of the 'War on Drugs' perspective.

Making the Transition to Harm Reduction

As described in Chapter Seven, the establishment of a *National Co-ordinating Committee on Drug Abuse* was recommended in 1983; this new body was to replace the rather more informal committee which had been in existence since 1971 but which was deemed to have been inadequate. The new National Co-ordinating Committee was established in March 1985 with the following formal terms of reference:

(i) to advise the Government on general issues relating to the prevention and treatment of drug abuse;

(ii) to monitor the effectiveness and efficiency of measures in force to prevent and treat drug abuse;

(iii) to facilitate communication between the various agencies involved in the prevention and treatment of drug abuse;

(iv) to submit a report to the Minister for Health on an annual basis.

The National Co-ordinating Committee was not established on a statutory basis, but presumably the requirement that it submit an annual report to the Minister was seen as offering a reasonable prospect that it would survive as an active standing committee, unlike its predecessor.

The new committee was to be chaired by a politician, Fergus O'Brien, who was at this time Minister of State at the Department of the Environment and who, by virtue of his previous experience as chair of the Special Governmental Task Force on Drug Abuse during 1982 and 1983, seemed uniquely suited to this task. The committee itself was made up of a mix of

civil servants, healthcare professionals, senior members of the Garda Síochána, voluntary and community representatives and some others.[21] Once again, however, the committee was based in the Department of Health and relied for research, administrative and secretarial support on the staff of that department. Its *First Annual Report* was published in June 1986, fifteen months after its inaugural meeting. It was indicated in the report that the committee had met on eight occasions during this initial fifteen month period.[22] This could be regarded as an acceptably frequent record of meetings, but there were already ominous signs that the committee was sliding into the pattern of its predecessor of the 1970s.

From a procedural perspective, the most significant change in the makeup of the committee was the resignation during this period of its chairperson, Fergus O'Brien, and his replacement by Liam Flanagan, Secretary of the Department of Health.[23] The reason cited for this change was Mr O'Brien's heavy workload at this time, but indeed it seemed predictable that such a busy politician - dividing his time between the Oireachtas, his departmental responsibilities in the Department of the Environment and his constituency work - would not be the ideal person to chair a committee such as this. The fact that the chairperson was now a senior civil servant from the Department of Health meant that the new committee had effectively reverted to the position of the discredited Inter-Departmental Committee of the 1970s, with control of the agenda and of the frequency of meetings once more back in the hands of departmental officials.

Equally importantly, a reading of the contents of the committee's first report would suggest that it was working in a relatively superficial administrative way, side-stepping policy issues and dilemmas and confining itself to

cursory and uncritical comment on the topics it had discussed. For instance, its paragraph on lifeskills[24] consisted of brief references to the development of lifeskills programmes in the Eastern and the North-Western Health Board areas, and to the necessity for extending these programmes to the country as a whole. It neither referred to the results of evaluative research on these programmes (which at best were only moderately encouraging.[25]) nor to the political controversy over lifeskills which was brewing at this time.

It is, however, in relation to HIV/AIDS that the reluctance of the National Co-ordinating Committee on Drug Abuse to engage in critical policy debate becomes most pointed. The 1986 report contained just one page of desultory comment on this subject,[26] with no reference to harm reduction or to the policy dilemmas inherent in responding to the transmission of HIV amongst intravenous drug users. An equivalent amount of space was given in the report to an uncritical recording of the views expressed to the committee by a visiting American, Ms Carla Lowe of the *Californians for Drug-Free Youth,* a parents' anti-drugs organisation.[27] Amongst these views were Ms Lowe's stated conviction that 'children from all backgrounds were involved' in drug abuse, and that cannabis 'is possibly the most dangerous of all drugs'.[28] These views were obviously questionable in an Irish, whatever about an American, context, but they were politically safe and uncontroversial.

Following the publication of this 1986 report, the National Co-ordinating Committee on Drug Abuse went into a period of drift, meeting rarely and never publishing another annual report. In 1989 the committee was 're-constituted',[29] which meant that almost all those nominally members of it

were replaced, largely by civil servants, and this re-constituted committee went on to produce a policy document, the *Government Strategy To Prevent Drug Misuse* in 1991.[30] This 1991 report will be discussed later in this chapter, but first it seems important to comment upon the failure of yet another policy-making body to function as intended.

The most obvious interpretation of the failure of this committee to function in accordance with its formal terms of reference again involves the Department of Health's distaste for power-sharing or for adopting a social networks approach to policy making. The committee had no statutory existence and, once the position of chair was abandoned by its political holder, power effectively reverted to the civil service. None of the committee members appear to have held radical views, particularly views favouring harm reduction, but obviously there were disagreements amongst them. To some extent, this lack of consensus seemed to irk those civil servants most concerned with drug issues, and, rather than working on producing a compromise, they sidelined the committee by simply not calling meetings.[31] It is interesting, for comparative purposes, to note that in Britain the Advisory Council on the Misuse of Drugs, which as a statutory body enjoyed a considerable amount of autonomy, debated the implications of HIV/AIDS for drugs policy more explicitly and more overtly. It published a number of reports on this topic, the first of which recommended the adoption of harm reduction strategies based on the much-quoted premise that 'The spread of HIV is a greater danger to individual and public health than drug misuse'.[32]

Given the failure of the National Co-ordinating Committee to debate harm reduction issues, the likelihood of any explicit formal debate of the topic seemed slight. However, in early 1988, Seanad Eireann had a debate on AIDS to which the Minister for Health, Dr Rory O'Hanlon, and his Minister of State, Terry Leydon contributed. Senators David Norris and Joe O'Toole had arranged briefings on HIV/AIDS for their colleagues immediately prior to the debate and, whether because of these briefings by experts in this area or because of a long-term interest in the subject, the contributions seemed extremely well informed. Almost all of the speakers took the view that HIV constituted such a threat to public health that it warranted a revision of the previous tradition of abstinence as the sole legitimate model for drug treatment and rehabilitation services. Furthermore, Senators who took this view were aware of the moral dilemmas which this entailed but felt that this was a policy nettle which had to be grasped. For instance, Dr John O'Connell spoke as follows:

> This is very disturbing. It is important to have energetic preventive measures targeted at this high risk group. It would do much to ensure that the epidemic here is controlled. I can understand the dilemma of the Minister and his Department. It is a very serious thing as to whether they should conspire in illegal acts, but free needle provision and methadone maintenance must be seriously considered by the Department ... Here the objections are raised. If you are going to provide needles, like methadone maintenance, it looks very like collusion with illegal activity, but with AIDS we are facing a problem of such enormity, such potential disaster for the human race that collusion is amply justified. I urge urgently [sic] on the Minister to make a decision on it as fast as possible.[33]

By and large, his colleagues agreed with Dr O'Connell, and in various other ways they expressed support for a radical rethink of policy approaches to drug users. Senator Nuala Fennell, for example, was just one speaker to refer to the Dutch idea of having a 'junkies union' in which the knowledge and skills of drug users could be harnessed in a health

promotional way - 'It may be an outrageous idea, but is well worth looking at'.[34]

The ghost at this harm reduction feast was Senator Don Lydon, a Fianna Fáil Senator, who argued trenchantly that communal moral standards must be maintained whatever the gravity of the HIV/AIDS situation. Although Senator Lydon was a clinical psychologist by profession, his views on AIDS bore no resemblance to those commonly expressed by British psychologists at this time, but instead were similar in language and general tone to the ideas of those who had criticised the HEB and its lifeskills programme. The flavour of Senator Lydon's contribution may be gauged from his assertion that: 'The whole population is not at risk. Drug addicts and promiscuous people are at risk. Sodomites are certainly at risk'.[35]

The most important speech of all in this debate, perhaps, was that of the Minister, Dr O'Hanlon. He had spoken first and so was uninfluenced by any of the subsequent speeches, but obviously his views were a disappointment to those who later argued for harm reduction. The Minister's speech had all the appearances of a carefully-drafted civil service text: it was orderly and factually detailed, yet it managed to avoid all reference to the policy dilemmas which this situation created for a Minister for Health. He referred to just one policy innovation in the drugs treatment system in Dublin, namely the establishment of an outreach programme for drug users within the Eastern Health Board,[36] but this was a brief reference which did not review the wider treatment service systems and their appropriateness for the new challenges posed by HIV. Towards the end of his speech he made the following brief reference to harm reduction:

> We are also monitoring what is happening in other countries in relation to the availability of free needles for drug abusers and also the use of methadone. To date we are not satisfied that we should not go in that direction but we are monitoring the situation very closely and when we are satisfied we will make a decision in whatever way we think is best.[37]

By comparison with most of the other contributions to this debate in Seanad Eireann (and no debate of a comparable nature took place in Dáil Eireann), the Minister's speech was remarkably stilted and cautious, and it might reasonably be inferred from it that he regarded Don Lydon's views on morality as more reflective of public opinion than those of the Senators who had advocated harm reduction. The Minister appeared to have decided that harm reduction was unacceptable to the Irish public and that even to debate it was unwise.

The reality, however, was more complex than this, because even at the time of this debate in Seanad Eireann harm reduction strategies were already being introduced; what was happening was that, without formal debate or public announcement of policy change, methadone maintenance was now being used more commonly in the National Drug Advisory and Treatment Centre at Jervis Street Hospital. Furthermore, the Eastern Health Board was planning a major expansion of its own direct services for drug users, and the new EHB services - which were to be based in an *AIDS Resource Centre* at the old Baggot Street Hospital - were to include not just methadone maintenance but also needle exchange.[38] It could perhaps be argued that this introduction of harm reduction strategies without public debate or formal policy announcement was not all that unusual, but that it corresponded to a common pattern of incremental policy change. What was most unusual was that such a policy shift - however incrementally it may have been introduced - was taking place at the same time as the Minister for Health was publicly indicating that he did not support such a revision of

traditional policy. While those whose day-to-day work involved them in contact with drug issues may have been aware of this contradiction, it did not impinge itself forcibly on to public consciousness or give rise to comment. An interesting exception was the reporting by the *Irish Times* of a speech by Dr O Hanlon in November 1988, at the opening of the *National Drug Treatment Centre* - a new unit necessitated by the closure of Jervis Street Hospital.[39] The Minister's speech was reported in the following terms:

> There is insufficient evidence to support the introduction of free condoms or needle exchange for drug abusers, the Minister for Health, Dr O'Hanlon, said at the opening of a major new drugs treatment unit in Dublin yesterday ... Dr O'Hanlon's remarks seem to cut across those made by the head of the Government's AIDS programme, Dr James Walsh, who earlier in the day had come out in favour of free condoms and needles for drug abusers.[40]

This quote is valuable both as an indication of how paradoxical this policy situation could appear when it was explicitly adverted to, and as confirmation of the way in which public health concerns about AIDS were now driving drug policy in Ireland.

It would be wrong to suppose that Ireland was uniquely affected by this policy dilemma, in which the health sector appeared to be breaking ranks with the criminal justice approach to working for a drug-free society. Nutbeam, Blakey and Pates (1991), in an international review of the issues involved in promoting health amongst injecting drug users, argued that:

> Making such a shift in policy has been a difficult task in many countries. Where it has happened, it has often occurred by default and without overt political support ... A better understanding of the issues and seriousness of the public health problem has lead to more rational and pragmatic policy responses, based on well presented public health arguments. However, these experiences indicate how important it is not to underestimate the difficulties and dilemmas facing policy makers who are being urged to

> overturn established public policy, and to run counter to public opinion.[41]

Bearing in mind, therefore, that the introduction of harm reduction policy and strategies was a contentious business in many countries, the next section will look in further detail at the implementation of these practices in Ireland. It will be argued that this incremental introduction of harm reduction, without formal debate or public announcement, can be seen as having both positive and negative consequences from a health promotional perspective.

The *Pros* and *Cons* of Covert Harm Reduction

Throughout the period covered in this chapter (1986-1996) harm reduction services and facilities were introduced in the covert, incremental way already described, and it was only towards the end of this period that this policy change began to be overtly discussed or explicitly acknowledged. Because change was introduced into the Dublin drug treatment system in this stealthy fashion it is not easy to be entirely accurate about when specific developments took place, but some of the more important events and initiatives are set out chronologically in Table 13.

Table 13

Introduction of Harm Reduction Practices into the Dublin Drug Treatment System

1987	**Limited availability of methadone maintenance at the National Drug Treatment Centre.**
1989	**Establishment by Eastern Health Board of AIDS Resource Centre, offering needle exchange, methadone maintenance and outreach work.**
1991-1993	**Establishment of localised 'satellite' clinics by Eastern Health Board, again offering needle exchange and methadone maintenance**
1996	**Introduction of mobile clinic / methadone bus**

From the perspective of those concerned about promoting health amongst Dublin's injecting drug users, the main advantage of this incremental policy change was that it confused opponents of harm reduction and avoided the emergence of public controversy such as that which had bedevilled the Health Education Bureau's lifeskills programme. The ambiguity surrounding this policy shift meant that there was no clearly identifiable target for those ideologically opposed to harm reduction, and this undoubtedly contributed to the fact that no sustained and coherent campaign for a return to 'abstinence only' policies emerged over the course of this decade.

It should be noted, however, that opposition to such practices as needle exchange and methadone maintenance was expressed sporadically, usually emanating from groups committed to the idea of abstinence as the only legitimate therapeutic goal for drug users as well as to the wider aspiration

to a drug-free society. One of the key players in the voluntary drug sector in Dublin, the Coolemine Therapeutic Community, had its origins in American models of rehabilitation which were axiomatically committed to abstinence. As described in Chapters Six and Seven, the Coolemine programme, from the time of its establishment in 1973, had been reasonably well funded from statutory sources and generally treated with deference by other players in the drug problems arena. In the early 1980s, before the identification of HIV, Jim Comberton, Executive Chairman of the Coolemine service had circulated in photocopy form a paper entitled 'The Self-fulfilling Prophesty [sic] of Physeptone Maintenance (1)'.[42] This was a pre-emptive strike at those who might lobby for the introduction of methadone maintenance in Ireland, and it was written in uncompromising, polemical language; it concluded:

> There have been no Government proposals or official speculation about the introduction of Physeptone Maintenance in the Republic of Ireland, and we have no reason to expect proposals in this direction. Our concern, drawing on the disastrous experience of other countries, is that we be ready to challenge the use of Physeptone Maintenance and make its rejection a matter of public policy.[43]

Jim Comberton's readiness to challenge *proposals* for the introduction of methadone maintenance was obviously frustrated by the fact that no such proposals were ever made; instead, the practice was introduced discreetly into the healthcare system, making it difficult for its opponents to know when it had started, how widespread it was, or whether it had Governmental approval to continue. A similar, but more lengthy document, was circulated by Jim Comberton in 1990, entitled 'Ireland's Young People Have a Right to a Drug-Free Life'.[44]

Again, what was most interesting about this 1990 paper was the sense that its author, while realising that harm reduction policy to which he was opposed was 'in the air', was confused as to what precisely was

happening. The content of the paper was primarily aimed at demonstrating that methadone maintenance and needle exchange were discredited British and Dutch social control policies – rather than therapeutic initiatives - and also that such policies were immoral. On the question of the morality of harm reduction, there was an interesting reference back to the 'Very high aspirations and principles [which] were voiced during the Right to Life controversy',[45] and it was concluded that:

> It is surely unacceptable that any Catholic organisation would be involved in getting drugs for addicts. In fact, His Holiness, Pope John Paul has been very vehement on this issue, and the rights of addicts, and has stated that 'you can't cure drug addicts with drugs'.[46]

However, on the question of what practical changes in service provision had occurred, Comberton was apparently on less sure ground. There was a reference to the Eastern Health Board's AIDS Resource Centre early in this 1990 paper, which Comberton interpreted as evidence that 'the Eastern Health Board has been pressured into introducing a centre for the distribution of needles and Methadone'.[47] Towards the end of the paper, however, he suggested that:

> We must be appreciative of the fact that to date neither the Irish Department of Justice or [sic] the Department of Health have pursued social control, or social engineering, policies in relation to drug addicts. There is now, however, pressure on the Department of Health to adopt the UK approach.[48]

This paper concludes by discussing the pressure on the Minister for Health to bow to harm reduction advocates, a pressure which Comberton urges him to resist because 'We cannot allow our ethical standards to be eroded or set aside'.[49]

Although Coolemine Therapeutic Community continued to espouse abstinence policies, it never mounted a high-profile or sustained public attack on harm reduction policy, and as the 1990s progressed its public

opposition to harm reduction was largely confined to feature articles or the letters' columns in newspapers.[50]

There were other professionals or lobbyists whose opposition to harm reduction also received occasional publicity. Amongst these was Gráinne Kenny, who was originally a member of the Irish organisation Community Action on Drugs (CAD) and who then went on to represent Ireland in an international organisation, Europe Against Drugs (EURAD.[51] And finally, as an example of the opposition to harm reduction which surfaced periodically amongst healthcare professionals, reference will be made here to the discussion which took place on this topic at the AGM of the Irish Medical Organisation (IMO) in October 1989. In view of the perceived gravity of the HIV/AIDS situation, it was decided that the IMO was 'to push for the introduction without delay of comprehensive methadone maintenance and needle exchange programmes and for educational publicity aimed towards at-risk groups'.[52] The debate on this issue was by no means characterised by unanimity however, and it was reported that:

> Dr John McNamara of Waterford said he thought it was time we spoke about the vast majority of people who are not perverts or addicts but who were paying their taxes and rearing their children and could not get treatment. There were people who needed hip replacements, immobile by day, sleepless by night, who might have to wait three years for their operation. These were honest to God people in our community who had to do without because of the allocation to these people.[53]

It appears however as though opponents of harm reduction were outmanoeuvred by this tactic of implementing new policy without first going through the conventional preliminaries of debate and public announcement. If the National Co-ordinating Committee on Drug Abuse had debated the introduction of harm reduction, the process would almost certainly have been slow and acrimonious, and might have given rise to general public controversy on the morality of this policy change. Instead,

as was the case with the earlier Inter-Departmental Committee during the 1970s, the National Co-ordinating Committee was consigned to limbo - rarely meeting and doing no real work - while departmental officials effectively controlled policy events in this sphere. What was different during the latter half of the 1980s was that it was not just external bodies and individuals who were kept at a distance from the policy process, but the Minister himself who - by choice presumably - played no major public role in the procedure and, at times, indicated that he was opposed to the introduction of such policy change.

The only official policy document to be published during this phasing in of harm reduction practices was the *Government Strategy to Prevent Drug Misuse* (1991), which was ostensibly the work of the reconstituted National Co-ordinating Committee on Drug Abuse.[54] However, as can be seen from the membership list of this committee, many of the senior civil servants appointed to it could not be expected to have had a detailed knowledge of the drugs scene, and some of them were replaced during the course of their work on this document. The report itself seems to have been prompted by the necessity to have a national drugs plan, comparable to that being prepared by other European countries, and it is difficult to resist the conclusion that its content and style were primarily dictated by Department of Health officials. In its content, this 1991 report did not attempt to grapple with the policy dilemma posed by HIV/AIDS or to discuss in detail what harm reduction entailed. In a critique written soon after its publication, this author (Butler, 1991) drew the following conclusion:

> Viewed in the context of Irish drug policy and practice over the past twenty five years, this report cannot be seen, however, as marking a radical departure. It is, in its overall tone, an administrator's report rather than a policy maker's report. It is, even more than the 1971 *Report of the Working Party on Drug Abuse,* concerned with closing

> down rather than opening up a debate, and with making arrangements rather than considering alternative policy positions. Given that for more than twenty years Irish drug policy was concerned with total abstinence and the achievement of a drug-free society, one might expect a full discussion of the policy changes which are contained in this new strategy. No such discussion is provided, however, and the phrase 'harm reduction' occurs just once in the main text.[55]

The re-constituted National Coordinating Committee on Drug Abuse fared no better than its predecessors and, following the publication of just one report, appeared to exist only in name.[56]

At one level, it could be argued that the tendency of departmental officials to keep their own counsel and to control policy events, rather than promoting public debate and participative decision-making, was functional from a health promotion perspective. Viewed in this light, the Department of Health had used its well-established political skills to introduce strategies which offered a good chance of reducing HIV transmission, and in so doing had further highlighted the naiveté and lack of such skills on the part of the Health Education Bureau. It would be unusual, however, if a policy process of this type - the very antithesis of the WHO's ideal type of health promotion policy - delivered consistently positive outcomes from a health promotional perspective, and some of the negative consequences of this covert and incremental style of policy making will now be considered.

In order to tease out these negative consequences, it is necessary to restate some of the defining features of harm reduction which were presented earlier in this chapter. The most important point, perhaps, was that harm reduction did not simply entail the introduction of practices which promised to reduce the risk of HIV transmission, but that it also – at least implicitly – reflected a view of drug users which no longer was based on notions of pathology and deviance. The new view of drug users as health service

consumers was one which ideally saw them as having strengths and competence, and as being uniquely well placed to advise on how risk might be reduced; they were to be seen as active collaborators with healthcare professionals in the task of HIV prevention, rather than as passive recipients of services delivered by professionals, on terms dictated by professionals.

In Dublin, however, because new strategies were surreptitiously introduced into the healthcare system, it was not just the opponents of harm reduction who were confused by this turn of events but also the service providers themselves. No new philosophy was enunciated and no training programmes set in place to bring about a change of minds and hearts in practitioners for whom the abstinence model was axiomatically valid. One way in which this confusion manifested itself was in the situation of newly recruited outreach workers for the Eastern Health Board's AIDS Resource Centre, who wondered if what they were doing in taking needles and syringes out of the centre was legal and in accordance with Health Board policy.[57] The greatest difficulty, however, arose in relation to the new National Drug Treatment Centre Board, which had relocated from its original base in Jervis Street Hospital to premises in Pearse Street, which were called 'Trinity Court'.

What appears to have happened was that harm reduction practices were introduced into (if not imposed upon) an existing service without any attempt at bringing about philosophical or attitudinal changes in long-serving staff. There was, therefore, a great disparity between practice and philosophy, which was problematic for both service consumers and professional service providers.[58] Drug users attending the Trinity Court service tended to complain that despite the availability of methadone

maintenance (and later of needle exchange), attitudes of staff were still moralistic and authoritarian; instead of offering an opportunity for constructive partnership, methadone sometimes appeared to become a source of conflict between service users and service providers. One HIV-positive woman, in a research interview during 1989, expressed her views about Trinity Court in the following terms:

> The only reason they are concerned about us now is because they think that if they keep us from using, then we won't spread the virus ... It was hard to get on the maintenance programme and it seems even harder now. I don't know if it's that they're too busy and can't cope. There are no fresh ideas ... When you can stand up for yourself they can't stand it. A lot of addicts going there live for their Phy (methadone) and are terrified.[59]

One striking public example of how Trinity Court staff attitudes had remained unchanged was to be seen in a 1989 paper by Peggy Comberton, Senior Social Worker at Trinity Court, in an issue of the *Irish Social Worker* devoted to AIDS. In this special issue, Peggy Comberton and Joan Cronin (a social worker who was employed at this time in the Ana Liffey Drug Project) took opposing sides in a debate on the merits of needle exchange. In her paper, Joan Cronin outlined the harm reduction rationale for needle exchange, and referred briefly to the preliminary evaluative research on British needle exchange schemes.[60] Peggy Comberton was unequivocal in her denunciation of needle exchange, and indeed of harm reduction generally, arguing that those who advocated harm reduction did so from a position of ignorance. 'It would appear', she wrote, 'that there are too few people expert in the field of addiction involved in analysing the situation and AIDS prevention planning'.[61] She then went on to provide the following 'profile' of a heroin addict:

> It would be useful, therefore to look at a profile of a heroin addict: he lives in a cocoon of his own making, of denial, delusion and avoidance. Contact with others is mainly to manipulate them into giving him what he wants. These usually include his parents, wife/husband, boy/girlfriend, GPs and others who do not understand addiction. He, of course, exploits relationships and situations, lies with great

> ease and blames everyone, his parents, agencies, hospitals, society, etc., for his situation and difficulties. He takes NO responsibility for his own life or what he does ...[62]

It is understandable that a long-serving social worker, with experience in Jervis Street and in Trinity Court, should hold views of this kind; these, after all, were the conceptualisations of drug users which had underpinned this centralised type of service provision since its inception (described in Chapter Six) in 1969. Nobody had publicly challenged the validity of such views of drug users or questioned their helpfulness from a practical perspective,[63] but obviously these were not views which were compatible with partnership approaches to working with drug users or which readily lent themselves to the development of specific harm reduction initiatives such as peer support networks. This latter concept of 'peer support' refers to the training and employment of current drug users in a health promotion and social support role amongst their peers, a concept which had been particularly associated with Dutch drug policy prior to the advent of HIV, and which clearly implies that drug users cannot be described in the categorically negative terms used by Peggy Comberton.[64]

During the second half of the 1980s, therefore, specific harm reduction practices were introduced into the Jervis Street/Trinity Court drug treatment centre, at the insistence of the Department of Health, in an attempt to stop the transmission of HIV amongst its clients. These changes were proposed by those Departmental officials (and most notably, it would appear, by Dr James Walsh, the National AIDS Co-ordinator) who were specifically concerned with HIV/AIDS, rather than by the moribund National Co-ordinating Committee on Drug Abuse. However, in the absence of an official announcement of a policy revision or a staff retraining scheme to accompany and support the newly introduced harm reduction practices, it appeared that the agency as a whole had not shifted philosophically or

attitudinally in its perception of clients. For Trinity Court staff this reluctance to change was not just, as had been implied in the article by Peggy Comberton cited above, that they saw their views as based on authoritative professional knowledge and experience; they also regarded harm reduction as in violation of the value systems which had previously underpinned their practice, and they expressed genuine and understandable qualms about the morality of the new practices which they had reluctantly accepted.[65]

What also added to the difficulties of working in Trinity Court during this period was the fact that clients were familiar with what was happening in the British drug treatment scene at this time and were not slow to compare the Trinity Court ethos with that prevailing in Britain. Sometimes these comparisons were made publicly, as in August 1989 when the *Irish Times* carried a feature on this topic. Dr Michael Farrell, a Dublin–born psychiatrist who specialised in drug treatment in London was quoted at length on what he saw as the desirable policy changes which now characterised British services:

> 'They (the drug services) are developing a more user-friendly, accessible service ... There must be an emphasis on harm reduction, an emphasis on people altering drug using behaviour so that they're not transmitting hepatitis B or HIV. We're talking about a new public health model of drugs services. We're talking about a health conscious drug user. They are like most people, they don't want to die', says Dr Farrell.[66]

Accompanying this was a reported account of his treatment at Trinity Court by a Dublin drug user named Sean; this young man was living in London at the time he spoke to *The Irish Times* and his comparison of the ethos of the London drug treatment system with that of Trinity Court was presented under the headline 'In Ireland they treat you like a scumbag'.[67] He conceded that methadone maintenance had been available to him when he

was last in Dublin, but, like the woman cited earlier in this section, he was highly critical of staff attitudes and of the general regime at Trinity Court. He concluded.

> Seeing is believing and you would want to see Trinity Court on a Saturday morning. Everyone has to be there before 12.30pm to get their methadone. I mean, it's like a cattle market. It's just a methadone feeding station, that's all it is a methadone feeding station.[68]

As referred to earlier in this chapter, one of the important health promotional implications of harm reduction was its emphasis on the *normalisation* of drug treatment services; what this means specifically is that in a fully developed harm reduction regime it would not be considered either necessary or desirable to confine the treatment of problem drug users to specialist centralised services, but that instead localised services and facilities would be made available for this purpose, utilising generic, primary care personnel. The policy rationale underlying the highly centralised service system in Dublin (which was discussed in Chapter Six) had never been publicly debated, but insofar as it was possible to discern any dominant policy rationale, it appeared to be based on negative stereotyping of drug users and on the perceived desirability of keeping them isolated from 'normal' health service users.

Another of the disadvantages of the incremental transition to harm reduction described here was that it delayed the introduction of localised services through its failure to produce clear and explicit guidelines on such contentious issues as the respective roles of the Eastern Health Board (the statutory health authority for the Dublin area) and the National Drug Treatment Centre, or on the role of GPs in the management of drug users. The 1991 *Government Strategy to Prevent Drug Misuse,* which has already been alluded to here, did touch on these issues; it did so, however, in a rather superficial way which begged practically all of the difficult policy

questions. For instance, its discussion of the role and function of Trinity Court (the National Drug Treatment Centre) gave no real indication of the seriousness of the structural tensions which were emerging between this body and the Eastern Health Board, and its proposal for an expanded membership of the Board of Trinity Court did not seem to be an adequate response to this problem. The tensions in question here may be seen as equally reflecting ideological disagreement and basic power politics. Ideologically, the development by the Eastern Health Board of its own locally-based drug treatment services, over the course of the decade discussed in this chapter, was driven by a public health preoccupation with HIV and, as such, was unequivocally based on a harm reduction philosophy; Trinity Court, as has already been argued here, had always operated on a more traditional abstinence philosophy and was, at best, a reluctant convert to harm reduction. Until the coming of HIV /AIDS, the National Drug Treatment Centre had enjoyed a virtual monopoly in the medical management of problem drug users, but the creation of its own service system by the Eastern Health Board obviously challenged this and began implicitly to question the *raison d'être* of Trinity Court.

The *Government Strategy to Prevent Drug Misuse* could have pointed out that the existence of a national treatment centre was now anomolous in the context of an evolving system of community-based harm reduction services and facilities; it could, even more radically, have simply recommended the closure of Trinity Court as a national centre funded by and accountable to the Department of Health and its integration into the Eastern Health Board service system. In fact, it did neither of these things but instead opted for a compromise situation in which it envisaged a greater role for the Eastern Health Board in the development of community drug services (including more involvement of general practitioners), while at the same time

recommending 'a strengthening of the role of the Drug Treatment Centre, Trinity Court, and an expansion of the Board membership'.[69]

This change to the Board membership in Trinity Court did not significantly improve matters, however, and for the five years (1991-1996) following the publication of the strategy document the relationship between Trinity Court and the Eastern Health Board continued to be uneasy and confused.[70] The policy differences between these two institutions were symbolised to some extent in the differing backgrounds of two of their key players. Dr John O'Connor, the Clinical Director of Trinity Court, was a consultant psychiatrist specialising in addictions, accustomed to a good deal of professional autonomy and apparently sceptical of the value of harm reduction. On the other hand, Dr Joe Barry, who acted as AIDS/Drugs Coordinator for the Eastern Health Board during this period, was a specialist in public health medicine, primarily interested in HIV prevention and pragmatically well-disposed towards harm reduction.[71]

Attempts by the Eastern Health Board to involve local general practitioners in the medical management of drug users also proved to be slow and complicated. It could, of course, be argued that regardless of the style of policy making, this was always going to be a difficult task; the general but implicit view for twenty years prior to the coming of HIV was that GPs should simply refer problem drug users to the national treatment centre, on the basis that methadone prescribing by GPs would be uncontrolled and would inevitably result in leakage of this drug onto the black market.[72] The 1991 *Government Strategy to Prevent Drug Misuse* contained two specific recommendations as to how GPs could be effectively drawn into the medical management of problem drug users. One of these borrowed from British service developments in this area in its proposal for 'the

development of Community Drug Teams under the auspices of the Health Boards to operate with the involvement of General Practitioners and other health professionals in targeted areas'.[73]

While the Eastern Health Board appeared to have become somewhat disenchanted with the national Drug Treatment Centre and to have placed more reliance on its own efforts to develop community services, its track record of collaboration with community-based professionals and local activists (as discussed in detail in Chapter Seven) was poor, and it could not be presumed that it would readily develop the capacity to change and improve in this regard. It would therefore have been helpful if the 1991 strategy document had been more detailed and elaborate in its depiction of the philosophy and methods of the Community Drug Team (CDT) rather than confining itself to a brief and uncritical account of what the creation of CDTs entailed.[74] It was not altogether surprising, therefore, that the first attempt by the Eastern Health Board to set up a CDT should have ended as disastrously as it did; this first venture was based in Ballymun, and consisted of a formal partnership between the Eastern Health Board and a voluntary body, the Ballymun Youth Action Project. The Ballymun CDT was set up in 1992, only to be dissolved in 1995 in a flurry of mutual recriminations which was reminiscent of earlier relationships between the health board and locally based drugs groupings. Conflict between the partner agencies was partly attributable to ideological differences about harm reduction, about which the Youth Action Project was less enthusiastic then the Eastern Health Board, but the report of an independent evaluator suggested that one of the fundamental difficulties with this project was confusion as to what a CDT was or how the two participating agencies were to collaborate. Something of the intensity of the bad feeling and confusion

involved may be gleaned from the following comments of the project's evaluator:

> It is essential that both partners are clear about why they are in partnership, what they wish to achieve and how they will do so. This evaluation has shown that such clarity did not exist, that the vision, aims etc., did not go much beyond general statements of aspiration, that the partners did not openly share their agendas for being in partnership, that they guessed at each other's motivation for being in partnership and never checked out their assumptions, that there were so many differing expectations of the CDT which were never articulated and dealt with and which ultimately resulted in inactivity, frustration and anger.[75]

This assessment of the reasons for the failure of the CDT pilot scheme may reasonably be interpreted, therefore, as evidence of the difficulties involved in the attempt to introduce quite radical change into the structure of drug treatment services without clearly and specifically setting out in advance the policy rationale and administrative mechanics of such change. Following the breakdown of the Ballymun pilot project, the Eastern Health Board appeared to abandon the CDT concept, although one other drug project, styling itself the Rialto Community Drug Project, evolved slowly and succeeded in holding together a partnership between local community activists and the EHB.[76] The new determination of the EHB to develop community-based drug services, which appeared to be a radical reversal of its policy during the period of the 'opiate epidemic', was greatly complicated in the 1990s both by its own inexperience and ineptitude at negotiating with local community groups and by the ambivalence of these local groups towards problem drug users. Typically, what happened between 1991 and 1996 was that local community groups which experienced drug use as seriously disruptive of their neighbourhoods started to compaign for 'something to be done'; such campaigning involved lobbying of constituency TDs and local authority representatives as well as direct lobbying of the EHB. However, when the EHB responded to such lobbying by attempting to set up local services, the communities involved

often expressed great antagonism to the siting of treatment facilities in their areas; the phrase 'not in my back-yard' (commonly abbreviated as NIMBY) was frequently used with reference to such communal ambivalence on this subject. One striking example of this NIMBY phenomenon occurred during 1995 when, in response to local agitation for the creation of a drug treatment service in Blanchardstown in west Dublin, the EHB attempted to open a methadone clinic in the gate lodge of James Connolly Memorial Hospital in Blanchardstown. This plan was greeted with great hostility by local residents who mounted a picket on the premises, and it was only after months of conflict that a resolution was achieved – involving a climb-down by the health board on its proposal for a methadone clinic in this premises.

When it came to creating community-based drug treatment services, therefore, health board officials and professionals tended to see themselves as victims of a hopeless no-win situation, as did elected public representatives: local community groups complained about the negative impact which untreated drug use was having on their neighbourhoods, yet rejected the establishment of what the authorities saw as appropriate local services.[77] It was abundantly clear that ideas about community participation and community empowerment, such as those contained in the Ottawa Charter, were rather naïve and superficial when applied to partnership or collaborative activities between statutory health authorities and local neighbourhood groupings. The involvement of local residents and community activists in the provision of treatment services was not an entirely benign affair devoted to the welfare of drug users, but tended to be characterised by huge ambivalence, with aggression towards or rejection of drug users as a regular feature of such activity. As concluded in Chapter Seven, this situation could be interpreted as justifying and vindicating the scepticism of the Eastern Health Board about community participation in

drug services and as confirming the Board's belief in the superiority of professionalism . Alternatively, in the light of this extended discussion of covert and incremental policy shifts, it could be seen that local antagonism towards drug users merely reflected the ambivalence of the Eastern Health Board's own position on this issue, as well as the difficulties which might be expected when quite radical changes were introduced into the treatment system without open discussion and elaborate re-training schemes.

Another specific recommendation of the *Government Strategy to Prevent Drug Misuse* (1991) was for 'the development of a greater role for General Practitioners in the treatment of drug misuse at community level with the central support of the Drug Treatment Centre'.[78] Again, the rather cursory treatment of this topic in the strategy document, and the failure to tease out the policy issues associated with such an initiative, meant that its implementation was unlikely to be a speedy and trouble-free business. The phrase 'a greater role for General Practitioners' was interpreted by many close to these issues as a code to describe the expansion of methadone maintenance prescribing by GPs, and there were two main difficulties which could be anticipated in this scheme. The first was, as already discussed here, that many (if not most) GPs appeared to share the common negative perceptions of drug users as devious, manipulative and aggressive, and therefore were unwilling to become involved in their treatment. The second difficulty was that harm reduction philosophies were regarded with a general scepticism by many and that there were specific objections to methadone prescribing by GPs: it was argued that GPs might prescribe excessive amounts of methadone for individual patients, which would lead to leakage onto the black market, and also that the black market for methadone would be supplied by drug users who would simply attend several doctors at one time and accumulate a supply for illicit sale. In

Britain, as will be recalled from Chapters Six and Seven, the debate as to whether GP prescribing of maintenance drugs was a good or a bad thing had been concerned with precisely these issues, in its efforts to determine whether GPs should be left with a high degree of clinical freedom in this matter or whether maintenance prescribing should be largely controlled by specialists based in centralised services.[79] While it could not be said that British policy makers had achieved any resolution of this dilemma, at least it could be said of the British situation that the issues had been clearly identified, discussed and researched over a considerable period; in Ireland, by contrast, these issues had never been publicly debated and it had always been assumed that GP prescribing of drugs such as methadone was more likely to do harm than good.

However, through the work of a small number of GPs who were committed to treating drug users, the Irish College of General Practitioners (ICGP) prepared and circulated a policy document on this topic in 1990.[80] This policy statement argued that GPs had a legitimate role in this field, while at the same time recommending that they should not work in isolation with such patients but should instead work collaboratively with other appropriate health and social services. While it would be naïve to interpret this statement as reflecting a broad consensus within the ICGP or a mass willingness on the part of family doctors to become involved in this peripheral and controversial area of their normal practice, it did help considerably to push ahead incrementally with the process of institutionalising methadone prescribing in general medical practice, and in 1992 the Minister for Health established an Expert Group to draw up a formal protocol which would govern methadone prescribing in community services.[81] The Expert Group was chaired by Dr James Walsh who was the National AIDS Co-ordinator at the Department of Health, and the group was convened under the aegis of

the National AIDS Strategy Committee rather then as part of the National Coordinating Committee on Drug Abuse.[82]

The Expert Group carried out its task of considering 'methadone prescribing, registration of drug users and licensing of general practitioners to treat drug users'[83] quietly and discreetly, consulting only with the Irish College of General Practitioners, the Pharmaceutical Society of Ireland and the Pharmaceutical Union. The group concluded its work in March 1993, recommending that methadone be used for maintenance purposes and in many ways reiterating the views of the ICGP as to what constituted good practice in this field. It decided not to recommend that the right to prescribe methadone should be restricted to specially licensed GPs, largely, it said, because it anticipated opposition to such a scheme from doctors' representative organisations, but compromised on this issue of GP autonomy by recommending that patients should be assessed by either Trinity Court or the health board specialist addiction service before starting on a maintenance programme with a GP.[84] The Expert Group displayed both political and linguistic skills in dealing with the question of registering maintained addicts; it noted that there was resistance to the use of the term 'register', but then went on to recommend what was effectively a registration system, namely the issuing of an identifying 'treatment card' for all such patients and the creation of a central treatment list.[85]

The same tensions between Trinity Court and the Eastern Health Board which have already been noted also manifested themselves in the workings of this Expert Group, with Dr John O'Connor of the former institution arguing for a more restrictive approach to methadone prescribing and needing some persuasion to sign up to the final document.[86] Dr O'Connor's reservations on this subject are also clearly evident in a short

paper, *Good Clinical Practice in Relation to Methadone Prescribing*, which he prepared for the Expert Group and which is included as an appendix to the group's report; his final caveat was expressed in terms of his belief that 'Methadone should always be regarded as an adjunct to treatment and not treatment per se'.[87]

What was most remarkable about this report was that, following its completion, it lay unpublicised – and unpublished - and with no serious attempt at implementation for a period of three years. This again illustrates the tendency of Department of Health officials to contain and control events until they decide that the policy climate is favourable for a particular policy initiative; and the only reasonable explanation for this delay in implementing the methadone protocol is that the civil servants involved deemed it prudent to wait until harm reduction in general was somewhat less controversial.[88] It is interesting to note, for example, that in February 1993 – as the Expert Group was completing its report and at a time when Eastern Health Board local clinics and harm reduction services were reasonably well established – Councillor Joe Connolly, a member of the EHB, received considerable publicity for his suggestion at a board meeting that drug addicts should be summarily rounded up by the army and detained; the Evening Herald, which gave this story banner headlines on its front page, reported it thus:

> An unrepentant Dublin councillor today defended his call that soldiers be used to round up addicts. 'This is war' said Eastern Health Board member Joe Connolly. Insisting that emergency measures were needed to deal with drugs, Councillor Connolly urged army patrols escort addicts off the streets for hospital treatment ... 'The army don't need powers of arrest to do this. Drug addicts are sick people, "Jekyll and Hyde" characters who become evil at night when they get drugs. It would be doing them a favour. We have to keep them off the streets'.[89]

This view of Councillor Connolly was not widely supported by his fellow board members nor did it make any appreciable impact on EHB policy and

service structures, but it does suggest that board members were not totally familiar with or supportive of harm reduction strategies at this time in 1993.

Three years later, however, when this methadone protocol was eventually publicised and a pilot scheme was initiated, there was no evidence that the intervening period had been used to improve public understanding of methadone maintenance or to sort out the practical arrangements for having GPs formally involved in this activity. The RTE news programme *Prime Time* did a lengthy feature on methadone maintenance on February 15, 1996; while this programme could be deemed to have been balanced in that it allowed for the expression of both positive and negative views on the subject, it was in its overall tenor supportive of methadone maintenance. The following Sunday, February 18, 1996, the conservative *Sunday Business Post* had a comment or editorial piece which was scathing in its criticism of *Prime Time* and what it saw as the unproven assumptions which underpinned the programme's case for methadone maintenance. In part, this editorial piece read as follows:

> We believe that the central assumptions and theses of this programme are entirely unproven, and it was quite wrong to broadcast it in the manner in which it was transmitted ... People suffering from addiction to substances such as heroin and vodka do have a fundamental right. That right is best exercised by the provision of help which, in large measure, comes in forms other than the substance which is being abused. That is to say, they should be helped to recover their physical strength and their self-esteem to regain their place in society. This will not be achieved by the creation of ghettoes of state-financed drug addiction.[90]

This hostility of the *Sunday Business Post* towards methadone maintenance can be regarded as further evidence of the negative side of covert policy-making; what the editorial was objecting to was what it saw as a policy *fait accompli,* and, ironically, it is likely that had there been a detailed and lengthy policy debate on methadone, the *Sunday Business Post* (with its

conservative economic views) would have been persuaded that this particular form of treatment was cost effective.[91]

It also became apparent in early 1996, as arrangements were made to have the methadone protocol implemented on a pilot basis,that during this three-year time lag no agreed scheme for payment of GPs had been established and this too had to be remedied.[92]

Finally, it should be noted that because of this discreet and unilateral style of policy-making by health policy makers the criminal justice sector, and most importantly the prison system, did not simultaneously introduce harm reduction strategies for opiate users for which it had primary responsibility. Heroin users who had been weaned off heroin in favour of prescribed methadone (which was taken orally) were likely if imprisoned to be given a quick detoxification and expected to remain drug-free while in custody. This was unsatisfactory from a harm reduction perspective since there was a serious risk that such prisoners would revert to using heroin, while sharing injecting equipment, which was in short supply in prison. By 1996, the last year covered in this thesis, the health system was still insufficiently convinced of the political acceptability of methadone maintenance to feel that it could argue persuasively for the introduction of this practice into the prison system.

In summary, the incremental introduction of harm reduction strategies into the drug treatment system in Dublin may be seen from a health promotional perspective as having both positive and negative consequences. In positive terms, the avoidance of public debate and heated controversy allowed for the gradual introduction of services and facilities which would previously have appeared to be totally unacceptable in Irish political culture. The

negative aspects of this covert style of policy are also clear, however: the introduction of harm reduction strategies was by normal standards a protracted affair, which frustrated those committed to harm reduction and lengthened the period of time during which injecting drug users were at greater risk of HIV infection;[93] the failure to spell out in detail the philosophical underpinnings of harm reduction meant that negative stereotypical views of drug users persisted despite the utilisation of new strategies, and also that health authorities and health care professionals were slow to come to terms with partnership or collaborative models of working with local community or other interest groups.

1996 – A Year of Transition

If 1996, the last year of the period studied in this thesis, was an eventful year for alcohol policy, with the publication of a national alcohol policy, it was also an interesting and significant year for Irish drug policy. A number of specific developments in drug policy took place during 1996 which generally suggested that there was now a greater willingness to make the policy process more overt and visible than it had been prior to this.

In October 1995 the Minister for Health had announced that the Eastern Health Board was to set up a new management sub-structure specifically designed to deal with the complexities of drug treatment and rehabilitation.[94] This was done immediately and the EHB's new drug management team went on to conduct a review of its work in this field during 1995 and to prepare a development plan for 1996. Two external reviewers, the British-based psychiatrist, Dr Michael Farrell, and a Dutch psychologist, Ernst Buning, were commissioned to do an assessment of the EHB's drug services, and their report – which reaffirmed the therapeutic value of methadone maintenance and was generally affirmatory and encouraging of

EHB community service developments – was included in the plan which was prepared for a Special Board Meeting on April 2, 1996.[95] The Eastern Health Board's plan for 1996 contained ten specific proposals for expanding its drug treatment services, the most ambitious of which was for an increase in the number of methadone maintenance places available from 1,400 to 2,500; this increase was to take place through a range of service and facility options, including new clinics, further involvement of GPs and the use of a mobile clinic. The EHB appeared to be buoyed up by the positive tone of the external reviewers' report and to be facing into the future with a degree of clarity and self-confidence that it had not previously displayed.

The 1996 development plan also reported that two new consultant psychiatrist posts in drug services had been established and that, with the inclusion of Dr O'Connor from Trinity Court, this had facilitated the division of the EHB's region into three catchment areas for the service delivery purposes.[96] This, on the face of it, was a most important innovation which appeared to signal the end of Trinity Court's role as an independent centralised service and a victory of sorts for the Eastern Health Board in its struggle to change the philosophy of drug treatment services which had existed since the establishment of the drugs unit at Jervis Street Hospital in 1969. However, the National Drug Treatment Centre Board had not been abolished, and the EHB report contained no detailed information or underlying rationale bearing on this new arrangement. Furthermore, the two external reviewers did not attempt any analysis of the confusion and conflict which still characterised relationships between the Eastern Health Board and Trinity Court.[97] The EHB's drug service plan appeared to be generally well received, or at least it could be said that it did not evoke any strongly negative public reactions.

Another highly significant policy development took place in early October 1996 with the publication of the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drug.*[98] This Task Force had a membership of seven Ministers of State under the chair of Pat Rabbitte, Minister of State to the Government, and had been established in July 1996 'to review the present arrangements for a coordinated approach to drugs demand reduction and, in the light of the review, to identify for Governmental Action any changes or additional measures needed to provide a more effective response to the problem'.[99] The report of this Ministerial Task Force, which became known colloquially as the "Rabbitte Report', was, in terms of its presentation and design, somewhat confusing and repetitive; when compared with the *National Alcohol Policy* (see Chapter Five) which was published at approximately the same time, the Rabbitte Report clearly lacked the polish of a policy document which had been compiled slowly, with careful drafting, re-drafting and design work all aimed at enhancing the visual appeal of the final product. Reading through the Rabbitte report, it becomes clear that all members of the Task Force had fought to stake a claim for their respective departmental sectors and that the resulting document was somewhat fragmented.[100] Perhaps because this report was produced hurriedly, it had, despite its confusion, an immediacy and a directness which was unusual in drug policy documents, and its authors appeared to be genuinely committed to doing something – and doing something quickly – to address Dublin's opiate problem.

The main conclusion reached by this Task Force, under the chairmanship of Pat Rabbitte, was that macro-environmental factors were causally significant in Dublin's opiate problem and that preventive or demand reduction work should reflect and incorporate this fact. The Rabbitte Report noted that the submissions which it received had consistently 'identified the same

underlying causes of problem drug use as had already been identified by the Group, i.e. social disadvantage/exclusion, characterised in high levels of unemployment, poor housing conditions, low educational attainment, lack of recreational facilities, etc.[101] The primary strategy recommended by the Task Force to deal with this newly acknowledged causal link between social deprivation and serious drug problems was the funding and establishment of eleven *Local Drugs Task Forces* (ten of which were to be in Dublin and one in Cork City). These Local Drugs Task Forces would consist of partnerships between statutory authorities and local community groups, with the intention of using them as a vehicle for targetting resources at areas where there was a high prevalence of problem drug use. The areas in question were designated in the Rabbitte Report and an initial commitment of £10 million was made towards the establishment of Local Drugs Task Forces in these areas. The Report also endorsed the use of methadone on a maintenance basis, and reiterated what had already been said by the Eastern Health Board about the necessity to reduce waiting lists for methadone.[102]

This proposal to establish Local Drugs Task Forces which would selectively target resources at those areas with an identified high prevalence of drug problems was very similar to the proposal of the Special Governmental Task Force (1983) to designate some parts of Dublin as *Community Priority Areas.* However, as discussed in Chapter Seven, this earlier proposal had not only been rejected by the Government of the day but had been kept secret, when the report of this 1983 Task Force was effectively suppressed. Some attempt should be made here, therefore, to explain why, thirteen years on, the Government was more amenable to environmental strategies for the prevention or amelioration of drug problems than it had been in 1983, when it had stuck solidly to individualistic explanations and strategies.

Perhaps one explanation for this new willingness to consider environmental approaches, which could broadly be described as community development programmes, was the obvious failure of all previous attempts to reduce the demand for drugs in socially deprived urban communities. Politicians who represented such communities were constantly aware of public criticism of their failure to deal effectively with drug issues, and politicians *en masse* were confronted with the public shock and outrage that followed the murder of the journalist Veronica Guerin in June 1996, apparently by criminals whose main source of income was drug trafficking. While one political response to this murder was to toughen supply reduction policy,[103] it seems plausible at least to conclude that this shocking event also gave a broad impetus to Irish drug policy making.

A second explanation for this willingness to set in place Local Drug Task Forces, which would include both *vertical* partnership between statutory authorities and local voluntary and community interests, and *horizontal* or intersectoral partnership between different sectors of the state, can surely be found in the vastly altered approach to social and economic planning which had prevailed from the late 1980s onwards. This approach was broadly characterised as one of social partnership, in which the state coordinated a network of the most prominent stakeholders in Irish social and economic life, rather than in terms of the state acting autonomously.[104] The dramatic upsurge in the Irish economy (the so-called 'Celtic tiger') and the relatively peaceful state of the country's industrial relations tended to be largely attributed to the success of the social partnership concept, so that it seemed quite natural that this concept should be extended in this way to community drug policy issues. While there was considerable evidence of conflict between the Eastern Health Board and local community groups, the Task Force pronounced itself 'impressed with the positive impact of the Inter-

Agency Drug Project in Dublin's North Inner City'[105] and in many ways used this project as a model upon which to base its proposals for Local Drugs Task Forces. It is also noteworthy that the Rabbitte Report in opting for a partnership approach to resolving drug problems did not draw upon any health promotional literature but instead described this social problem as a 'cross-cutting'[106] issue – a reference to a central tenet of the Strategic Management Initiative (SMI) which pointed out that important public policy objectives were frequently attainable only through inter-sectoral collaboration.[107] In further pursuance of this interest in managing cross-cutting issues, the Ministerial Task Force recommended the establishment of a *National Drugs Strategy Team,* which would consist of representatives of relevant public sector interests as well as community and voluntary representatives. This Strategy Team, which was to report to a new Cabinet Drug Committee, was intended in line with the general philosophy of SMI to institutionalise organisational networking; what it proposed to do was to take senior civil servants out of their parent departments for up to half their working week, thus encouraging them to tackle drug problems as members of an intersectoral team rather seeing these problems from their traditional 'departmentalist' perspective.

It seems reasonable to conclude, therefore, that while the Rabbitte Report may be seen as health promotional in tenor, it was not explicitly or self-consciously so. It was ironic, however, that a committee comprised of Ministers of State representing a wide cross-section of governmental activities, and chaired by a Minister of State from the Department of the Taoiseach, should ultimately produce a policy report which, in its essence, was closer to health promotion theory than any report previously produced under the aegis of the Department of Health. Referring back to Harrison and Tether's three models of policy coordination, which were discussed in

Chapter One and which have served as a framework for analysing health policy developments throughout this thesis, it would seem clear that the third model – *the organisational networks model* - is very similar to the public policy model which now underpins the entire social partnership system.[108] The creation of community development approaches to drug problems in deprived urban areas arose, therefore, from the application of such an organisational network concept by a broadly-based Ministerial group rather than from the application of health promotional concepts to this issue by the Minister or Department of Health. It would seem that within the Department of Health nobody made any serious attempt to utilise health promotional concepts in the creation of community-based responses to problem drug use, despite the proliferation of policy statements consistently framed within this rhetoric.

The final – and some might say the most important - explanation for the content of the Rabbitte Report has already been alluded to: the healthy state of the public purse in 1996, as opposed to the recessionary state of 1983, meant that politicians now had the money to invest in large-scale community development projects. Furthermore, with an impending general election, the politicians who drew up this report were anxious to have their recommendations implemented as speedily as possible so that in the forthcoming election campaign they could claim credit for these new programmes;[109] this obviously meant that the establishment of the Local Drugs Task Forces was pushed forward at a pace dictated by political concerns rather than at the more leisurely pace of the civil service.

Conclusion

The main objective of this chapter was to trace the evolution and adaptation of Irish drug policy between 1986 and 1996, the era of HIV and AIDS.

The necessity for change arose initially from the recognition that injecting drug users were infecting one another through the practice of needle sharing and that, through sexual behaviour, such drug use constituted a bridge for the further transmission of HIV into the general population. It was argued that the introduction of pragmatic public health strategies – such as the use of prescribed oral methadone as a heroin substitute, or the provision of sterile injecting equipment through needle exchange schemes – was especially difficult in a policy arena where public debate on drug issues had not been generally encouraged and where it had been previously assumed that all sectors of government were committed to a 'drug-free' society. Aside from this understandable preoccupation with public health issues, the period studied in this chapter may also be seen as one in which, however reluctantly, Irish society was moving towards an acceptance of the fact that illicit drug use was here to stay and that its broader impact, particularly through drug-related crime, demanded some policy adjustments in this country.

The difficulties experienced by the Health Education Bureau in promoting the lifeskills approach to health education (see Chapter Eight) presented a salutary example of what health promotionists could expect should they offend public moral sensibilities. However, it was shown in the present chapter that, on an incremental basis, harm reduction strategies which would have previously been regarded as unconscionable were introduced into the Irish healthcare system. It was suggested that the covert style of policy change could in many ways be seen as functional, in the sense that it avoided public controversy and made it difficult for those opposed to harm reduction to have a clear target for their attacks. On the other hand, it was suggested that this style of policy making was dysfunctional in that it did not facilitate attitudinal or philosophical change in long-standing services

and personnel; neither did it identify and resolve the confusion which arose between new locally-based services and the existing centralised services.

It was argued here that throughout this period, 1986-1996, the Department of Health continued to dominate, if not indeed monopolise, the policy process, and that it was only in the last year of that decade (1996) that a broad environmental and multi-sectoral strategy for the prevention of drug problems was adopted by a committee in which,ironically, the health sector was not dominant. Many factors which contributed to the new approach recommended by the so-called Rabbitte Committee were identified: not least of these was the buoyant state of the national economy which meant that funding for new initiatives was available, while the explicit interest in public policy and management engendered by SMI led to a new recognition of drug problems as 'cross-cuting' issues which demanded appropriate intersectoral solutions.

The second aim of the thesis as a whole, as set out in Chapter One, was to ascertain: "Which were the main interest groups or organisations within the policy making process: how did they interact and to what extent was this process coordinated by either national or regional authorities?" (p.24). It seems appropriate here, in the light of the foregoing discussion of the role of the Department of Health in coordinating Irish drug policy, to present some final answers to these questions for both alcohol and drugs. In each of these two arenas there was, as predicted, a wide and potentially bewildering range of players involved in the policy process. All of the central government departments identified in Table 1 contributed to policy, as did executive statutory bodies, such as the Garda Síochána, the health boards and the schools. The drinks industry (represented from 1981 on by its umbrella body, the *Drinks Industry Group*) lobbied consistently

throughout the study period, but obviously no similar group existed to argue the cause of illicit drugs. The complexity of the policy process was also evident from the fact that no simple generalisations were possible about 'the medical profession', since medical doctors did not function as an homogeneous group in relation to alcohol and drug issues. For instance, as discussed in Chapter Four, there were significant differences between public and private psychiatrists in their attitudes towards the necessity for or value of inpatient alcoholism treatment, and in the present chapter it was pointed out that there was no consensus amongst general practitioners as to their role in the management of illicit drug problems. Also as predicted in Chapter One, the Roman Catholic Church was an important contributor to alcohol and drug policy throughout the study period; as with the medical profession, however, the style and content of these Church interventions into policy varied considerably depending upon the time and the specific issues which were in question. There were, finally, various interest groups which emerged in a 'bottom-up' way in an attempt to influence policy: for example, Mothers Against Drunk Drivers, which is referred to in Chapter Five, could be regarded as a single issue lobby group, solely concerned with drink driving legislation, while the community-based drugs groups discussed in Chapter Seven had wider concerns with many aspects of prevention and treatment.

The primary role of coordinating the activities of these disparate groups from a health perspective was played throughout the period studied by the Department of Health. As has been demonstrated throughout the study, this coordinating role was one which was both conferred by successive Ministers for Health and also actively grasped and retained by senior civil servants. However, in terms of three models of policy making outlined in Chapter One, the Department of Health did not succeed in coordinating

alcohol and drug policy in a rational or corporate way, with all of the participants acknowledging and deferring to the health interest. In view of the complexity of the issues, the conflicting cultural perspectives on alcohol and illicit drug use, and the diverging interest groups involved in these arenas, it would be naïve in the extreme to expect the Department to have achieved this. Instead, it would seem that the model of *partisan mutual adjustment* best described how the Department of Health coordinated alcohol and drug policy over the period studied here. This model sees the coordinating role as one which acknowledges from the outset that the participants have distinctive and frequently conflicting policy agendas, which would mean in this instance that the prospect of achieving optimum health promotion outcomes is highly unlikely; instead policy is made by a process of negotiation and compromise, resulting in an end-state which falls far short of what advocates of the corporate approach would see as ideal. This is not to attribute incompetence or lack of political skill to the Department of Health but rather to conclude that, even when the policy rhetoric had become explicitly health promotional in tone, the Department continued with a traditional policy style which offered no real hope of achieving health promotion goals. This traditional style of policy making took it for granted that there were significant conflicts of interest amongst the various contributors to the policy process, and limits to the degree to which other sectors of Government or other interest groups would cooperate in the achievement of health objectives; control of policy making was kept firmly within the grasp of the Department, despite the creation of structures which were ostensibly intersectoral, with care being taken to avoid public controversy or Ministerial embarrassment.

The *organisational networks* model of policy coordination is one which consists of the creation and maintenance of a network of policy makers

across the array of organisations and interest groups involved in an area of common policy development; this model obviously precludes any single department from monopolising the proceedings, and is likely to involve sub-units or peripheral sections of large organisations rather than whole departments or organisations. Although organisational networking would seem to offer the best hope of making real progress in the achievement of health promotional objectives, it did not feature to any extent in the Irish alcohol and drug policy domain for the period studied here. However, as already noted in this chapter, the creation of a National Drug Strategy Team under the broader public service rubric of the Strategic Management Initiative represented an important policy coordination development along these lines. It is not possible within the limits of this study to assess how this new networking structure functioned, and of course it is noteworthy that no comparable structure was proposed for the achievement of healthy public policy on alcohol.

In Chapter Ten, the last chapter of this thesis, both sections of the thesis – that dealing with alcohol and that dealing with illicit drugs – will be brought together and the overall utility of health promotion as an analytic framework will be considered.

Chapter Nine: Footnotes

[1] While it is understandable that the advent of HIV should concentrate the minds of intravenous drug users in Dublin, as reflected in this tendency to speak of 'the virus' as though there were no other viruses, it should be acknowledged from the outset that drug users were much more likely to be infected by hepatitis (particularly hepatitis C). See R. Smyth, E. Keenan, A. Dorman and J. O'Connor, 'Hepatitis C Infection among Injecting Drug Users attending the National Drug Treatment Centre', *Irish Journal of Medical Science,* 164 (1995), pp 267-268.

[2] *Health: The Wider Dimensions.* (Dublin: Department of Health, 1986), p.26.

[3] See the discussion of health risk in Chapter One ('The New Public Health: A New Morality?') in A. Petersen and D. Lupton, *The New Public Health: Health and Self in the Age of Risk.* (London: Sage, 1996), or M. Douglas, *Risk and Blame: Essays in Cultural Theory.* (London: Routledge, 1992).

[4] For an early example of how HIV/AIDS was presented to the Irish medical profession, see D. Freedman, A. Shattock, J. Stuart and H. McLaughlin, 'Acquired immunodeficiency syndrome', *Irish Medical Journal, 82,* (1989), pp 135-138.

[5] It is only since 1995 that research has radically transformed scientific understanding of the natural history of HIV in an infected person's body and has led to the widespread use in developed countries of new antiviral treatments, which appear to control the level of HIV (or 'viral loads') in an infected person. For a discussion of these new developments in relatively non-technical language see E. King, 'HIV Prevention and the New Virology' in J. Oppenheimer and H. Reckitt (eds), *Acting on AIDS: Sex, Drugs and Politics.* (London: Serpents' Towl, 1997), pp 11-33.

[6] For a well-known example of this genre in the USA see R. Shilts, *And the Band Played On: People, Politics and the AIDS Epidemic.* (Penguin, 1988); for an Irish text which is somewhat similar see G. Philpott, *Deep End.* (Dublin: Poolbeg, 1995).

[7] In Britain, for example, Falmer Press initiated a series *Social Aspects of AIDS* under the general editorship of Peter Aggleton of Goldsmiths' College.

[8] J. Mann, '... for a global challenge', *World Health* (March 1988), p.4.

[9] Male homosexual behaviour had remained a criminal offence in the Republic of Ireland as a result of inherited British legislation, namely the Offences Against the Person Act 1861. A campaign to have this law reformed was started in 1979 and was headed by a gay activist, David Norris; having failed in the Irish courts, Mr Norris appealed to the European Court of Human Rights which in 1988 ruled that this

Irish law was in breach of the European Convention on Human Rights and Fundamental Freedoms. The law in Ireland was not amended, however, until the Criminal Law (Sex Offences) Act 1993 eventually decriminalised male homosexual behaviour for those over the age of 17.

[10] Gay Health Action was the first Irish organisation to produce health education leaflets on HIV/AIDS. Through its contacts with American gay activists, including some medical doctors who visited Ireland and conducted training and education here, the group developed a knowledge of and familiarity with the issues which it utilised in all publication of educational materials aimed at an Irish audience. Although primarily aimed at a gay audience, the leaflets were used *faute de mieux* by all kinds of interested groups. There is a brief account of the origins of the Gay Health Action group in G. Philpott, op.cit.

It was not until May 1987 that the Department of Health launched its own information programme on AIDS (Press Release - Launch of AIDS Public Information Programme, May 1, 1987).

[11] For a succinct analysis of the concept see E. Single, 'Defining harm reduction', *Drug and Alcohol Review, 14* (1995), 287-290. For a fuller text on international approaches to harm reduction see P. O'Hare, R. Newcombe, A. Matthews, E. Buning and E. Drucker, *The Reduction of Drug Related Harm.* (London: Routledge, 1992).

[12] The development and underlying rationale of methadone maintenance was discussed in Chapter Six (see note 3, Chapter Six); needle and syringe exchange schemes simply consisted of the provision of new injecting equipment for intravenous drug users so as to eliminate or reduce the practice of sharing such equipment amongst a number of users. Some such schemes operated strictly on the basis of one-for-one exchange, where used 'works' were replaced by old, while other schemes took a more flexible approach.

[13] As will become clear throughout this chapter, opposition to harm reduction strategies could be expressed in two main ways: it could be claimed purely on practical grounds that these strategies did not in fact reduce harm, or alternatively it could be claimed that, whether or not they were effective, they were morally unacceptable because they condoned drug use and thus violated communal value systems. Frequently, the two styles of argument were mixed by individual critics of harm reduction.

[14] Health education of this kind is an interesting example of how health service providers and prevention workers had to adapt to HIV. Some of the early advice to intravenous drug users suggested that needles and syringes could be made sterile by immersion in boiling water; this advice had to be abandoned when drug users pointed out that the boiling water bent and distorted their 'works'. More enduring advice on this topic suggested that bleach might be used or, failing this, that shared works might be flushed out with cold water (it was noted that hot water could cause blood to coagulate and thus increase risk).

[15] The idea that drug users could play a key role in helping other drug users had previously referred only to former users or 'recovering' addicts; in the harm reduction scene, however, it was now being suggested that currently using addicts (who had themselves adopted health promoting practices) could become peer workers.

[16] G. Edwards, 'What Drives British Drug Policy?', *British Journal of Addiction*, 84 (1989), p.223.

[17] The Council of Europe's Pompidou Group attempted, somewhat belatedly perhaps, to set down the basic principles of outreach work and to codify them in a systematic way; see T. Rhodes, *Outreach work with drug users: principles and practice.* (Strasbourg: Council of Europe, 1996).

[18] For an interesting discussion of the relationship of harm reduction policy to the wider debate on legalisation see E. Single, op.cit.

[19] See E. Engelsman, 'Dutch Policy on the Management of Drug-Related Problems', *British Journal of Addiction, 84* (1989), pp 211-218.

[20] See T. Hesketh, *The Second Partitioning of Ireland: The Abortion Referendum of 1983.* (Dublin: Brandsma Books, 1990).

[21] The following persons were appointed to the committee:
Mr Fergus O'Brien, TD., Minister of State at the Department of the Environment;
Mr Joe O'Rourke, Assistant Secretary, Department of Health;
Mr Brendan Meehan, Assistant Secretary, Department of Education;
Mr Michael Haydon, Superintendent, Customs & Excise;
Mr Noel Ryan, Assistant Secretary, Department of Justice;
Deputy Commissioner John Paul McMahon, Garda Síoochána;
Superintendent Phil Sheridan, Garda Drug Squad;
Mr Tony O'Dalaigh, Principal Officer, Department of Labour;
Dr Michael G. Kelly, Medical Director, Drug Advisory and Treatment Centre, Jervis Street Hospital;
Dr Allene Scott, Medical Director, National Drugs Advisory Board;
Mr Donal O'Shea, Chairman, Health Education Bureau;
Mr James Comberton, Executive Chairman, Coolemine Therapeutic Community;
Mr John Balance, Chairman, Community Action on Drugs, National Federation;
Ms Grainne Kenny, Secretary/P.R.O., Community Action on Drugs, National Federation;
Ms May O'Brien, Womens' Affairs Officer, I.T.G.W.U.;
Ms Aine Flanagan, Community Care Programme, Eastern Health Board;
Mr Joseph O'Toole, Irish Congress of Trade Unions;
Dr Desmond Corrigan, School of Pharmacy, Trinity College;
Mr Noel Usher, Assistant Principal, Public Health Division, Department of Health, Secretary to the Committee;

Mr Fergus O'Brien, T.D., Minister of State at the Department of the Environment, resigned due to the extra responsibilities assigned to him by the Government. Mr P.W. Flanagan, Secretary, Department of Health, was appointed as the new Chairman.

Mr Michael Haydon, Customs & Excise retired and was subsequently replaced by Mr J.A. Kiernan.
Mr Noel Ryan, Assistant Secretary, Department of Justice, resigned and was subsequently replaced by Mr Desmond Matthews, Assistant Secretary, Department of Justice.
Mr John Balance, Chairman, Community Action on Drugs, National Federation, resigned due to business commitments.

First Annual Report of the National Coordinating Committee on Drug Abuse. (Dublin: Stationery Office, 1986).

22 *First Annual Report of the National Coordinating Committee on Drug Abuse,* cit.sup., p.6.

23 Ibid., p.6.

24 Ibid., p.10.

25 See N. Dorn and K. Murji, *Drug Prevention; A Review of the English Language Literature.* (London: ISDD, 1992).

26 *First Annual Report of the National Coordinating Committee on Drug Abuse,* cit. sup., pp 7-8.

27 Ibid., p.11 and p.21.

28 Ibid., p. 21.

29 Given the dormant nature of this committee it is hard to be definitive as to when it was re-constituted - 1989 or 1990. One member of the committee, when told that he was no longer a member and that the committee no longer existed, quoted the remark of Dorothy Parker on being told that Calvin Coolidge had died - 'How could they tell'?

30 *Government Strategy To Prevent Drug Misuse.* (Dublin: Department of Health, 1991).

31 The task of chairing the committee quickly devolved to civil servants somewhat lower down the hierarchy than the Secretary. One such civil servant, looking back at these events between 1986 and 1990, told this writer that he had stopped having meetings. His precise words were: 'If you think that I'm going to sit around trying to chair a meeting with all these f*****s fighting with one another ... I make drug policy in this country.' This conversation took place informally in February 1993.

32 Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse (Part 1).* (London: HMSO, 1988), p.75.

33 *Seanad Eireann Debates* (Vol. 118).

34 Ibid., Column 1842.

35 Ibid., Column 2082.

[36] Ibid., Columns 1830-1831.

[37] Ibid., Column 1831.

[38] The AIDS Resource Centre began to function in 1989, both as a centre for clients who attended there and as a base for outreach to the city as a whole.

[39] The wisdom of retaining a single, centralised, drug treatment centre, instead of decentralising and normalising these services, will be discussed later in this chapter. The closure of Jervis Street Hospital, in which the old National Drug Advisory and Treatment Centre was located, presented an obvious opportunity for reviewing this policy option; it might have been taken up by the National Co-ordinating Committee on Drug Abuse if this body had functioned as intended.

[40] *The Irish Times,* November 18, 1988. It is clear from this report that Dr Walsh, the National AIDS Coordinator, was anxious to play down any apparent conflict between his views and those of the Minister. It is also noteworthy that in this report it is mentioned briefly and in matter-of-fact way that: 'A fourth element of the programme, methadone maintenance, has already been introduced as part of the course for some patients'.

[41] D. Nutbeam, V. Blakey and R. Pates, 'The Prevention of HIV Infection from Injecting Drug Use - A Review of Health Promotion Approaches', *Social Science and Medicine, 33* (1991), pp 977-983.

[42] J. Comberton, *The Self-Fulfilling Prophesty [* sic*] of Physeptone Maintenance (1).* (Dublin: Coolemine Programme Information Sheet, no date).

This was not printed commercially or sold publicly, but was confined to the relatively narrow circle of drug workers of this period in the early 1980s.

'Physeptone' was the proprietary name of the methadone most commonly prescribed at this time.

[43] Ibid., p.5.

[44] J. Comberton, *Ireland's Young People Have a Right to a Drug-Free Life.* (Dublin: Coolemine Unpublished Paper, 1990).

[45] Ibid., p.9.

[46] Ibid., p.9. This allusion to the views of the Pope (which are not referenced in any way) may be interpreted as an oblique criticism of two new voluntary drug services in Dublin, the Ana Liffey Project which was founded in 1982, and the Merchant's Quay Project which was founded in 1989. The founding director of the Ana Liffey Project was Frank Brady, a Jesuit priest, while the Merchant's Quay Project was founded by Seán Cassin, a Franciscan priest and former Coolemine worker. Both of these 'Catholic' organisations were unequivocally committed to harm reduction. The Ana Liffey Project had given out free condoms since the late 1980s, and the Merchant's

Quay Project - through its 'health promotion' section - gave out clean needles/syringes and condoms. These new voluntary drugs agencies broke the monopoly which Coolemine had enjoyed on the voluntary side since its establishment in 1973.

47 Ibid., p.1.

48 Ibid., p.12.

49 Ibid., p.13.

50 Typical examples would be Jim Comberton's letter to the *Evening Herald,* October 4, 1993, which was published under the heading 'Methadone is no answer'; also *The Star*, November 22, 1993, had a feature on the proposal to formalise methadone maintenance by Irish GPs, which included a quote from Jim Comberton to the effect that 'It's asking doctors to prostitute themselves'.

51 See, for example, Gráinne Kenny's letter to the *Garda Review* (March 1993) under the heading 'Economist has it wrong'. This was a response to an article by a German economist, published by this magazine in October 1992, advocating a more liberal drug policy. Ms Kenny's style of debate was always robust, and she started this rebuttal of the earlier article by asking 'What qualifies an economist to advise on drugs?' This was followed by later references to 'armchair generals making pronouncements from the safety of their ivory towers'. Ms Kenny herself had no relevant degree or professional qualification.

52 *Irish Medical Times,* October 13, 1989.

53 Ibid.

54 *Government Strategy to Prevent Drug Misuse.* (Dublin: Department of Health, 1991).

55 S. Butler, 'Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed', *Administration, 39* (1991), p.229.

56 In reply to a written Parliamentary Question from Tony Gregory, T.D., Brendan Howlin (then Minister for Health during late 1994) said that: 'The [National Coordinating] Committee met on two occasions in 1992, on two occasions in 1993 and has not met to date in 1994'.

It should be pointed out that the Minister for Health had also set up a *National AIDS Strategy Committee,* which issued a report in 1992. Dr James Walsh, who was a Deputy-Chief Medical Officer in the Department of Health, was appointed National AIDS Coordinator and in this capacity was a member of both these committees. Dr Walsh was a public health doctor who had not previously been involved with drug problems, and he took a pragmatic line on harm reduction in relation to both drug use and sexual behaviour. He had a high media profile in the late 1980s and sometimes was perceived as being an embarrassment to the Department of Health because of his frank discussion of the issues involved in HIV prevention – as in the case

referred to in the text where he issued a public statement which was contradictory of a speech made by his Minister on the same day. Because he was a medical doctor, however, his role was crucial in instructing or advising other medical practitioners of the imperative of accepting methadone maintenance, needle exchange and other harm reduction strategies. For an interesting journalistic piece on Dr Walsh, see: 'People: Dr James Walsh, the Department of Health's AIDS Expert', *The Sunday Tribune,* May 21, 1989.

[57] This is based on discussions during 1989/90 with these workers; they described a situation in which their supervisors appeared to give conflicting messages as to what they should or should not do, and on occasion it appeared to be instruction by nudge and wink.

[58] This is largely based on this writer's recollection of this time and on discussions with both staff of Trinity Court (the new service) and service consumers

[59] S. Butler and M. Woods, 'Drugs, HIV and Ireland: Responses to Women in Dublin', in N. Dorn, S. Henderson and N. South (eds), *AIDS: Women, Drugs and Social Care.* (London: Falmer Press, 1992), pp 63-64.

[60] J. Cronin, 'The Question of Needle Exchange', *The Irish Social Worker, 8(1),* (1989), pp 11-12. Empirical studies of the outcomes of needle exchange schemes have generally come up with positive findings; see, for example, G. Stimson, M. Donoghue, R.Hart and K. Dolan, 'Distributing Sterile Needles and Syringes to People Who Inject Drugs: The Syringe-Exchange Experiment', in J. Strang and G. Stimson (eds), *AIDS and Drug Misuse: The Challenge for Policy and Practice in the 1990s.* (London: Routledge, 1990), pp 222-231; or D. Des Jarlais et al, 'HIV Incidence Among Injecting Drug Users in New York City Syringe Exchange Programmes', *The Lancet, 348* (1996), pp 987-991.

[61] P. Comberton, 'Drug Addiction and AIDS', *The Irish Social Worker, 8(1),* 1989, pp 9-10.

[62] Ibid.

[63] No scientific evidence in support of this negative perception of the personalities of drug users has ever been adduced. O'Mahony and Smith (1984), for example, compared the personality characteristics of heroin addicts in Mountjoy Prison with those of non heroin-using prisoners and a normal control group of civil servants from the Department of Justice. No difference was found in the propensity for self-deception between any of these groups.

P. O'Mahony and E. Smith, 'Some Personality Characteristics of Imprisoned Heroin Addicts', *Drug and Alcohol Dependence 13* (1984), pp 255-265.

[64] Peer support networking amongst drug users, as a means of harm reduction, did evolve slowly in the Eastern Health Board towards the end of the period studied in this chapter. Specifically, during 1995/96 the EHB collaborated in an EU funded project; see F. Trautman and

C. Barendregt, *The European Peer Support Project: Development and Encouragement of Peer Support Initiatives for AIDS Prevention in IDU Communities* (Utrecht: National Institute for Alcohol and Drugs, 1996).

65 A particularly clear and explicit expression of this perspective – that professional healthcare values were being compromised by harm reduction – was contained in a conference paper 'AIDS and Drug Abuse – Therapeutic Dilemmas' read by Sally Stafford-Johnson, Clinical Psychologist at Trinity Court, at a conference *The Challenge of AIDS – A Focus on Behaviour and Behaviour Change*, organised by the Psychological Society of Ireland at University College Dublin on April 21, 1989.

66 *The Irish Times,* August 8, 1989.

67 Ibid.

68 Ibid.

69 *Government Strategy to Prevent Drug Misuse,* cit. sup., p.2.

70 This view is based on the writer's contacts with personnel from both of these agencies over this period of time. In informal contacts, each side was forthright in its criticism of the other and in its resentment of the other's resources. By and large, however, this never erupted into overt hostility.

71 Dr O'Connor's scepticism and caution is clearly demonstrated in 'Is methadone maintenance the answer in drug misuse?', *Irish Medical Times,* 4 March, 1994.

Dr Barry's more positive views on harm reduction are discernible, for instance, in his editorial in *AIDS/Drugs News* (First edition of an Eastern Health Board newsletter, May, 1993).

72 See, for instance, 'Most GPs won't have anything to do with drug addicts', *Irish Medical Times,* 17 January, 1986. This journalistic piece in a GPs' trade paper essentially summarises what seems to have been the dominant view of GPs, namely that drug users were more trouble than they were worth – they were seen as devious and manipulative, and their treatment in a general practice setting was seen as off-putting for more conventional patients and likely to arouse the interest of the Garda Drug Squad.

73 *Government Strategy to Prevent Drug Misuse,* cit.sup., p.2.

74 For a summary of how CDTs evolved and performed in Britain see J. Strang and S. Clement, 'The introduction of Community Drug Teams across the UK', in J. Strang and M. Gossop (eds), *Heroin Addiction and Drug Policy: The British System.* (Oxford University Press, 1994), pp 207-221.

75 C. Forrestal, *Evaluation Report on Ballymun Community Drug Team.* (Dublin: Community Action Network, 1996), p.36.

[76] See M. Bowden, *Rialto Community Drug Team: Policy Discussion Paper.* (Rialto CDT, 1996).

[77] Roisin Shortall, T.D., who was chairperson of the Eastern Health Board at this time, spoke at a seminar to launch the Rialto Report (see reference 89 above) in Dr Steeven's Hospital in October 1996. She spoke with great frankness of the sense of frustration experienced by Dublin TDs in responding to local demands for drug services, largely echoing the views of health board officials that nothing satisfied the residents of these areas. Ms Shortall also added that for TDs whose constituencies straddled affluent and deprived areas there was a great temptation to simply ignore requests from constituents from the latter area to become involved in the setting up of drug treatment services. She said that efforts to create such services were invariably rejected by the same constituents, who had earlier lobbied for them, and that in any event very few of the residents of deprived areas turned out to vote on election day. It was, she concluded, easier and more electorally rewarding to concentrate on fixing footpaths and planting trees in more affluent parts of the constituency.

In informal discussion, two other Dublin-based TDs made similar points to this writer.

[78] *Government Strategy to Prevent Drug Misuse,* cit.sup., p.2.

[79] For a succinct analysis of how British policy on this topic vacillated over time see A.Glanz, 'The fall and rise of the general practitioner' in J.Strang and M.Gossop (eds), *Heroin Addiction and Drug Policy : The British System.* (Oxford University Press, 1994), 151-166.

[80] Irish College of General Practitioners, *Policy Statement on Illicit Drug Use and Problems of Drug Addiction,* (1990).

A key role in drafting this document was played by Dr. Fergus O'Kelly, whose involvement in community drug services in the south inner-city of Dublin was discussed in Chapter Seven; he has also acted as informant for this writer on the general topic of GP management of drug problems in Dublin for this section of Chapter Nine.

[81] *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone.* (Dublin: Department of Health, 1993). It should be noted that the printed copy of this document is dated March 1993, although it was not made available in this format until early 1996.

[82] Apart from Dr Walsh, the other members of the Expert Group were:

Dr Joe Barry, Drugs/AIDS Coordinator, Eastern Health Board;
Mr Tony Geoghegan, Project Leader, Merchant's Quay Project;
Dr Fergus O'Kelly, Irish College of General Practitioners;
Dr John O'Connor, Clinical Director, National Drug Treatment Centre, Trinity Court;
Dr Brion Sweeney, Consultant Psychiatrist, Eastern Health Board;
Mr Dermot Ryan, Department of Health, secretary to the Group.

[83] *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone,* cit.sup., p.2. The terms of reference of the Expert Group were not spelt out more formally than this.

[84] Ibid, p.12.

[85] Ibid, pp 8-11.
The Expert Group was undoubtedly aware of the fact that in Britain the register of addicts which was kept by the Home Office had fallen into some disrepute and was about to be abolished.

[86] Tony Geoghegan of the Merchant's Quay Project, who was a member of the Expert Group, has acted as informant on this subject, as has Dr. Fergus O'Kelly.

[87] *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone,* cit. sup., p.18.

[88] The single most important step which the Department of Health would have to take to implement this protocol was the negotiation of payment systems with the Irish Medical Organisation (IMO); work on these negotiations did not commence until 1996.

[89] 'Addicts: Call in the Army', *Evening Herald,* February 12, 1993.

[90] 'State-financed drug addiction', *Sunday Business Post* February 18, 1996.

[91] In the United Kingdom the then Conservative Minister for Health, Dr Brian Mawhinney, had set up a review group on drug treatment services in 1994. It was widely believed that Dr Mawhinney hoped that this group would report the treatment was ineffective, thus allowing him to scale down harm reduction services. In fact, the review group concluded that harm reduction services were effective and, most tellingly, that for every pound expended on harm reduction there was a saving of seven pounds to the Exchequer as a whole. See *The Task Force to Review Services for Drug Misusers: Report of an Independent Survey of Drug Treatment Services in England.* (Wetherby: Department of Health, 1996).

[92] For evidence of conflict about payment systems for GPs taking part in the methadone programme see 'GPs encouraged to treat drug users' and 'ICGP and IMO clash over methadone drug', *Irish Medical Times,* February 2, 1996.

[93] Comparative statistics compiled by the European Monitoring Centre for Drugs and Drug Addiction (an EU body which is based in Lisbon) show that while Ireland has a low incidence of AIDS by European standards, it has a high proportion of AIDS cases which are related to drug injecting. The cumulative proportion of AIDS cases related to injecting in Ireland at the end of 1996 was 43.8%; this statistic varied considerably across the EU, generally reflecting the extent to which different member states had been quick to introduce harm reduction practices. In Italy this statistic was 63.5%. On the other hand, the UK figure was 6.4% and the figure for the Netherlands was 10.6%. The source of these figures is: *1996 Annual Report on the State of the*

Drugs Problem in the European Union. (Lisbon: European Monitoring Centre for Drugs and Drug Addiction, 1997).

94 For a detailed account of this Ministerial announcement see *Irish Times,* October 23, 1995.

95 *Drug Service – Review of 1995 and Development Plans for 1996.* (Document prepared for special board meeting of Eastern Health Board, April 2, 1996).

96 Ibid., p.4.

97 In an informal discussion with this writer during June 1996, one of the two reviewers, Dr Michael Farrell, suggested that this was such an obvious structural problem that it was unnecessary for him and his colleague to mention it.

98 *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.* (Dublin: Department of the Taoiseach, 1996).

99 Ibid., p.6.

100 In addition to Pat Rabbitte (Minister of State to the Government), the *Ministerial Task Force on Measures to Reduce the Demand for Drugs* consisted of the following:

Bernard Allen,	Minister of State at the Department of Education;
Brian O'Shea,	Minister of State at the Department of Health;
Austin Currie,	Minister of State at the Departments of Health, Education and Justice;
Gay Mitchell,	Minister of State at the Departments of the Taoiseach and Foreign Affairs;
Liz McManus,	Minister of State at the Department of the Environment;
Bernard Durkan,	Minister of State at the Department of Social Welfare.

101 *First Report of the Ministerial Task Force on Measures to reduce the Demand for Drugs,* cit.sup., p.33.

102 Ibid., p.41.

103 In the immediate aftermath of Veronica Guerin's murder, the following supply reduction legislation was enacted:

- the Criminal Justice (Drug Trafficking) Act 1996 which provided for the detention of persons accused of drug trafficking for up to seven days, and which allowed the courts to draw inferences from the failure of accused persons to mention certain facts during questioning;

- the Criminal Assets Bureau Act 1996 which established the Criminal Assets Bureau on a statutory footing;

- the Proceeds of Crime Act 1996 which, in conjunction with the Criminal Assets Bureau Act, was aimed at identifying criminally acquired assets (including the assets of drug traffickers) and depriving criminals of these assets.

104 See, for example, R. O'Donnell, 'Irish Policy in a Global Context: From State Autonomy to Social Partnership', in J. Walsh and B. Leavy (eds), *Strategy and General Management: An Irish Reader.* (Dublin: Oak Tree Press, 1995), pp 299-321; or *A Framework for Partnership- Enriching Strategic Consensus through Participation.* (Dublin: National Economic and Social Forum,1997).

105 *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs,* cit.sup., p.45.

106 Ibid., p.12.

107 SMI was an attempt to reorganise the Irish civil service and public administration generally so as to conform to modern business management practices. See D. Byrne et al, *Strategic Management in the Irish Civil Service: A Review Drawing on New Zealand and Australia.* (Special Issue of *Administration,* Vol. 43, no. 2, Summer, 1995); also *Strategic Management Initiative: Delivering Better Government.* (Dublin: Stationery Office, 1996).

108 For a review of organisational network theory and its application to public policy see W. Kickert, E. Klijn and J.Koppenjan (eds), Managing Complex Networks: Strategies for the Public Sector. (London: Sage, 1997).

109 From his personal acquaintance with community activists during this time, this writer was aware of the impatience of Pat Rabbitte at the delay in setting up the Local Drugs Task Forces; with characteristic wit, Rabbitte complained about debate 'of a theological nature' which he saw as delaying this process.

CHAPTER TEN

ALCOHOL, DRUGS AND HEALTH PROMOTION IN MODERN IRELAND: A CONCLUSION

Introduction

The previous eight chapters have presented a detailed account of how Irish health policy dealt with alcohol and drug issues during the period from 1945 to 1996; this account was essentially given in the form of two case-histories, one relating to alcohol and the other to illicit drugs. The aim of this, the final chapter of the thesis, is to pull these two stories together analytically so as to attempt to answer the following interrelated questions which were posed in Chapter One:

> **to what extent did Irish health policy on alcohol and drugs move towards a health promotional perspective over the course of the period studied?**
>
> and
>
> **what lessons concerning the general practicability of health promotion may be learnt from this study of alcohol and drug policy?**

It was not the intention of this thesis to argue prescriptively that health promotion *should* be introduced as the dominant paradigm governing health policy on mood altering substances or indeed health policy generally, but rather was it hoped to use alcohol and drug policies as two closely related case studies, analysis of which might throw some light on the viability of health promotion.

As set out in Chapter One, health promotion is a policy perspective which has been developed by the World Health Organisation (WHO), implicitly at first but since the 1970s in an increasingly explicit and public way. Health promotion, in some ways, reflects the disillusionment with conventional biomedical practices and institutions which has been a

feature of the latter half of the twentieth century: its proponents argue that society has developed a misplaced and exaggerated trust in medicine and in 'high-tech' health care systems dominated by the medical profession.[1] Health promotion has emerged, therefore, as an alternative set of beliefs and practices which attempts to redress the balance by demoting curative medicine from its dominant position and replacing it – or at least complementing it - with a renewed emphasis on disease prevention and on supporting and maintaining good health. For many authors, health promotion is synonymous with 'the new public health',[2] a reference back to the 'old' public health - the major nineteenth century reforms which radically improved public health in urban areas through environmental measures, such as clean water supplies, sanitation, food hygiene and better housing standards. Thus, it is argued, morbidity and mortality in the latter half of the nineteenth century were reduced through diverse measures aimed at environmental change, rather than as a result of specific technical developments in medicine or surgery. It would be a distortion of conventional health promotion belief or rhetoric to suggest that it has totally turned its back on curative medicine; rather would it be more accurate to say that health promotion attempts to bring the emphasis back to primary health care - away from what might be seen as an over-reliance on hospital medicine with its trappings of medical specialism and sophisticated technology.

Health promotion policy, as it has evolved in the second half of the twentieth century and particularly as it has been espoused by the WHO,

has obvious parallels with its nineteenth century counterpart: foremost among these is its belief that improvements in human health are more likely to result from broad environmental measures than from better resourced or more technically effective health sector interventions. For health promotionists, however, the concept of environment is considerably broader than that espoused by their nineteenth century forebears. For the Victorian reformers 'environment' referred simply to the physical habitat, especially those urban neighbourhoods which were seen as inimical to human health; for present-day health promotionists the notion of 'environment' has been extended to incorporate a complex host of social, cultural, political and economic issues. The concept of 'community' has a central place in this new public health, as do the related concepts of 'participation' and 'empowerment'. In summary, it is argued that ordinary people (ordinary in the sense that they are lay people, not health care professionals) have an important role to play in creating and sustaining 'health promoting environments' in their own neighbourhoods or communities. It is commonly implied, and sometimes stated explicitly, that there is a moral imperative on the part of these ordinary people to participate in creating and working on a health agenda for their communities; and it is also emphasised that health authorities should 'empower' such participation where communities are prevented by poverty, political disenfranchisement or other factors from such participation in health promotion. The health promotion ideal, therefore, is one of partnership or collaboration between health professionals and the laity, as opposed to the previous tradition which consigned non-

professionals to a relatively passive and subordinate role in healthcare matters.

While health promotion has a much greater emphasis on collective or communal activity than is the norm in conventional biomedicine, it also has its own distinctive viewpoint on the importance of individual behaviour or 'lifestyle' for morbidity and mortality. Individuals, it is argued, contribute significantly to shaping their own health status through the choices which they make in terms of food consumption, exercise, sleeping patterns and sexual behaviour, as well of course as their choices in relation to alcohol and drug use. This emphasis on individual behaviour and its importance for health is balanced, however, by an equal emphasis on the central role of structural or environmental factors in shaping individual choices, so that health promotionists seek to avoid the worst excessives of naive individualism, an individualism which could easily degenerate into a form of 'victim blaming'. It is recognised that not all social contexts or environments are equally conducive to health, and so policy is directed at changing the environment with a view to 'making the healthier choice the easier choice.'[3]

From a policy making perspective, health promotion differs radically from traditional health policy in its insistence that real improvements in the health status of a society cannot be solely reliant on the health sector of Government. Instead, it is argued that all public policy has health implications and that public health can only be effectively promoted

through the conscious collaboration of all sectors of Government; this intersectoral collaboration is aimed at bringing about what health promotionists describe as 'healthy public policy'. While the health promotion agenda may generally be seen as an ambitious one, this specific aspect of it, which envisages the health sector as securing the cooperation of all other governmental sectors seems particularly ambitious and difficult to realise.

The above account of health promotion, much of which was summarised under the rubric of the *Ottawa Charter* in Chapter One, sets the scene for a final analysis of what has been presented and discussed in the preceding eight chapters. The policy document *Health: The Wider Dimensions,* which was published by the Department of Health in 1986, was the first explicit and detailed exposition of health promotion by Irish statutory authorities. As noted in Chapter One,[4] this document concluded its account of health promotion and its applicability to Ireland with the suggestion that: 'The cynical and fatalistic will probably dismiss such an approach as a grand design incapable of being achieved'. The findings of this thesis indicate that during the period studied Irish health policy on alcohol and illicit drugs made relatively little progress in the realisation of health promotional aspirations. Whether these findings warrant the description 'cynical and fatalistic' is a moot point, but they certainly confirm the naivete of those who aspire to a 'grand design' without spelling out in detail how such a design can be achieved. Proponents of health promotion have generally failed to pay as much attention to policy

strategies as they have to the statement and reiteration of their aspirations; by and large, they have succeeded in making clear *what* it is they wish to achieve, while virtually ignoring the question of *how* these radical aspirations are to be attained. Later in this chapter, there will be a review of alcohol and drug policy making processes in Ireland over the half-century studied in the light of the models outlined by Harrrison and Tether[5] which were discussed in Chapter One.

However, before reviewing these policy-making processes, there will be an analytic summary of the main issues dealt with in Chapters Two through Nine, with the Ottawa Charter again providing the organising framework.

Alcohol, Illicit Drugs and Healthy Public Policy

If health promotion were to move beyond rhetoric and become a reality, it would have to confront and shape a socio-cultural environment infinitely more complex than the physical environment which was successfully tackled by the public health reformers of the nineteenth century. One of the main advantages of using two similar, though subtly different, case studies in this thesis is that it allows for a more detailed analysis of the difficulties faced by the health sector in challenging the *status quo,* in cultural, economic and political matters, than would be possible if just one of these topics had been studied. It may be argued from an objective biomedical perspective, that the similarities between the consumption of alcohol and the consumption of illicit drugs greatly outweigh the

dissimilarities: each may be considered in terms of toxicity and associated long-term or short-term health risk; each may be considered in terms of potential for addiction or dependency; and each may be considered in terms of impact on the behaviour or personality of individual users and what might be considered the knock-on effects on society. However, the findings of this thesis demonstrate clearly that Irish health policy has not been moving towards the creation of a unitary, rational, or research-based, substance abuse policy. Instead, alcohol policy and drug policy have generally moved forward as parallel activities, involving different actors pursuing different agendas, and with science or research making, at best, a modest contribution in each of these two related arenas.

When the alcohol and illicit drugs stories are looked at together, it becomes clear just how difficult it is for policy makers to be governed by rationality when that rationality clashes with both 'conventional wisdom' and sectional interests of one kind or another. The conventional wisdom or cultural perspective on alcohol in Ireland appears to portray this substance as essentially benign; it is a familiar drug which has always been part of our everyday environment, so that epidemiological and public health arguments that it is a dangerous drug and that consumption levels and drinking patterns should be changed or regulated (see Chapters Four and Five) appear moralistic and out of touch with popular sentiment. It was argued in Chapters Two and Three that, prior to the coming of the disease concept, Ireland could be considered to have had, in cultural and political terms, a balanced approach to alcohol and that at least some of

this balance was lost by the relatively uncritical importation of a concept which was ideologically functional in the USA - its country of origin - but not obviously needed in Ireland. Be that as it may, the diffusion of the disease concept to Ireland contributed to the emergence of a new cultural perspective on alcohol, a perspective which was antithetical to public health in that appeared to exaggerate the importance of individual predispostion and understate the negative attributes of alcohol.

On the other hand, illicit drugs, which are of more recent origin, have been conventionally portrayed and popularly accepted in Ireland as being unspeakably evil, so that it is acceptable to describe public policy in this area in terms of a 'war on drugs'. Rational policy analysis suggests that neither supply reduction strategies nor demand reduction strategies have any real chance of making society drug-free, thereby winning the war on drugs. One only has to consider the failure of prison authorities to make Irish prisons drug free to realise how unrealistic it is to aim at insulating the country as a whole, so as to exclude illicit drugs. To some extent, drug use has become normalised, especially amongst young people, and demand reduction strategies appear to offer relatively little hope of radically reversing or altering this situation. Instead, rational policy analysis tends to the view that it would be better to accept pragmatically that we must learn to live with some level of drug use and promote health through various forms of harm reduction strategy; such strategy would include primary preventive lifeskills education of the type discussed in Chapter Eight which might have universal application, as well as the

methadone maintenance and needle exchange programmes discussed in Chapter Nine which might be more selectively targetted at sub-groups of problem drug users. However, it also appears to be the case that to large sections of the general populace such harm reduction strategies are immoral and quite unacceptable, and that, even if it is just to be a symbolic crusade, they remain devoted to the idea of a war on drugs.

What has consistently emerged from the previous eight chapters is that, although there have been many actors involved in the policy process over the half century studied, ultimate decisions as to what Irish society will accept in this sphere are made by political leaders. Health care professionals, civil servants, church authorities, community activists, captains of industry and the media all contribute in important ways, but the final decision as to the shape of public policy on alcohol and illicit drugs is taken by elected politicians; as is to be expected in democratic societies, decisions of this type are largely dictated by politicians' judgements of what the electorate wishes or at least will tolerate.

In Chapter Two reference was made to the relationship of Daniel O'Connell to Fr. Mathew and the latter's temperance crusade of the 1840s; O'Connell, an exceptionally astute judge of what would now be called the 'grassroots', had a brief dalliance with the temperance movement but eventually rejected it since he judged it to be antipathetic to popular sentiment on alcohol. While it may seem somewhat fanciful to compare Daniel O'Connell's relationship with the Fr. Mathew temperance

movement with Minister for Health, Michael Noonan's, relationship with the drafting of a national alcohol policy in 1996 (described in detail in Chapter Five), there are interesting parallels. The epidemiological evidence and the general thrust of the public health perspective on alcohol suggested that, in the interests of health, Irish public policy on alcohol should become 'drier' and should utilise control strategies. These health promotional arguments for making alcohol consumption less easy for individual drinkers and for creating an environment in which alcohol was less normalised were presented in scientific terms, whereas the Fr. Mathew argument of the 1840s was presented primarily in moral terms. In each instance, however, a practising politician deemed these anti-alcohol arguments to have gone beyond what was popularly and electorally acceptable. As Minister for Health, Michael Noonan was involved during 1996 in the launch of the long-awaited National Alcohol Policy. Even though the policy document was quite vague and aspirational, and could certainly not be interpreted as being aggressively 'neo-prohibitionist', as drinks industry lobbyists liked to portray such health promotion initiatives, Mr. Noonan was clearly uncomfortable with anything that smacked of paternalism in relation to alcohol. He told the press conference at the official launch of the policy that he was not planning 'to legislate for virtue' and that he favoured a situation in which citizens of Ireland would be provided with information but then left to 'make individual sovereign decisions in their own interest'.[6]

Despite being Minister for Health, Mr. Noonan had obviously decided that, whatever the scientific merits of the public health perspective, the Irish policy climate was not yet receptive to the radical alcohol control strategies which this perspective entailed; any lingering doubts which he might have had on this topic must have been banished by the controversy which attended the introduction of the Road Traffic Act 1994 and the speedy softening of the new penalties for drunk driving contained in this legislation (see Chapter Five). The debacle which followed this attempt to make Irish roads safer demonstrated just how difficult it was to challenge cultural perceptions about alcohol or to operationalise the Ottawa Charter concept of 'healthy public policy' in this sphere. However, in the context of the two case-studies contained in this thesis, it is clear that Mr. Noonan's remarks at the launch of the National Alcohol Policy are best understood as specific reassurance that he did not intend to engage in a radical drive to change Irish drinking habits, rather than as an expression of general philosophical beliefs which he planned to apply consistently as Minister for Health. If his libertarian views on alcohol consumption had been interpreted as also applying to the use of illicit drugs, there would certainly have been a political controversy greater even than that which arose from the introduction of the Road Traffic Act 1994. Nobody interpreted his remarks in this way, however, or commented upon the double standard which was implicit therein: in relation to alcohol it was being suggested that Irish people should be left free to make their own choices, while in relation to currently illicit drugs a more paternalistic and prohibitionist regime remained unquestioned.

What emerges from an analysis of the two case studies is just how a wide a gap there is between the rhetoric of health promotion and the political realities which have to be judged by elected leaders, particularly ministers. Politicians, rather than any of the other policy actors, are the ultimate judges of popular readiness to change, and it appeared to be their view that the Irish were not ready at the end of the period studied to accept what would in any event be a paradoxical change: that is, the simultaneous introduction of tougher and more paternalistic alcohol policies alongside more liberalised, or at least more pragmatic, drug policies - all in the name of health promotion.

Sociologists and others who have criticised health promotion, and particularly the concept of 'healthy public policy' on the grounds that it represents a new form of social control or 'health fascism', in which more and more aspects of human behaviour and social life are brought under the sway of medicine and healthcare, appear to have an exaggerated view of the power and influence of these latter institutions. Health promotionists in Ireland have not been successful in persuading the populace that alcohol is more risky than it has been conventionally portrayed in recent times; equally, of course, they have had only limited success in persuading the Irish public of the validity of harm reduction models, which make it clear that illicit drugs are not as uniformly evil as they have been conventionally portrayed. In terms of policy coordination and public sector management, what is clear is that the Irish health sector has not succeeded in articulating a coherent health promotion strategy in relation to alcohol and illicit drugs

to which other governmental sectors have given assent and active cooperation.

Community Participation

As mentioned above and as discussed in greater detail in Chapter One, the concept of 'community participation' has been central to the wider health promotion project, featuring in all the key WHO texts, in Irish policy documents on this topic and in much of the secondary literature. In the Ottawa Charter health promotion is defined as 'the process of enabling people to increase control over and improve their health'.[7] This is a democratic concept which challenges the power and control previously enjoyed, almost indeed monopolised, by health care professionals and health care authorities. In popular terminology, community participation in health promotion represents 'bottom-up' activity, and where communities fail to become spontaneously involved in such initiatives it is envisaged that the role of the 'experts' is to empower or facilitate such actions. However, the limitations of this concept have become evident throughout the detailed presentation of the two case studies in this thesis.

If the alcohol story is looked at first, it is apparent that over the course of the half-century studied no significant locally-based social movements of a health promotional nature emerged in the alcohol sphere. The only large-scale and enduring social movement in the alcohol field to make a lasting impression in Ireland during this period was Alcoholics Anonymous (AA), which had come to Ireland, adapted successfully to a

policy climate which was very different to that of its country of origin, and had gone from strength to strength. As was pointed out in Chapter Three, AA as an organisation is solely concerned with providing help to individuals who wish to stop drinking, and is specifically precluded by its Traditions (that is, its written administrative charter) from taking a public stance on policy issues or becoming involved in lobbying for any policy or form of service provision. This is not to detract in any way from the value of AA for individual problem drinkers, but merely to make the point that it is not concerned with problem prevention in any broad health promotional sense. As discussed in Chapters Three, Four and Five, AA was one element in the wider 'disease concept', an individualistic concept which purported to integrate drinking problems into a conventional biomedical framework and which was largely antithetical to health promotion.

For much of the period studied, but particularly in the late 1950s and throughout the 1960s, the disease concept was promoted in Ireland in a modernist way as representing a new scientific and non-moralistic approach to drinking problems; in this view, problems could be largely explained in terms of the individual deficits or predispositions of a minority of drinkers, with little responsibility being attributed to alcohol itself. The Department of Health played no role in the initial introduction of the disease concept to Ireland but did eventually adopt this approach, the high point of which was its espousal of and financial support for the Irish National Council on Alcoholism (INCA) in the early 1970s (see Chapter Three). By the time the Department of Health began to move

tentatively towards its exploration of the public health perspective in the late 1970s, important changes had taken place in Irish drinking practices: there had been a generalised decline in temperance sentiment[8] and an accompanying normalisation of alcohol, with particular increases in numbers of women drinkers and young drinkers. However, even following the establishment of the Health Promotion Unit in the Department of Health in 1988 and the decision to formulate a National Alcohol Policy, no significant initiatives to empower local or community-based alcohol prevention programmes emanated from the Department of Health. As indicated in Chapter Five, the policy making process favoured by the Health Promotion Unit in its development of the national alcohol policy was not of the *social networking* style; even the working group which ostensibly was appointed to draft this policy was excluded by the HPU from anything but the most superficial participation in the policy process. This obviously did not bode well for future networking and collaboration with local groups on alcohol issues.

In the completed text *National Alcohol Policy - Ireland* (1996) there is a half-page section which deals with community initiatives, starting with the declaration that: 'Community action has the potential to be a powerful influence for both social and environment-directed interventions'.[9] However, the remainder of this section is vague and unconvincing on this topic, citing just two Irish examples of 'best practice' in this sphere: the first of these refers to a Southern Health Board training programme in health education for professionals and volunteers who work with

community groups, while the second describes parental initiatives to organise alcohol-free discos for teenagers in various parts of the country . The 'Action Plan' of this policy document is equally vague and brief on this theme, promising merely that the Department of Health will 'Support community initiatives which promote the National Alcohol Policy' and then referring in broad terms to youth work programmes.[10]

National Alcohol Policy - Ireland makes brief reference to international research on the development of community prevention programmes, some of which have taken place in countries (such as Finland and Sweden) where the policy climate is more favourable to temperance than is the case in Ireland.[11] However, no detailed discussion of these programmes is offered nor, as stated above, is there any strategy outlined for developing similar programmes in Ireland. It has to be concluded, therefore, that there is no evidence of the spontaneous emergence of any significant community initiatives aimed at the prevention of alcohol-related problems in Ireland; neither does it appear that the Department of Health has the will or the capacity to mobilise or empower such community initiatives. The reality is that, in most instances, communal celebrations in Ireland have alcohol consumption as a central element and may indeed be sponsored by the drinks industry; this is a reality which is far from the rhetoric of health promotion and community participation.

When the focus is switched to community participation in preventing or responding to problems associated with the use of illicit drugs, a different

but equally complex set of questions is raised about the realisation of health promotional ideals. During the period described as the 'opiate epidemic' (1980-1985), which was the subject of Chapter Seven, there was an unprecedented rise in community development activities focused on heroin use in those areas of Dublin with the highest prevalence of such problems. In contrast to the situation which prevailed in relation to alcohol, there was no shortage of bottom-up initiatives aimed both at primary prevention and at treatment and rehabilitation of existing problems. Individually and collectively, these community responses to heroin could be seen as ideal types of health promotion activity: they involved local residents and primary health care personnel working collaboratively to deal with the heroin problems at local community level. It will be recalled from Chapter Seven, however, that the statutory health authorities (specifically the Eastern Health Board and the National Drug Advisory and Treatment Centre) rather than welcoming community participation of this kind and seeking to work in partnership with it, appeared to regard it as impertinence and demonstrated considerable antipathy towards the vision of those involved in community responses to heroin problems. The statutory health service response was based on a traditional biomedical model which viewed heroin addicts as individual 'patients' and took little stock of environmental factors; it was assumed within this traditional framework that treatment of addicts was best delivered by health care experts, preferably in centralised and specialist services. Even when the Eastern Health Board began to become more directly involved in the provision of addiction counselling within its

Community Care services, this type of service provision was of a traditional - albeit decentralised - clinical style, provided by 'experts' and with little or no reference to community participation .

In summary, it can be said that the health promotional perspective of community activists who worked to develop local responses to heroin problems was not welcomed by the health authorities, and that the attitude of these authorities to the burgeoning community response to drugs was not one of partnership and support but rather one of considerable antipathy. Even as late as 1995, the first attempt at formal partnership between the Eastern Health Board and a local drug agency - the Ballymun Youth Action Project - had collapsed in acrimony and disarray (see Chapter Nine), and it was only in 1996 that the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs established the structure of the local drug task force to facilitate partnerships at community level.

This delay in setting up community-based responses, consisting of the collaboration of the statutory health authorities and local groupings, was perhaps predictable. As indicated in Chapter One, government in Ireland has tended to be highly centralised, with an underdeveloped local government sector, and the concept of community care in the Irish health system has generally referred to the provision of non-institutional services rather than to the development of radical participative structures at local level. Furthermore, health care professionals have generally been

socialised within traditional education and training systems, which emphasise their technical expertise and which do not readily predispose them to power-sharing with lay people.

It would be misleading, however, to convey the impression that local participation in the response to heroin or other serious drug problems reflects a communal consensus of a welfare type, a consensus which is invariably benign towards drug users and is automatically superior to service provision by professionals. As mentioned in Chapter Seven and further explored in Chapter Nine, some community activism took the form of aggressive rejection of both drug dealers and drug users, categories which frequently overlap and sometimes are effectively indistinguishable in local drug scenes. Informal community policing, which appears on the face of it to be a liberal and worthwhile venture, can quickly turn into aggressive vigilante activity, and certainly there were occasions when unofficial evictions or opposition to proposed local treatment services suggested that activists, while protecting their communities, were reinforcing and perpetuating the social exclusion of drug users. It could be argued that had the statutory authorities been quicker to form partnerships with community groups, this might have led to a less aggressive form of community activism. It could equally be argued that the notion of community participation in health promotion has been propounded uncritically and superficially, without due recognition of its negative potential. In his 1982 minority report to the Barclay Report on community social work in Britain, Robert Pinker suggested that: 'It is one of the

stubbornly persistent illusions in social policy studies that eventually the concept of community - as a basis of shared values - will resolve all our policy dilemmas'.[12] Later in this report, Pinker argued explicitly that local or community-based services were not necessarily welcomed by their recipients: specifically, he concluded that in the history of British social policy it was the nineteenth century Poor Law which was the most localised and intimate form of service provision, and that it 'was just this distinctive quality of parochial social service that added a uniquely hurtful dimension to the experience of stigma among the recipients of poor relief'.[13] In Britain there has been no detailed study to date of local partnership approaches to the management of drug problems, but in a recent review of British drug policy MacGregor commented in passing on the negative potential of such activity; referring back to the tradition of the Poor Law, she speculated that drug users could become 'a new stratum of vagrants excluded from each parish's social provision ...'.[14] While it falls just outside the timeframe for the present study, it should be noted that the enactment in Ireland of the Housing (Miscellaneous Provisions) Act 1997, ostensibly aimed at fostering community participation in 'estate management' and facilitating the eviction of 'anti-social' tenants, is another example of a policy development which may have the unintended consequence of scapegoating and excluding drug users and their families from the neighbourhoods in which they live.[15]

In conclusion, it seems clear from this study of Irish alcohol and drug policy in the second half of the twentieth century that the notion of

community participation in health promotion is a great deal more complex and contentious than is suggested in formal aspirational policy statements on this topic. It also seems clear that if health promotion is to move beyond rhetoric in this area of community participation, it must acknowledge and grapple with the tensions and ambiguities identified here.

Individual Lifestyles

To members of the public with just a passing acquaintance with health promotion, it may be that its very essence consists of educational messages advising them that their health status is largely determined by their 'lifestyles' and urging them accordingly to cultivate healthy lifestyles. However, it was made clear in Chapter One that health promotion philosophy as developed and enunciated by WHO was intended to incorporate both *individualistic* and *communitarian /collectivist* approaches to health, and that policy which consisted solely of individualistic strategies could not really be regarded as coming under the rubric of health promotion. Individualism as a philosophy is usually associated with traditional conservative or New Right politics and is regarded as antithetical to public health.[16] It is commonly assumed that individualism is popular with such political groupings because it does not question or disturb existing economic arrangements or call for any radical restructuring of society in the interests of social justice or equity. The data presented in this thesis also suggest, however, that individualistic health promotion of this kind - when analysed in its own right and leaving aside

these major socio-economic issues - can throw up a range of technical and moral complications.

In relation to alcohol, it has proven difficult for health educators to come up with any clear message with which to replace the comforting idea that personal levels of consumption are unimportant for most drinkers who are not 'alcoholic'. By 1996, when the National Alcohol Policy was eventually published, the validity and practical utility of 'sensible' or 'safe' drinking guidelines presented in terms of 'units' of alcohol - which had been popular for the previous decade - had been questioned to such an extent that they were simply dropped in this country. There is, in absolute terms, no such thing as a 'safe' drinking level: alcohol consumption carries risk regardless of dosage, although this risk is clearly influenced by dosage/consumption level, as it is by pattern and by a host of other individual and contextual factors. What appeared to be emerging, therefore, from this view of risk was that educational messages should be aimed at specific groups, such as drivers, students or pregnant women rather than at an undifferentiated public. The fact that moderate alcohol consumption appears to confer health benefit also complicates the task of health educators, and perhaps the overall conclusion one might form from a close reading of this part of the National Alcohol Policy was that the Department of Health had by now developed a keen sense of how contentious this topic could be and was committed, above all else, to avoiding trouble.

Chapter Eight, which dealt exclusively with the controversy which surrounded the Health Education Bureau's use of the lifeskills approach to health education, clearly demonstrated the moral issues which could bedevil individualistic health education. It could be argued that with increasing evidence of the normalisation of recreational drug use amongst Irish young people, lifeskills programmes had much to offer this country, and indeed this model has continued to be used; however, because of the potential for controversy and conflict with those who would be happier with traditional didactic programmes, these models are likely to be used in a more careful and circumspect way than was the style of the Health Education Bureau.

In overall terms, the findings of this thesis confirm that, as was the case with other elements of health promotion, the implementation of programmes aimed at fostering healthy lifestyles is considerably more difficult than is suggested by the relatively superficial rhetoric of national and international policy documents on this topic.

Treatment in a Reoriented Health Service?

The health promotional aspiration to a 'reoriented health service', one in which prevention of illness is given priority over curative functions and in which access to primary health care is seen as more important than the creation of specialist services, is the last specific element of the Ottawa Charter to be considered here. The term 'primary health care' is somewhat ambiguous in developed countries, but generally it is taken to

refer above all else to the roles and functions of general medical practitioners. There are a number of rather obvious practical problems which militate against the development of a major health-promoting role by GPs, and some of these will now be looked at in the context of health service responses to drug and alcohol problems.

First of all, as discussed in Chapter One, health promotion as a concept did not originate within the medical profession, and the professional socialisation of doctors has tended to continue with its emphasis on curative functions within a traditional biomedical model.[17] Secondly, it is also important to note that within the Irish healthcare scene, as in many countries, GPs are independent professionals rather than health service employees and, as such, may not be especially familiar with or well-disposed towards official pronouncements about health promotion. Finally, general medical practice is based upon seeing large numbers of patients for relatively brief consultations, and the complex psychosocial issues raised by problem drinkers and problem drug users may not be readily managed within this context.

Chapter Five, which dealt with the formulation of the National Alcohol Policy, concluded that by and large no reorientation of the health service had taken place or seemed imminent in relation to alcohol. The creation of community-based alcoholism treatment programmes did not automatically lead to substantial reductions in hospital admissions for such problems; on the contrary, inpatient admissions for drinking problems remained

stubbornly high, although length of stay for such admissions did shorten. No specific strategy for changing the attitudes or practices of GPs with regard to alcohol consumption and related problems was devised, and referral to specialist services -either the inpatient mental health system or the new community alcoholism services - appeared to be the norm. Furthermore, it seemed as though the Irish public had come to expect that alcoholism should be treated in inpatient settings and also to view community-based services as technically inferior or second-best. If, as was suggested explicitly in Chapter Four, there were two conflicting paradigms - the disease concept and the public health or health promotional perspective on alcohol - then it would have to be concluded that, both in terms of professional practice and popular expectation, the disease concept was an easy winner.

The response of the Irish healthcare system to illicit drug use and its related problems, when viewed in terms of a 'reoriented' service, was found to be different though equally problematic. For most of the period studied, Irish healthcare policy was based on an implicit assumption that illicit drug users were a deviant and devious group, quite unsuited to primary healthcare and best treated in specialist settings away from 'normal' patients. One element of this philosophy was the view that GPs who became clinically involved with drug users might be cajoled or coerced into inappropriate prescribing, thus perpetuating rather than resolving the problem of dependency. Those few GPs who had participated energetically and conscientiously in bottom-up community

programmes during the era of the 'opiate epidemic', as described in Chapter Seven, were neither thanked nor encouraged for taking this initiative, and it was only in the late 1980s -when the relationship between needle-sharing and HIV transmission amongst injecting drug users became apparent- that official policy began to swing towards the view that family doctors had a role to play in the management of drug problems. As detailed in Chapter Nine, the task of involving GPs in this activity, and in particular the task of institutionalising methadone prescribing by GPs, was a difficult and complex one which was tackled in a covert and incremental style by the Department of Health. By 1996, however, significant progress had been made on the establishment of a formalised system or protocol which promised to normalise methadone prescribing by making it more accessible through general medical practice, while at the same time setting in place controls and safeguards which were intended to prevent malpractice in this area and avoid leakage of methadone into the black market. There is, however, no getting away from the contentious nature of methadone maintenance, especially when it is normalised within general medical practice. To those who favour it, the creation of a GPs' methadone protocol represents a humane and pragmatic policy development which is effective and evidence-based; to its opponents, such a protocol simply facilitates the cynical use of medical technology for social control purposes.. Ultimately, perhaps all that can be concluded is that abstract statements about reorienting health services and maximising the role of primary healthcare systems provide relatively little practical guidance for health policy makers, since they fail to acknowledge the

cultural ambivalence and value conflicts which characterise such harm reduction practices as methadone maintenance.

Policy Making for Health Promotion

As pointed out earlier in this chapter, advocates of health promotion have been more forthright in setting out their aims and objectives than in providing detailed accounts of how these aims and objectives might be achieved. While academic authors have attempted to look in detail at the policy-making process and at the utility of various models of policy making,[18] the emphasis in official policy documents (particularly the Irish health policy documents referred to throughout this thesis) has been almost entirely on the statement of aims and objectives. The three models of policy coordination outlined by Harrison and Tether 1987) and discussed in Chapter One - the *rational-comprehensive, partisan mutual adjustment* and *organisational networks* models - have, by and large, been useful for analytic purposes throughout this thesis. It may be said by way of generalised concluding comment that the policy events described in this thesis have usually been discussed and framed in terms of rationality (the first model), implemented incrementally and with much compromise (as per the second model), but have shown most promise in health promotional terms when they have occasionally involved organisational networking (the third model). This conclusion will now be discussed in some detail.

All of the Irish policy documents which deal with health promotion have been implicitly based upon rationalistic assumptions. Increasingly, however, they have made explicit use of a rational or *managerialist* approach to health policy and service provision, largely consisting of the establishment of national goals and targets the achievement of which, it is suggested, would promote the health of the nation. This managerialist approach is exemplified in the 1995 document *A Health Promotion Strategy: Making the healthier choice the easier choice* which was referred to earlier in this chapter. Goal and target setting of this kind is based on an economic rationalism which does not, in the main, acknowledge the complexities and difficulties of health promotion which were discussed initially in Chapter One of this thesis and then illustrated in detail in the subsequent eight chapters. There is no reason to conclude, on the basis of the material presented in this thesis, that such mechanistic goal and target setting has anything to contribute to health promotion in relation to alcohol and drugs; and academic policy analysis is generally sceptical of its appropriateness and value in an arena characterised by philosophical ambiguity, political conflict and competing economic interests.[19]

The health-promoting structures which were established in the late 1980s (and which were discussed in Chapters One and Five) could not generally be deemed to have been a success in creating and sustaining a dynamic policy process. The Cabinet sub-committee on health promotion which was at the top of the structural pyramid appears not to have functioned at

all; referring to this element of the total structure, Cecily Kelleher (who is Professor of Health Promotion at University College Galway) has written cryptically : 'A new cabinet subcommittee for health promotion was formed comprising relevant ministries influencing health status, though in fact this group never met in plenary'.[20] It seems reasonable to infer from this that high-level political commitment to the concept of health promotion was lacking. The findings of this thesis suggest that there is no political commitment to the application of health promotion concepts to alcohol policy, but that on those occasions when politicians of at least Minister of State level became personally involved in the formulation of policy on illicit drugs, this accelerated the policy-making process and gave it a new impetus (see Chapters Seven and Nine). In the absence of sustained high-level political commitment to health promotion, a great deal depended upon two other elements of the structure - the Advisory Council on Health Promotion and the Health Promotion Unit. However, on the evidence of their performance in formulating a national alcohol policy (see Chapter Five), neither of these structures was effective in realising health promotional ideals. The failure of these structures is acknowledged in *A Health Promotion Strategy: Making the healthier choice the easier choice* where, without detailed or critical analysis, it is concluded that: 'Experience would suggest, however, that there are certain shortcomings - largely of a practical nature - associated with those arrangements'.[21] This report then proposed to replace the *Advisory Council on Health Promotion* with a new *National Consultative Committee on Health Promotion,* although in the absence of detailed

argument or critical analysis it was difficult to see how this innovation involved anything other than a change of name.

Without doubt, however, the major policy-making structure identified consistently throughout this thesis was the Department of Health itself, and it was also demonstrated that the style of policy making pursued by the Department was usually closest to the partisan mutual adjustment model. What this meant was that civil servants in Health did not promote health in a way that involved the adoption of bold innovative strategies, calculated to draw them into battle with politicians or with colleagues from other departments; instead, they tended to react to events slowly and conservatively, rather than being proactive, and to reach compromise pragmatically and discreetly. It is difficult to avoid the stereotyped conclusion that within the culture of the civil service it has been and continues to be more important to avoid embarrassing mistakes than to conceive of new and imaginative initiatives. It is difficult, for instance, to imagine the Department of Health being embroiled in the controversy about lifeskills which grew up around the Health Education Bureau, and it is, to some extent at least, creditworthy that harm reduction strategies were introduced without public outcry. Equally, however, it has to be recognised that the Department took no initiative and displayed no leadership in relation to the diffusion of the disease concept of alcoholism into Ireland from the mid-1940s onwards; neither was it quick to respond to the first wave of illicit drug use in the late 1960s or to the 'opiate epidemic' at the end of the 1970s; and its management of the task of

formulating a national alcohol policy between 1987 and 1996 was, from a health promotional perspective, extremely disappointing. It would seem to be important, therefore, for health promotion generally and for alcohol and drug policy in particular, that the Department of Health's control of these matters should be shared more widely rather than remaining the sole property of Health.

To conclude on a positive note, by the end of the study period the concept of organisational networks in public sector management in Ireland had become popular in the context of the wider *Strategic Management Initiative,* and it was explicitly recognised that important public policy goals could only be achieved through partnership arrangements between different sectors of Government, as well as the collaboration of non-governmental agencies.[22] It was argued in Chapter Nine that the work of the ministerial group which led to the publication of the so-called *Rabbitte Report,* although not based in the Department of Health, had done more to advance health promotion in the illicit drugs field than any initiative previously emanating from Health. The *National Drugs Strategy Team* which resulted from this report may be seen as a somewhat formalised version of the organisational networks discussed in Harrison and Tether (1987), and it too remained outside Health, although it had a senior civil servant from Health as a team-member. While it is too early to form any definitive judgement on the effectiveness of this National Drugs Strategy Team, it is clear that it represents a new approach to policy making and

implementation in relation to illicit drugs, and it is interesting to consider whether a similar body could ever be established in the alcohol field.

Alcohol, Drugs and Health Promotion – The Way Forward?

The historical evolution of Irish health policy on alcohol and illicit drugs during the second half of the twentieth century has been presented in considerable detail in this thesis. What clearly emerges from the study is that health promotional aspirations are not easily attained, and certainly there is no question of health promotion emerging as an inevitable historical development, driven by its own logic and rationality. On the other hand, health promotion has a coherence and a logic to it which recommends it to policy makers and, potentially at least, to the general public. The final paragraphs of the thesis will therefore attempt, in the light of all the foregoing history, to make a number of practical and realistic recommendations which might advance the health promotional cause, without degenerating into the rhetoric and purple prose of health promotion, which has been criticised at various points in the thesis.

Essentially, there are two linked recommendations which are offered here for the reader's consideration. The first refers to the *content* of policy documents and of educational or promotional literature aimed at the general public, while the second is concerned with *structures* for policy-making and policy implementation.

On the first issue, that of content, there is much to be said for policy statements and educational materials which reflect honestly and in detail the ambivalence and moral ambiguity which surrounds most of our attitudes towards pleasure and risk in the sphere of psychoactive drugs. It seems reasonable to proceed on the basis that most people, given the opportunity, will behave in ways that safeguard their health. However, it is also reasonable to acknowledge (as is made clear *ad nauseam* in introductory texts on alcohol and drug problems) that people are accustomed and committed to the use of mood-altering drugs which give them a break or relief from the stress of tedium of everyday living, and that their use of these drugs reflects their own calculus or sense of balance between risk and pleasure. What this thesis has revealed is a reluctance in this country to acknowledge the risk associated with alcohol, alongside a reluctance to acknowledge the positive or pleasurable effects of illicit drug use. Perhaps it would be best if a common policy framework was devised for alcohol and illicit drugs, which clearly and explicitly reflected this risk/pleasure calculus, so that within this framework objective information on risk could be provided to the public in a non-moralistic and non-pathologising style. The most obvious framework for such a programme would be *harm reduction,* applied not just to illicit drugs but also to alcohol. The acceptance and implementation of this recommendation would undoubtedly incur criticism, most probably on the basis that it normalised 'drug abuse' and undermined supply reduction policies and strategies. However, as described in Chapter Nine, harm reduction has already been introduced, albeit covertly, into the Irish drug treatment

scene, and it has also been enshrined as the dominant policy perspective in countries such as Holland and Australia without directly challenging supply reduction systems. The War on Drugs metaphor is interesting in this context, because during wartime there is usually a heightened sense of cultural consensus and social integration, and an expectation that in the face of the external enemy critical debate and internal differences should be set aside. It now seems time to abandon this military rhetoric with its assumption that open debate and discussion are treasonous, or that ordinary people are too ignorant or impressionable to be subjected to such debate.

The second recommendation concerns policy and management *structures.* In view of the first recommendation, what are obviously missing are bodies which would create and sustain open debate on alcohol and drug issues. In the half-century studied, the only alcohol-related lobbying body to function here was the Irish National Council on Alcoholism (INCA), which started with a public commitment to the disease concept of alcoholism but then became paralysed and inactive as a result of internal ideological conflict. Since the closure of INCA, there has been no national organisation which promotes debate on alcohol issues, and it would seem obvious that the situation could only be improved by the creation of such an organisation – independent of the Department of Health. Similarly, the need for an independent policy advisory body on drugs, (comparable perhaps to the British Advisory Council on the Misuse of Drugs) emerges from the history presented here, where successive

attempts to create such a body have foundered because of their integration into the Department of Health.

Finally, and again emphasising the difference between policy formulation and implementation, it would seem critical to the achievement of health promotional aims and aspirations that executive bodies in this area should be truly intersectoral. Despite constant references to the importance of intersectoral collaboration in health promotion literature, the Department of Health does not emerge from this study as a body which has genuine commitment to or capacity for such work; if 'departmentalism' is an impediment to health promotion, it seems that fair to say that it not merely that other departments refuse to acknowledge the health aspect of their work, but that the Department of Health also has developed a style of doing things its own way. The single most important development to promise change in this area was the proposal by the Rabbitte Committee in 1996 to set up a National Drugs Strategy Team, based not on health promotional principles, but on the new approach to public sector management enshrined in the Strategic Management Initiative (SMI). The National Drugs Strategy Team was set up in 1997, outside the Department of Health and with an independent identity; referring back to the policy models used throughout this thesis, it may be seen as institutionalising the organisational networks model. No full evaluation of the work of this Strategy Team is yet available, but it appears on the face of it to be working in a different way to anything which preceded it. It begs the question 'why not a National Alcohol Strategy Team?'.

In conclusion, alcohol and drug use are here to stay. It seems unlikely that any major breakthrough in medical science will transform the management of related problems, so for the foreseeable future this will be an issue for social policy. Health promotion, while not living up to some of the wilder claims made on its behalf, continues to be a helpful framework for policy-making, and the analysis of policy-making, in this area.

Chapter Ten: Footnotes

[1] See, for example, I. Illich, *Limits to Medicine: Medical Nemesis,* cited in note 24, Chapter One.

[2] As an example of this use of the phrase by advocates of health promotion see J. Ashton and H. Seymour, *The New Public Health: The Liverpool Experience.* (Milton Keynes: Open University Press, 1988); for a moe critical sociological exploration of this concept see A. Petersen and D. Lupton, *The New Public Health: health and self in the age of risk.* (London: Sage Publications, 1996).

[3] See *A Health Strategy: Making the healthier choice the easier choice.* (Dublin: Department of Health, 1995).

[4] See note 12, Chapter One.

[5] See note 17, Chapter One.

[6] See note 41, Chapter Five.

[7] *Ottawa Charter for Health Promotion.* (Geneva: WHO, 1986), p.1.

[8] See D. Ferriter, *A Nation of Extremes: The Pioners in Twentieth Century Ireland.* (Dublin: Irish Academic Press, 1999).

[9] *National Alcohol Policy – Ireland.* (Dublin: Stationery Office, 1996), p. 33.

[10] Ibid., p. 62.

[11] Ibid., pp 28-29.

[12] R. Pinker, 'An alternative view', in *Social Workers: Their Role and Task.* (London: Bedford Square Press, 1982), p. 241.

[13] Ibid., p. 245.

[14] S. MacGregor, 'Medicine, Custom or Moral Fibre: Policy Responses to Drug Misuse', in N. South (ed.), *Drugs: Cultues, Controls and Everyday Life.* (London: Sage, 1999), p. 83.

[15] For a preliminary discussion of this legislation see C. O'Connell, 'Tenant Involvement in Local Authority Estate Management: A New Panacea for Policy Failure', *Administration,* 46 (1998), pp 25-46.

[16] See, for instance, the discussion of individualism in F. Baum and D. Saunders, 'Can health promotion and primary health care achieve Health for All without a return to their more radical agenda?', *Health Promotion International,* 10 (1995), pp 149-160.

[17] For an argument that nothing has changed fundamentally in the education and training of doctors, even by the mid 1990s, see G. Guldan, 'Obstacles to Community Health Promotion', *Social Science and Medicine,* 42 (1996), pp 689-695.

[18] See, for instance, N. Milio, 'Making healthy public policy; developing the science by learning the art: an ecological framework for policy studies', *Health Promotion,* 2 (1988), pp 263-274.

[19] For a critique of this managerialist approach to health promotion in Australia and internationally, see F. Baum and D. Saunders, op. cit.

[20] C. Kelleher, 'Promoting Health', in J. Robins (ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947-1997.* (Dublin: Institute of Public Administration, 1977), p. 37.

[21] *A Health Promotion Strategy: Making the healthier choice the easier choice,* cit.sup., p.30.

[22] Although they fall outside the study period, two important Irish publications which reflect this new approach to public sector management are: National Economic and Social Forum, *A Framework for Partnership – Enriching Strategic Consensus through Participation..* (Dublin: NESF, 1997); R. Boyle, *The Management of Cross-Cutting Issues.* (Dublin: Institute of Public Administration, 1999). For an example of the popularity of this concept on the international front see W. Kickert, E. Klijn and J. Kopperjan (eds), *Managing Complex Networks: Strategies for the Public Sector.* (London: Sage, 1997).

Appendix 1

List of key informants who contributed to this study

The following are informants who were formally interviewed in connection with the research for this thesis:

Ms Aine Flanagan: Senior Management Official, Eastern Health Board, with special responsibility for drug issues during the 1970s and 1980s;

Mr Jim Comberton, Executive Director of Coolemine Therapeutic Community (1979-1998);

Mr Barry Cullen, Community Worker, St. Teresa's Gardens, Dublin (1982- 1985) and Director, Ana Liffey Drug Project (1989-1992);

Mr Barry Desmond, Minister for Health (1982-1987);

Mr Eugene Donoghue, Head of Training and Education at the Health Education Bureau (1979- 1987);

Mr Paul Harrison, Project Leader, North Inner-City Youth Drug Project (1982-1983);

Ms Noreen Kearney, Member of the Working Party on Drug Abuse (1968 – 1971), and also of the Committee on Drug Education (1972-1974);

Ms Barbara Law, Social Worker at National Drug Advisory and Treatment Centre, Jervis St. Hospital and subsequently at National Drug Treatment Centre, Pearse St. (1971-1999);

Dr John McCormack, Consultant Psychiatrist, Eastern Health Board Forensic Psychiatric Service (1971-1999);

Superintendent Denis Mullins, Founder and Head of the Garda Síochána Drug Squad (1967-1984);

Mr Art McRory, Assistant Editor, *The Pioneer* (1977- 1989);

Mr Joe O'Rourke, Assistant Secretary at the Department of Health (1975 –1990)

Fr W.J. Reynolds, Director of the Pioneer Total Abstinence Association (1985-1989);

Mr Declan Roche, Director of the Rutland Centre (1981- 1989);

Mr Tom Ryan, General Manager of the Voluntary Health Insurance Board (1982-1994).

In addition to the above who were formally interviewed for this project, there were other informants who contributed to the research process in a less formal but nonetheless important way through their willingness to discuss and provide information on specific issues. These included: Dr Joe Barry, specialist in public health medicine, Eastern Health Board: Dr Ruth Barrington, formerly of the Department of Health and curently Chief Executive Officer of the

Health Research Board; Ms Sally Edwards, former Director of the Irish National Council on Alcoholism; Mr Shane Grey, former Director of the Irish National Council on Alcoholism; Fr Paul Lavelle, priest of the Archdiocese of Dublin and formerly of the Catholic Social Service Conference; Dr Mary-Ellen McCann of Ballymun Youth Action Project; Mr Martin Tansey, Chief Probation and Welfare Officer, Department of Justice; Ms Carmel Tobin, formerly of the Irish National Council on Alcoholism; Mr Michael Walsh, Programme Manager Eastern Health Board; Mr Matt O'Connor, formerly of the Secretariat of the Eastern Health Board.

Dr Desmond Corrigan of the School of Pharmacy, Trinity College Dublin, read a number of chapters in draft form and provided advice and general assistance on policy issues relating to illicit drug use in this country, and Dr Dermot Walsh of the Health Research Board did the same in relation to that portion of the thesis which deals with alcohol.

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