HRB Overview Series

Development of Ireland's drug strategy 2000–2007

8

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The Health Research Board (HRB) is the lead agency supporting and funding health research in Ireland. We also have a core role in maintaining health information systems and conducting research linked to national health priorities. Our aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy.

Our information systems

The HRB is responsible for managing five national information systems. These systems ensure that valid and reliable data are available for analysis, dissemination and service planning. Data from these systems are used to inform policy and practice in the areas of alcohol and drug use, disability and mental health.

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The main subjects of HRB in-house research are alcohol and drug use, child health, disability and mental health. The research that we do provides evidence for changes in the approach to service delivery. It also identifies additional resources required to support people who need services for problem alcohol and drug use, mental health conditions and intellectual, physical and sensory disabilities.

The **HRB Overview series** reviews specific health or social issues in the areas of problem alcohol and drug use, child health, disability and mental health. It is envisaged that each issue in the series will be used as a resource document by policy-makers, service providers, researchers, community groups and others interested in the topic area.

The **Alcohol and Drug Research Unit** is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The ADRU maintains two national drug-related information systems and is the Irish national focal point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The unit also manages the National Documentation Centre on Drug Use. Through its activities, the ADRU aims to inform policy and practice in relation to problem alcohol and drug use.

HRB Overview Series publications to date

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Contents

Abbreviations

ADRU	Alcohol and Drug Research Unit
AP	Action Plan appended to the *National Drugs Strategy 2001–2008* (Department of Tourism, Sport and Recreation 2001)
CCSI	Cabinet Committee on Social Inclusion
CDB	County/City Development Boards
CIP	*Critical implementation path: National Drugs Strategy 2001–2008* (Department of Community, Rural and Gaeltacht Affairs 2004b)
CND	Commission on Narcotic Drugs
CSO	Central Statistics Office
DCRGA	Department of Community, Rural and Gaeltacht Affairs
DMRD	Drug Misuse Research Division
DPAG	Drug Policy Action Group
DPMP	Drug Policy Modelling Program
ESRI	Economic and Social Research Institute
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESSD	European Society for Social Drug Research
HRB	Health Research Board
HSE	Health Service Executive
IDG	Inter-Departmental Group on Drugs
IHRC	Irish Human Rights Commission
INCB	International Narcotics Control Board
IPA	Institute of Public Administration
IPRT	Irish Penal Reform Trust
ISSDP	International Society for the Study of Drug Policy
MQI	Merchants Quay Ireland
MTR	*Mid-term review of the National Drugs Strategy 2001–2008* (Department of Community, Rural and Gaeltacht Affairs 2005)
NACD	National Advisory Committee on Drugs
NDC	National Documentation Centre on Drug Use
NDRDI	National Drug-Related Deaths Index
NDS	*Building on experience: National Drugs Strategy 2001–2008* (Department of Tourism, Sport and Recreation 2001)

NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NESC	National Economic and Social Council
NESF	National Economic and Social Forum
OECD	Organisation for Economic Co-Operation and Development
OMCYA	Office of the Minister for Children and Youth Affairs
ONDCP	Office of National Drug Control Policy
PR	*Progress report: National Drugs Strategy 2001–2008* (Department of Community, Rural and Gaeltacht Affairs 2004b)
REHAB	*National Drugs Strategy 2001–2008: report of the Working Group on Drugs Rehabilitation* (Department of Community, Rural and Gaeltacht Affairs 2007)
SMI	Strategic Management Initiative
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1 Introduction

On 10 May 2001 the Taoiseach, Bertie Ahern TD, and the Minister of State with responsibility for the Drugs Strategy, Eoin Ryan TD, jointly launched *Building on experience: National Drugs Strategy 2001–2008* (Department of Tourism, Sport and Recreation 2001). In his speech launching the NDS,[1] the Taoiseach commented that after 30 years of anti-drugs work, Ireland had only just begun to properly understand the 'complex dynamics of drug misuse':

> If you think back just a short time, public drugs policy was very simple and summed up in the phrase 'just say no'. While we must never forget that we do want people to say no to drugs, this approach ignored all sorts of basic issues fundamental to reducing drug misuse. As time has moved on, policy has also radically developed. Prevention and treatment have taken their place alongside policies to tackle supply, which have themselves evolved significantly. (Ahern 2001)

The Taoiseach outlined how this deepening understanding was reflected in the NDS both in the greater range of responses and the expanded number of response levels, including international, national, regional, local, community and family. Moreover, the NDS set out an overall strategic objective, to significantly reduce the harm caused to individuals and society by drugs misuse, and to do so through a concerted effort on four activity 'pillars' – Supply Reduction, Prevention, Treatment and Research. To ensure that 'a sense of urgency and momentum' drove the implementation of the NDS, the Taoiseach stated that specific objectives had been set under each of the four pillars as well as 100 actions, with an agency or agencies assigned responsibility for the delivery of each action. The Taoiseach set out his expectations of the managers responsible for implementing the NDS:

> The actions involve a considerable challenge to everyone who is involved in tackling the drugs problem. The review process has been very encouraging, but achieving the Strategy's objectives will require a step change in co-operation and activity. Many agencies and organisations will have to examine their own structures and procedures in order to ensure that they are delivering. (Ahern 2001)

As artefact, the NDS conveys a similar air of authority and quiet determination. Produced in book format, complete with its own ISBN, it was laid out in an elegant and spacious A4 format, printed in black and red on white, with a three-colour cover depicting an out-of-focus group of five individuals. Occupying just under 140 pages, the document contains a review of the current situation; a report on the results of an investigation of international best practice, and of an extensive public consultation; a set of detailed conclusions; and a strategic framework and action plan for the next seven years.

In subsequent years a suite of companion documents, similarly designed and produced, was published by the Department of Community, Rural and Gaeltacht Affairs (DCRGA),[2] elaborating on the implementation of the NDS, and reporting and reviewing progress:

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1 The acronym NDS will be used throughout this overview to refer to the *National Drugs Strategy 2001–2008*.

2 Following the general election of mid-2002, the Department of Tourism, Sport and Recreation was reorganised and responsibility for co-ordinating the implementation of the NDS transferred to the newly established DCRGA.

2004: *Critical implementation path*: *National Drugs Strategy 2001–2008* (CIP) contained, in matrix form, all 100 actions and a maximum of five steps leading to the completion of each action. In 2007, an additional critical implementation path for the new and revised actions in the NDS, following the recommendations in the mid-term review of the NDS, was released on the DCRGA website.

2004: *Progress report*: *National Drugs Strategy 2001–2008* (PR) reported on the nature and extent of the drug problem in Ireland since 2001, and on progress made in achieving each of the 100 actions and also in relation to other drug initiatives such as the local drugs task forces, the Young People's Facilities and Services Fund and the Premises Initiative.

2005: *Mid-term review of the National Drugs Strategy 2001–2008* (MTR) looked broadly at progress made for each of the 100 actions and, under each pillar, identified a number of areas that needed to be prioritised in the remaining period up to 2008, and made a series of changes to the actions, including the addition of eight new actions and changes to 17 of the existing actions.

2006: *Report of the Working Group on Drugs Rehabilitation* (REHAB) developed an 'integrated rehabilitation provision' as recommended in the MTR.

Readers seeking an account of developments during the lifetime of the NDS should consult these documents,[3] together with the final review of the NDS, which was due to be published in the months following the publication of this overview. In addition, readers should consult the National Report on the drug situation, the responses and the consequences in Ireland, which is produced annually by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB), for submission to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Readers should also consult ADRU's quarterly newsletter, *Drugnet Ireland*, launched in 1999, which reports on policy, research and service developments. These national reports and newsletters are available on the websites of the EMCDDA and the HRB.[4]

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Rather than provide a narrative of developments during the life of the NDS, this overview seeks to analyse the NDS as policy instrument: it explores how the NDS was designed and developed, and the strategic management processes and governance arrangements put in place to support implementation. The objective is to gain insights into how these infrastructural elements may influence the outcomes of the strategy.

3 The acronyms CIP, PR, MTR and REHAB will be used throughout this overview to refer to these various documents. These documents are all available on the DCRGA website at www.pobail.ie

4 www.emcdda.europa.eu/publications/national-reports ; www.hrb.ie

As mentioned earlier, in launching the NDS in 2001, Taoiseach Bertie Ahern referred to the complex dynamics of drug misuse and the need for a step-change in the level and nature of responses. In line with this invitation to take a non-linear approach, this overview is informed by the work of strategic management researcher and thinker Henry Mintzberg (1994, 2007). Over the course of a 30-year project researching and thinking about the strategy process in both the private and public sectors, Mintzberg has reached the conclusion that *intended* strategy is almost never the same as *realised* strategy. He explores how organisational leadership, structure and resources, as well as developments in the external environment, conspire to alter the course of the best-laid plans.

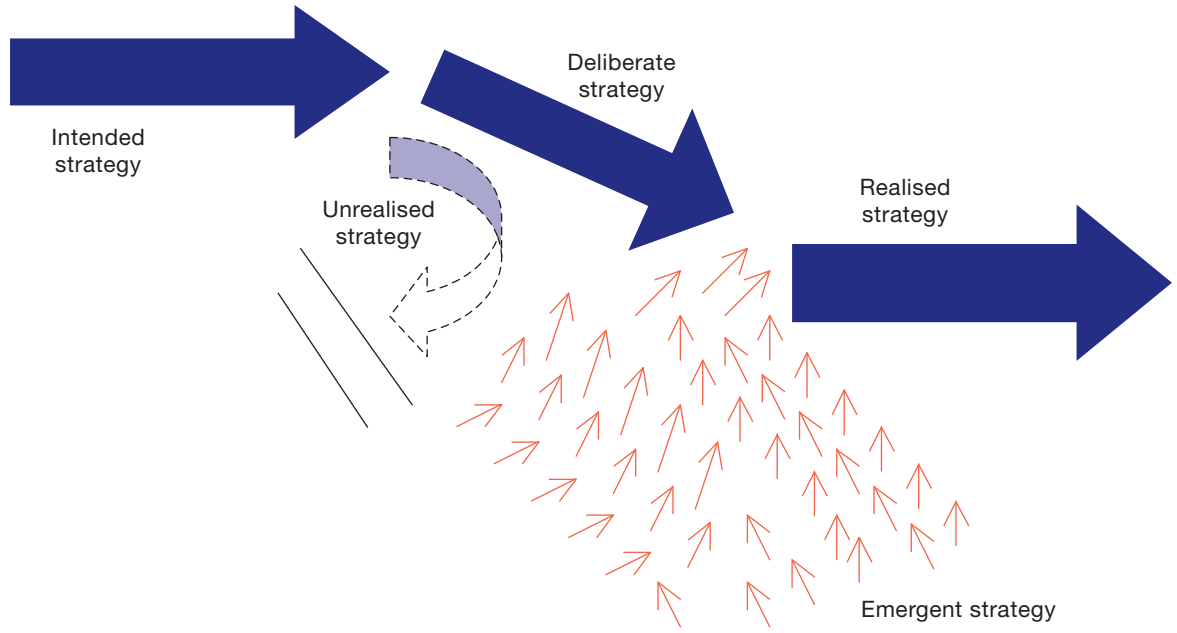

Figure 1.1 Mintzberg's representation of the five strategic forms

Expressing the distinction between intended and realised strategy in another way, Mintzberg observed that a strategy may be *formulated*, but it also *forms* as it is implemented. He identified five 'strategic forms': strategies as intended plans, before action, and as realised patterns, after action; as deliberate strategy, when the intentions are more or less realised in the actions; as unrealised strategy, when the intentions are not realised; and as emergent strategy, when the patterns realised in action were never intended (see Figure 1.1). This array of strategic forms may all be detected at various stages in the account that follows of the formulation and formation of Ireland's drugs strategy between 2001 and 2007.

Chapter 2 explores the direction set in the NDS – how the direction was set, how it was supported by a framework of objectives and key performance indicators, and how it was intended to be realised

through a series of 100 actions. This exploration highlights the way in which extraneous factors – notably bureaucracy and politics, both integral components of the public policy process – help to determine the direction that is set, or intended, and the way in which this direction is realised.

Helping to shape the strategic direction, and influencing the way it unfolds, are the values and beliefs and the evidence base that underpin and inform the choice of strategies. Chapter 3 reviews the ways in which rational and non-rational data feed into the strategy process. While much is made of the need for 'evidence-based policy', i.e. policy based on evidence derived from scientific research, there is an equal need for 'policy analysis', examining the available options and assessing the optimal combination of choices. Public opinion, as revealed through surveys and media debate, is widely recognised as helping to shape Ireland's policy response to the issue of illicit drugs. However, during the lifetime of the NDS, little systematic scientific research has been undertaken on how these policy drivers work or how they influence policy choices.

It is 'action' that drives strategy forwards through time. Given the long time horizon and the attendant complexity, the opportunities for deviation from the strategic course are myriad. Chapter 4 describes the mechanisms designed to co-ordinate strategic action. The relationships between the various organisations with responsibility for implementing the NDS are unpicked through looking at not only the co-ordination mechanisms but also different aspects of the governance framework – who was responsible for what decisions, and at what level? This exercise sheds light on the strengths and weaknesses of the mechanisms employed to co-ordinate the NDS and suggests opportunities for developing other mechanisms to support the integrated implementation of the strategy.

While Chapters 2–4 dwell on aspects of the ways in which intended strategy is realised – how the direction is set, how information and values inform choices, and how strategy is implemented – this chapter focuses on Mintzberg's second main strategy stream – emergent strategy. Three types of change that may occur in the wider environment are outlined and the associated strategic responses. While changes in trends, new research findings and other information may result in strategic responses that align with the overall objective and goals of the NDS, and which may be termed 'deliberate' strategy, other changes, in related policy domains, and strategy that emerges independently of the NDS, tend to result in separate and independent strategies – 'emergent' strategies. It is important to maintain control over these emergent strategies in order to maintain strategic direction.

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In undertaking this analysis of the development of Ireland's drugs strategy, insights into good practice with regard to both illicit drugs policy and public-sector strategic policy development have been drawn from three principal sources. First, reports and analyses published by the European Monitoring

Centre for Drugs and Drug Addiction (EMCDDA) [5] in respect of drug policy and strategy, and public expenditure on the drugs issue, and by the Pompidou Group[6] with respect to the NDS pillar themes and also on ethical issues relating to illicit drugs have informed this overview. Second, the work of the International Society for the Study of Drug Policy (ISSDP), which was founded in 2007,[7] has been drawn on. In particular, the ISSDP has hosted two international conferences, and many of the papers presented at these meetings, and other work published by members of the organisations represented at the conferences, have provided a wide range of research-based evidence on aspects of drugs policy. Third, the work of a number of organisations dedicated to economic, social and public policy research in general in Ireland has been used: these organisations include the Economic and Social Research Institute (ESRI), the Institute of Public Administration (IPA), the National Economic and Social Council (NESC) and the National Economic and Social Forum (NESF).[8] Finally, in 2007 Taoiseach Bertie Ahern TD requested the Organisation for Economic Co-operation and Development (OECD) to undertake a major review of the Irish public service, with a view to making recommendations as to future directions for public service reform. The report on this review was published in April 2008 and its findings have informed this analysis.

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Although focusing on the NDS as policy instrument, this overview does not consider the wider canvas of Irish drug policy. Although the terms 'strategy' and 'policy' are often used interchangeably, policy is a broader concept than strategy. While a strategy sets out goals, objectives and timeframes, and action plans to achieve the targets, a policy covers a wider canvas, setting out principles and assumptions governing the policy domain and helping to determine relationships between the drugs policy domain and other policy domains. To cover this wider canvas would entail a much larger and more complex study than is possible within the scope of the HRB Overview series.

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5 A decentralised agency of the European Union, the EMCDDA's role is to act as the central source of comprehensive information on drugs and drug addiction in Europe. Information is provided to the EMCDDA by national focal points (NFPs) in each member state: in Ireland, the Alcohol and Drug Research Unit (ADRU) of the Health Research Board, the publisher of this overview, is the NFP. www.emcdda.europa.eu

6 Founded by the former French president Georges Pompidou in 1971 as the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, the 'Pompidou Group' became part of the Council of Europe in 1980. Having devoted its first 20 or so years to developing data-collection and monitoring methodologies, the Pompidou Group, at its 2003 Dublin Ministerial Conference, agreed a new structure for the work of the Group, based on six platforms – prevention, treatment, criminal justice, research, ethics and airports. www.coe.int/T/dg3/pompidou/

7 The stated aim of the ISSDP is to develop relations among drug policy analysts, provide a forum for high-quality drug policy analysis, develop the scientific base for policy decisions, and improve the interface between researchers and policy-makers. www.issdp.org

8 More information on these bodies may be found on their websites: Economic and Social Research Institute, www.esri.ie ; the Institute of Public Administration, www.ipa.ie ; the National Economic and Social Council, www.nesc.ie ; and the National Economic and Social Forum, www.nesf.ie

For example, a study of drug policy would require an exploration of the processes underpinning the development of drugs policy, including the influence of international drug policies and EU-level commitments on policy decisions in Ireland; the legislative framework governing the drugs area; the development and implementation of drug-related measures in other policy domains such as education, employment, environment, justice, health and social welfare; and the public policy debate in relation to the drugs issue, including the research and information base, the array of stakeholders and participating groups, the means by which the debate is carried forward, the contribution of the media, the role of politicians and others as policy decision-makers, and the influence of this debate on drugs policy. These wider policy issues are referred to in the following pages but only insofar as they impact on a discussion of the development of Ireland's drugs strategy. They each merit fuller attention on their own terms.

2 Setting direction

2.1 Introduction

'Strategic planning' has been part of the toolkit of the corporate manager since the 1960s (Mintzberg 1994). It is a means of planning for a longer time horizon than that assumed by 'operational' planning, for example three or more years, and is particularly useful for planning in unstable or turbulent environments and in conditions of uncertainty or complexity. The two types of planning – strategic and operational – often occur together, and the drugs domain is no exception. The EU has had both a 10-year drugs strategy (2005–2012) with broad qualitative aspirations (Council of the European Union 2004), and a shorter, four-year action plan (2005–2008) with quantified outputs (Council of the European Union 2005), which is due to be replaced in 2009 with a new action plan within the parameters set out in the strategy. Similarly, in Ireland, the strategic objective and aims of the NDS represent the government's long-term, qualitative goals; the pillar objectives and key performance indicators represent the short-term, quantitative targets (EMCDDA 2007a: 11).

Clearly a strategic plan cannot remove the instability or the turbulence, but it can help to reduce the uncertainty experienced by an organisation in such circumstances. It can do this by ensuring that the assumptions held by different actors are made explicit and a common set of values and principles arrived at, and that these form a solid platform for a set of agreed organisational goals and objectives. These shared understandings provide a framework for concerted action, and for increased responsiveness to external changes and increased flexibility.

The NDS represented the first attempt to adopt a strategic approach to the illicit drugs issue in Ireland. This chapter explores the origins, scope, and structure of the NDS – why was it developed, who developed it, and what was included in it? It highlights ambiguities in the strategic direction set for Ireland's drug policy over the period 2001–2008. While not unwanted, such ambiguity needs to be recognised and carefully managed.

2.2 Strategic review

The choice in 2000 of a formal strategic plan as the appropriate policy instrument for formulating illicit drugs policy in Ireland was driven by developments in public policy-making at national and international level. In 1996 the report *Delivering better government* (Co-ordinating Group of Secretaries 1996), published as part of the government's Strategic Management Initiative (SMI),[1] recommended the development of strategic frameworks to strengthen the capacity of government departments and offices to analyse policy issues and formulate policy options. Cross-cutting issues, i.e. issues where cross-departmental action, commitment and expertise were required to solve problems, were specifically discussed. The authors of the report recommended that cross-departmental teams be established to address these cross-cutting issues, and that lead responsibility

1 The purpose of the SMI was to reform Ireland's civil service so that it would make a greater contribution to national development, provide excellent services to the public and make effective use of resources.

for co-ordinating the work of these teams be given to a government department and a Minister of State. Drugs were identified as one of the issues that would benefit from this approach.[2]

In 1998, at the 20th special session of the United Nations General Assembly (UNGASS), held to consider how to enhance action to tackle the world drug problem, Ireland signed up to the resulting Political Declaration, which asserted the importance of 'national strategies to reduce both the illicit supply of and the demand for drugs' (UNGASS 1998a: Clauses 1–2). According to the subsequent action plan (UN 2000: Annex, Section 9c),[3] the ideal national drugs strategy would comprise:

- an assessment of the problem
- the definition of needs and resources
- the establishment of priorities and goals
- the setting up of timeframes for specific activities and results
- the determination of the roles of the agencies concerned.

Such a strategy would be implemented through the development of a national action plan that would adopt a multi-sectoral approach, would be endorsed by an appropriate national body, and would be accompanied by a framework for assessing and reporting results.

Closer to home, and in line with the 1998 UNGASS Political Declaration, the EU Drugs Strategy 2000–2004 adopted the principle of a drugs strategy that was 'global, multidisciplinary, integrated and balanced…, in which supply and demand reduction are seen as mutually reinforcing elements' (Council of the European Union 1999: Section III). The NDS explicitly acknowledged the need to align its time horizon with that of the EU Drugs Strategy, and its four-pillar structure reflected the global, multidisciplinary, integrated and balanced approach adopted by the EU.[4]

2.2.1 The Review Group

In April 2000, in line with the commitment made in the recent social partnership agreement (Department of the Taoiseach 2000), the Cabinet Committee on Social Inclusion (CCSI) asked the Inter-Departmental Group on Drugs (IDG) with responsibility for overseeing the implementation of the national drugs strategy to review the existing strategy. The IDG formed a Review Sub-Group

2 The other cross-cutting issues included child care, employment, competitiveness, unemployment and social exclusion, financial services, and local development.

3 The Action Plan was agreed in 1999 to ensure the implementation of the Declaration on the Guiding Principles of Drug Demand Reduction, which was also agreed at the 1998 UNGASS.

4 The NDS stated: 'In line with the EU Drugs Strategy, the new Strategy will run from 2001 to 2008' (para. 6.7.1). However, the EU Drugs Strategy only ran from 2000 to 2004. The error was due to an expectation that the EU strategy would be coterminous with the UNGASS action plan, which ran from 1998 to 2008 (Kelly J, DCRGA, personal communication, 2003).

to manage the process.[5] This Review Group comprised six government officials representing government departments with responsibilities in the drugs area, and two members from the National Drugs Strategy Team representing the Garda Síochána and the community sector. Among the officials, one was an assistant-secretary, while the others were at principal and assistant principal officer level.

The four previous groups that had reviewed and developed national policy responses to the illicit drugs issue in Ireland had comprised representatives of different stakeholder groups, who would have enjoyed a greater degree of independent authority than civil servants.[6] The most far-reaching changes were recommended by the two groups that were composed entirely of politicians. Thus, according to Butler (2002a), the Special Governmental Task Force on Drug Abuse (1984), established in 1983 and comprised entirely of Ministers of State, expressed the 'potentially radical' view that the 'opiate epidemic' was due to wider socio-economic causes rather than individual pathologies. Butler suggested that the decision to appoint this task force of junior government ministers 'presumably 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' (pp. 140–141). However, in the event, the task force's call for the establishment of 'community priority areas', where extra resources for youth and community development, including job creation and training, would be made available, was ignored by government. It was not until a second task force, also comprised entirely of Ministers of State, was established in 1996 that the same call was issued and this time government acted on the recommendation.

That the Review Group formed in 2000 did not see its role as being either to break new ground or to challenge prevailing assumptions is suggested by its choice of a short title for the NDS: 'building on experience'.[7] This choice intimates that what had gone before had worked and would be retained. There were several strong and enduring links between current drug policy in 2001 and the very earliest policy positions. For example, all national drug policy documents since the 1970s, including the NDS, had adopted what is referred to as a 'balanced approach', addressing the reduction of both supply and demand. In addition, what might be called infrastructural issues, i.e. means of

5 Throughout this overview this Review Sub-Group will be referred to as the Review Group or the 2000 Review Group.

6 Butler (1991, 2002a) provides a comprehensive account of the evolution of drugs policy in Ireland since the late 1960s, highlighting four milestones in the evolving perception of the 'drugs problem' and responses to it. They include the *Report of the Working Party on Drug Abuse* (Working Party on Drug Abuse 1971), the report of the Special Governmental Task Force on Drug Abuse (1984, never published), the *Government Strategy to Prevent Drug Misuse* (National Co-ordinating Committee on Drug Abuse 1991), and the two reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996, 1997).

7 The phrase 'building on experience' had been used in international drug policy documents that would have informed the thinking of the Review Group. The UNGASS Declaration on the Guiding Principles of Drug Demand Reduction (1998b) listed 'building on experience' as its sixth action point, characterising it as comprising training on all aspects of the design, execution and evaluation of strategies and programmes, and thorough evaluation and information sharing. The EU Drugs Strategy 2000–2004 (Council of the European Union 1999) described its approach to demand reduction as 'building on previous experience'.

co-ordinating responses across a number of different government departments and agencies to what was recognised as a 'complex' issue, and the need for research to ensure an evidence-based policy, were also acknowledged in the early policy documents.

While remaining within the same broad 'prohibitionist' church, and pursuing the same 'balanced approach', drug policies issued since the early 1990s have revealed a shift in attitudes towards the nature of the drugs problem, and a change in thinking with regard to the nature and purpose of prevention and treatment measures. The growing concern with the public health consequences of injecting drug use and the growing recognition of the community dimension of the problem led to changes in the way demand reduction measures in particular were delivered. Reflecting these shifts, the term 'abuse' began to disappear from use: the 1991 strategy referred solely to 'misuse', the 1996/97 Ministerial Task Force on Measures to Reduce the Demand for Drugs to 'misuse' and 'abuse', and the National Drugs Strategy to 'use' and 'problem drug use'.

The NDS was most closely linked to the reports of the Ministerial Task Force (1996, 1997); indeed, it might be regarded as a sequel to the two reports (cf. NDS: Section 3.1). The Review Group that drew up the NDS concluded that the approach recommended by the Ministerial Task Force provided a 'solid foundation', endorsed the approach and simply proposed an expansion and strengthening of the pillars and principles underpinning it (NDS: para. 6.1.7). Nearly a fifth of the actions listed in the AP appended to the NDS[8] focused on enhancing the infrastructural provisions made by the Ministerial Task Force.

In one important respect the NDS turned its back on the experience of the previous 30 years. It narrowed the scope of Ireland's drugs policy by focusing on 'problem drugs', by which it meant opiates, and by excluding from consideration altogether substances such as alcohol and prescription and over-the-counter (OTC) drugs – all of which topics had been addressed by various of its predecessors. Focusing on opiates as the principal 'problem drug' meant that the NDS tended to target young people living in disadvantaged areas and vulnerable groups such as prisoners.

2.2.2 Review and revision of the drugs strategy

In 2000 the new social partnership agreement between the government and the social partners, *Programme for prosperity and fairness*, included the following commitment to review the measures introduced on foot of the recommendations in the reports of the 1996/97 Ministerial Task Force:

> The overall operation of the National Drugs Strategy will be reviewed and evaluated in the period of this Programme. As the number of drug misusers taking treatment increases, the requirement to provide training and employment opportunities to assist them towards a full recovery will also increase. In the context of the review of the National Drugs Strategy, workplace initiatives dealing with drug misuse will be considered. (Department of the Taoiseach 2000: 82)

8 Actions 1 and 78–94

This statement indicates that the perceived need was to review policy responses as a consequence of the interventions already made, in particular to respond to the new needs emerging as a consequence of the growing number of drug users in treatment. In other words, it was a question of 'problem succession' rather than a need to consider new or emerging trends in the illicit drugs market, and the emerging problem was perceived to be rehabilitation and social reintegration.

The terms of reference drawn up for the review broadly reflected the sequence of steps recommended in the UNGASS Action Plan agreed in 2000. The first step was to review the problem; the next two steps were to review the response to the problem; and the final task was to revise or modify the existing drugs strategy to meet the gaps and deficiencies identified (NDS: para. 1.1.1).

The terms of reference restricted the scope of the review in several significant ways. It was to focus on 'problem drug use', defined as 'drug use which causes "social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs" ' (NDS: para. 2.1.1). Other forms of drug use, such as experimental or recreational use, were excluded. The drugs to be considered, moreover, were illicit drugs, or, more accurately, 'controlled' drugs as provided for in the Misuse of Drugs Acts 1977 and 1984 and the schedules to those Acts. Other problematic substances, such as alcohol, tobacco, prescription or over-the-counter (OTC) drugs, were not to be considered. These restrictions had the effect of focusing the review on vulnerable groups, such as young people, coming mainly from socio-economically disadvantaged backgrounds or areas.

The first task of the Review Group was to 'identify the latest available data on the extent and nature of problem drug use in the country as a whole, any emerging trends in drug misuse and the areas with the greatest level of problem drug use'. It reported in detail on the findings of this task in Chapter Two of the NDS, entitled 'Overview of drug misuse in Ireland'.

Having surveyed the available data, including treatment data, statistics on infectious diseases, vital statistics (deaths), drug-related arrests and offences, and drug seizure data, and European sources, the Review Group described recent national and regional trends in drug misuse, the types of drugs misused, and drug misuse among specific populations, including prisoners, young people, early school-leavers, and third-level students. Looking at other 'at-risk' groups, the Review Group confirmed that epidemiological evidence continued to validate the correlation between drug misuse and poverty. In response to concerns raised in the course of the public consultation on the drugs strategy, the Review Group also reported evidence in relation to other at-risk groups, including the homeless, the Traveller community, and those involved in 'prostitution'.

Although noting that cannabis and ecstasy were the two most commonly used illicit drugs in Ireland, just ahead of heroin, the Review Group identified heroin as the main source of 'problem drug use': 'in terms of harm to the individual and the community, heroin has the greatest impact' (NDS: Section 2.12). The Review Group did not define the nature of the 'harm' or its 'impact'. However, it gave examples of drug-related risk behaviours suggesting that danger to public health was one harm, for example injecting drug use and the sharing of injecting equipment among prisoners (NDS: Section

2.6), drug use by homeless people in public spaces, and working in prostitution 'to make money for drugs' (NDS: Section 2.8).

Two omissions from the review of the current situation given in Chapter Two of the NDS are notable. First, absent was any consideration of the drug supply side.[9] Previous drug policy documents had considered the domestic market in some detail. This gap is particularly remarkable when weighed against the fact that 21 of the 100 actions in the AP that was appended to the NDS were concerned with supply reduction. Second, as already noted, the terms of reference of the Review Group did not cover licit substances, including alcohol, tobacco, prescription and over-the-counter (OTC) drugs. The Ministerial Task Force, whose work the Review Group was reviewing, had similarly not been mandated to look at the misuse of licit substances, but it had expressed the view that strategies addressing drug misuse 'should ideally provide a coherent, integrated response to all forms of substance abuse, including alcohol' (1996: 35). Notwithstanding the exclusion of licit substances from its terms of reference, the Review Group reported that in the public consultations on the current drugs strategy, alcohol misuse had been identified as 'a major problem in Irish society, particularly among young people'. Reviewing the available research regarding alcohol and tobacco use among young people in Ireland (NDS: paras 2.7.6–2.7.10), the Review Group found that the statistical evidence supported the public perception, and that studies on young people consistently showed a progression from use of tobacco or alcohol to use of cannabis and then other drugs.

In his Foreword to the NDS, the Minister of State with responsibility for the Drugs Strategy, Eoin Ryan TD, stated that he had communicated the public's concern with regard to alcohol to the Minister for Health and Children, that a national alcohol awareness campaign had recently been launched, and that he would seek to ensure 'close liaison' between the implementation of the drugs and alcohol strategies. The NDS sought to translate close liaison into action by establishing 'formal links' at local, regional and national level between the two policy domains and calling for 'complementarity' between the different measures being undertaken (NDS: para. 6.7.1).

The Review Group's next task was to outline the then current drugs strategy, including the role of the statutory agencies and the community and voluntary sectors, in terms of a systematic, rational structure, comprising:

- supply reduction
- education, prevention and awareness
- risk reduction, treatment and rehabilitation
- inter-agency co-ordination and integration
- community/voluntary sector participation in the design and delivery of the strategies.

9 The NDS contained scattered and unrelated remarks on the illicit drug market, for example regarding the interpretation of drug seizure data (NDS: paras 2.4.4, 2.5.1), the distinction between drug dealing and drug using in relation to housing evictions (NDS: paras 2.8.4, 2.8.5), and the provision of an overview of the international drugs trade (NDS: Section 4.1).

Chapter Three of the NDS delivered on this task, outlining the then current response in terms of 'four distinct but interlinked pillars': Supply Reduction; Prevention (including education and awareness); Treatment (including rehabilitation and risk reduction); and Research. Although the Review Group had not been invited to consider research as an organising category, the considerable deficiencies in the research data available, which were noted in Chapter Two of the NDS (NDS: Sections 2.3, 2.11 and paras 2.5.1, 2.10.3), and the recent setting up of the National Advisory Committee on Drugs (NACD), no doubt contributed to the inclusion of the category.

The Review Group was also tasked with examining the impact of the current strategy, identifying major gaps and deficiencies, and examining international trends, developments and best-practice models. The outcomes of these examinations were described in Chapters Four and Six of the NDS document. Chapter Four examined 'international responses to drug misuse', including responses in the European Union, in seven European jurisdictions (the Netherlands, Portugal, England, Scotland, Spain, Sweden and Switzerland), and in Australia. The Review Group particularly considered substitution treatment models in the European Union, and harm-reduction approaches generally. It concluded that the Irish government's approach incorporated 'the full range of supply and demand reduction approaches which are the hallmarks of modern drugs strategies in other jurisdictions studied by the Group' (NDS: para. 6.1.2).

In Chapter Six the Review Group reviewed the measures introduced on foot of recommendations in the reports of the Ministerial Task Force (1996, 1997). Co-ordination efforts and the involvement of the voluntary and community sectors in the full range of responses to the drugs issue were heralded as successful: the local drugs task forces were deemed 'a positive development' (NDS: para. 6.1.3); 'huge strides' had been made in providing treatment for those dependent on drugs (NDS: para. 6.1.4); there were 'encouraging' signs with regard to the rehabilitation and re-integration of former drug users (NDS: para. 6.1.5); mainstreaming, the setting up of the NACD, projects developed as part of the Young People's Facilities and Services Fund (YPFSF), the agreement of a joint policy on prison-based drug treatment services, and the establishment of a pilot Drug Court were all listed as 'significant achievements' (NDS: para. 6.1.4).

Rather than assessing the impact or outlining gaps and deficiencies in the current strategy, the authors concluded broadly:

> Given the complex nature of drug misuse, the Review Group recognises that it will take time for many of these measures to make a significant impact on the problem. However, the Review Group believes that the present approach provides a ***solid foundation*** from which all those involved in trying to tackle the problem should work for the future. The new Strategy should therefore, ***endorse*** the existing approach and should expand and strengthen the pillars and principles which underpin it. (NDS: para. 6.1.7; emphasis in original)

The sixth, and final, task of the Review Group was to 'consider how the current National Drugs Strategy, including the structures involved in its development and delivery, can be revised or modified to meet the gaps and deficiencies identified' (NDS: para. 1.1.1). In Part II of the NDS, entitled 'Towards a New Strategy', the Review Group set out the strategy and action plan for the next seven years. It was in this section that the revisions and modifications to the existing strategy were identified.

The Review Group called for the introduction of a planning, reporting and evaluation system:

> The Group believes the current Drugs Strategy would be further strengthened if all State Agencies involved in its delivery specify annual targets in terms of outputs and desired outcomes for their respective programmes and initiatives. This should be agreed with the IDG [Inter-Departmental Group on Drugs], in consultation with the NDST [National Drugs Strategy Team], and used as a benchmark for performance review on an annual basis by the Cabinet Committee on Social Inclusion. Such a development would sharpen the focus of the Strategy and bring further clarity to its aims and objectives for service providers, drug misusers and the public at large. (NDS: para. 6.1.8)

It also developed a four-pillar approach based on the first three themes identified in its terms of reference – Supply Reduction, Prevention, and Treatment – and an additional pillar, Research, reflecting the weaknesses found in the research function. Although not identified as a 'pillar', co-ordination, which had been specifically considered in the review of current responses, was also assigned a set of objectives and key performance indicators. Some 17 actions were identified to enhance the existing framework of national-level institutional co-ordination.[10]

2.3 Strategic framework

The NDS strategic framework was constructed around a hierarchy of goals and targets (see Figure 2.1). The strategic direction was expressed in a single overarching and general objective, which cascaded down through a series of nine broad aims, to four pillars that linked to eight operational objectives and 23 key performance indicators (KPIs), which were underpinned by 100 actions. The whole system was accompanied by a separate co-ordination 'pillar', with associated operational objectives, KPIs and actions. The expectation appears to have been that the high-level aspirations would provide an overarching logic uniting the whole, while, simultaneously, the underpinning actions would 'drive the new strategy forward' (NDS: para. 6.1.10).

10 Actions 1 and 77–94

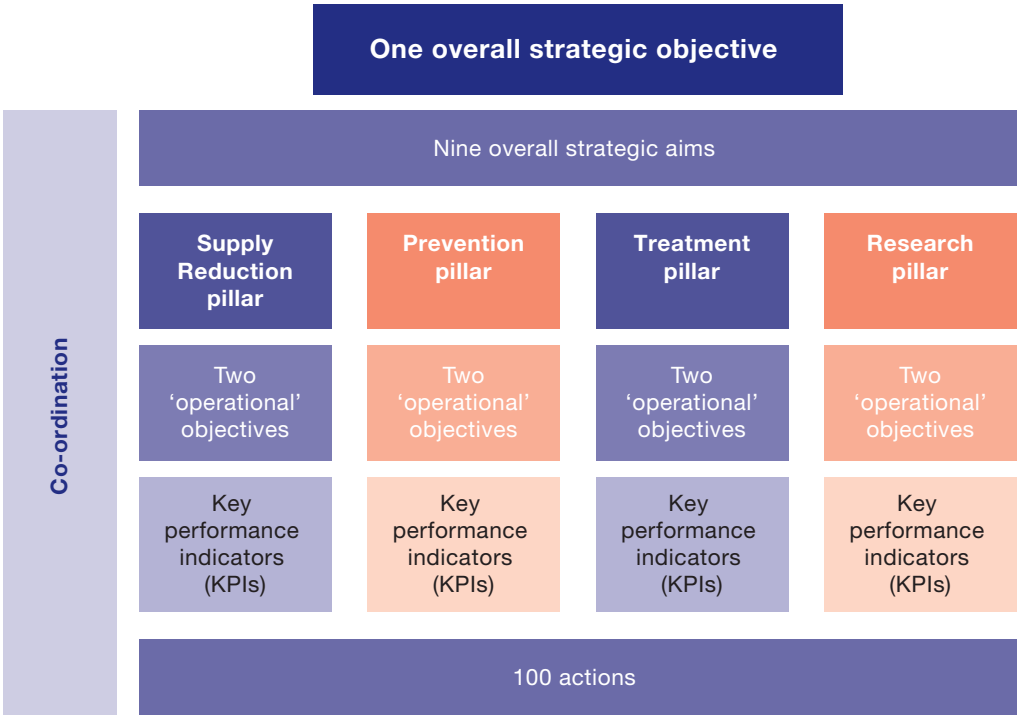

Figure 2.1 Schematic view of the strategic framework introduced in the National Drugs Strategy 2001–2008 (after NDS: para. 6.7.1)

The overall strategic objective reflected a harm-reduction philosophy and this was reflected in the nine strategic aims, and in the four pillars. The nine strategic aims would reduce drug-related harm to individuals and society by (1) reducing the availability of drugs, risk behaviours associated with drug misuse, and the harm caused by drug misuse to individuals, families and communities, (2) increasing awareness, understanding and clarity throughout society of the dangers of drug misuse, and also increasing the strength and number of partnerships in and with communities to tackle the problems of drug misuse, and (3) providing treatment and other supports to re-integrate people with drug misuse problems into society. The four pillars linked directly to the overall strategic objective by operationalising the 'concerted focus' on supply reduction, prevention, treatment and research referred to in that objective.

Each pillar was supported by two 'operational' objectives. The linkages between these operational objectives and the overall strategic objective and aims were not entirely systematic (see Appendix 1). Thus, the strategic aim to 'reduce the harm caused by drug misuse to individuals, families and communities' was reflected in only one operational objective under the Treatment pillar, and then only partially, focusing on minimising harm to the individual. Conversely, the operational objectives to reduce access to illicit drugs (Supply Reduction pillar), to equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development (Prevention pillar), and to understand the factors which contribute to Irish people, particularly young people, misusing drugs (Research pillar), did not link to any of the nine strategic aims.

Finally, at the base of the hierarchy of goals and objectives, the KPIs mapped unevenly to their related operational objectives. Among the five Supply Reduction KPIs, four linked to the operational objective to reduce availability of drugs, and one to reducing access to drugs. On the demand reduction side, among the Prevention KPIs, two-thirds of the KPIs focused on one operational objective, one aligned with the other operational objective, and the remaining two did not contribute to either of the operational objectives. All seven KPIs under the Treatment pillar related to the operational objective to do with treatment, rehabilitation and a drug-free lifestyle, and none to the objective regarding the reduction of drug-related harm.

The Steering Group that conducted the mid-term review of the NDS (2005) reported that 'the current aims and objectives of the Strategy are fundamentally sound and that progress is being made across the pillars of the Strategy' (MTR: para. 8.2). The Steering Group, however, completely revised the KPIs, reducing them in number from 23 to 14. Intended to 'measure the effectiveness of the NDS in the future' (MTR: para. 1.2), the new KPIs were quantified (and some time-bound) targets, developed on the basis of 'available data', rather than being actions drawn from the AP (see Appendix 1).[11]

Notwithstanding the strengthening of the measurement process, it is debatable to what extent the new KPIs, with the exception of the Treatment KPIs, helped to track progress against the operational objectives under the four pillars. The four new KPIs under the Treatment pillar reflected the operational objectives of improving access to treatment and the availability of and access to harm-reduction services. However, the causal connections between the operational objectives and KPIs under the Supply Reduction and Prevention pillars are less clear. For example, there was now no KPI measuring progress towards reducing access to drugs among young people. With regard to Prevention, it is open to debate whether there was a correlation between the two KPIs (stabilisation, and reduction in prevalence, of drug use in the general population) and the operational objective – greater societal awareness about the dangers and prevalence of drug misuse.

A strategic framework of objectives and performance indicators is useful in ensuring logical alignment of actions and effective use of scarce resources (Boyle and Fleming 2000). Furthermore, in a recent review of Ireland's system of government and administration (Organisation for Economic Co-operation and Development [OECD] 2008), the authors argued that informed policy debate and decision-making was impeded by a lack of enhanced departmental performance information (e.g. performance targets, performance measures, evaluation reports and benchmarking):

> Performance measures can be used as powerful tools for informed political decision making. They will not make large impacts on public-sector effectiveness, however, unless this information is used as a tool to better weigh political choices. Dialogue on performance targets and information is thus essential. This can take several forms: between ministers and the Prime Minister; as part of the deliberations of a cabinet committee; and as a parliamentary debate. (pp. 164–165)

11 Nineteen of the 23 KPIs in the original NDS were actions taken from the list of 100 actions comprising the AP. While these may have represented milestones, i.e. evidence of actions completed, they gave no quantifiable indication of progress against the objectives.

However, there are risks. Frameworks of objectives and performance indicators can lead to an 'over-preoccupation' with measuring (Baker 2004). A resulting danger is that the activities and the out-turns that can be counted tend to be the ones that are measured, to the exclusion of less tangible and less quantifiable, but no less important, activities and results. For example, measurements of drug use prevalence and drug seizures or drug-related crime may predominate, at the expense of measurements of risk and protective factors associated with social and economic deprivation (Hughes and Anthony 2006).

It may be argued that when the supply and use of illicit drugs are reduced, the harms caused by the market in illicit drugs inevitably decline as well, and that the strategic objective and the KPIs are logically consistent. However, recent investigations into the evidence for positive associations between law enforcement efforts to reduce supply and any consequent reductions in prevalence have shown that the two are not necessarily linked. There are supervening variables in respect of the dynamics of the illicit drugs market, involving both suppliers and consumers, and the nature of official responses, all, or any, of which may have a mediating effect (Trace *et al*. 2004). In a survey of UK drug policy, Reuter and Stevens (2007) argued that there was no research showing that tougher enforcement, more prevention or increased treatment had substantially reduced the number of users or addicts in a nation: 'There are numerous other cultural and social factors that appear to be much more important' (p. 81).

In recent years work has been carried out to identify and understand the precise nature of drug-related harms (International Drug Policy Consortium 2007; Trace *et al*. 2004; Roberts *et al*. 2003; MacCoun and Reuter 2001). In their assessment of the UK's drug policy in 2007, Reuter and Stevens found that the bulk of drug-related harms (drug dependency, deaths, infections, crime and mental illness) occurred among people dependent on drugs such as heroin or cocaine, rather than among the much larger population of occasional users, and that drug-related problems were disproportionately concentrated in areas of social and economic disadvantage. Notwithstanding the 'political implausibility' of ignoring drug use prevalence rates in the general population, they argued that the UK government should focus its efforts on where it could make the greatest impact – reducing the levels of drug-related harms (crime, death and disease and other associated problems) through the expansion of and innovation in treatment and harm-reduction services.

In recent years work has also been undertaken to quantify and measure drug-related harms, not least by Ireland's neighbour, the United Kingdom. In 2002, accepting the argument for pursuing harm-reduction goals while not losing sight of the long-term aspiration to reduce the supply and use of drugs, the British government updated its 1998 national drugs strategy, adopting an overarching objective to reduce the harm that drugs cause to society, including communities, individuals and their families (Baker 2004: 53). In 2004 it agreed an overall Public Sector Agreement (PSA) target for this strategy, including: 'to reduce the harm caused by illegal drugs including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system' (MacDonald *et al*. 2005: 2). In 2005 it released a Drug Harm Index (DHI), intended to measure

progress towards the new target (MacDonald *et al*. 2005). The DHI combines a series of national indicators of harms, including drug-related crime, community perceptions of drug problems, drug nuisance, and the various health consequences that arise from drug abuse (e.g. HIV, overdose, death). In 2007 a new Public Service Agreement (PSA) target for the reduction of drug- and alcohol-related harms was issued (HM Treasury 2007) and the new national drug strategy, issued in February 2008, was to support the achievement of the target. To date, the published updates of the DHI for 2004 and 2005 (MacDonald *et al*. 2006; Goodwin 2007) show that the index has fallen every year since 2001.

2.4 Action

The NDS strategic framework was to be implemented by means of 100 actions contained in the Action Plan (AP) in Part II of the NDS document. This section explores the mix of drug policy interventions included in the AP, as a means of investigating further the nature of the strategic direction set for drugs policy in Ireland. While the list of 100 actions is organised according to the government department or state agency with overall responsibility for implementation, it is possible to align the actions with the pillars included in the NDS and this organising framework is used in this section.

At the outset it should be noted that the NDS pillars represented a hybrid of two possible classificatory schemes for drug policy interventions (cf. Ritter and McDonald 2008, 2005). It combined one 'aim' – Supply Reduction – with two 'inputs' – Prevention and Treatment – and one 'infrastructural' component – Research.

2.4.1 Supply reduction

One of the overall aims of the NDS was to reduce the availability of illicit drugs, and the two operational objectives under the Supply Reduction pillar were to contain the size and extent of the illicit drug market, particularly the market in opiates, and to reduce access to drugs. The AP focused on interdiction (intercepting drugs destined for Ireland outside the country) and interrupting supply within Ireland, particularly at local level. This twin emphasis reflected the views expressed by the Review Group in discussing supply reduction: on the one hand, international co-operation was regarded as essential to deter traffickers (NDS: paras 6.2.2, 6.2.3), and on the other hand, not just law enforcement agencies, but also individuals, families, communities and a range of statutory and non-statutory agencies, were to have a role to play in curtailing the amount of illicit drugs in circulation (NDS: para. 6.2.5). Not addressed in a systematic manner by the Review Group was the potential role of law enforcement agencies in reducing the harms associated with drug-related activities, as distinct from reducing the supply of drugs.

Arguably, focusing on the outcome 'supply reduction' rather than on the activity 'law enforcement' narrowed the scope of the AP. Law enforcement encompasses a much wider range of interventions,

including not only interdiction and reduction of the drug supply but also activities to reduce drug-related harms, for example drug testing, the containment of public nuisance, diversion, and judicial and correctional policies. The AP included just three law enforcement actions that would contribute to the reduction of drug-related harms – in the areas of diversion of young people showing early signs of problem alcohol or drug consumption, arrest referral and drug treatment courts.[12]

Caulkins (2002) argued that a comprehensive and integrated approach to drug law enforcement, reducing not only supply and access to drug markets but also the demand for drugs and the harms arising from drug use, is more cost-effective than focusing on supply reduction activities exclusively. Similarly, a systematic review of 132 evaluations of drug-related law enforcement interventions from around the world (Mazerolle *et al*. 2007, 2005) indicated, tentatively, the advantages of an approach integrating supply reduction and harm-reduction interventions. The authors found that, overall, the law enforcement interventions that were shown to be effective included proactive and partnership policing, engaging with communities and reducing the harms associated with drug market operations, and diversion. Reactive measures such as raids were found to have an immediate but short-term impact only, while multi-jurisdictional task forces improved outputs and communications but there was little evidence of an effect on outcomes. Drug seizures, crop eradication, undercover operations (when used independently of other tactics), intensive policing (when undirected and used independently of other tactics) and the creation of drug-free zones did not seem to be effective.

2.4.2 Prevention

Since the Working Party on Drug Abuse reported in 1971, prevention has been regarded as a key component in reducing the demand for illicit drugs in Ireland. Moreover, ever since that first report, prevention has been recognised as comprising three separate strands – generating awareness of the dangers associated with drug use; educating people with regard to drugs and drug misuse; and mitigating personal circumstances or broader socio-economic and cultural conditions believed to contribute to drug use. This approach, focusing on inputs, was taken by the Review Group in drafting the measures under the Prevention pillar in the NDS.

Having reviewed the evidence and the results of the public consultation on the existing national drugs strategy, and bearing in mind the constraints imposed by its own terms of reference, the Review Group identified young people as the main target for prevention in the NDS. The actions in the AP were intended to strengthen young people's resilience by fostering positive stable relationships with family or key community figures, and thereby enhance their sense of belonging to family or social group or locality and increase their educational and training opportunities and employment prospects. As a corollary, schools and the wider community were identified as ancillary targets, and the need to link drug-specific interventions with interventions in related areas such as youth crime prevention and mental health promotion strategies, employment, education and training initiatives was recognised (NDS: para. 6.3.1). Mirroring these intentions, the two Prevention pillar objectives

12 Actions 13, 19 and 20

focused on creating 'greater societal awareness about the dangers and prevalence of drug misuse', and on equipping 'young people and other vulnerable groups with the skills and supports necessary to make informed choices'. Reviewing the place of harm reduction in the NDS, Mayock (2003) argued that the Prevention pillar did not include harm-reduction options, although this had been recommended by the Ministerial Task Force (1997: 45–46). While the two Prevention pillar objectives are arguably open to a harm-reductionist interpretation, none of the Prevention KPIs target the reduction of drug-related harm.

Awareness of a risk-based approach, focusing on outcomes, was to be acknowledged in the years following the publication of the NDS. In 2001 the National Advisory Committee on Drugs (NACD) published a report reviewing the whole drug prevention field (Morgan). Reporting on prevention responses to drug use in the EU, the EMCDDA has developed a framework that approaches drug prevention from two perspectives – the nature of the risk to be tackled, and the target group for the intervention. It identifies four classes of response strategies that tackle various categories of risk: (1) environmental strategies, which tackle risks occurring at a societal level, mostly by shaping attitudes, normality perceptions etc.; (2) universal strategies, which work to reduce risks occurring at a general population level, by deterring or delaying onset of substance use; (3) selective strategies, which focus on specific sub-populations whose risk of drug misuse is significantly higher than average, e.g. disadvantaged youth; and (4) indicated strategies, which target individuals exhibiting indicators highly correlated with risk of substance misuse, e.g. a psychiatric disorder or school failure.[13]

This risk-based and targeted approach claims to provide a more comprehensive and nuanced framework that helps understanding of the prevention task in terms of its impacts, rather than the awareness, education, mitigation framework used in the NDS, which focuses on the inputs. The weakness of the latter approach was highlighted by the findings of a process evaluation of the 2003–2005 national drugs awareness campaign (Sixsmith and Nic Gabhainn 2007). The evaluators found that the campaign had fallen short of the identified criteria for success, including the identification of target audiences, which, in turn, might have led to a reduction in the 'latent effectiveness' of the campaign.

Applying the EMCDDA framework to the 100 actions in the AP leads to the identification of several additional actions, usually included under the Supply Reduction pillar, which could equally well be regarded as Prevention responses, for example the diversion of individuals away from the criminal justice system or the deterrence of drug dealing on licensed premises.[14] The application of the EMCDDA framework also highlights the strengths and weaknesses of the approach to prevention adopted in the NDS. The prevention actions all targeted young people, with the majority of measures addressing universal risks, and a few measures addressing environmental or selective risks. Other at-risk groups were not considered and no indicated response strategies were included. For example, although the Review Group acknowledged the AIDS Strategy 2000 (National AIDS

13 www.emcdda.europa.eu/html.cfm/index1568EN.html

14 Actions 19, 27 and 28

Strategy Committee 2000), it did not reflect the recommendations contained in that strategy, which called for closer integration of services for people with HIV/AIDS and those for problematic drug users, for example in the areas of awareness raising, counselling, health education and prevention. More recently, problem drug use among older age groups has been identified as a matter requiring targeting (EMCDDA 2008a).[15]

2.4.3 Rehabilitation and harm reduction

When it called for the review of the existing national drugs strategy, the 2000 national social partnership agreement highlighted a concern with regard to the provision of rehabilitation services: training and employment opportunities needed to be increased as the number of drug misusers entering treatment increased (Department of the Taoiseach 2000: 82). The agreement contained a commitment to expand treatment and rehabilitation services for drug misusers, and to strengthen health board structures and information systems in this area (p. 94). In the NDS, both treatment and rehabilitation were addressed by the first of the two objectives set under the Treatment pillar, 'with the ultimate aim [for the client] of leading a drug-free lifestyle'. Minimising harm 'to those who continue to engage in drug-taking activities that put them at risk', which was not dealt with in the partnership agreement, was the subject of the second objective under the Treatment pillar. Rehabilitation and harm reduction will be considered separately below.[16]

Following the fact that rehabilitation had been expressly mentioned in the initial commitment by the social partners to review the then national drugs strategy, and that the need to include rehabilitation had been confirmed in the consultation phase (NDS: paras 5.4.6, 5.4.7), the Review Group included rehabilitation in the first of its two Treatment pillar objectives, and two out of seven Treatment KPIs related to rehabilitation. The Review Group defined rehabilitation as 'the provision of the necessary supports to enable a recovering misuser to attain an acceptable quality of life' (NDS: para. 6.4.11), and incorporated it in 20 actions in the AP.

Just as it had emphasised the need for a wider variety of treatment approaches to meet the diverse patterns of drug misuse and addiction and the needs of individual drug misusers, the Review Group also emphasised the need for a wide variety of rehabilitation supports to meet the needs of individual drug misusers when they entered the recovery phase. To this end the AP included rehabilitation along with treatment in actions intended to improve customer-focused service provision[17] and the quality of service delivery.[18] The AP also identified a series of actions intended to enhance the components of the rehabilitation process, including training and employment,[19] and accommodation.[20] It also

15 Launched in February 2008, and jointly funded by the Health Service Executive and the Department of Community, Rural and Gaeltacht Affairs, a new National Public Awareness Campaign on Drugs used a selective prevention strategic approach. It targeted recreational cocaine users in the 15–34-year age group.

16 Treatment-related actions in the AP are considered in Section 5.2 below with regard to 'managing change'.

17 Actions 40, 48, 54 and 57

18 Actions 46 and 50

19 Actions 49 and 74–76

20 Actions 61 and 68

addressed the particular rehabilitative needs of young people[21] and drug misusers in prison.[22]

Despite this comprehensive coverage, four years later, the MTR reported that in the public consultation process the Steering Group had received a strong message about 'a more comprehensive and interlinked approach to rehabilitation' (MTR: para. 5.19). The MTR stock-take of progress in respect of individual actions showed that 17 of the 19 actions relating to rehabilitation were completed or ongoing, or that progress was being made, with only two requiring considerably more progress. However, it seems that the close association with treatment (14 of the 19 actions addressed both treatment and rehabilitation), and the dispersal of responsibility for actions addressing rehabilitation across several agencies (the Prison Service, Department of Health and Children, health boards, local authorities and FÁS) may have resulted in the perception that rehabilitation was not being adequately addressed. The MTR recommended that Rehabilitation should be made a fifth, separate pillar of the NDS and that a working group should be set up to develop 'an integrated rehabilitation provision' (MTR: para. 5.19; Action 5.25.2).

Reporting in 2007, the Working Group on Rehabilitation elaborated on the NDS definition of rehabilitation, teasing out various aspects, including the need for a structured development process and a continuum of care, with the ultimate aim of achieving maximum quality of life and reintegration into the community (REHAB: para. 1.12). It took the view that rehabilitation was an umbrella concept, encompassing harm reduction and treatment as well as rehabilitation and reintegration. At the same time it expressed the view that rehabilitation need not necessarily lead to a drug-free lifestyle: 'Views in respect of treatment range from abstinence to harm reduction, both of which are considered as valid approaches. This **duality of approach** must continue to be catered for and reflected in the services provided for treatment and rehabilitation' (REHAB: para. 2.19; emphasis added).

Having conducted a stock-take of treatment and rehabilitation services available, the Working Group concluded that a range of services was already in place. Emphasising the continuum of care model and enhanced case management and care planning already identified in respect of treatment provision in the NDS, the Working Group identified three steps now needed to implement the measures under the Rehabilitation pillar – co-ordination of services, the development of quality standards and associated training of staff. One notable omission from the work of the Working Group was tackling the stigmatisation and negative stereotyping of recovering and recovered problem drug users. The Review Group had identified these social phenomena as obstacles for those wishing to access treatment, find accommodation or employment, or reintegrate into their families, communities and society (NDS: paras 6.4.14–6.4.17).

With regard to harm reduction, the Review Group noted that 'traditionally' the dominant trend in drug treatment policy had been towards abstinence, but that international practice and views expressed in the course of the public consultation had both highlighted the recognised link between drug misuse and the spread of disease, e.g. HIV and hepatitis C, and that this had led to 'the need to adopt

21 Action 60

22 Actions 22 and 24

strategies that reduced the risks posed by such behaviour both to the individual misuser and the wider community' (NDS: para. 6.4.19). The gradual and covert nature of this shift in policy, driven by officials and professional treatment service providers working together out of the public eye, has been well documented (Butler 2002b; Barry 2002).

The lack of transparency, and of public debate on the policy shift, means that conflicting interpretations of the policy response have been possible. It has been suggested that the adoption of a harm-reduction treatment model might not have represented 'a concern and commitment to tackle the drug problem in a meaningful or effective manner', so much as a way 'to cordon off the drug problem and protect the general public by keeping drug users under control, if not by criminalising their activity, then more subtly endorsing their drug use by choosing to offer a substitute drug to diminish if not eliminate criminal behaviour associated with drug use' (Loughran 1999: 311). Alternatively, it has been argued that Irish policy-makers could have chosen to publicly announce their choice of a harm-reduction approach based on ideological assumptions. However, they preferred 'to shroud the policy process in ambiguity by introducing harm reduction practices without debate, announcement or a clearly presented rationale' (Butler and Mayock 2005: 420). These authors argued that, given the prevailing Irish cultural and political climate, 'to break the silence on harm reduction through the creation of a national debate on the moral issues inherent in drug policy might in fact prove to be counterproductive for those committed to harm reduction' (p. 422).

Although acknowledging that the spread of drug-related diseases had been controlled somewhat in Ireland through the introduction of needle exchanges, submissions to the Review Group and participants in the consultation fora on the national drugs strategy repeatedly voiced the need to increase efforts to minimise the spread of infectious diseases, especially hepatitis C, via injecting drug use. Needle exchanges were still seen as the principal measure: the view was expressed that a properly planned and co-ordinated nationwide needle and syringe exchange service would have 'a positive effect on drug-taking practices' (NDS: para. 5.4.8). A concern was also expressed about the need to reduce the proportion of drug misusers who were injecting. Endorsing the arguments put forward, the Review Group concluded, 'The need to develop and expand existing harm-reduction measures and to investigate scientifically-based innovative responses, appropriate to Irish circumstances and consistent with our obligations under international conventions while also taking account of international best practice, is vital for the protection of drug misusers, those they live with and the wider community' (NDS: para. 6.4.19). The Review Group also acknowledged the need to align its approach with that set out in the National AIDS Strategy (NDS: para. 6.4.20).

The NDS adopted a two-pronged approach – reducing rates of sharing injecting equipment and reducing the level of injecting drug misuse – arguing that they were both 'essential elements of containing the spread of HIV and Hepatitis C etc. among injecting drug misusers and should also contribute to a decline in the prevalence of these diseases among the non-using population' (NDS: para. 6.4.20). The AP included two actions to enhance access to needle and syringe exchange

facilities and services,[23] and an action to investigate the effectiveness of other measures to minimise the sharing of equipment among at-risk groups.[24] It also included an action to develop good-practice outreach models, to help reduce the level of drug-related deaths among those continuing to use.[25]

The Review Group was clear that heroin prescribing and injecting rooms were not acceptable harm-reduction options. Having reviewed provision of these services in Switzerland, the Netherlands and Spain, it felt that, given the fact that further evaluation and continued research was required to establish objectively the benefits of such treatments, and given Ireland's international obligations under the UN drug conventions, the introduction of such harm-reduction strategies in Ireland was not yet warranted. The Review Group noted, 'the situation should be kept under review and the results of research, both national and international, should be monitored' (NDS: para. 4.13.3).

In 2005 the Steering Group that undertook the mid-term review of the NDS noted the increase in the incidence of hepatitis C, to a level higher than the EU norm, and the ongoing prevalence of HIV, and also the fact that hepatitis C was transmitted more easily than HIV through sharing injecting equipment (MTR: para. 5.23). It replaced Action 62 with a stronger action, calling for the expansion of needle exchange and related harm-reduction services across the country and increasing availability in the evenings and at weekends (MTR: para. 5.25). The Steering Group did not return to the issue of providing safer injecting facilities, but these had been considered as part of the review of harm-reduction approaches commissioned by the NACD (Moore *et al*. 2004). Undertaken in response to Action 100 in the AP, this review restricted itself to harm-reduction approaches aimed at minimising the sharing of equipment used to administer drugs. The review found that there was room to expand the scope and reach of harm-reduction measures, such as the exchange of needles, syringes and other drug use paraphernalia, tailoring services to the characteristics of target groups, and education and support for drug users. With respect to supervised drug consumption rooms and heroin prescribing, the review found that the evidence for their effectiveness was still not conclusive. It also pointed out that legal restrictions on such initiatives in Ireland would have to be lifted and that careful consideration would have to be given to the impact in reference to international treaties.

In a study of whether Ireland was prepared for the introduction of safer injecting facilities (SIFs), O'Shea (2007) concluded that the political climate was not open to, or ready to debate, the idea and that, as previously with methadone treatment, it would have to be done discretely: 'It is … difficult to see a mechanism by which SIFs can reach the [political] agenda in any formal sense given the current structures. … The study demonstrates that it is perhaps "a bridge too far" in the current political climate and any change will be incremental, and may well arise from service providers attempting to initiate change from the ground up' (p. 86).

23 Actions 62 and 63

24 Action 100

25 Action 64

2.5 Maintaining direction

Butler (1997, 1991) argued that, up to the mid-1990s, Irish policy on the drugs issue did not contain a clear definition or description of the problem it was seeking to address. While acknowledging that the Ministerial Task Force had 'publicly and unequivocally accepted that a causal link exists between poverty and serious drug problems, and that demand reduction measures should be selectively aimed at those neighbour-hoods or communities where a high prevalence of drug problems coincides with generalised social exclusion or disadvantage' (1997: 5), Butler argued that the Ministerial Task Force had generally avoided tackling the 'the difficult questions … the awkward but fundamental questions' (p. 6).

It is apparent that the NDS similarly did not contain any clear statement as to the nature or causes of the drug problem. The principal intention in drafting the NDS was to enhance the administration and delivery of the policies identified by the Ministerial Task Force. Having reviewed the extent and nature of drug use in Ireland in the late 1990s and having found that the most commonly used illegal drug was cannabis, followed by ecstasy, the Review Group concluded that, in terms of harm to the individual and the community, heroin had the greatest impact (NDS: Section 2.12). The NDS did not provide an account of the nature of the harms or their impacts.

The NDS also displayed an ambivalence about the purpose of the policy response. The overall strategic objective – to reduce the harms caused by drug misuse to individuals and to society – was potentially self-defeating: the measures to reduce harms to society (preventing crime, reassuring the frightened or providing employment) might lead to lower priority being given to meeting the complex needs of people addicted to drugs (Neale 2006). The four pillars included objectives leading both to a drug-free lifestyle and to the reduction of harm among those who continued to use. The mixing of inputs and outputs in the identification of the pillars – Prevention and Treatment on the one hand, and Supply Reduction on the other – resulted in inconsistencies in the pattern of responses. Law enforcement measures received little attention among the list of 100 actions, although they might have helped to reduce drug-related harms; the full range of possible prevention interventions was not addressed. Harm-reduction measures were most fully developed under the Treatment pillar, while actions under the Prevention pillar suggested ambivalence with regard to the purpose of prevention measures. In short, the NDS failed to clarify the balance to be struck between the two approaches. This ambivalence was explicitly acknowledged by the working group on rehabilitation (REHAB) in 2007, which recognised both abstinence and the reduction of drug-related harms as acceptable alternative outcomes.

Recent theorising on the public policy process suggests that such ambivalence is an inherent and necessary part of the policy process. Stone (2002) argued that *policy development* is not a rational project, based on a linear progression from identifying a goal, the nature of the problem preventing attainment of the goal and the means to eliminate the problem. Rather, it is a *political process*, in which actors pursue contradictory objectives simultaneously, make trade-offs between competing

objectives, or even change their objectives. Stone defined *policy making* in political communities as 'the struggle over ideas. Ideas are a medium of exchange and a model of influence even more powerful than money and votes and guns. … Ideas are at the center of all political conflict. Policy-making is a constant struggle over the criteria for classification, the boundaries of categories, and the definition of ideals that guide the way people behave' (p. 11). Stone defined *policy reasoning*, whereby policy is thrashed out, as 'reasoning by metaphor and analogy … trying to get others to see a situation as one thing rather than another' (p. 9). In such a political policy development process, ambiguity is essential as it enables the transformation of individual preferences into collective goals through making room for compromise and co-operation in negotiations. Ambiguity gives policy-makers room to manoeuvre, to alter and adjust policies as circumstances alter. Arguably, the ambiguity in the NDS strategic framework and in the AP allowed for just such shifts: the broad political consensus on the NDS is indicative of the efficacy of the ambiguity contained in it.

Managing this ambiguity is a critical challenge. To sustain a dynamic relationship with the overall direction set for a strategy depends on the availability of real-time relevant information and timely decision-making. However, to develop effective response mechanisms in a public sector environment, in which the need for transparency and accountability is paramount (Litton and MacCarthaigh 2007), attention also has to be given to the capacity of the system to make sound decisions, based on adequate evidence and deliberation. These matters will be taken up in the next two chapters.

3 Informing choices

3.1 Introduction

In recent years the concept of 'evidence-based policy', i.e. policy based on scientifically derived data or information, has become a *sine qua non* of public policy. It offers assurance that chosen policy interventions will work and that they will deliver value for money. In democratic jurisdictions, public opinion is another important driver of policy choices. Public preferences may be expressed through a variety of channels, including opinion polls and the media.

Just how information and opinion flow through into policy is a complex reflexive process that permeates all stages of policy development and implementation. This chapter briefly surveys how the capacity to obtain and use research-based evidence and to understand public opinion has developed during the lifetime of the NDS. Progress has been made but there is room for strengthening, and leveraging use of, the information and research base.

3.2 Empirical evidence

Discussing the public policy process in relation to illicit drugs, MacCoun and Reuter (2001) proposed that policy-makers should adopt a 'policy analytic' standard of proof, based on theory, the available evidence and analysis of the consequences, risks and benefits, which will yield a 'reasonable confidence' in the outcomes to be achieved by the interventions. In discussing the linking of research and drug policy, Hartnoll's (2004) description of how evidence (knowledge derived sensibly from empirical research) is used in developing drug policy chimes with MacCoun and Reuter's definition: 'a step-by-step process of building evidence through observation, developing theory, testing hypotheses and crossing information, including results from RCTs [randomised controlled trials] if available' (p. 21). Published in 2008, the OECD review of the Irish public service similarly argued that greater use of independent a *priori* policy evaluations would lead to improved evidence-based advice being considered by the government prior to decisions being made.

3.2.1 Extent and nature of drug misuse

The need to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland was included as one of the nine overall strategic aims of the NDS. Two operational objectives under the Research pillar highlighted the need for data on the extent of drug misuse among all marginalised groups and for a greater understanding of the factors contributing to Irish people, particularly young people, misusing drugs. (NDS: para. 6.7.1). During the life of the NDS much progress was made in strengthening the range of data available on the extent and nature of the drug problem in Ireland. Having considered the five indicators of 'drug misuse' identified by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Review Group identified five sources of information on the extent and nature of the drug problem (NDS: Section 2.1). Progress made with regard to each of these sources during the lifetime of the NDS is noted below.

1. *Prevalence of drug use:* In 2002/2003, the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) of Northern Ireland commissioned the first all-island survey of prevalence rates for illicit drug use, and also use of alcohol, tobacco and drugs such as sedatives, tranquillisers and anti-depressants. The survey was re-run in 2006/2007.[1]
2. *Treatment for problematic drug use:* Two national registers record drug treatment data in Ireland – the National Drug Treatment Reporting System (NDTRS) and the Central Treatment List (CTL). The NDTRS is an epidemiological database on treated drug and alcohol misuse in Ireland, administered by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB). The CTL is a complete register of all patients receiving methadone as treatment for problem opiate use in Ireland, administered by the Drug Treatment Centre Board (DTCB). Comparing the data gathered by the two systems between 1998 and 2003, Long (2005) anticipated that as the penetration by the NDTRS deepened, the difference between the two systems would increase and the NDTRS would be the more comprehensive data set with regard to the number of people in drug treatment in Ireland.
3. *Deaths owing to drug use:* Although the NDS called on the Central Statistics Office (CSO) to establish a database on drug-related deaths,[2] in the event, the departments of Justice, Equality and Law Reform and Health and Children funded the Health Research Board to set up and host the National Drug-Related Deaths Index (NDRDI). In September 2005 the HRB launched the NDRDI. In 2008 preliminary results on all drug-related deaths for the period 1998–2005 were published (Lyons *et al*. 2008). Data on alcohol-related deaths from 2004 onwards are also included in the NDRDI.
4. *Infectious diseases associated with drug use:* The Health Protection Surveillance Centre (HPSC) introduced a surveillance system for hepatitis B in 2004, and for hepatitis C in 2007. In October 2006 the HRB published an overview on blood-borne viral infections among injecting drug users in Ireland between 1995 and 2005 (Long 2006). It was based on disease notifications reported to the HPSC and on *ad hoc* research studies.
5. *Crime associated with illicit drugs:* Following the introduction in 1999 of the Garda IT system PULSE, offences were categorised as either 'headline', i.e. serious crimes, including some drug-related offences, or 'non-headline', i.e. less serious crimes, including less serious drug-related offences. Under the Garda Síochána Act 2005 responsibility for the compilation and publication of recorded crime statistics transferred from the Garda Síochána to the Central Statistics Office (CSO). In April 2008 the CSO adopted a new Irish Crime Classification System, which includes a distinct category, 'Controlled Drug Offences'. This category is organised under three headings – Importation/Manufacture of Drugs, Possession of Drugs, and Other Drug Offences, which includes forged or altered prescription offences, and obstruction under the Misuse of Drugs Act. 'Driving/in charge of a vehicle under the influence of drugs' is included in a different category, 'Dangerous and Negligent Acts'.

1 The reports from both iterations of the survey are available on the website of the NACD at www.nacd.ie

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With regard to the justice and correctional systems, the NDS called for the establishment of 'a framework to monitor numbers of successful prosecutions, arrests and the nature of the sentences passed'.[3] The Steering Group that undertook the mid-term review of the NDS noted that work had commenced on this action but at the time of writing it had not been completed (MTR: paras 3.5, 3.6). Looking to the future and improving the utility of data sources on drug-related crime, Connolly (2006a) called for a series of changes in data collection methods to reflect the increased inter-agency orientation of policy approaches and to ensure co-ordination between data systems.

In a recent development, following the adoption of the life cycle approach to social inclusion policy in Ireland in 2005/2006 (see Section 5.3.1 below), a call has emerged for the mounting of longitudinal studies to support the operationalisation of this policy approach (Whelan and Maître 2008a, 2008b). This new call has implications for the drugs policy domain and its research agenda (Pike 2008). Longitudinal studies of different aspects of drug use have already been undertaken in Ireland stretching back over a number of years. These studies have included several on substance use among adolescents (Mayock 2005; Brinkley *et al*. 1999; Grube and Morgan 1990); a study of the social development, family background, health (including alcohol and illicit drug use) and well-being of Irish children and their families (Cleary *et al*. 2004); a study of treatment outcomes in prison (Pugh and Comiskey 2006); and the Research Outcome Study in Ireland (ROSIE), a treatment outcome study that monitored the progress of opiate users entering treatment between September 2003 and July 2004, commissioned by the NACD.[4] It may be anticipated that more longitudinal studies will be called for by policy-makers seeking to understand how a 'general analytic framework' for a life cycle approach to the drug-related aspects of social inclusion policy might develop, and how the varying needs of individuals may be built into the design of both services that provide protection against risks and innovative social policy measures that address unmet needs and pre-empt problems.

3.2.2 Improving performance

In Ireland, the Strategic Management Initiative (Co-ordinating Group of Secretaries 1996), which called for the development of sectoral strategies such as the national drugs strategy, also called for the application of quality service principles throughout the public service. Quality service depends on two factors – aspiring to a standard of quality defined by the customer, client or citizen, as well as to a standard defined solely on technical grounds, and seeking to continuously improve the level of service and quality in line with these standards. Over 30 actions in the Action Plan (AP) appended to the NDS reflected these quality principles by calling on various government departments and state agencies to monitor, review or evaluate the efficacy or effectiveness of various procedures and programmes and to use the findings to improve the quality of their services, and calling on them to promote quality standard and best-practice models through means such as benchmarking, training and accreditation.

In the years following the publication of the NDS, thinking with regard to the delivery of quality

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4 Information on the ROSIE study, including the seven ROSIE Findings bulletins published to date, may be found on the website of the National Advisory Committee on Drugs at www.nacd.ie

services in the Irish public sector, including the drugs field, received further attention. In line with Action 50 of the AP, the NACD (2003a) hosted a seminar on quality in addiction services. Contributors at this seminar widened the definition of 'quality' to encompass the perspectives not only of patients, clients and customers but also of professionals, service providers and policy-makers. In 2006 the National Economic and Social Forum (NESF) published a report on delivering quality public services in Ireland. It recommended that services be designed and planned around the users' needs, based on a lifecycle approach and focusing on 'transition points' in people's lives, such as a troubled teenager dropping out of school, and deliver services tailored to her or his needs. With their focus on the needs of the individual, the adoption of 'continuum of care' and 'case management' models, and models for enhancing inter-agency working, the NDS, the MTR and REHAB reflect a similar concern with quality.

In 2008, in a further fillip to the enhancement of service quality, the EMCDDA launched an Internet portal, which will provide information on best practice in the areas of drug-related prevention, treatment, harm reduction and social reintegration (Burkhart and Hildebrand 2008).[5] Concentrating on illicit drugs and polydrug use, the portal offers professionals, policy-makers and researchers an array of tools and standards to improve the quality of interventions and highlights examples of evaluated practice.

3.2.3 Interpretive research frameworks

National drug policy documents prior to the NDS had attempted to include social analysis and explanation of the illicit drug use phenomenon. The report of the Working Party on Drug Abuse (1971) discussed the existence of a drug-using sub-culture and the concept of 'sociological dependence'; the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997) discussed drug use in the context of 'youth culture'. While the NDS referred to social indicators of problem drug use, including age, gender, socio-economic status and cultural context (NDS: Chapter Two), it did not attempt a general social explanation.

In recent years commentators on social drug research around the world have observed that the medical model of drug research has dominated the drug research agenda (Bourgois 2008; Frisher 2007; Higate 2006; Korf *et al*. 2005). As a result, the pathology of the individual has predominated in drug research and analysis, rather than the social context of drug use; the emphasis has been on problematic drug use as opposed to drug use in general; and research has tended to focus on questions arising out of the policy process rather than on questions arising out of wider issues of social theory. In researching the development of generic indicators of a community drug problem in the Irish context, in a report commissioned by the National Advisory Committee on Drugs (NACD), Loughran and McCann (2006) argued that while the individually focused pathological approaches to understanding substance use might help in dealing with dependent or addictive use, they failed to help in understanding the social and cultural context of drug use, and therefore the drugs issue

5 Web link www.emcdda.europa.eu/themes/best-practice

at a community level. The authors proposed a social constructionist approach: 'A perspective that incorporates critical social analysis would act as a safeguard to interpretations that simply reflect widely held positions instead of struggling to understand the lived experience of communities in which drug use has been labelled problematic' (p. 41).

Notwithstanding the predominance of the medical model of drug research, the link between socio-economic disadvantage and problematic drug use has long been recognised in Ireland. Starting in the 1980s, drug treatment data began to show an overlap between concentrations of problem drug users and of people experiencing disadvantage, and policy interventions to address this linkage were proposed (Butler 2002a). In the 1990s O'Gorman undertook research into the nature of the links between deprivation (a structural process) and drug use (an individual choice) through an empirical study of heroin use and social exclusion in Dublin. She concluded: 'In such settings, individual drug-using careers were seen to develop in a more dysfunctional way, with the ensuing local prevalence of problem drug use further exacerbating conditions for all residents and resulting in a powerful, mutually reinforcing, dynamic of the social exclusion–problem drug use phenomenon' (O'Gorman n.d.: 140). This double spiral of disadvantage was acknowledged by the Ministerial Task Force (1996: 7).

The link between social exclusion and problem drug use continued to figure prominently in the research agenda set out in the NDS and the AP. Research objectives included having data on the extent of drug use among marginalised groups, and understanding why young people misuse drugs; studies were to be undertaken on groups at risk of or vulnerable to becoming involved in problematic drug use, 'e.g. Travellers, prostitutes, the homeless, early school-leavers etc'.[6] The NACD commissioned and published reports on drug use among Travellers (Fountain 2006) and the homeless (Lawless and Corr 2005). Using a risk-based approach, both studies helped to clarify the dynamics of social exclusion. Lawless and Corr noted that there are a number of risk factors common to homelessness and problematic drug use and that numerous research studies have consistently shown that the proportion of homeless people who use drugs is significantly higher than the proportion among the general population. However, they also noted that research has not conclusively shown the nature of the relationship between the two conditions. Fountain reported the evidence for the presence of nine types of risk factor for problematic drug use among Travellers, and demonstrated how these nine areas of risk serve as a list of the ways in which disadvantage contributes to social exclusion and problematic drug use. Fountain used the risk factors as a framework for analysing qualitative information.

The social-inclusion and the risk-factor approaches reflect a structural/functional conception of society. Individuals act rationally and the outcomes of their encounters with various risk factors may be altered by adjusting social structures or functions in order to strengthen the protective factors. Other commentators have suggested that the social explanation is somewhat more complex. Examining young people's situated accounts of their drug-related activities, Mayock (2005) argued that models of risk that relied on individualistic and rationalistic assumptions overlooked the social

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contingency of many of young people's drug-related activities. Similarly, in a recent review of the 'normalisation' thesis of drug use, Measham and Shiner (2008) moved beyond explanations of drug use based on rational action models and individualised risk management. They argued that drug use should be regarded as the result of 'a complex interplay' between structure and agency, which could be understood in terms of recent criminological theories of 'situated choice' or 'structured action'.

Other recent social theoretical approaches have concentrated on cultural processes and how these shape the environment in which individuals encounter illicit drugs. Acknowledging a double issue of the *International Journal of Drug Policy* devoted to contemporary social theory in drug research, drug policy and harm reduction (Moore and Rhodes 2004), Higate (2006) outlined a series of theoretical approaches that focus on the social context – post-modernity and consumer capitalism, and the role of embodiment, of space and of place. He concluded his synthesis of the emerging literature on social theory in the drugs field thus:

> In starting from an understanding that individuals – be they drug users or otherwise – might appear to act in contradictory or irrational ways, we might usefully consider their embodied and spatialized social practices. These ways of conceptualizing drug users and drug use, while not immediately reconcilable with the policy interface, nevertheless are vital if we are to move towards understanding the complexities of both problem and recreational drug use in contemporary society. (p. 136)

As an alternative to exclusively social analysis and explanation, integrative approaches to inquiring into substance use have been proposed. Such approaches constitute a means of transcending the researcher's own categories and moral concerns or of gaining a more complete grasp of the complex dynamics of substance use. Integrative approaches could include investigating all ingested substances, alcohol and tobacco as well as illicit drugs (Hunt and Barker 2001); investigating the topic from the perspective of the individual and their social context, and of the substance itself (Hunt and Barker 2001; Zinberg 1984); or involving a wide variety of disciplines such as epidemiology, economics, sociology, criminology, psychology and neuroscience, anthropology, or their sub-disciplines, in the one research approach (Ritter 2006; Ritter and Cameron 2005; Singer 2001; Thomas *et al*. 2007).

3.3 Analytical and evaluative evidence

Once empirical research has been completed, published and disseminated, the need still remains to interrogate the results, to review the various options within the context of the competing demands for action, in order to arrive at the optimal policy solution. The EMCDDA recognised this intervening step in its three-year work programme for 2007–2009 (2006a), inserting the enhancement of data analysis as a goal between its two other goals – to consolidate monitoring and reporting, and to communicate more effectively with key audiences. The EMCDDA identified the following actions under its goal of enhancing data analysis: working more closely with experts, and increasing investment in statistical modelling and multi-indicator data synthesis.

Although the NDS, in describing its own programme of work, mentioned 'analysis' (NDS: para. 1.3.1), it is not clear what analytical work was undertaken in formulating the NDS. In this section some contributions that formal analytical and evaluative methods can make to enhancing the evidence base for policy-making are explored.

3.3.1 Financial and economic analysis

Since 2000 the EU's drugs action plans (Council of the European Union 2000, 2005) have been calling on member states to work towards being able to report drug-related public expenditure. The EMCDDA has undertaken considerable work on this matter, commissioning studies on drug-related expenditure in member states (Reuter 2004, 2006; Postma 2004; Kopp and Fenoglio 2003) gathering data on aspects of drug-related expenditures directly from member states (EMCDDA 1998, 2003a); and developing a framework and methodology for gathering data on drug-related public expenditures in member states on a regular systematic basis over time (EMCDDA 2008b; Reuter 2004, 2006).

Estimating drug-related public expenditure is a crucial element in policy evaluation, indicating effort, efficiency and sustainability. In Ireland an expenditure review of local drugs task forces (LDTFs) (Goodbody Economic Consultants 2006) called for regular reporting of expenditure by projects, together with reporting of performance against a set of 24 qualitative and quantitative indicators, as a means of monitoring the performance of projects. Public expenditure data (including its expression in a ratio to the country's total public expenditure or its GDP) may also be used to make cross-country comparisons, which can be useful in assessing the impact of a nation's drug policy and in benchmarking performance. Understanding the drugs budget can also help to reveal the framing of a country's political and policy debate. For example, the changes in the US federal drugs budget since 2002, when expenditure on interdiction began to increase and spending on prevention decrease, have been cited as evidence of a significant shift in US drug policy that might otherwise have gone unnoticed (Carnevale Associates 2008).

The compilation of information on drug-related public expenditure is a preliminary to estimating the social costs of drug use in member states (EMCDDA 2008b; Ballotta and Bergeron 2006). The social costs comprise not only costs arising from direct expenditures on treatment, prevention and law enforcement interventions and research, but also the costs incurred by the user (illness or death), and externalities such as the social cost of care, loss of productivity, criminality, and quality of life foregone. While public expenditure indicates effort being expended, estimates of social costs, based on a cost-of-illness (COI) approach, indicate the opportunity cost, i.e. the amount of resources that have been used because of the illicit drug phenomenon, which could be used elsewhere if the drugs problem did not exist. The potential benefits of estimating the social costs include the provision of data for building a business case for investment, more effective targeting of resources, measuring progress, identifying information gaps, and improving the evidence base for modelling the effects of policy interventions (Roberts *et al*. 2006; Single *et al*. 2003).

During the lifetime of the NDS, reports estimating the social costs of illicit drug and/or other substance use have been published for certain countries, including Australia (Collins and Lapsley 2002), England and Wales (Godfrey *et al*. 2002), France (Kopp and Fenoglio 2002), Luxembourg (Origer 2002), Spain (Garcia-Altes *et al*. 2002), and the United States (Office of National Drug Control Policy 2001). These studies have generally used the cost-of-illness (COI) approach. Single *et al*., in the second edition of the international guidelines for estimating the costs of substance abuse, published by the World Health Organization (WHO) in 2003, acknowledged a number of outstanding conceptual and methodological issues, and work to resolve these continues. For example, guidelines have been developed for estimating the avoidable as opposed to the unavoidable costs of substance abuse (Collins *et al*. 2006): unavoidable costs include costs for drug abuse in the past, which continues to impose a cost on society; avoidable costs are those costs incurred in the present, which could be reduced through public policy initiatives and behavioural changes. Collins *et al*. also expressed the hope that a third edition of the WHO's international guidelines on aggregate social costs would be forthcoming, reflecting progress made in areas such as epidemiological evidence about the effects of substance abuse and the identification of drug-attributable crime. Suggestions have also been made to reduce the uncertainty surrounding the data used to estimate the social costs of substance use, and tackling conceptual problems in transferring a health approach to a 'condition', such as problematic drug use, where health care costs may be a minor component (Moore and Caulkins 2006). Finally, methodologies are being developed to fine-tune social cost estimates by disaggregating costs by type of drug, by type of user, and by type of use over the user's lifetime (Pacula 2008; Moore 2007).

From the evidence available to them, Kopp and Fenoglio (2003) estimated that public expenditure on the drugs issue represents approximately 5% of the total social costs of illicit drugs. They observed that this ratio indicates not only the scale of the benefits to be reaped from estimating the social cost of the drug problem, but also the scale of the additional research time and resources needed to estimate the total social costs, as distinct from public expenditure alone. Reuter (2006) questioned the value of this additional expenditure, given that the counter-factual, or opportunity cost, posed in COI studies, is not one that can be attained. He argued that an understanding of the public drug budget, and the distribution of effort, suffices to help in deciding whether the level and composition of illicit drug policies are appropriate.

A further class of economic analysis is economic evaluation, which involves the identification, measurement, valuation and comparison of the costs and consequences of two or more specific alternative interventions. Such evaluations fall into three categories – cost-effectiveness studies, cost-utility studies and QALY (Quality Adjusted Life Years) analysis. These techniques address specific policy choices, and focus on changes in, rather than levels of, policies and problems (Godfrey and Parrott 2007). Social cost estimates are regarded as a necessary input to cost-effectiveness and cost-benefit analyses of drug-related interventions (Chisholm *et al*. 2006).

In Ireland, a pharmoeconomic analysis was undertaken as part of a study commissioned by the National Advisory Committee on Drugs into the possible use of buprenorphine as an intervention in the treatment of opiate dependence syndrome (National Medicines Information Centre 2002). The authors described two defining characteristics of pharmoeconomic analysis: it determines both the inputs (costs) and the outputs (consequences) as a result of a drug intervention, and it frequently compares alternative courses of action. In the buprenorphine study, the researchers compared buprenorphine therapy with methadone therapy; from the results, they concluded that in Ireland use of buprenorphine appeared to be less cost-effective than methadone, but suggested that it might be cost-effective in certain settings and called for further study and analysis.

3.3.2 Modelling

In 2001 the EMCDDA published a scientific monograph highlighting the potential of modelling to assist drug policy analysis. Modelling was defined as 'a way to simplify and understand complex processes or structures which may use mathematical or statistical techniques' (p. 11). It can be applied either to existing data, to gain a deeper understanding of the key features and relationships between factors contained within the data, or, where there is little or no data, to estimate the missing data or to enhance the interpretation of the available but scarce data, to deepen understanding of unobservable processes and relationships, or to forecast trends. In short, it can be used to describe, to explain, to predict, and to integrate different disciplinary approaches or to evaluate programmes (Bammer 2007).

Modelling techniques may be applied to a variety of drug policy topics, including drug markets, drug-related treatment and harm-reduction interventions, drug control measures, or the social costs of drug use. To give just one example, observing that the prevailing mental models guiding policy discussions on drug use in populations over time 'implicitly superimpose a static framework on an intrinsically dynamic phenomenon', Caulkins (2007) suggested that dynamic system modelling could assist in the choice of enforcement, prevention, treatment or harm-reduction interventions at different stages of the model, which are both more cost efficient and more cost effective. Furthermore, 'it can bring people together, whereas static framings are often divisive, pitting special interest groups against each other. … essentially every mode of intervention has a useful role to play at one point or another in the drug use cycle' (p. 6).

The Australian Drug Policy Modelling Program (DPMP) plans to develop systems models of the dynamic interactions between law enforcement, treatment, prevention and harm-reduction interventions (Ritter *et al*. 2007). To do so, good information about the effects of various interventions is needed. To this end, the DPMP has embarked on a series of systematic reviews of various classes of drug-related interventions in order to provide the building blocks for such models (Mazerolle *et al*. 2005; Ritter and Cameron 2005; Soole *et al*. 2005).

To conclude with another specific example, in the area of public policy research, much thinking has gone into modelling policy change (Sabatier 1999) and various policy models have been applied to drug policy change. For example, in Switzerland the advocacy coalition network model has been applied to explain how in the course of 20 years the Swiss shifted from a prohibitionist policy position to a harm-reductionist position (Kűbler 2001). In Ireland, the organisational network model has been used to explain changes in drug and alcohol policy over the second half of the 20th century (Butler 2002a). Given the ambiguity evident in national drug policy (see Section 2.5 above), Kingdon's (2003) 'multiple streams' policy model might be useful in modelling Irish drug policy-making in the first decade of the 21st century. Kingdon identified three streams flowing through the policy system – problems, policies and politics. These streams flow independently of one another, but every so often some event causes them to converge to form a 'policy window', and a policy 'issue' may arise as a result. For example, a media exposé of injecting drug use in a public space may spark a political debate and perhaps lead to a policy decision to provide safe injecting facilities. Alternatively, a political event, such as a change of government, may provide an opportunity to reappraise and change policy. When a policy window opens, a 'policy entrepreneur' initiates action that attaches the problem to an event, or the event to a policy, and wins political support for the newly-identified solution or policy.

Premised on notions of complexity and chaos in the agenda-setting stage of the policy process, the multiple streams model possesses several features suggesting its relevance to contemporary policy-making in the drugs policy domain in Ireland (Zahariadis 1999). It models policy-making under conditions of ambiguity; while acknowledging the rational element in policy-making, it seeks to explain policy when clarity and logic are not apparent; it emphasises ideas and context; and it eschews the assumption that the process is controlled. Zahariadis concludes: 'If the multiple streams approach indeed gives an accurate picture of policymaking, it can be fruitfully used to explain policymaking and perhaps to reform it, but, more important, to devise strategies to cope with it' (p. 90).

3.3.4 Evaluation

With regard to evaluation, a KPI under the Co-ordination heading in the NDS called for 'an independent evaluation of the effectiveness of the overall strategic framework by end 2004'. Action 2 in the AP spelt out how this evaluation was to be conducted:

> … establish an evaluation framework for the Strategy, incorporating the performance indicators against which progress under the four pillars will be assessed. Annual reports and mid-term evaluations would facilitate progression towards key strategic goals. The cost-effectiveness of the various elements of each pillar of the new Strategy should be established to enable priorities to be established and a re-focusing, if necessary, of strategic objectives from the mid-term evaluation stage at 2004.

In the event, a 'mid-term review' was carried out in 2004 by a Steering Group, comprising representatives of relevant government departments and agencies and of the relevant voluntary and community organisations, and the results were published in 2005. The Steering Group concluded that 'the current aims and objectives of the Strategy are fundamentally sound' (MTR: para. 8.2), although not revealing how it had reached this conclusion. Moving down the strategic framework, it reported on a detailed examination of the actions contained in the AP appended to the NDS and a review of the KPIs. It recommended the addition of eight new actions, the replacement of nine of the existing actions and amendments to a further eight, and a complete revision of the NDS's key performance indicators.

Not specified in the NDS was a final evaluation. The process that was adopted towards the expiry of the NDS, in 2008, was similar to that used by the Review Group in 2000/1 and the Steering Group in 2004/5. A steering group, containing representatives from the key statutory, community and voluntary interests, was formed by the Minister of State with responsibility for the Drugs Strategy, Pat Carey TD, and had its first meeting on 10 January 2008. The Minister of State described the group's tasks as follows:

> Over the coming months, the group will be examining the progress and impact of the current Strategy, the degree to which it continues to be relevant and the operational effectiveness of the structures involved. They will also be looking at developments in regard to drug policies at EU and international levels. At the conclusion of the process, the Steering Group will submit recommendations to me on the shape and direction of the new Strategy. (Carey 2008)

At EU level, the EMCDDA has been active in leading the development of drug strategy evaluation tools. In reviewing member states' evaluations of their national drugs strategies (2004a), the EMCDDA distinguished between evaluations according to their timing and their depth. First, evaluations might be ex ante, interim or ex post: ex ante evaluations, before implementation, assess the need or establish a baseline; interim evaluations help to adjust interventions and objectives; and ex post evaluations focus on the entire intervention period, looking at the final results and the design of new interventions. Second, evaluations might function at the level of (1) monitoring, collecting data regarding the drug phenomenon and responses, (2) evaluating implementation, assessing the value added by the interventions, or (3) assessing impact, judging both the outcomes (short-term effects) and the impacts (long-term effects) of the interventions on the drug phenomenon. The EMCDDA's review of member states' use of strategic evaluation methods found that Ireland had undertaken evaluations at all three stages of the evaluation cycle, and that the evaluation had penetrated to the second level – evaluating progress, achievements, and failures. The EMCDDA found that no member state had proceeded as far as an evaluation of impacts but suggested that a structured approach to strategic planning, such as that taken in Ireland, was 'a prerequisite for a more developed evaluation approach' (p. 80).[7]

7 The EMCDDA based its evaluation framework on that devised by the European Commission for EU activities in general (2004a).

In a separate publication (2004b), the EMCDDA described the evaluation of the EU's strategy and action plan 2000–2004. It described three 'phases' in evaluating the impact of the strategy and action plan:

6. Estimate the extent and nature of plan implementation, based on a questionnaire completed by all member states.
7. Assess success in meeting strategic objectives, based on thematic papers drawn up by the EMCDDA, describing the main achievements in the priority fields of action under the plan.
8. Evaluate impact, based on 'snapshots' drawn up by the EMCDDA and Europol, describing the relevant aspects of the epidemiological situation together with the main responses in 1999 and in 2002–2003, with the aim of discerning trends between these dates.

On the basis of this three-phase evaluation, the European Commission (2004b) was in a position to comment in some detail on the impact of the actions in the EU drugs action plan 2000–2004 on the EU's strategic targets in the drugs domain. For example, while the evaluation did not report any evidence to indicate that the goal of reducing drug use prevalence had been achieved, the snapshot data suggested that there had been an overall levelling off in the upward trend in drug use. The discernment of trends was regarded by the EMCDDA as central to establishing a causal relationship between interventions and developments in the policy domain in a given time period.

3.4 Public opinion

MacCoun and Reuter (2001) pointed out that empirical evidence and scientific analysis are not the only sources of information with regard to the illicit drugs issue. Values, and moral arguments, influence the selection, measurement, interpretation and evaluation of research findings; philosophical positions, while not necessarily explicitly stated, help to shape the politics of drug policy formation. In short, 'opinion' is an important source of information helping to determine drug policy choices. The authors identified two types of opinion – 'elite' and 'public'. 'Elite' opinion is the arguments and views of prominent individuals and organisations, published in the media; 'public' opinion is revealed in opinion polls. Both sources of opinion were acknowledged by the NDS.

The role of the mass media in creating awareness and understanding of the issues around drug misuse was reviewed in the NDS. Those consulted on the drugs strategy expressed 'considerable concern' about the way the drugs issue was presented in the national media. It was felt that drug misusers were being stigmatised by some sections of the national press and that this was 'unhelpful to the goals of generating community support for the provision of treatment and rehabilitation services'. There were calls for the provision of 'accurate, unbiased information' for the media, and 'greater journalistic responsibility in the reporting of drugs issues' (NDS: para. 5.3.10). The Review Group expressed the view that mass media responses to the drugs issue should reinforce the key messages of drug awareness and education programmes: 'it is felt that the media can help foster a broader awareness, which, in particular, can help generate parental understanding of and

engagement with, their children about approaches to reducing the risk of drug involvement' (NDS: para. 6.3.9). The NDS action plan called for encouragement for 'the media to play a larger role in creating a greater understanding of drug misuse throughout society'.[8]

What little research or analysis has been done on the role of the media in relation to the drugs issue in Ireland in recent years has tended to bear out the views expressed in the public consultations and by the Review Group. Two research studies (O'Brien 1998; Murphy *et al*. 1998) on media coverage of ecstasy, undertaken after the Ministerial Task Force had completed its work in 1997 and before the NDS was released in 2001, indicated that the national news media's presentation of drugs and drug use tended to be from an 'abstentionist' viewpoint. In a review of how opioid misuse had been tackled in Dublin over the previous 20 years, Barry (2002) observed that reporting of drug issues in the national media had not mirrored the shift from an abstentionist to a harm-reduction perspective: 'The national television station, RTE, and the main newspaper of record, the Irish Times, have both assigned reporting of the drug issue to their crime correspondents rather than their health correspondents and the opportunity for leadership from the "quality" media has not been grasped' (pp. 6–7).[9] New comprehensive and systematic scientific research is required, to provide more up-to-date information on the role and impact of the Irish media in relation to the issue of illicit drugs, and to obtain a more nuanced understanding: the two research studies into media coverage of ecstasy in Ireland, mentioned above, indicated that the pattern of coverage and treatment of the issue was complex, depending on the drug being discussed, the type of media (broadsheet, tabloid etc.), the type of media coverage (factual reporting or opinion writing), and the resources available to cover the story.

An area of policy research not considered or addressed in the NDS was research into public opinions and attitudes with regard to illicit drugs and drug use. In 1999 the HRB had instigated a nationwide general population survey (containing 39 questions) of knowledge, attitudes and beliefs with regard to illicit drugs and drug use in Ireland (Bryan *et al*. 2000). The survey was repeated two years later, in 2001, but was discontinued thereafter.[10] In its place the all-Ireland drug prevalence survey, administered in 2002/2003 and again in 2006/2007,[11] included four questions – one with regard to

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9 In 2007 the Drug Policy Action Group posted on its website, under the heading 'Is the debate on drug policy beginning at last?', three editorials from *The Irish Times* (dated 24 November 2006, 13 December 2006, and 9 March 2007) on events, including drug-related killings and the publication of drug-related research, which questioned the acceptability of Ireland's emphasis on criminal justice measures in its response to the illicit drugs problem.

10 A brief report on the results of the second iteration of the knowledge, attitudes and beliefs general population survey was included in the 2001 National Report on the drug situation in Ireland (DMRD). Reports on subsequent smaller, regional or sectoral, surveys of knowledge, attitudes or beliefs regarding various aspects of the drugs issue are written up in subsequent national reports. These annual national reports are available online at www.emcdda.europa.eu/publications/national-reports

11 The survey is administered jointly by the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland. Full information on the survey is available on the website of the NACD www.nacd.ie

respondents' attitude towards drug addicts, two probing different aspects of respondents' opinions about drug policy and drug-related behaviours among other people, and one enquiring into their perceptions of the risks associated with use of different drugs (NACD *et al*. 2006; NACD and Ipsos MORI 2008). These four question types are drawn from the EMCDDA model questionnaire (2002).[12] To date, the only results published relate to cannabis and cocaine – respondents' opinions on policy with regard to cannabis use, and their views on cannabis use in general and the perceived risks associated with regular cannabis use (NACD and DAIRU 2005), and the perceived risks related to trying cocaine or crack once or twice (NACD and DAIRU 2006, 2008).

It has been argued that the independence and objectivity of opinion polls on the drugs issue are questionable because the questions in the survey instruments are generally 'constructed' by the policy-makers for their own purposes (Boekhout van Solinge 2002). However, cultural sociologist Jeffrey Alexander (2006) argued that opinion polls, along with the mass media and civil associations, are necessary 'communicative institutions' that help to maintain a fully functioning 'civil sphere', alongside a set of 'regulative institutions', including voting and party competition, political office, and the law. Alexander defined the civil sphere as 'a world of values and institutions that generates the capacity for social criticism and democratic integration at the same time', and public opinion as 'the sea inside of which the civil sphere swims. Public opinion is the middle ground between the generalities of high-flown discourse and the ongoing, concrete events of everyday life. It is filled with collective representations of ideal civility, but it is also defined by strong expressions of negativity' (pp. 4–5).

In a systematic study of opinion polling in Ireland since its inception in the early 1970s, moreover, Lyons (2008) argued that public opinion polls are unique in giving citizens a direct voice, but that they have their limitations. He argued that poll results can only have meaning through interpretation, based on proper evaluation, including examining the type and frequency of the survey instrument used, the questionnaire used, the sampling procedure, and comparison with previous or contemporary survey data. Having established the precision and accuracy of poll results by these means, he suggests, the substantive significance of participants' responses can then be fully appreciated.

3.5 Using evidence

In an overview of a conference held in Dublin in 2005 on evidence-based policy, the heads of the two host organisations observed, 'Neither the supply nor demand for research into policy design processes is adequate. This removes a key input from the policy debate …' (Gaffney and Harmon 2007: 7). They emphasised the need to join up the policy research and policy advice functions across the boundaries between the policy and the research communities. This task may be tackled either by devising mechanisms that bridge the divide or by working to lower the barriers on the supply and the demand side.

12 The one deviation from the EMCDDA model questionnaire is in relation to the question regarding policy on cannabis use: the Irish questionnaire distinguishes between cannabis for medical use and for recreational use.

At European level, Ireland, through the Department of Health and Children and the Health Research Board, participates in two bodies that seek to bridge the divide between research and policy in the illicit drugs field by facilitating the transfer of information and knowledge. First, the EMCDDA acts as the central source of comprehensive information on drugs and drug addiction in the EU. In its 2007–2009 work programme (2006), the EMCDDA identified as one of its three goals 'communicate more effectively with key audiences' and outlined how it has tailored its outputs to meet the needs of four specific audiences: for example, providing policy-makers with reports, briefing papers, risk assessments, information databases; scientists with scientific monographs, technical data sheets, statistical bulletins; practitioners with programme planning and development tools, portals on best practice; and European citizens with user-friendly online reporting tools as well as media campaigns. Second, at its 2003 Dublin Ministerial Conference, the Pompidou Group of the Council of Europe agreed to organise its work around six platforms – prevention, treatment, criminal justice, research, ethics and airports. The main function of these platforms is to support the exchange or transfer of new knowledge, information and opinions between policy-makers, professionals and other field workers and scientists, and to promote and develop common standards of good practice.

Within Ireland, since 2000, two mechanisms have been established to help bridge the gap with regard to the flow of information on drug-related issues from researchers to policy advisors; they are both under the auspices of the Department of Community, Rural and Gaeltacht Affairs, which has responsibility for co-ordinating the implementation of the NDS. The National Advisory Committee on Drugs (NACD) was established in 2000. Its goal is to advise the government in relation to prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland, based on its analysis of research findings and information available to it; to this end it may conduct, commission and analyse research on issues relating to drugs. Drawn from the statutory, community, voluntary and academic research sectors, together with senior level representation from the relevant government departments, the membership of the NACD reflects the range of different perspectives in the field of drug misuse.[13] Between 2001 and 2005 the NACD sought both to increase awareness and understanding of the drug policy issues and to build capacity to understand the role of research in informing policy at local level by piloting a community and voluntary sector research grant scheme. An evaluation of the scheme (Ennals 2007) found that it more than met its aims and the author recommended that an annual research grant scheme be set up in partnership with regional drugs task forces (RDTFs).

Set up in 2002 on foot of a recommendation in the report of the Interim Advisory Committee on Drugs (2000), the National Documentation Centre on Drug Use (NDC) has played an important role in disseminating information and fostering knowledge creation about illicit drugs and, more recently, alcohol. With a collection of up-to-date literature on drug use and addiction and a number of online bibliographic databases, the NDC provides the research and policy communities with ready access to electronic and hardcopy documentation on all aspects of drug use.[14]

13 For further information visit the NACD website www.nacd.ie

14 For further information visit the NDC website www.hrb.ie/ndc

Initiatives have also been take to address the supply and demand-side issues that impede efficient and effective transfer of research evidence. With regard to communication mechanisms, several recent studies have highlighted the importance of establishing a communication channel through which information can flow in an appropriate and timely manner. Direct and informal interaction and dialogue between researchers and policy-makers appear to have merits; where the channel is academic in character and where the level of direct interaction between policy maker and researcher is low, knowledge tends not to transfer so readily (Hall 2008; Kerr and Wood 2008; Ritter 2008; Wood *et al*. 2008; Hughes 2007). Lenton (2007) depicts an informal and unpredictable process whereby a lone 'policy entrepreneur' intervenes at opportune moments to proffer solutions to perceived policy problems. On the demand side, policy advisers need to understand how to make effective use of research in policy-making, for example through use of what has been termed a 'policy research cycle', which addresses key questions – how do you anticipate research needs, prioritise research, procure research, manage a research portfolio, ensure research is used, and assess whether research has had an impact and why (Grant 2007).

In recent years one approach has been proposed that eliminates, rather than bridges, the boundary between the research and the policy communities, and the study of drug use and the development of evidence-based drug policy have been identified as a potential site for applying this newly developing science – Integration and Implementation Sciences (IIS) (Bammer 2007). This science is based on three pillars: (1) systems thinking and complexity science, which lead people to look at the whole and its relationship to the parts of an issue; (2) participatory methods, which allow all stakeholders to make a contribution; and (3) knowledge management, exchange and implementation, which encourage recognition of different forms of knowledge and knowing, and foster better understanding of how action occurs, for example, how policy is made, and how it can be influenced by evidence. According to Bammer (2005), 'The vision for Integration and Implementation Sciences is to provide solid theoretical and methodological foundations to allow complex societal issues to be systematically addressed using evidence-based approaches.'

3.6 Making choices

The previous sections have shown considerable progress in strengthening the provision of information and research in Ireland to support drug policy development during the lifetime of the NDS. However, considerable challenges still remain, as evidenced by the conceptual and procedural issues still facing the research community, the gaps in scientifically-based understanding of the role and influence of public opinion on policy, and by the number of issues involved in the transfer of research-based evidence and information into the policy arena. In this final section discussion turns to one final question – the role of the decision-makers, the politicians, and whether and how they make use of research-based evidence and other information in choosing policy options.

With regard to 'policy reasoning', Irish drug policy researchers have suggested that there has long been reluctance on the part of Irish politicians to address, and make choices with regard to, the wider strategic questions. It has been argued that, ideologically, there has been a cross-party consensus both that 'drugs' are a social problem in and of themselves and that they exacerbate the crime problem in Ireland: they are an 'evil' and to be prohibited (Murphy 2002). It has also been argued that, sociologically, political leaders have not encouraged or participated in explicit public debate on the concept of harm reduction in relation to illicit drugs, in order to contain sensitive and potentially divisive national social issues (Butler and Mayock 2005). In a recent review of Ireland's system of government and administration (OECD 2008), the authors argued that informed policy debate and decision-making in Ireland was impeded by a lack of 'enhanced departmental performance information' (i.e. performance targets, performance measures, evaluation reports and benchmarking). Furthermore, the authors observed that the electoral and party systems, and the opportunities they provide for clientilist politics, 'can tend to focus the political debate on anecdotes and local issues. This creates a culture concentrating on attributing blame, which distracts from examining national government-wide issues, and finding evidence-based collective solutions and giving these solutions time to work' (p. 261). Although the authors were not discussing political debate on drug policy, their comments might apply to the drugs policy domain.

A comparison of the Seanad debates that kick-started the processes leading to the development of the NDS in 2000, and to the development of the strategy to succeed the NDS in 2007/2008,[15] reveals shifts in content and tenor between the two debates and it is tempting to suggest that these shifts were due, in part at least, to the enhanced use of evidence by the politicians. It is evident that, in the second debate, information and research evidence relating to the drugs issue were more generally cited.[16]

Speakers in the 2000 Seanad debate tended to eschew discussion of the goal of drug policy, and focused mainly on the nature of the problem and the solutions. The general view was that drugs were a 'scourge', an 'evil trade', and the goal was broadly to solve the problem 'or at least put a dent in it'. Just two contributors referred to a more specific policy goal of greater security for individuals. With regard to the nature of the problem – the 'scourge' or 'evil trade' – a number of speakers used anecdotal evidence, speaking of their own encounters with the drug world and seeing at first hand its tragic effects on individuals, families and communities. There was discussion of various substances,

15 The two debates in Seanad Éireann on the national drugs strategy were held, first, on 21 June 2000 (Vol. 163), and, second, over four days in 2007/8, including 17 October 2007 (Vol. 187), 19 December 2007, 30 January 2008 and 6 February 2008 (Vol. 188). The debates were retrieved on 3 October 2008 from www.oireachtas.ie

16 This comparison uses the stages of the policy process implied in the 'rationality project' (Stone 2002) – identifying the policy goal, the problem (i.e. the gap between the goal and the current situation), and the solution (intended to close the gap). Stone demonstrated how, at each stage of this rational process, there are multiple understandings of what appears to be a single concept, how these understandings are created, and how they are manipulated as part of a political strategy.

including alcohol, and debate as to whether different substances should be treated differently. One speaker referred to the danger of the drug problem spreading to the middle classes. The problem was attributed to a number of causes, ranging from social and economic deprivation, to the existence of a 'drug culture', to individual poor self-esteem, low educational achievement and the pressures experienced by young people. With regard to solutions, speakers generally endorsed the responses initiated by the Ministerial Task Force reports (1996, 1997). Eoin Ryan TD, Minister of State with responsibility for the Drugs Strategy, stated that the more he examined the problem, the more he was of the opinion that the long-term solution lay in tackling educational disadvantage. Thinking of the health risks associated with injecting drug use, one senator claimed that the only solution in the long-term was to legalise all drugs. In this way, the price and quality of substances consumed could be controlled, the suffering minimised and entry barriers to the drugs market raised.

Seven years later, the 2007/2008 Seanad deliberations on the drugs strategy indicated shifts in the policy reasoning. Discussion of the nature of the problem now included calls for alcohol to be addressed in conjunction with illicit drugs, and expressions of concern with regard to cocaine. A notable shift was the increased number of contributions regarding the goal or purpose of drug policy, and in particular the moral dimension. Speakers discussed the freedom of the individual vis-à-vis the safety of the wider society; concerns were raised about the social and cultural malaise of the country, the effect that increased prosperity had had on personal lifestyles, including drug and alcohol use, and the need for moral leadership; acknowledging the spread of drug use among the middle classes, several speakers raised the need for individuals to assume personal responsibility for the consequences of their own actions, including the perpetuation of the drug trade. One speaker called for a rational rather than a moral approach; rather than responding to a perceived crisis with slogans and short-term measures, there was a need for a rational approach and for credible measures to reduce the harm associated with drug misuse.

Recent thinking has extended to means of engaging not just policy researchers and policy advisers in face-to-face deliberations about policy options, but also decision-makers, i.e. politicians. Having reviewed the options for connecting research, policy and practice, the Pompidou Group (2004) identified as its preferred option a 'stakeholder partnership', a three-way collaboration between government, science and the market as a basis for the exchange of knowledge and development of drug policy. In Ireland a study of whole-of-government approaches to cross-cutting policy issues, Whelan *et al*. (2003) described how social partnership, collaboration across the main sectors of Irish society, performs such a function. They described how advisory groups such as the National Economic and Social Council (NESC) and the National Economic and Social Forum (NESF), with broad-based representation of all the social partners and reporting to the Department of the Taoiseach, play a critical role in supporting the development and implementation of key national policies.

The British–Irish Council (BIC)[17] provides one model of how such a 'stakeholder partnership', incorporating not only researchers and policy advisers but also policy decision-makers, might work in the drugs policy domain. Since 2002, the BIC's sectoral working group on the misuse of drugs has convened meetings of relevant government ministers, officials, professionals and academics to share information on topics including targeting the proceeds of drugs trafficking; drug awareness campaigns; emerging trends in drug misuse and treatment modalities; business support for anti-drug strategies; rehabilitation; drugs strategy development; and engaging with communities around drug use.

17 Established in 1999 on foot of the 1998 Good Friday Agreement, the British–Irish Council (BIC) is a forum where members have an opportunity to consult, co-operate and exchange views with a view to agreeing common policies or common actions in areas of mutual interest for the benefit of all. Members comprise the British and Irish governments, the devolved administrations of Northern Ireland, Scotland and Wales, and Jersey, Guernsey and the Isle of Man. Further information available at www.britishirishcouncil.org

4 Implementing strategy

4.1 Introduction

The illicit drug problem is regarded as a complex problem, requiring responses from a wide range of different organisations operating across a range of different sectors. To ensure effective implementation, co-ordination of efforts is a critical requirement. Co-ordination has been accorded a prominent status in international drug policy documents, including the UN Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (UN 2000: Objective 2) and the EU Action Plan on Drugs 2000–2004 (Council of the European Union 2000: Action 1.3.1). In Ireland, the need for co-ordination in developing and implementing illicit drug policy was acknowledged as early as the 1970s (Working Party on Drug Abuse 1971). In the NDS, while not being designated a pillar, co-ordination was accorded two operational objectives and three key performance indicators in the NDS.

'Co-ordination' falls somewhere on a continuum between 'co-operation' and 'integration'. On the one hand, co-operation may be regarded as organisations 'working together' on specific tasks or activities such as information sharing, while co-ordination refers to the 'alignment' of activities within separate organisations. Co-operation and co-ordination are not mutually exclusive: different organisations may both co-ordinate their activities and co-operate on specific tasks (EMCDDA 2003b). Integration is of a rather different order. The OECD report on the Irish public service (2008) called for an 'integrated service': it characterised 'integration' as mechanisms, systems and structures designed to facilitate the different elements and sectors that comprise the broad Irish public service 'to work cohesively together', to display a 'greater connectivity across the different sectors/ agencies'.

It is apparent from the repeated efforts to strengthen the procedures used by the co-ordination mechanisms, outlined in the following section, that they have not been able to address adequately the complexity involved in managing a 'cross-cutting issue' such as illicit drugs. This is due in part to the different governance frameworks within which different entities operate, which influence the ways in which they carry out their responsibilities in relation to implementing actions and developing policies; and it affects the degree of transparency and the level of accountability. In recent years the notion of policy integration – with its emphasis on shared decision-making and performance management – has entered the Irish public-sector discourse; it offers an alternative way of meeting the complex challenges that arise in implementing strategies such as the NDS and of ensuring greater transparency and accountability.

4.2 Co-ordination mechanisms

Co-ordinating mechanisms, put in place on foot of recommendations in the 1996/97 reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, have continued under the NDS. They include a series of committees or groups comprising representatives of the relevant public, voluntary and community sector organisations who meet to co-ordinate the development and implementation of illicit drug policy. These co-ordinating mechanisms are arranged hierarchically,

cascading down from national government to local community level, but with provision for ideas to flow up through the mechanisms as well. The need for continuous adjustments, as outlined in this section, suggests there are high transaction costs involved in participating in these co-ordination mechanisms. The possible causes of these high costs are explored in subsequent sections.

4.2.1 Cabinet Committee on Social Inclusion (CCSI)

The Ministerial Task Force (1996) called for the establishment of a Cabinet Drugs Committee, chaired by the Taoiseach and comprising the ministers for health, environment, justice and education, and the Minister of State to the Government (Pat Rabbitte TD, who chaired the Ministerial Task Force). It was to give 'political leadership in the fight against drugs'. In 1997, recognising the links between social exclusion, drugs and alienation, the Cabinet Drugs Committee was established as the Cabinet Committee on Social Inclusion and Drugs including Local Development (CCSI). It was to be chaired by the Taoiseach and comprise nine government ministers and link the work being done on local development, the national anti-poverty strategy and the national drugs strategy (Ahern, 1 October 1997; Flood, 2 December 1997). The NDS reported that the CCSI now comprised some 12 ministers and ministers of state, including the Minister of State with responsibility for the Drugs Strategy, that it met monthly and its responsibilities included, *inter alia*, reviewing trends in the area of problem drug use, progress in implementing the national drugs strategy and resolving political or organisational difficulties (NDS: para. 1.1.2).

4.2.2 Inter-Departmental Group on Drugs (IDG)

Not specifically called for by the Ministerial Task Force (1996/97), the IDG grew out of the National Drugs Strategy Team (NDST), which was established on foot of a Ministerial Task Force recommendation, and which was set up at two levels – policy and operational; the IDG evolved out of the policy component of the NDST. Comprising assistant secretaries from government departments represented on the Cabinet Drugs Committee, this policy component was tasked with addressing policy issues arising out of implementing the government's anti-drugs strategy and reporting to the Cabinet Drugs Committee. In 2001 the NDS explicitly referred to the IDG, as distinct from the NDST, and specified its composition and set out its terms of reference, including advising the CCSI on policy matters to do with illicit drugs, resolving operational issues or conflicts between different departments or agencies in respect of implementing the NDS, approving the plans and initiatives of the drugs task forces, and evaluating their implementation jointly with the NDST.[1] The NDS also identified a number of measures designed to bind individual government departments more firmly into the IDG:[2] to ensure a high level of representation and attendance, the Minister of State with responsibility for the Drugs Strategy was to chair the IDG, and those departments and agencies participating in the IDG were to commit themselves in writing to the process.

1 Actions 79 and 82

2 Actions 78–84

Three years later, the MTR reported that the measures to elicit stronger commitment had failed: government departments had not always been represented at a senior level and the IDG had tended to meet only in conjunction with the NDST, thereby compromising its role as policy adviser to the CCSI. To strengthen the IDG's decision-making role, the MTR recommended a series of reforms, including expanding membership, requiring representation at a senior level, and specifying the number and scope of meetings to be held (MTR: paras 7.12, 7.13; Action 7.23.3).

4.2.3 National Drugs Strategy Team (NDST)

On foot of a recommendation in the first report of the Ministerial Task Force (1996), the operational component of the NDST was to comprise experienced personnel from the relevant departments and their agencies, who would be seconded to work together to implement the drugs strategy. It was a networked form of organisation:

> Those seconded to the Team will be guaranteed direct access to their Ministers and to the heads of their Departments on all matters related to drugs. While accountability for individual programmes will remain with the relevant Ministers, the Strategy Team will be mandated by the Government to work together to implement the Government's strategy so that, while remaining officers of their parent Department, they will be instructed to take an overview of the requirements of the Government's strategy. (p. 44)

The NDST was the first interdepartmental committee tackling a cross-cutting issue, established under the Strategic Management Initiative (SMI), whose chair (Jimmy Duggan) was made accountable to the Cabinet (Lyons M, personal communication, December 2008). In 2001 the NDS spelt out the NDST's terms of reference, including ensuring effective co-ordination between government departments and state agencies and the community and voluntary sectors in the delivery of drugs task force plans and overseeing their implementation, and in liaising with and developing the organisational capacity and performance of drugs task forces.[3] The NDS also sought to ensure the sustainability of the NDST by requiring the IDG to regularly review representation on, and resourcing of, the NDST,[4] and by requiring departments and agencies both to inform the NDST of any initiatives which would affect task force areas and to include written acknowledgement of NDST and drugs task force membership in their business plans and work programmes.[5] The MTR called for the operational capacity of the NDST to be the subject of ongoing review and for its membership to be revisited to ensure that the views of the regional drugs task forces were represented (MTR: paras. 7.9–7.11).

3 Actions 85–87 and 89–91

4 Action 83

5 Action 88

4.2.4 National Drug Rehabilitation Implementation Committee (NDRIC)

In 2007, in developing the fifth pillar, Rehabilitation, the Working Group on Drugs Rehabilitation recommended the establishment of an additional co-ordinating mechanism – the National Drug Rehabilitation Implementation Committee (NDRIC). Comprising representatives of the relevant government departments, state agencies and voluntary and community sector organisations, the NDRIC was tasked with developing protocols and service level agreements (SLAs) to facilitate 'inter-agency working'. For reporting purposes, the NDRIC was to work alongside the NDST and report directly to the IDG (REHAB: Table 3.1).

4.2.5 Local and regional drugs task forces

Acknowledging previous efforts to co-ordinate the work of agencies providing drug-related services, the Ministerial Task Force (1996) stated that effective co-ordination needed to be locally-based, inter-agency, and have strong participation by the community and voluntary sectors.

> What are needed are effective mechanisms to show that the 'vicious circle' of drugs-related decline can be replaced with a 'virtuous circle' of stability, renewal and development. This means that established community leadership is respected and the various institutions of the State are shown to be responsive and effective. (p. 45)

The Ministerial Task Force recommended the establishment of a local drugs task force (LDTF) in each of 11 areas (10 in Dublin and one in Cork) identified as having the most acute drug problems in the country, and which were also designated as economically and socially disadvantaged (Sinclair 2006). It pointed out that the Partnership companies, established under the Operational Programme for Local Urban and Rural Development 1994–1999,[6] provided a structure for the government, social partners and voluntary/community sectors to work together in these areas, and the Local Employment Service (LES), which worked independently within the Partnership framework, was regarded as a model for how the LDTFs could work. The LDTFs were to comprise representatives of all relevant state agencies, the relevant local authority, the local youth service and voluntary drug agencies, together with community representatives; the chairs were to be nominated by the local partnerships in order to ensure a link with other local developments. The tasks of the LDTFs were to draw up a profile of all existing or planned services and resources available in the area to combat the drug problem, and to agree a development strategy to build on these. The strategy was to be complementary, and additional, to existing or planned services and to the local Partnership and LES programmes. Funding was to be allocated by central government, once the NDST had assessed the

6 The Operational Programme for Local Urban and Rural Development 1994–1999 was one of the programmes that made up the European Union-supported Community Support Framework for Ireland. It was designed to bring about social and economic development at a local level, to involve and enable local communities to be involved in that development in a formal way, and to achieve physical improvements to the environment.

plans. In the event, the Ministerial Task Force (1997) reported that 13 local drugs task forces had been established;[7] a fourteenth, Bray, was identified in 2000.

The NDS reported that the LDTFs had been a 'positive force' and an 'effective mechanism for tackling the drug problem' (NDS: para. 6.1.3); their principal strength was seen as allowing local community and voluntary groups to work hand in hand with the state agencies. Noting the call in the public consultation fora for further LDTFs across the country, but finding no conclusive evidence that other urban areas were experiencing a level of drug problem equivalent to that experienced in the existing LDTF areas, the Review Group that drafted the NDS preferred to call for the establishment of 10 regional drugs task forces (RDTFs), to provide coverage of the whole country. Like the LDTFs, the RDTFs were to monitor the nature and extent of drug misuse in their region, identify gaps in service provision, and develop a co-ordinated and integrated response to tackling the problem. They were also to provide information and regular reports to the NDST and develop regionally relevant policy proposals, in consultation with the NDST.[8]

The relationship between the government and the task forces has been dogged by tensions arising out of perceptions regarding the role and attitudes of government towards these locally based bodies (Butler 2008). In two reports published in 2005, the Steering Group that undertook the mid-term review of the NDS and the LDTF Chairs and Co-ordinators Network respectively highlighted the particular transaction costs being incurred by members of the LDTFs: voluntary and community sector LDTF members were reported to be suffering from burn-out or from a lack of understanding of their role; representatives of statutory agencies on LDTFs were reported to be isolated at a local level with insufficient support from their agencies, or to be exposed to criticism by representatives from the voluntary or community sectors, who attacked them for the failures of their employers. The Steering Group called for the strengthening of the representation of the voluntary and community sector on national-level co-ordinating bodies, and this call was repeated by the LDTF Chairs and Co-ordinators Network. At a systems level, the Steering Group also reported calls for the provision of multi-annual budgets for LDTFs. This call was repeated by the LDTF Chairs and Co-ordinators Network, which also called for LDTFs to have strategic plans, and for government departments and statutory agencies to provide specific dedicated action plans setting out their intentions locally, to help inform the planning process at local level and to ensure alignment between national and local initiatives. Finally, David Connolly, the chair of the LDTF Chairs and Co-ordinators Network, argued that the manner in which financial accountability was maintained was impeding the performance of the drugs task forces:

> Task Forces were not meant to be legal structures in the main. They were set up as structures in which people have committed themselves to lead a response to the local

7 The original designated 11 LDTF areas were Ballyfermot, Ballymun, Blanchardstown, Clondalkin, Dublin North Inner City, Dublin South Inner City, Dublin 12, Finglas-Cabra, Cork City, North East Dublin and Tallaght. The South Inner City was then split, to create the Canal Communities LDTF, and Dun Laoghaire/Rathdown was added (Lyons M, personal communication, December 2008).

8 Actions 92–94

> drug problems. Increasingly, there is a system of administration that has been imposed on those structures and has consequently been imposed on local projects. Some of which is the worst that I have seen in recent years. It is vital that this is not allowed to stunt the innovation and responsiveness of LDTF's; therefore a balance with good governance needs to be found. (LDTF Chairs and Co-ordinators Network 2005: pp. 5–6)

4.3 Political and administrative co-ordination

In 1997 the new Taoiseach, Bertie Ahern TD, expanded the remit of the Cabinet Drugs Committee to include social inclusion, and announced the appointment, for the first time, of a Minister of State with responsibility for drugs: 'Deputy Flood to be Minister of State at the Department of Tourism and Trade with special responsibility for local development — he will also be responsible for the National Drugs Strategy Team [sic]' (Ahern, 9 July 1997);[9] although not a member of the Cabinet, this Minister of State sat on the CCSI. In 2000 the Review Group that drafted the NDS considered the creation of a post of 'National Drugs Co-Ordinator', along the lines of the 'Drugs Czar' in the UK and USA, but concluded that the Minister of State was 'in a good position to promote a cross-sectoral approach' (NDS: para. 6.6.3).

Following the general election of 2002, and a reorganisation of government portfolios, the new Minister of State with responsibility for the Drugs Strategy, Noel Ahern TD, was assigned to the newly formed Department of Community, Rural and Gaeltacht Affairs (DCRGA), where a National Drugs Strategy Unit was located. He was also assigned responsibility for housing and urban renewal in the Department of Environment, Heritage and Local Government. This assignment of joint responsibility was in recognition of the perceived strong community dimension to the drugs issue and the need to address the drugs problem in conjunction with deprivation in communities. Following the election of a new government in May 2007, and calls from the community sector for a dedicated drugs minister, Pat Carey TD was appointed as the responsible Minister of State and his responsibilities were cut back to their 1997 scope, including the drugs strategy and community affairs, both located within the DCRGA. In May 2008 John Curran TD succeeded Minister Carey in the position.

The Minister of State is a member of the CCSI and chairs the IDG. These two functions are designed to ensure more effective communication between the IDG and the CCSI. The Minister of State also oversees the review of the national drugs strategy and the development of new strategies. In 2007 the Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Act mandated the Minister for Community, Rural and Gaeltacht Affairs to co-ordinate the implementation of the NDS, including 'services and facilities to counter drugs misuse in areas of the State where such misuse is significantly higher than in other areas of the State'.[10] With regard to other ministers and

9 Chris Flood TD filled the post from July 1997 to January 2000, and was succeeded by Eoin Ryan TD from February 2000 to June 2002. Under the 1996/97 Ministerial Task Force political and administrative co-ordination was to be provided by the Cabinet Drugs Committee and the NDST respectively.

10 The government as a whole retains responsibility for approving strategies to counter drug misuse in the state.

organisations with roles and responsibilities for implementing the NDS, the Act does not limit or in any way assume their powers, functions and responsibilities, but rather provides for appropriate consultation.

With regard to the assignment of lead responsibility for the co-ordination of the NDS to a government department, following the general election of 1997, the NDST was located in the newly-established Department of Tourism, Sport and Recreation. In 2000 the Review Group noted that this Department's drug-related roles included chairing and providing the secretariat to the IDG and the national assessment committee for the Young People's Facilities and Services Fund (YPFSF); it also had responsibility for the National Advisory Committee on Drugs (NACD). Having considered relocating the co-ordination role in a larger department, such as Taoiseach or Health, which would have had greater influence, the Review Group recommended its retention in the Department of Tourism, Sport and Recreation, first, because it would be 'objective' in relation to all the thematic areas covered by the national policy, and, second, because it had overall responsibility for local development and for co-ordination of a number of different programmes promoting social inclusion (NDS: para. 6.6.2).

Following the election of the new government in June 2002, the Department of Tourism, Sport and Recreation was restructured and all its drug-related responsibilities moved to a Drugs Strategy Unit in the newly-formed DCRGA. The AP tasked the DCRGA with co-ordinating the implementation of the NDS in partnership with government departments, state agencies and community and voluntary sectors, and with bringing issues which might have a detrimental effect on the implementation of policy to the attention of the CCSI.[11] The MTR further elaborated the role of the DCRGA: co-ordination involved advising and supporting the Minister of State, driving the implementation of the NDS, monitoring and reporting on the implementation of the various NDS actions and highlighting gaps and issues arising for the attention of the IDG and the CCSI (MTR: para. 7.14).

4.4 Government departments and state agencies

Responsibility for implementing the 100 actions appended to the NDS was clearly assigned to various government departments or state agencies, and sometimes jointly to two or more bodies. This arrangement ensured that government departments and state agencies clearly recognised not only their own responsibilities but also their accountability for particular actions in the action plan.

The NDS recommended that the operational objectives and KPIs be incorporated in the Statements of Strategy of government departments and agencies, and a critical implementation path, identifying dependencies, developed by departments and agencies for each action that came within their remit, by the end of 2001 (NDS: para. 6.7.2).[12] The NDS contained no budgetary commitments and the

11 Action 1

12 In compliance with this requirement, in 2004 a *Critical Implementation Path* (CIP) (Department of Community, Rural and Gaeltacht Affairs 2004a), setting out the timeframes and milestones for the completion of each of the 100 actions, was published.

introductory note to the CIP stated that the projections contained in the implementation path were dependent on the resources being available. In 2005 the MTR noted that government departments would have to seek funding through the annual Estimates process to implement the various recommendations, and that in many cases they would have to refocus existing resources, rather than receive additional resources (MTR: para. 8.8).

Budget allocations, as set out in the annual Estimates according to departmental Votes, clearly identify responsibilities and accountabilities for policy initiatives. They are regarded as useful in analysing the policy mix, for example, in the drugs domain, the ratio of supply reduction interventions to demand reduction interventions (EMCDDA 2008b; Pacula 2008; Moore 2008, 2005; Reuter 2004). Caution is required, however, in interpreting data on public expenditure as they may be drawn from budget documents, or they may represent estimations of non-budgeted expenditures; furthermore, the level of expenditure does not always result in a similar-sized effect.

In Ireland comprehensive, reliable data on drug-related public expenditure have been and continue to be difficult to obtain (EMCDDA 2008b, 2003a, 1998). The Review Group included an estimate of drug-related public expenditure for the year 2000 in its review of the state's response to the drug problem in Ireland (NDS: Section 3.7), but an official involved in compiling the figures subsequently noted that 'there was great difficulty in producing a consistent, well-founded estimate' (Reuter 2004: 26).

The MTR stated that a measure of public expenditure on the drugs issue was 'vital to gauge the cost effectiveness of the different elements of the Strategy' (MTR: para. 8.11). It proposed that expenditure directly attributable to drugs programmes (e.g. drug services provided by the health service, Garda drug units, drug-specific training of prison officers etc.) should be measured. Although this would not capture the overall resources devoted to addressing the direct and indirect costs of drug use, it would give an indication as to 'the overall budget priorities accorded to this issue' (para. 8.11). Starting in 2006 the government has published an annual estimate of the budgetary provisions for drug-related measures for the previous year. The DCRGA, which has been responsible for collating this expenditure data, advises that the figures are indicative only: they have not been derived from budget sources but from calculations of proportions of larger budgets spent on drug-related matters.

Table 4.1 summarises the data reported for drug-related public expenditure in Ireland in 2000, 2005 and 2006. It shows how budgetary information can represent the distribution of responsibilities. It also demonstrates why it is essential to enhance the accuracy and relevance of the budgetary data that are collected if the exercise is to add value. It is generally held that public expenditure on supply reduction activities exceeds that on demand reduction by a ratio of two to one (Moore 2008; Reuter 2004). The Irish data for 2000 reflect this ratio, but the data for 2005 and 2006 reflect the reverse. No explanation has been given for this reversal in expenditure proportions, but it is most likely due to changes in the way budgetary data have been collected and emphasises the need for data collection

to be complete, accurate and consistent over time: 'The budget is the financial mirror of government policy; if the budget excludes important expenditure, there can be no assurance that scarce resources are allocated to priority programmes and that proper control and public accountability are enforced' (EMCDDA 2008b: 31).

Table 4.1 Estimates of drug-related public expenditure in Ireland, 2000, 2005 and 2006

Department/Agency	2000 (€m)	2005 (€m)	2006 (€m)
Community, Rural and Gaeltacht Affairs, Dept of	0	34	43
Tourism, Sport and Recreation, Dept of	11.56	0	0
Education and Science, Dept of	7.49	3.78	12.14
Enterprise, Trade and Employment, Dept of	4.7	0	0
FÁS	0	14.5	18.6
Environment, Heritage and Local Government, Dept of	Not available	0.55	0.461
Health and Children, Dept of	32	2.74	0.978
Health Service Executive	0	82.05	85.053
Justice, Equality and Law Reform, Dept of	123.19	8.67	9.53
Garda Síochána	Not available	23.7	33.4
Irish Prison Service	Not available	5.0	5.0
Revenue Commissioners	1.9	9.24	6.525
State Laboratory	0.59	Not available	Not available
Total	**181.43**	**184.23**	**214.687**

Sources: **2000 estimate:** NDS, Section 3.7; **2005 estimate:** National Report 2007 prepared for the EMCDDA by ADRU, Section 11.1; **2006 estimate:** National Report 2007 prepared for the EMCDDA by ADRU, Section 1.4. The estimate for 2000 was originally estimated in punts, and has been converted to euro at the rate of Ir£1.00:€1.27.

4.5 Regional and local mechanisms

A recent study of the implementation of drug policy under the Australian federal system of government showed how its enactment depended on who had the power to bring such a policy into being and who had the power to prevent its coming into force (Ryder 2008). There is evidence to suggest that the distribution of power is an important factor in the Irish context as well. It is noted in Section 4.2.5 above that the drugs task forces were intended to act as conduits for cascading down national drug policy priorities, but that the NDST was also to report upwards on policy innovations at local and regional levels. A close reading of the RDTFs' first round of strategies and development plans, submitted to the NDST in 2005/6, reflects how this two-way flow worked and reveals that a number of new issues were emerging at regional and local level (Pike 2006b).

While the NDS focused entirely on illicit drugs, the majority of the RDTF strategies addressed both alcohol and drug misuse. The urban versus rural location of drug misusers presents a number of challenges with regard to policing drug markets and providing services to problematic drug users:

these types of issues were not addressed in the NDS but, hardly surprisingly, they were raised by a number of RDTFs. Various RDTF strategies highlighted other issues not mentioned in the NDS – misuse of licit drugs, drug use among older age groups, not just the young, and equality.

The role and responsibilities of local authorities with respect to the drugs issue was initially narrow but has been growing since 2001. The AP included three actions for local authorities to address within their remit of housing and environmental management – ensuring access to housing for recovering drug misusers, undertaking the collection and safe disposal of injecting equipment to ensure public safety, and the design of housing estates to mitigate the risk of drug-related activities in their vicinity.[13]

In 2000, county and city development boards (CDBs) had been established in every county and city area to integrate public and local service delivery. Local government and local development bodies, the social partners and state agencies were are all represented on these boards. The CDBs' task was to prepare and oversee the implementation of a 10-year strategy for integrated economic, social and cultural development in their local area. The AP called on the CDBs to specially consider the needs of those areas experiencing high levels of drug misuse when drawing up these city- and county-wide development strategies.[14] These strategies were completed by 2002. An evaluation (NDP/CSF Evaluation Unit 2003) of social inclusion mechanisms, established under the CDBs to co-ordinate the delivery of social inclusion measures at local level under the NDP 2000–2006, found that, while Social Inclusion Monitoring (SIM) groups had performed a valuable networking function, they had not contributed to greater co-ordination or integration in the delivery of social inclusion measures. Moreover, the authors believed they were unlikely to do so in the remaining lifetime of the NDP. The evaluation report recommended two radical revisions: (1) the social inclusion measures in the NDP should be streamlined, and (2) the CDB social inclusion co-ordination process should shift from co-ordinating organisations and delivery structures to focusing on outcomes for socially-excluded groups.

In early 2005 the Minister for the Environment, Heritage and Local Government required that each CDB carry out a review of its strategy, concentrating on its core co-ordination role and producing a clearly-defined implementation programme for 2006–2008, with a reduced number of actions. To support the process of reviewing CDB strategies, the Department engaged consultants to carry out an objective synthesis of the CDBs' 34 individual strategic reviews. This process coincided with the roll-out of the new social inclusion policy framework in 2005 (NESC), which proposed organising social inclusion policies not by target groups but according to the stages of the life cycle, i.e. children, people of working age, older people, and people with disabilities, thus assuring a more integrated approach. This life cycle approach was adopted in the new social partnership agreement (Department of the Taoiseach 2006), the new National Development Plan and the new national social inclusion plan (Government of Ireland 2007a, 2007b). In the new social partnership agreement (p. 76),

13 Actions 68–70

14 Action 71

a commitment was made to ensure the CDBs could operate effectively as a vehicle for supporting a more integrated approach to service delivery at local level, and to ensure that the SIM groups were fully supported by the CDBs and the relevant government departments and state agencies. The last two policy documents also referred to CDBs as the key co-ordinating body at local level.

Tasked with examining how to strengthen the role of CDBs in light of the commitment made in *Towards 2016*, the consultants (Indecon International Economic Consultants 2008) reported that the CDBs were perceived to be effective in the area of social inclusion policies and helped to bring key actors together and provided fora for communities. However, they took the view that the CDBs had limited influence on national policy and recommended establishing a National CDB Co-ordination Group to give impetus to the work of CDBs, to inform the Cabinet on key emerging issues, and to address any obstacles. They recommended that formal mechanisms be established to ensure that some weighting was given by national department/statutory agencies to the views of CDBs in relation to local measures. They called for political and administrative support for the role of the CDBs: 'Guidance by An Taoiseach and relevant Ministers to Departments, local authorities and statutory agencies on what is expected from CDBs and the required co-operation of their constituent organisations is needed' (p. 62).

4.6 Working in partnership

The NDS includes an overall strategic aim 'to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse' (NDS: Section 6.7). Although there are no operational objectives or key performance indicators (KPIs) associated with this aim, the AP assigns responsibilities to departments and agencies to support and develop the role of the community and voluntary sectors.[15]

On the supply reduction side, community policing had been endorsed by the Ministerial Task Force (1996). In the AP, the Department of Justice, Equality and Law Reform was tasked with establishing 'best practice guidelines and approaches for community involvement in supply control activities with the law enforcement agencies',[16] and individual agencies were given specific roles, including the Garda Síochána,[17] the Customs Service,[18] and the Irish Prison Service.[19] In Europe, a Pompidou

15 Not discussed here are initiatives undertaken in conjunction with families (especially parents) and the corporate sector. Five actions in the AP addressed the roles of parents and families, and the MTR introduced a new cross-pillar action to develop family support services. Although the public consultation on the national drugs strategy in 2000 had identified a role for the corporate sector in relation to the drugs issue, the Review Group did not pick up on these ideas in the AP. However, in 2002 *An agreed programme for government* (Fianna Fail, Progressive Democrats) made a commitment to support initiatives to expand corporate social responsibility; this was to apply in areas affected by social and rural disadvantage, including drugs.

16 Action 5

17 Actions 8, 11, 27 and 28

18 Action 15

19 Action 24

Group forum on open drug scenes, drug-related crime and public nuisance, held between 2004 and 2006, found that a number of member states, including Ireland, were moving away from reactions to breaches of controlled drugs legislation based on repression and strict law enforcement, to partnership approaches, involving collaboration between law enforcement, social and health services and other stakeholders, including local communities (Connolly 2006b).

In 2005, following extensive deliberation (National Crime Council 2003; Joint Committee on Justice, Equality, Defence and Women's Rights 2005), an alternative approach to community policing, involving co-operation between the Garda Síochána and local authorities, was introduced in the Garda Síochána Act. Joint policing committees (JPCs) were to be established in local authority areas to serve as a forum for consultations, discussions and recommendations on matters affecting the policing of the local authority's administrative area, and in particular to keep under review the levels and patterns of crime, disorder and anti-social behaviour in that area, including the patterns and levels of misuse of alcohol and drugs. 'Local policing fora' were to be established, as JPCs considered necessary, to discuss and make recommendations to the relevant JPC.

On the demand reduction side, the health service authorities were tasked with developing management plans with local communities with regard to the location and establishment of local treatment and rehabilitation facilities, and training peer-support groups.[20] User groups were to be enabled both to increase societal understanding of drug misusers and drug misuse issues and also to inform drug misusers about the services available for them.[21] The statutory agencies were to ensure that training was provided for voluntary and community workers in the drugs field.[22]

Having been recognised as a key player in addressing the illicit drugs issue in Ireland by the Ministerial Task Force (1996) and by the NDS, civil society itself – generally defined as that activity that takes place between the state and the market place – assumed roles with regard to the development and implementation of drug policy during the period 2001–2007. The adoption of these roles mirrored initiatives at UN and EU levels to engage civil society in the development and implementation of drug policy (Pike 2006a). At both international and national levels, debate surrounds the concepts of civil society, citizenship and social capital, and whether the related discourse reflects a neo-liberal response to the rolling back of the welfare state or a deepening of democratic activity. Having reviewed the empirical evidence available in Ireland, Geoghegan and Powell (2008) concluded:

> … while active citizenship in the community sector may have been largely co-opted as a tool of government, it has the potential to reflexively re-imagine itself as a democratic force where active citizens resist the alienating experience of 'thin' representative democracy through non-mediated use of the public sphere; to build counter-public

20 Actions 53 and 66

21 Action 96

22 Actions 72 and 90

> discourses that champion the needs of the poor and marginalised; and to challenge governments which they believe have lost touch with the democratic aspirations of the people (p. 48).

There is evidence to suggest that both interpretations of 'active citizenship' apply in the drugs policy domain. Acknowledging the quality of the input by members of civil society to the development and mid-term review of the NDS, both the Review Group and the Steering Group commented on the 'mature and deep level of understanding of the nature of the current drug problem and the burden it places on individuals, their families, communities and society' evident in the public consultation process (NDS: Section 5.1; MTR: para. 2.1). The Review Group also noted that this deep understanding ' … should not be confused with any broader acceptance of drug misuse. The consultation process was, by and large, free of moral or ethical discussions on the rights and wrongs of drug misuse or associated issues about freedom of choice.' The Review and Steering Groups also acknowledged the contribution of the civil society sector through the local and regional task force mechanisms.

On the other hand, several CSOs have made 'non-mediated use of the public sphere', through lobbying, undertaking independent research, convening conferences, or writing policy discussion papers. For example, during the life of the NDS, CityWide Drugs Crisis Campaign, a voluntary group which aims to promote and support a community development approach to the drugs problem, has organised a number of marches and rallies, conferences and seminars, and research projects calling for increased attention to and resources for various aspects of the drugs issue.[23] The Irish Penal Reform Trust (IPRT) and Merchants Quay Ireland (MQI), two voluntary organisations, combined to stimulate debate on aspects of drugs policy, including the need for needle exchange in Irish prisons (Lines *et al*. 2004), and the need to rethink the 'war on drugs' by means of a conference on the topic in August 2006, which was sponsored in conjunction with UISCE (Union for Improved Services, Communication and Education – a peer support and education group for people who use drugs). Finally, the Drug Policy Action Group (DPAG), founded in 2006 to promote 'an approach to drug policy that challenges ineffective, unfair and counterproductive laws on drugs and advocates for positive health and social service responses to drug use in Ireland', has published to date (November 2008) three policy discussion papers (Cassin and O'Mahony 2006; Cox and McVerry 2006; O'Mahony 2008a). CityWide and the Drug Policy Action Group are both members of the Civil Society Forum on Drug Policy in the EU established by the European Commission in 2007 (European Commission 2008; Pike 2008a; Randall 2008).

4.7 From cross-cutting issue to integrated system?

Ireland's drug policy involves a wide range of government departments, state agencies, community and voluntary sector organisations. A hierarchy of co-ordinating mechanisms is in place to ensure

23 See *Drugnet Ireland*, 5 (July 2002), 9 (November 2003), 17 (Spring 2006) and 22 (Summer 2007) for reports on CityWide campaigns, meetings and rallies.

these different entities meet to address the issues arising in implementing the NDS. However, governance arrangements serve to undermine the effectiveness of these mechanisms. While responsibility for actions is clearly assigned, budgetary lines for drug-related activities are not clearly defined, reducing the level of transparency. Without transparency, it is difficult to achieve full accountability. Responsibility for drug-related policy shifts and changes according to the level at which activities are being undertaken, be it national or sub-national level. The ethos and expectations of various bodies may differ significantly, resulting in very different and not always compatible approaches. Tensions and conflicts of interest between the statutory and voluntary/community sectors, and between entities within sectors, have been described above.

A review of the Irish public service, published in 2008 by the Organisation for Economic Co-operation and Development (OECD), found that the Irish public service had created structures and systems to enable 'horizontal co-ordination', but it had remained segmented vertically, resulting in 'sub-optimal coherence in policy development, implementation and service delivery' (p. 12). Moreover, with respect to co-ordinating mechanisms, such as those in place in the drug policy domain, the OECD commented that, with membership drawn largely from the assistant secretary-general level, which comprised a small number of officials, who were required to sit on a number of different interdepartmental committees, there could be 'co-ordination fatigue' (p. 240). The OECD report pointed out that thinking on co-ordination was moving away from what might be termed the mechanistic approach adopted in the Strategic Management Initiative (SMI) of the 1990s, based on structures and systems, towards a more organic, knowledge- and values-based approach. The OECD report argued that the first round of public service reforms, introduced under the SMI, focused on internal reforms and that the Irish public service now needed to focus on citizens and their expectations, and to target delivery of services towards the achievement of broader societal goals.

The OECD recommended that if Ireland was to realise its broad societal goals, it needed to develop 'an integrated public service system'. The review identified four main areas where reform was needed to achieve greater integration – ensuring capacity, motivating performance, developing a citizen-centred approach, and strengthening governance. While all four areas are critical to realising an integrated public service system, just two are explored here in relation to the integration of drug policy development and implementation – motivating performance, and strengthening governance.

4.7.1 Motivating performance

The OECD report (2008) called for performance information that focused not only on inputs and processes, but also on outputs and outcomes and what had actually been delivered, in order to better understand and measure how the public service is achieving its overarching outcomes and high-level societal goals.[24] Steps to achieve this type of information could include the alignment of goals, objectives and targets across departments and agencies, and making stronger links between

24 Performance information might include financial and non-financial performance targets and measures, evaluation reports, and benchmarking studies.

budget preparation and the overall policy goals and objectives.

The OECD report acknowledged the existence of whole-of-government output targets, contained in national development plans, agreed programmes for government, social partnership agreements or sectoral strategies, but reported that there was no mechanism to link deliverables outlined in departmental strategy statements to these national goals and priorities:

> Absent such a mechanism, the outputs and outcomes for which bodies are accountable become the sum of departmental targets rather than government-wide priorities. Although these would ideally add up to a coherent government strategy, this is not necessarily the case. Many departments have goals that are potentially conflicting … . As the Public Service is continuously subject to these trade-offs, a whole-of-government strategy could make its policy choices and priorities more transparent. (p. 157)

The NDS itself called for departments to incorporate the NDS objectives and key performance indicators in their statements of strategy (NDS: para. 6.7.1). In recent years there have been calls for greater integration of public sector activities around policy goals, for example in educational disadvantage or suicide prevention. The adoption of the lifecycle framework for formulating social inclusion policy may also be expected to lead to a closer alignment of various sectoral strategies including drugs (see Section 5.3 below).

The OECD report called for stronger links between the budget preparation process and performance information in order to strengthen the focus on policy results (see Sections 3.3.1 and 4.4 above for a discussion of these links). The combined use of a medium-term (two to three years) expenditure framework and performance information would make it easier to plan spending to achieve the desired goals. The report proposed that medium-term spending plans could be linked to departmental output statements, first introduced in the Irish public sector in 2007, so as to focus more clearly on results and 'to stimulate political debate directed at finding the balance among the various societal demands' (p. 161). In a recent study by the EMCDDA (2008) on the feasibility of reporting annually on drug-related public expenditure across all EU member states, it was reported that, in Ireland, such an approach was possible:

> Hopefully, budgeting and reporting on arrangements on drug-related matters in the public sector will become more transparent in the coming years as all government financial issues gain in transparency. In Ireland, for example, a Management Information Framework is to be introduced: one of its main roles will be to improve the management of resources once allocated, and to provide for increased transparency and accountability in the use of these resources. Annual output statements are to be published by government departments, and which will match key outputs and strategic impacts to financial and staffing resources. (pp. 13–14)

4.7.2 Strengthening governance

The OECD report (2008) defined public governance as 'the formal and informal arrangements that determine how public decisions are made and how public actions are carried out, from the perspective of maintaining a country's constitutional values as problems, actors and times change' (p. 236). It distinguished between governance structures that supported individual (and institutional) accountability and those that supported collective outcomes; public service reforms to date had concentrated on individual accountabilities for efficiency and effectiveness rather than on collective accountabilities, and as a result, there had been a risk of fragmented responses. With regard to co-ordination, such as that in place in the drugs policy sector, the report observed that while it might have facilitated more joined-up policy-making or decision-making for the civil service, it had not, 'in or of itself, facilitated a broader whole-of-government, integrated public service or citizen-oriented perspective' (p. 240).

As an alternative to co-ordinating mechanisms, the OECD report explored the concept of networking. It outlined the networking model adopted by the Office of the Minister for Children (OMC), established in 2005, where staff from different government departments (including Health, Education and Justice) had been brought together in one location (the Department of Health and Children), to work in a networked way on issues of strategic national importance with regard to children. The report observed:

> Policies that cut across the function responsibility of a number of departments can lead to difficulties in determining who is the overarching 'owner' accountable for the service provided. The work to date by the OMC has demonstrated that there is value in ensuring that units, such as the Irish Youth Justice Services, remain connected to their parent department (Department of Justice, Equality and Law Reform). This ensures that they have ongoing interaction with, and input to the development of policies targeted at children while also ensuring that accountability for the services they deliver remains within the remit of their Minister. This guarantees that historical mismatches between children's policy and youth justice policy can be addressed. (pp. 241–242)

The network structure and functioning of the OMC is akin to that proposed by the Ministerial Task Force (1996) for the NDST, as described in Section 4.2.3 above. While endorsing the OMC network model, the OECD report cautioned that it might not suit all situations. Other research bodies have proposed networking models that explicitly address the need to include local-level organisations in the network structure. For example, in its report (2006) on improving the delivery of quality services in the public sector, the National Economic and Social Forum (NESF) called for 'a more "collaborative" and "networked" form of governance', with central government (rather than individual government departments) setting the overall strategic priorities, with longer planning and funding horizons, and with, at the local level, greater flexibility and autonomy for service providers, including organisations in the community and voluntary sectors. Reporting on a review of responses to open drug scenes and drug-related crime in over 30 cities, including Dublin, sponsored by the Pompidou

Group, Connolly (2006b) reported that most countries had acknowledged that 'the complexity of the problem requires a multi-faceted response developed and implemented in partnership between relevant agencies and stakeholders'. His report concluded with a series of good-practice guidelines for 'partnership working', covering problem analysis and planning, structure and co-ordination, communications, trust and conflict, training and education, and recruitment and status of partnership.

As well as a networked organisational form, the OECD report recommended three infrastructural adjustments to support effective networking. First, strong strategic leadership by the centre of government is needed. The departments of the Taoiseach and of Finance need to lead in developing vision and direction rather than focusing on the more traditional control roles. Such leadership would ensure that policy is appropriately sequenced, paced and related to broad societal goals that arise out of the 'meta-strategies' such as programmes of government, social partnership agreements and other high-level strategy documents.

Second, line departments need to adjust their role: they need to lead policy development in their sector. Specifically, line departments need to convene clusters of stakeholders, including experts, resources and good practice, around a particular policy issue, and, rather than simply ensuring that information is shared among these stakeholders, they need to manage their clusters so that the various partners work in a complementary rather than a competitive fashion. They also need to move away from monitoring inputs and processes to monitoring performance. The report observed that line departments could make 'a very significant effort in their capacity to better analyse the linkages between costs (including personnel), and the actual outputs and outcomes of agencies' (p. 248)

Third, an accountability system and framework that promote and encourage integrated approaches need to be fostered. The report called for a 'performance-based accountability' (PBA) system, in which organisations are held accountable for performance measured in terms of outputs and outcomes, rather than inputs and processes. It also called for an accountability framework in which the roles and relationships of various actors are clearly defined. On the one hand, politicians and the Oireachtas should identify the issues and design strategies, set clear objectives, and focus political dialogue on desired results and realistic measurable targets, rather than on inputs and processes. On the other hand, the public service should provide information, advice, and mechanisms to facilitate decision-making and monitoring.

5 Managing change

5.1 Introduction

In preceding chapters the formulation of Ireland's drugs strategy in 2000/2001 is described and the processes and structures required to support its realisation over its lifetime are discussed. In this chapter three broad categories of change that have occurred during the lifetime of the NDS and which have led to the formation of new drug-related actions and strategies, both within the ambit of the NDS and in the wider illicit drug policy domain in Ireland, are described.

It is apparent that changes and adjustments made in response to new trends, evidence and information on the drug situation have tended to be made in line with the strategic framework as set out in the NDS. To use Mintzberg's (1994) terminology (see Chapter 1 above), they have become part of the 'deliberate' strategy that has unfolded as the 'intended' strategy has been implemented. However, other changes have resulted in new strategic approaches to the drugs issue being developed at a remove from the NDS, either in related policy sectors or by organisations operating without reference to, independent of, the NDS. These strategic initiatives have not always proved amenable to alignment with the original intentions of the NDS. Following Mintzberg, these strategies may be termed 'emergent', and they may affect the realisation of the NDS as originally intended. The key to effective strategy is to ensure that adequate controls are in place: as well as simple feedback loops for monitoring and controlling deliberate strategy, the control of emergent strategies requires other types of measures such as special feedback functions and new governance arrangements.

5.2 New trends, evidence and information

The mid-term review of the NDS (Department of Community, Rural and Gaeltacht Affairs 2005) contains examples of how data revealing emerging trends, research evidence and new information relevant to the illicit drugs issue led to changes being made to the actions within the NDS. For example:

- New research data showing an increase in cocaine use and a growing incidence of polydrug use led to a new action and an amendment to an existing action in order to increase the availability and range of treatment options (MTR: paras 5.12, 5.13; Action 5.25.1).
- New research findings with regard to the role of the family unit in preventing problem drug use led to a new action (MTR: paras 7.18–7.21; Action 7.23.5).
- Experience gained over the first four years of the NDS saw adjustments to the quality of services. For example, the MTR called for a shift from the use of a protocol for the treatment of under-18-year-olds, regarded now as 'overly restrictive', to the adoption of broad guidelines and models for treatment based on the four-tiered approach (MTR: para. 5.14; Action 5.25.3); acknowledging that stigma might attach to the children of drug users attending full-time childcare facilities,[1] the MTR called for a switch from the provision of crèches to the provision of drop-in play/crèche areas (MTR: para. 5.15).

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Over the lifetime of the NDS a number of procedures and mechanisms were put in place to handle and respond to this flow of new evidence and information. They included:

- project planning
- reporting
- mid-term review
- early warning system
- political oversight
- co-ordinating mechanisms

The Review Group that formulated the NDS recommended that the operational objectives and KPIs be incorporated in the Statements of Strategy of government departments and agencies, and a critical implementation path, identifying dependencies, be developed by government departments and agencies for each action that came within their remit, by the end of 2001 (NDS: para. 6.7.2). In 2004 a *Critical implementation path* (CIP) (Department of Community, Rural and Gaeltacht Affairs) was published. In his Foreword to the CIP, the Minister of State with responsibility for the Drugs Strategy, Noel Ahern TD, stated: 'Through the CIP, we can gain important insights into the strengths and obstacles within the Strategy and refocus our efforts, if necessary. … the Strategy must be flexible enough to tackle any new challenges facing it.'

The NDS called for the publication of an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the strategy.[2] Just one progress report (PR) on implementing the NDS was published (Department of Community, Rural and Gaeltacht Affairs 2004). The National Drugs Strategy Team was required to prepare an annual report for submission to its parent department, reporting on its work with drugs task forces and the allocation of monies to projects.[3]

In 2004/2005 a mid-term review of the NDS was conducted and a report (MTR) published (Department of Community, Rural and Gaeltacht Affairs 2005). The Steering Group that undertook the review concluded that 'the current aims and objectives of the Strategy are fundamentally sound' (MTR: para. 8.2). Moving down the strategic framework, it reported on a detailed examination of the actions contained in the AP appended to the NDS and a review of the KPIs. It concluded that progress had been made across all four pillars, although the rate of progress varied from action to action; it recommended the addition of eight new actions, the replacement of nine of the existing actions and amendments to a further eight. Finally, the Steering Group recommended a complete revision of the NDS's key performance indicators. According to the Steering Group, its recommendations would 'refocus priorities', 'accelerate the roll-out and implementation of

2 Research pillar KPI (NDS: para. 6.7.1) and Action 2

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various key actions' and 'serve to strengthen the overall shape of the Strategy and actively drive its implementation for the next three years' (MTR: para. 8.3).

Steps to develop an early warning system to provide information on emerging trends in drug use were undertaken. In May 2005 the Council of the European Union replaced the 1997 Joint Action concerning the information exchange, risk assessment and control of new synthetic drugs with a Council Decision. While broadening the scope beyond new synthetic drugs to include all new psychoactive substances that might pose public health and social threats, the Council Decision maintained the three-step approach established under the joint action: (1) an early-warning system to identify new drugs as they appeared on the European market, (2) a mechanism for assessing the risks of these drugs, and (3) a decision-making process (control measures) through which these products might be placed under control in the EU member states, including Ireland (EMCDDA 2007b).

On foot of the 1997 Joint Action, the Department of Health in Ireland had set up an *ad hoc* Early Warning Committee on New Synthetic Drugs. In 2001 this committee was placed on a formal basis within the National Advisory Committee on Drugs (NACD) and the remit of its Early Warning and Emerging Trends Sub-Committee was extended to include the monitoring of emerging trends. Subsequently, in response to an objective set in the *Agreed Programme for Government 2002–2007* (Fianna Fáil and the Progressive Democrats 2002), the NACD developed a model for a drug trend monitoring system (DTMS) (O'Gorman *et al*. 2007). Using data gathered through traditional indicators of drug use and drawn from drug research, and also new means such as a trends monitor network, focus groups, and a media monitoring system, this model was designed to identify new patterns of drug use, new drug-user groups, and regional patterns of drug use and drug markets. In 2007 the NACD issued an invitation for expressions of interest in tendering for establishing and managing a DTMS in Ireland. To date (November 2008), no further action has been taken.

To strengthen the role of the Oireachtas in scrutinising drug policy, the NDS called for the establishment of a dedicated drugs subcommittee of the existing Select Committee on Tourism, Sport and Recreation, which would meet at least three times a year.[4] However, this action was not implemented, 'partly due to the wide range of responsibilities of that Committee' (MTR: para. 7.22); instead, the Steering Group that undertook the mid-term review of the NDS recommended that 'the Minister of State meet with the full Committee to discuss the Strategy and its implementation twice a year' (MTR: 7.22). In addition, the remit of the Minister of State with responsibility for the Drugs Strategy was altered to try and enhance the Minister's responsiveness: in 2002, following a general election, the Minister of State, Noel Ahern TD, was given responsibility for housing and urban renewal, on the assumption that there was an overlap between housing issues and the needs of drug users; following the 2007 general election, this decision was reversed (see Section 4.3 above for a full account). In January 2005, the Minister of State with responsibility for the Drugs Strategy announced an Emerging Needs Fund (ENF) of €1 million per annum. Its purpose was to ensure that the Minister had funds available to respond in a timely manner to emerging trends in problem drug use.

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Co-ordinating mechanisms and their roles in reviewing trends and new information, reporting on the implementation of the NDS and advising on issues arising and how to respond to them are described in Section 4.2 above.

5.3 Wider policy context

Formulated in 2000/2001 as a follow-on to the national drugs strategy developed by the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996, 1997), which acknowledged the link between problem drug use and socio-economic deprivation, the NDS was explicitly set within the context of Ireland's wider social inclusion policy. Developments within this social inclusion policy context have consequences for sectoral strategies in the same broad area, including the drugs strategy. In this section the impact of developments in the social inclusion policy framework are considered, together with the implications of more recent sectoral strategies in the same policy environment. The relationship between illicit drug and alcohol policy has followed a separate and distinct course, described in the NDS as one based on 'complementarity'.

Unlike the systems and procedures put in place to respond to new trends and new information, there are no specific mechanisms put in place to address and respond to the types of policy shifts featured here. However, it is equally clear that politicians, officials, researchers, analysts, service providers and so on are engaged in ongoing deliberations and debate, that ideas evolve, and so new policy and strategy responses emerge. These changes are probably more evident in hindsight.

5.3.1 Social inclusion

The Review Group that drafted the NDS welcomed the situating of illicit drug policy within the context of social inclusion: 'The Group fully recognises that, notwithstanding the obvious benefits for communities affected by the drugs problem of having a specific drugs strategy, the best prospects for these communities, in the longer term, rest with a social inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country' (NDS: para. 6.1.9). Since its adoption in Ireland as a policy framework, following commitments made by the Irish government at the UN World Summit on Social Development in Copenhagen in 1995, the concept of social inclusion has been operationalised in a series national policy documents including national anti-poverty strategies (1997, 2002) and national development plans (NDPs) (Government of Ireland 2000, 2007a). At difference times different aspects of the concept have been emphasised, or different interpretations have been brought to the fore, and this has influenced policy responses in areas such as illicit drug policy. Two examples are given here – 'social capital' and the 'life cycle approach' to social inclusion.

Mentioned in the NDP 2000–2006, the concept of 'social capital' in connection with socio-economic deprivation was taken up by the newly-elected Fianna Fáil–Progressive Democrat coalition government in 2002. In its agreed programme for government, the government included actions to

develop thinking on social inclusion and the role of social capital. A subsequent study of the policy implications of social capital (NESF 2003) defined it as informal social support networks, friendships, neighbourhood generosity, interpersonal trust and voluntary activity. These processes, in turn, were identified as crucial to the functioning of a democratic, inclusive and cohesive society built on social well-being, equality and sustainable competitiveness. It was asserted that the generation of social capital would benefit young people in particular, through reducing the rates of suicide, dropping-out, drug misuse and anti-social behaviour. Sport and art were identified as important sources of social capital. The Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2004) took up this issue, investigating in depth and reporting very positively on the effectiveness of investment in sport and the arts as a deterrent against youth substance abuse. A number of studies exploring how involvement in sport and the arts was associated with increased social and economic well-being were undertaken (Lunn and Kelly 2008; Lunn 2007; NESF 2007).

It is beyond the scope of this overview to explore how this policy debate has influenced policy decisions in the illicit drugs area. However, it is noteworthy perhaps that on 7 October 2008, in a reply to a Parliamentary Question, John Curran TD, Minister of State with responsibility for the Drugs Strategy, emphasised that the provision of sport and recreational facilities was to be viewed as just part of a wider social inclusion policy approach: 'While the provision of sport and recreational facilities may have a role to play, they will not, in themselves, provide the solution to the misuse of illicit substances. Ultimately, I believe that it is only through addressing the risk factors through both the National Drugs Strategy — and the broader social inclusion agenda — that we can ultimately reduce the prevalence of problem drug use in our society.'

Within the context of Ireland's National Reform Programme (Department of the Taoiseach 2005), the National Economic and Social Council (NESC) rolled out a revised social inclusion policy framework in 2005. It proposed two innovations in the way in which social inclusion interventions were to be delivered: (1) interventions should be organised according to a life cycle framework, comprising four categories – children, people of working age, older people, and people with disabilities, and (2) greater recognition and weight should be given to the role of services in providing protection against risks and to activist measures, or innovative social policy initiatives, in meeting unmet needs and pre-empting problems, as opposed to focusing entirely on income transfers. While not altering the direction of drug policy, the new framework changed the way in which the drugs issue was to be approached. In the subsequent social partnership agreement (Department of the Taoiseach 2006), NDP (Government of Ireland 2007a) and anti-poverty strategy (Government of Ireland 2007b), the drugs issue was addressed under the categories Children (0–17 years) and Young Adults (18–29 years). The national anti-poverty strategy included an extra category, Communities, for innovative measures in areas such as arts, sport, and active citizenship, which are expected to have an impact on the illicit drugs issue. The policy research implications of the adoption of the life cycle framework are described in Section 3.2.1 above.

5.3.2 Towards a shared vision

In recent years several sectoral strategies within the wider social inclusion policy framework have indicated a need for a more integrated approach to social inclusion policy. In 2005 the Educational Disadvantage Committee[5] submitted its final report. It went beyond the Department of Education and Science's *DEIS* (*Delivering equal opportunity in schools): an action plan for educational inclusion* (2005), which focused on equality of opportunity in schools, to propose 'an integrated national strategy for achieving educational equality, that will result in an inclusive, diverse and dynamic learning society without barriers' (p. 26). Acknowledging two dimensions of equality – not just equality of opportunity but also of condition (Crowley 2006) – the Committee proposed three strategic goals, the first of which was to 'achieve educational equality in the broader context of achieving social inclusion'. Possible objectives under this goal included an integrated approach to addressing poverty and other issues that contribute to educational disadvantage, such as employment and income resources, drug and alcohol abuse, violence, and inadequate and sub-standard housing; another possible objective suggested under this goal was 'joined up' social inclusion policies, strategies, service provision and practices between government departments and public authorities.

Published in 2006, the suicide prevention strategy *Reach out* (Health Service Executive *et al*.) set out a vision, a new element in sectoral strategies, which envisioned a society in which the mental health and well-being of the whole population would be valued, and in which the needs of those with mental health problems or with alcohol or other drug abuse problems were met in a caring way. This vision was accompanied by a set of guiding principles, including 'shared responsibility', whereby 'no single organisation, group or sector can be solely responsible for suicide prevention'.

It is too early to see how these calls for integrated strategic approaches to social inclusion policy issues have been responded to. However, they do mirror the recommendations made in the OECD report (2008) on the reform of the Irish public service, which are discussed in Section 4.7 above.

5.3.3 'Complementarity'

Alcohol has occupied a special place in relation to illicit drugs policy. Public submissions to the 2000 Review Group on the drugs strategy revealed a 'strong sense that alcohol and drug misuse were related in Irish society. The view was expressed that there needs to be greater awareness, particularly amongst parents and young people of the association between these types of abuse' (NDS: para. 5.3.8). Furthermore, there were repeated calls 'to expand the current response to include all illicit drugs, as well as alcohol and prescribed medication' (NDS: para. 5.4.2). Notwithstanding these views, and the acknowledgement by the Ministerial Task Force (1996) that long-term prevention of drug misuse needed to address alcohol misuse as well, the NDS maintained the separation of illicit drugs policy from alcohol policy, preferring the principle of 'complementarity'. During the current

5 The Educational Disadvantage Committee was established in 2002, under Section 32 of the Education Act 1998, to advise the Minister for Education on 'policies and strategies to be adopted to identify and correct educational disadvantage'. The abolition of the Educational Disadvantage Committee was announced in the *Summary of 2009 Budget Measures – Policy Changes*, Annex D, published on 14 October 2008. Retrieved on 1 November 2008 at www.budget.gov.ie

millennium, the need for greater organisational support and resources for alcohol policy has seen calls for closer links between the alcohol and illicit drug policy domains (Strategic Task Force on Alcohol 2002, 2004).

From a cultural and political perspective, the path to policy convergence has been tortuous (Muscat *et al*. 2005; Butler 1991, 2002a). However, with a growing body of research, information and understanding at both European and Irish levels about the commonalities and the differences (EMCDDA 2006b), Irish policy-makers have become increasingly confident about building closer links between drug and alcohol policies. Completed in the course of 2005, the majority of the first round of RDTF strategies and action plans include alcohol along with drugs (Pike 2006). In July 2006 the Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (comprising members of the upper and lower houses of the national Parliament) published a report, reviewing whether and how the national alcohol and illicit drugs policies should be combined. While calling for alcohol to be added to the agenda of the NDS, the Joint Committee refrained from recommending a combined, or joint, strategy. Instead, it recommended 'that alcohol should be included in a new national substance misuse strategy. This will have the effect of cementing alcohol policy at the Governmental level, satisfying growing public demand for an integrated policy response to alcohol-related problems.'

In March 2005 the Steering Group that conducted the mid-term review of the NDS (Department of Community, Rural and Gaeltacht Affairs 2005) viewed favourably the recommendations made in the two reports of the Strategic Task Force on Alcohol with regard to the links between alcohol and illicit drugs (MTR: para. 7.17). However, it cautioned that they should only be developed if the capacity were available and the funding for drug-related projects was not diluted as a result. The Steering Group took the view that the formation of closer synergies between the two policies at a strategic level had been hindered by the lack of equivalent managerial structures in the alcohol policy sector. It recommended that a working group involving key stakeholders in the alcohol and the drugs fields be established to explore the opportunities for 'better co-ordination' and 'closer synergies' between drugs and alcohol policies, including the question of a combined strategy. This working group was convened in late 2006 under the auspices of the Department of Health and Children and at the time of going to print (November 2008) had not reported.

5.4 Independent initiatives

Several policies on drug-related issues have been adopted by the Irish government over and above the range of issues and topics addressed in the NDS. It is not clear whether or how the following initiatives have been aligned with the stated overall strategic objective and goals articulated in the NDS. It is also not evident whether or how the relationship between these types of policy initiatives and the NDS strategic framework or action plan was considered. And yet these issues have the potential to affect the realisation of the objective and goals set out in the NDS.

5.4.1 International policy

The only reference to international-level responses in the NDS was in connection with reducing drug supply in Ireland: the Review Group found that 'international co-operation in measures to reduce supply is important', given the increased mobility of, and the international context in which, drug traffickers operate, and because it reflected a society's interest in curtailing drug misuse both nationally and internationally (NDS: paras. 6.2.2, 6.2.3). Under the Supply Reduction pillar the NDS included a KPI, 'to co-operate and collaborate fully, at every level, with law enforcement and intelligence agencies in Europe and internationally, in reducing the amount of drugs coming into Ireland'; and actions in the AP called on the Garda Síochána and the Customs Service to co-operate fully with law enforcement and intelligence agencies in Europe and internationally in reducing the amount of drugs coming into Ireland.[6] Otherwise, the NDS was silent with regard to international-level responses to the issue of illicit drugs.

To date, the 1991 *Government strategy to prevent drug misuse* has been the only national policy document to consider the co-ordination of the Irish response to illicit drug policy issues at the international level. It proposed the establishment of a sub-committee of the National Co-ordinating Committee on Drug Abuse to prepare and co-ordinate international meetings and conferences, and to deal with the co-ordination between government departments on the international aspects of the fight against drugs (National Co-ordinating Committee on Drug Abuse 1991: 24–25). This role was not considered by either the 1996/97 Ministerial Task Force or the NDS.

A quick scan of selected government departments highlights the complexity of international linkages with respect to illicit drug policy. For example:

- The Department of Community, Rural and Gaeltacht Affairs supports the Minister of State with responsibility for the Drugs Strategy on the British–Irish Council (BIC), where Ireland has lead responsibility for advancing work in relation to the problems associated with the misuse of drugs. Information on topics ranging across both supply and demand reduction has been shared at the meetings of ministers and of officials from the nine jurisdictions that participate in the BIC.
- The Department of Foreign Affairs provides policy advice to the government on international aspects of the trade in illicit drugs and is responsible for co-operation with international bodies, including the United Nations and the Organization for Security and Co-Operation in Europe, in relation to illicit narcotics. It is also responsible for the Irish input into the EU's policies on international co-operation in combating the manufacture, transport and sale of narcotic drugs.
- The Department of Health and Children provides policy advice on health-related aspects of social inclusion, including drug abuse,[7] and in relation to the licensing, supply and usage of

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7 Other health-related aspects of social inclusion include health inequalities, homeless adults, the national anti-poverty strategy, Travellers, prisoners, asylum seekers, voluntary activity, equality and diversity issues, HIV/AIDS, and sexually-transmitted infections.

medicines. It is responsible for co-operation with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Pompidou Group of the Council of Europe.

- The Department of Justice, Equality and Law Reform provides policy advice on a wide range of topics, all of which have an impact on the illicit drugs issue – criminal law and justice, policing, courts, prisons, and youth justice. The Department or state agencies under its aegis co-operate with a range of international policy and operational bodies, which consider, among other matters, illicit drugs, for example EUROJUST, EUROPOL, the European Union Crime Prevention Network, and the Council of Europe's European Committee on Crime Problems. The Department also supports the Minister in implementing the Intergovernmental Agreement on Co-operation on Criminal Justice Matters within the framework of the British–Irish Intergovernmental Conference.

These and other government departments or state agencies attend, either jointly or singly, meetings of, or provide information to, the UN drug policy-making and implementing bodies, including the UN Office of Drugs and Crime, the Commission on Narcotic Drugs and the International Narcotics Control Board. They may also attend, or support preparations for, meetings of the Horizontal Drugs Group of the European Council.

A study of drug policy-making at EU level shows how the allocation of responsibilities at international level can have a significant influence on the shape of policy, and suggests how co-ordination of efforts at this level, as called for in the 1991 strategy, could have an effect. Elvins (2003) described how law enforcement agencies in EU member states, including Ireland, had led in developing EU-level illicit drug policy, and how, as a result, drug policy developed on the basis of notions of 'protection' – from the impact of illicit drugs on public health, from the crime associated with drug users, and from the violence and corruption linked to drug traffickers. Solutions were proposed by networks of 'epistemic communities', i.e. knowledge-based experts, and generally adopted by the EU institutions. As a consequence, anti-drugs trafficking policies had converged across all member states, while harm-reduction strategies had been left to the discretion of individual states. The result is a much more heterogeneous range of harm-reduction policies in different countries, as opposed to the increased similarity of anti-drugs trafficking policies.

5.4.2 Prison-based drug policies

With regard to provision of treatment and rehabilitation services in prisons, the 2000 Review Group noted that, 'mainly due to capacity constraints', prisons did not provide the range of treatment options available in the wider community (NDS: para. 6.4.4). To address this short-coming the Review Group called for prison-based treatment and rehabilitation programmes to be expanded to meet the demand, and for the implementation of the recommendations of the Steering Group on Prison-Based Drug Treatment Services (Irish Prison Service 2000).[8] The Steering Group's report had established

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policies underpinning the provision of treatment and rehabilitation services, including:

- providing continuity of care between the community and prison, and on return to the community;
- ensuring equivalence of care in the community and in prison;
- tackling viral diseases in prison, both preventing their occurrence and using the opportunity to introduce prisoners to hepatitis C and HIV treatment, 'as they [prisoners] are often more stable in prison than they have been in the community'; and
- integrating or developing rehabilitation programmes for drug misusers who are stabilising their drug problem or who are abstinent.

In 2006 the Irish Prison Service released its strategy for keeping drugs out of prison. It had two aims: to eliminate the supply of drugs into prisons, and to provide prisoners with a range of opportunities to encourage them to adopt a drug-free lifestyle. As well as focusing on supply reduction measures, the strategy recognised that a range of evidence-based treatment options was necessary, including assessment and through-care planning; information, education and awareness programmes; opiate replacement therapies; methadone detoxification and reduction programmes; symptomatic treatment options; mental health care; voluntary drug testing units; and motivational interventions. The strategy did not consider harm-reduction measures for those drug users who continued to use drugs, for example measures to ensure safe injecting.

Over the lifetime of the NDS there was continuing debate about the stated policy to render prisons 'drug-free' versus the need to provide harm-reduction services to reduce the spread of blood-borne viruses in prisons through injecting drug use. Two Irish NGOs, the Irish Penal Reform Trust and Merchants Quay Ireland, were active in promoting harm-reduction measures in prisons. They published a report highlighting the level of blood-borne diseases among the Irish prison population and the absence of measures such as the provision of condoms, bleach and syringes (Lines 2002), and promoted a study of needle exchanges in prisons in six countries, showing their efficacy (Lines *et al*. 2004). The Steering Group that conducted the mid-term review of the NDS commented that the greater vulnerability of prisoners to infectious diseases because of the higher prevalence of infection in the prison population merited giving further consideration to 'the many harm reduction approaches available for implementation in Irish prisons' (MTR: para. 5.9). However, the MTR did not identify any KPIs or actions relating to harm-reduction services in prisons.

In a review of Ireland's prison drugs policy, O'Mahony (2008a) called for 'a more rational, effective and rehabilitative prison system', which would place more emphasis on the reduction of harm caused to prisoners by the current drugs culture in prisons, rather than concentrating efforts on reducing the supply of drugs. He also called for more stress on abstinence-based treatments than on methadone substitutions, the improvement of prison conditions and the provision of an environment conducive to the general rehabilitation of offenders. In a separate review of how the recommendations made in

the first report of the Ministerial Task Force (1996) influenced ongoing drug policy over the following decade, Butler (2008) commented with regard to the resistance of the Minister for Justice, Equality and Law Reform, Michael McDowell TD, to the introduction of harm-reduction strategies in the prison system in the course of 2004:

> From a strategic management perspective, what is striking about Minister McDowell's proposal to create drug-free prisons … is not so much the moral absolutism upon which it is based or the fact that the proposal seems impracticable, but that it represents an old-fashioned 'departmental' policy initiative, a solo run taken outside of and without reference to the cross-cutting structures now in place. (p. 138)

5.4.3 Legislative instruments

The action plan appended to the NDS included just two actions with regard to legislation, calling on the Department of Justice, Equality and Law Reform to review the 'ongoing effectiveness' of criminal legislation in tackling drug-related activity, and on the Department of the Environment and Local Government to evaluate the impact of enforcement activity under the Housing Acts (evictions, excluding orders) on homelessness.[9]

Despite the lack of reference to legal instruments in the NDS, some 20 pieces of legislation with implications for drug-related policy were passed during the first seven years of the NDS (see Appendix 2). They covered drug control; drug trafficking and dealing; law enforcement; curbing public nuisance, including drug-related activities; intoxication; and drug testing. The extent to which these legislative measures were developed with, or had, regard to the strategic objective or goals of the NDS is not clear; some new legislative provisions raised issues never mentioned in the NDS or in any of its associated policy documents, for example drug testing.

Drug testing was never discussed in the NDS or in the MTR and yet, during the lifetime of the NDS, it was introduced in a variety of contexts and for various reasons. In February 2002 a compulsory substance testing programme was introduced as part of a Defence Forces Substance Abuse Programme. Reporting to Dáil Éireann after the first year of operation, the Minister for Defence, Michael Smith TD, stated that 'the primary objective of compulsory random drugs testing [in the defence forces] is deterrence'. In 2005 drug testing was provided for in the Maritime Safety Act, the Safety, Health and Welfare at Work Act, and the Railway Safety Act – in each case the intention was to reduce the risk of harm both to others and to the individual using the substance. The Prisons Act 2007 made provision for drug testing in Irish prisons in the interests of making them drug free.

9 Actions 6 and 25

The debate on whether and how to introduce drug testing in Irish schools continues. In its guidelines for developing a school substance use policy, published in 2002, in line with Action 43 of the NDS, the Department of Education and Science did not refer to testing in schools; the guidelines tended to favour a pastoral rather than a disciplinary response to drug misuse. In the same year the Seanad (Senate) debated the introduction of mandatory drug testing in schools: issues raised included the need for drug education in schools as a first preventive step; the need for resources and professional personnel to be provided for students who tested positive; the need to cater for the period after the process of counselling and support had been completed, if there was further drug-taking by the student; and, finally, the question of whether the state was 'impinging on freedom and personal rights by going down that road' (Burke 2002). In a subsequent survey of drug testing in schools in European countries, Ireland was one of four countries that responded that 'testing takes place sporadically' (Nilson 2004). It was further reported that, in Ireland, regulations for testing are decided by the schools themselves in consultation with the parents. While stopping short of calling for mandatory drug testing, Fine Gael (2007) recently pledged: 'We will ensure that, where teachers and parents decide to introduce random drug and alcohol testing at secondary schools, the Department of Education and Science will cover the costs of such testing' (p. 23).

In 2008 the Pompidou Group Expert Committee on Ethics reported the results of its work since 2003 on the ethics of drug testing in schools and in the workplace. It concluded that drug testing was acceptable only if carried out by health professionals bound by confidentiality requirements and wishing to refine their diagnosis, or if performed in response to a request from a law enforcement or judicial body, in accordance with strict legislative provisions. The Committee went on to comment:

> All other testing procedures in schools or the workplace pose an ethical problem founded on international, universal and absolute rights. It would be appropriate to take steps to prohibit such procedures, and to seek to achieve the same ends by means that show greater respect for privacy, family life and the fundamental rights of every individual and are more appropriate for such purposes, in particular for preventing young people from developing drug addiction and adults in high-risk jobs from causing accidents.

5.5 Controlling change

Unlike Foucault's pendulum, which moves in its own plane and independently of the earth's movement, a strategic plan cannot be separated from its environment. The purpose of a strategic plan is to provide a stable framework for action within the wider, dynamic and often unstable and uncertain environment; if a strategy is to continue to be effective, when a change occurs in the wider environment, that change needs to be assessed and reflected, if necessary, in appropriate changes to the strategy.

The preceding sections in this chapter have given a flavour of how changes occurring in the wider environment have been responded to. Certain changes in the operating environment of the NDS, for example new trends in drug use patterns, new research evidence or new information on the efficacy

of existing strategic actions, have been amenable to control through the adjustment of actions in the AP. These may be termed 'deliberate' strategies, in line with the 'intended' strategy as set out in the NDS. Other changes in the wider public policy environment, for example new thinking on how to approach social inclusion policy or how to combine approaches in different policy domains more effectively, have had a more oblique connection to the NDS. These may be termed 'emergent' strategies, as may changes falling in the third and final category. This last category includes policy changes introduced without reference to the NDS and where it is not clear whether or how the intention behind these initiatives has been compared with, or assessed against, the intentions behind the NDS. This last category of 'emergent' strategies has the potential to undermine the realisation of the objective set out in the NDS.

Mintzberg (1994) viewed all these categories of changes and the consequent adjustments, collectively referred to as 'strategy formation', as occurring within 'a mysterious black box … difficult to get inside and understand formally' (p. 82). What goes on inside this black box will, according to Mintzberg, never be formalised, articulated or rationalised: strategy formation is a continuous process based on informal, complex and dynamic (messy) managerial processes, using soft information and intuition. Actors and stakeholders in a strategy may all participate in this strategy formation process, for example, in the case of the NDS, politicians, officials, researchers, analysts, experts, service providers, service users, and the individuals and communities affected by the operations of the illicit drugs market.

In discussing how to work around this 'black box', how to support the strategy formation process, Mintzberg identified four ways of seeking to maintain control of both intended and emergent strategies. These four approaches are noted here in order to demonstrate the underlying principle that effective control requires not just mechanisms to control the realisation of intended strategy, but also functional and governance arrangements designed to ensure that emergent strategy is taken into account.

Planning – The process of formulating a strategy provides an opportunity to ensure a control framework is in place. The planning and formulation of the NDS, undertaken by the Review Group in 2000/2001, provided a systematic articulated account of programmes and actions. This helped to clarify the responsibilities of various government departments and state agencies, to co-ordinate action over the lifetime of the NDS and to facilitate control of the implementation of the NDS as intended.

The plan – A formal document, the plan acts as a channel for communicating strategic intentions and also provides the benchmark against which progress in implementing the intended strategy is monitored and performance controlled. It provides a simple feedback loop for controlling deliberate strategy. Mintzberg also proposed a more elaborate four-part approach to strategic feedback, incorporating control of not only intended and deliberate strategy, but also emergent strategy. Thus, as well as assessing (1) the degree of realisation of intended strategies and (2) the performance of these deliberate strategies, strategic control should also assess (3) all strategies that were realised,

i.e. intended and emergent, and (4) the performance of all strategies, both deliberate and emergent, and their impact on the desired strategic goals and objectives. In relation to the NDS, this would suggest that initiatives within the wider policy context, and strategies adopted without reference to the NDS, should also be monitored and their impact on the realisation of the NDS assessed.

Planners – Mintzberg suggested that over and above their formal roles in formulating and monitoring implementation of a plan, planners may also have additional roles that feed into and support the strategy formation process. These roles include helping to find possible strategies through detecting patterns in the actions being undertaken and in the strategy as it unfolds, through feeding new data and analysis into the strategy formation process, and through acting as a catalyst to strategic thinking among participants within the process. Through these roles, planners have the capacity to feed information on emergent strategies into deliberations on the drugs strategy and the realisation of the objective and goals as intended.

The organisational context of planning – Referring back to his earlier studies of basic organisational forms, Mintzberg associated formal strategic programming (planning) with the 'machine organisation', which he described thus: 'Classic bureaucracy, highly formalized, specialized, and centralized, and dependent largely on the standardization of work processes for co-ordination; common in stable and mature industries with mostly rationalized, repetitive operating work' (pp. 398–399). While it is apparent that the NDS as a planning document has many of the characteristics of a formal strategic plan (high-level objectives and goals cascading down through operational goals and performance indicators to actions, and a hierarchy of co-ordination mechanisms), it is also apparent, from the account provided in this chapter and in Chapter 4, that the national drugs strategy is not situated within an organisational form akin to Mintzberg's machine bureaucracy. With a wide variety of government departments, state agencies and voluntary and community-sector organisations involved in developing policy and in delivering on the NDS, there are a number of complex governance issues, including divergent interests and values and competing organisational priorities, which are inconsistent with a simple machine bureaucracy organisational form.

Of the organisational forms identified by Mintzberg, arguably a more relevant organisational context in which to consider drug-related strategy formation in Ireland, is the 'adhocracy organization',[10] defined thus: 'Organized to carry out expert work in highly dynamic settings, where the experts must work cooperatively in project teams, coordinating the activities by mutual adjustment, in flexible, usually matrix forms of structure' (p. 398). Within such a context Mintzberg suggested a strategy formation process characterised as follows:

> ... a very loose form of strategic programming [planning], which outlines broad targets and a set of milestones while leaving considerable flexibility to adapt to the dead ends and creative discoveries along what must remain a largely uncharted route. In a sense these plans look more like general performance controls than specific action programs, or perhaps more fairly, something in between. (pp. 408–409)

10 The other basic organisational forms identified by Mintzberg are entrepreneurial, professional and diversified.

6 Conclusions

In December 1999, on the eve of the new millennium, President McAleese gave an address to both Houses of the Oireachtas, in the course of which she posed the following question:

> The decisions we make now and in the years ahead, the values which imbue those decisions and the use we make of today's opportunities, these will give our future its shape, its depth. They will determine the kind of Ireland we hand on to future generations for while we have, thankfully, come a long way, we still have a distance to travel before our star stops over an Ireland where the shadows have lifted for all. The choices are ours. Will the old iniquities and inequalities lurk beneath the veneer? Will idealism be dulled by selfish materialism, shrill begrudgery and apathy or will we bequeath to our children a land of peace, prosperity, equal opportunity and respect for difference? (p. 1885)

A framework for equality policy, based on respect and dignity, and the statutory institutions to sustain it had already been put in place. Since the mid-1990s national planning documents, such as national development plans, national anti-poverty plans and national partnership agreements, had all been founded on a commitment to, among other things, equality. A series of statutory bodies to promote aspects of equality had been established, including the Combat Poverty Agency in 1986, the National Council on Ageing and Older People in 1997, the National Consultative Committee on Racism and Interculturalism in 1998, the Equality Authority in 1999, and the National Disability Authority in 1999.

Published in April 2001, the NDS is notable for the absence of language reflecting this ethos. While the Review Group welcomed the locating of Ireland's drug policy within the wider social inclusion policy framework, the strategic objective of the new strategy was 'to reduce harm to individuals and to society'. The NDS adopted an instrumentalist approach without reference to ideals such as equality, respect and dignity, or human rights. This approach was also reflected in the language of the Taoiseach in his speech launching the NDS, as described in the introduction to this overview.

Notwithstanding this rhetorical parsimony, the actions contained in the NDS addressed issues in relation to equality of opportunity for drug users, for example with regard to provision of information and access to services, the disposition and cultural attitudes towards clients of those delivering services or developing policies, the reduction of stigmatisation of those involved in drug misuse, and structural and resourcing arrangements that would facilitate equal opportunities for all. The Research pillar, moreover, identified research needs in relation to minority and disadvantaged groups, the fulfilment of which would serve to reduce their disadvantage and inequalities.

While the NDS included actions to establish equality of opportunity for those engaged in drug misuse, insofar as it targeted the vulnerable from disadvantaged backgrounds or areas, it may be argued that it served to isolate or exclude these individuals and communities and thereby reinforce their inequality (Crowley 2006). During the lifetime of the NDS, there have been calls to expand the scope of Ireland's drug policy, for example, to address the spread of illicit drug use to social classes other than the socio-economically disadvantaged, or drug misuse among all age groups, not just

young people; to jointly tackle the misuse of illicit drugs and alcohol, and also to bring the misuse of licit drugs, including over-the-counter and prescription drugs, within the one substance misuse strategy.

The civil liberties, or human rights, of those suspected of trafficking or dealing in illicit drugs, was another issue not considered by the NDS, notwithstanding the fact that concerns had been raised as early as the 1970s. In 1971 the Working Party on Drug Abuse had commented that there should be 'no undue interference with the freedom of the individual as far as any changes in procedures relating to search and arrest' (para. 3.2). In the mid-1990s Tim Murphy, in a critique of Ireland's prohibitionist drug policy (1996), commented that 'another highly significant social cost of drug prohibition is the abuse of civil liberties which inevitably accompanies the active criminalization of basically "victimless" conduct' (p. 54). As examples of 'active criminalisation', he cited the discussion in the *Government strategy to prevent drug misuse* (National Co-ordinating Committee on Drug Abuse 1991) about the detention of individuals suspected of concealing drugs in body cavities, and the provision for seven-day detention for suspected drug dealers in the Criminal Justice (Drug Trafficking) Act 1996.[1] In a recent publication, in which he made a case for the abolition of drug prohibition in Ireland, Paul O'Mahony (2008b) argued that the use of drugs is a human right. Far from promoting a laissez-faire approach to this right, O'Mahony argued that implementation of this right would bring two sets of gains – 'negative' gains by eliminating or at least diminishing the ills associated with prohibition, and 'positive' gains by changing the relationship between citizens and the state, and thereby strengthening the impact of drug education, treatment and social relations.

In recent years the connection between human rights and illicit drugs has become more widely recognised. In 2004 the Council of the European Union made explicit reference to human rights, among other matters, in the preface to the EU drugs strategy for 2005–2012:

> This new Drugs Strategy is based first and foremost on the fundamental principles of EU law and, in every regard, upholds the founding values of the Union: respect for human dignity, liberty, democracy, equality, solidarity, the rule of law and human rights. It aims to protect and improve the well-being of society and of the individual, to protect public health, to offer a high level of security for the general public and to take a balanced, integrated approach to the drugs problem. (para. 2)

In the run-up to 2008, which marks both the conclusion of the UNGASS 10-year action plan on drugs and the 60th anniversary of the signing of the Universal Declaration of Human Rights (UDHR), several international non-governmental organisations (NGOs) took the opportunity to set out their

1 The Irish Human Rights Commission and the Irish Council for Civil Liberties both raised concerns with regard to the Criminal Justice Act 2007, which introduced changes to Ireland's criminal justice system to help combat, among other things, drug-related crime, including the curtailment of a person's right to personal liberty through the extension of the power to detain an individual for seven days, as provided for in the Criminal Justice (Drug Trafficking) Act 1996 (Connolly and Morgan 2007).

policy positions on the relationship between human rights and drug control (IDPC 2008; Barrett *et al*. 2008; Lines and Elliott 2007). These bodies called for the recognition of individuals' human rights within the context of the prohibitionist framework. In March 2008, at the 51st session of the Commission on Narcotic Drugs (CND), which saw the launch of the year-long review of the UNGASS 10-year action plan, the CND passed a resolution (N0. 51/12) reaffirming that countering the world drug problem must be carried out in full conformity with the purposes and principles of the Charter of the United Nations and other provisions of international law and, in particular, with full respect for all human rights and fundamental freedoms and on the basis of the principles of equal rights and mutual respect.

In 2007 the Irish Human Rights Commission (IHRC), established by statute in 2001, announced in its second strategic plan, for 2007–2011, that, as well as continuing to review relevant legislation, it would now also seek to influence policy formulation and legislative drafting at an earlier stage than hitherto. The IHRC did not refer to illicit drugs but, in a report released to coincide with the 60th anniversary of the signing of the UN Charter on Human Rights (2007), the Irish section of Amnesty International did discuss the relationship between human rights and illicit drug use. Assessing the 'reality' of human rights in Ireland, Amnesty International described how Ireland has championed human rights on the international stage but identified areas at home where the Irish state 'has not respected, protected or fulfilled all right or the rights of all' (p. 1). The report suggested that these gaps were the result of the state's failure to follow human rights principles in its planning and decision-making processes. While drug users were not included among the 'vulnerable groups' considered in this report, drug use was mentioned as an exacerbating factor among those experiencing human rights violations because of imprisonment or homelessness. Amnesty International concluded its report with a series of recommendations on how Ireland could move towards a human-rights-based approach in its social and economic policies.

In an essay on the management of public sector activities, Henry Mintzberg (1996) highlighted the importance of articulating the value system underpinning the activity. Equality, human rights or some other set of principles would represent such a value system. Mintzberg argued that in the public sector, control needs to be firmly rooted in values and beliefs, rather than in plans and performance targets, or in rules, regulations and standards. He observed that public sector, or government, activities comprise not simply transactions between a supplier and a customer, but also interactions with individuals who may act, at different times, as clients, citizens, or subjects of the state. This complex and ever-shifting web of inter-relationships requires a management system that is commensurately fluid and adaptable and yet capable of making difficult trade-offs between conflicting interests and of acting at all times in the public interest. Mintzberg argued that the most appropriate model was a 'normative-control model [which] is not about systems but about soul. Here it is attitudes that count, not numbers. Control is normative – that is, rooted in values and beliefs' (p. 81).

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In exploring the elements of Ireland's drugs strategy, each chapter of this overview has highlighted underlying tensions.

First, in setting direction, it is apparent that there has been an ongoing disconnect between the strategic objective and goals on the one hand, expressing a simple aspiration to reduce the harm to individuals, families and society from illicit drugs, and, on the other hand, the operational objectives and key performance indicators, some of which directed effort towards the prohibition of the illicit drug market and a drug-free society. Arguably, this 'duality of approaches' has created a space in which politicians can manoeuvre, responding to different needs and audiences at different times. A critical challenge for effective strategic management is to achieve a balance between the competing demands for ambiguity and for precision, to ensure that political expediency does not crowd out consideration of the evidence base or, equally, that a slavish adherence to analytical certainty does not preclude innovation and bold policy. Two activities which would help to ensure effective management of this ambiguity are the development of a more rigorous system of performance measurement, including the development of a drug harm index and associated measurement system, and the development of integrated performance through measuring and evaluating outputs and outcomes, rather than inputs and processes.

Second, with regard to informing the choices underpinning decisions in pursuit of the desired strategic direction, there are two broad information types – scientifically derived, or evidence-based, information, and public opinion. The two streams of information reflect the rational and the non-rational components of the decision-making process. During the lifetime of the NDS considerable effort has gone into building up the evidence base, while little comprehensive, systematic, scientific investigation of the nature of public opinion and the role of the media has been undertaken. Furthermore, while there have been significant strides in building the evidence base, there have been gaps in the use of overt analytical, modelling and evaluative approaches. Finally, steps have been taken to bridge the divide between researchers and policy-makers in Ireland. This communication gap is widely perceived as creating a significant barrier to effective use of research-based evidence.

Third, with regard to implementing the drugs strategy, exploring both the mechanisms for co-ordinating it and also the allocation of responsibilities to individual entities for implementing it, has highlighted governance issues. While the various actors, including government departments, state agencies and voluntary and community sector organisations may share common aspirations with regard to the implementation of the NDS, various bodies have other organisational priorities, which can run counter to the NDS objective. Recent thinking on new ways of working in the public sector, in particular using networked organisational forms and integrated performance management systems, may offer ways of overcoming some of the organisational barriers to working together towards a common strategic objective.

Fourth, during the lifetime of a strategy, changes occur in the wider environment that elicit strategic responses that can create tensions, as new strategy emerges that contradicts, or is in conflict with, the intended strategy. The NDS is no exception. A system of strategic control is needed that can

accommodate both simple feedback loops to control the implementation of the intended strategy, and also control measures to contain emergent strategies. This latter category of measures may involve not only more complex control systems but also adjustments of organisational functions and systems to increase capacity for responsiveness and flexibility in the presence of instability and dynamic change.

Mintzberg (1994) argues that, although formal strategic plans serve a useful purpose in ensuring the future is taken into account in a rational manner, the co-ordination of activities and the control of events, no amount of strategic planning will ever eliminate uncertainty. In order to realise an intended strategy, Mintzberg believes it is crucial to recognise that strategy development is a continuous process, based on real-time 'learning-formation' rather than on prior 'formulation'. If this premise is accepted, two requirements for realising strategy become apparent.

- Tension is an inherent part of strategy development and it is through continuously looking for, working with, managing and resolving these tensions that strategy moves forward in an effective manner. It is these very instabilities and conflicts that are the stuff of strategy. The tendency to reduce uncertainty, to seek stability by focusing on that which is amenable to control, distracts from the real task of the strategist.
- Continuous and inclusive debate and deliberation on the direction and contents of strategy is at the heart of strategy formation. It is through open, informed and critical debate, involving all players and drawing on all possible sources of information and all perspectives, that the insights gained from strategic implementation, and practical and acceptable options for resolving critical strategic tensions, are found.

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In his more recent work *Tracking strategies* (2007), Henry Mintzberg's concept of 'crafting', rather than managing, strategy suggests how the challenges in handling the tensions inherent in the strategy process might be usefully thought about. Mintzberg argued that management of the strategy formation process, which he had termed the 'black box' of strategy in his earlier work on strategic planning (1994), was based on a combination of three main approaches to human endeavour – craft, art and science. He argued that science (analysis) assists in revealing patterns in events and in operationalising strategies, but that as strategy is about synthesis, rather than analysis, science plays only a small role and should not be over-emphasised. This leaves craft and art, and, in particular, the interplay between the two – between experience and insight, between learning and visioning. Given that art is a difficult concept to grasp, let alone manage, Mintzberg concluded that the concept of crafting best captures, and helps understanding of, the process by which effective strategies come to be:

> Managers who craft strategy are involved, responsive to their materials; they learn about their organizations and industries through personal touch. They are also attuned to experience, recognizing that while individual vision may be important, other factors must also help to determine strategy. (p. 377)

Mintzberg outlined various aspects of crafting strategy, which may be conceived of as comprising five (interchangeable) phases of a process cycle:

1. *Managing stability:* maintain the effectiveness of the system. Change is not a constant state and, to ensure strategic effectiveness, it is important not so much to be able to manage change as to know when to promote and instigate it.
2. *Detecting discontinuities:* detect the subtle developing discontinuities that may either undermine the existing system or present a special opportunity
3. *Knowing the business:* Have deep personal knowledge and intimate understanding of the business.
4. *Dealing with patterns:* Detect emerging patterns, help them to take shape, create the climate in which a wide variety of strategies can grow.
5. *Reconciling change with continuity:* Know when to exploit established strategies and when to encourage new ones; understand past patterns and learn about capabilities and potential.

The roles of different broad groupings of actors in relation to the different phases of Mintzberg's strategy crafting process, as they occur within the illicit drug policy domain in Ireland, are briefly explored below.

'Detecting discontinuities' and 'reconciling change with continuity' (Phases 2 and 5) are not straightforward processes. Information may be intangible or encrypted, and sensitivity and subtlety of thought are needed to process the available evidence. Arguably, in a public sector policy domain such as illicit drugs, it is politicians and citizens who, between them, have the greatest capacity to detect and to process this information. Politicians interact with and hear the views of a wide range of interested parties; they weigh up the arguments, take competing needs and demands into account, and make decisions. Citizens and civil society organisations set out the arguments for various positions and approaches, based on their own experiences, beliefs and attitudes, and needs or wants, and contribute to the testing of ideas and the building of a public discourse.

Irish politicians have generally taken a leadership role in strategic reviews of drug policy and strategy development, promoting innovation and championing new approaches. In recent years, however, this level of activity has declined. The NDS was formulated by a Review Group with no political representatives on it; the action in the NDS calling for the establishment of a dedicated drugs sub-committee of the Oireachtas Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs was not realised. While political debate on the drugs issue has benefited from an increased flow of information on the nature of the drug situation and the responses, and deliberations have extended to considering the desired outcomes as well as the immediate situation, greater analytical capacity is needed. Ideas on how best to enhance the information available to politicians, and their capacity to use this information in their policy deliberations, through creating opportunities for politicians to engage directly with researchers and the market and to build their understanding of the

evidence base, were canvassed in the OECD report (2008) on its review of the Irish public service. Published in November 2008, the report of the Task Force on the Public Service (2008), which presents an action plan in response to the OECD review, has, to some extent, picked up on these ideas.

It is debatable whether civil society – that area of society between the market and the state – has made a contribution commensurate with its full potential. Since the mid-1990s civil society organisations, particularly in the voluntary and community sectors, have been recognised as playing a vital role in tackling the illicit drugs issue. They have both partnered the government in planning and delivering drug-related services, and contributed to policy debate. However, other civil society platforms have not figured so prominently. Apart from the public consultations on the NDS in 2000, 2004 and 2008, there has been no regular or systematic monitoring of public opinion since 2001. No research on the contribution of the Irish media to public understanding of, and debate on, the issues surrounding illicit drugs has been completed yet in the 21st century. The Task Force on the Public Service (2008) recommended 'a deeper and better-structured dialogue with the public as citizens and customers about policy formation as well as service design and delivery' (p. 15). The structured dialogue was to include responses by public bodies to the input of citizens, indicating what changes are being made and explaining why other suggestions are not being acted on.

With regard to 'managing stability' and 'detecting patterns' (Phases 1 and 4), the necessary information is more likely to be obvious and tangible. The monitoring and review of key performance indicators and their associated objectives and goals, the evaluation of interventions, and analysis and modelling, all provide means of tracking progress and of assessing and increasing the effectiveness of interventions. However, researchers, analysts and policy advisers need to be cognisant of and address numerous procedural, technical, conceptual and even ethical issues associated with the choice and use of such methods.

Despite the increase in the level and quality of information gathered, the need persists for further data gathering, for example more detailed data on drug-related harms and public expenditure on the drugs issue, for greater co-ordination of data-gathering activities, for example between different agencies within the criminal justice sector, and for acceptance of evaluation as an integral part not only of programme activities but also of policies and strategies. Increased use of analytical and modelling techniques can help assess the relative merits of different response options, be it responding at different stages of a drugs 'epidemic' or seeking to understand how to influence the policy process itself. In developing knowledge and understanding of the issue, care is needed to ensure that the most appropriate research and information-gathering approaches are used, that they are relevant to the needs, and aligned with the overall goals, of the policy-makers. The choice of approach can influence perceptions of the nature of the problem, highlighting different factors, and determine the nature of the solutions.

Finally, 'knowing the business' (Phase 3) may be regarded as the particular bailiwick of service providers and service users, be they located in government departments, state agencies, the voluntary or community sectors, families, or the private sector. Critical to effective crafting of strategy is ensuring that the knowledge held by these various actors – their first-hand experience and understanding of the problems and of the solutions that work – can feed into the policy development process in a timely and appropriate way.

During the life of the NDS this knowledge transfer has been undertaken via the comprehensive consultation processes, undertaken during the review of the drugs strategy in 2000/01, in the course of the mid-term review in 2004/05, and again in the end-of-term review of the NDS in 2008. Furthermore, service providers and the voluntary and community sectors have been represented on the national co-ordination mechanisms, and on regional and local drugs task forces.

Mechanisms to facilitate the engagement of all actors in the illicit drugs policy domain in ongoing debate and deliberation on issues have been explored in the course of this overview. In other policy domains, forums comprising representatives of all the social partners have been proved useful forums for addressing policy issues and for reaching consensus on ways forward that are often innovative and far-reaching. The OECD's (2008) blueprint for the integration of public-sector activities – through the development of networked organisational forms, in which different actors contribute on the basis of their mandates and their specialist competencies within a framework of shared goals and values, sound governance frameworks and performance management systems that measure outputs and outcomes, rather than inputs and processes – is another option. Both these models assume strong leadership from the centre, i.e. the departments of the Taoiseach and of Finance, which will help to develop, articulate and monitor the realisation of broad societal goals and the means of achieving them. Refocusing the role of the centre in an integrated public service – reducing its control function in order to allow it to focus on the more strategic aspects of its responsibilities – is one of the priorities set by the Task Force on the Public Service (2008).

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As this overview goes to press, work is drawing to a conclusion on the new national drugs strategy for the period 2009–2016. The new strategy has been formulated following a process very similar to that which preceded the formulation of the NDS: a review group comprising representatives of the public, voluntary and community sectors has reviewed the current situation, engaged in an extensive process of consultations with the public and with organisations involved in the implementation of the NDS, considered the research evidence and the wider policy environment, and formulated a new strategy. This overview has not tried to pre-empt the direction, shape or content of this sixth iteration of Ireland's overall approach to the issue of illicit drugs. Rather, it has attempted to analyse the challenges in managing the national drugs strategy and to provide a survey of recent research and thinking with regard to good practice in managing illicit dugs strategy. These challenges are ongoing: finding appropriate responses will contribute to the realisation of the desired strategic outcomes.

Appendices

Appendix 1: National Drugs Strategy 2001–2008

Strategic objective

To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research

Overall strategic aims

1. To reduce the availability of illicit drugs;
2. To promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;
3. To enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
4. To reduce the risk behaviour associated with drug misuse;
5. To reduce the harm caused by drug misuse to individuals, families and communities;
6. To have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and
7. To strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.

The four pillars

8. Supply reduction
9. Prevention
10. Treatment
11. Research

The following table lists the two operational objectives set for each pillar, together with the Key Performance Indicators (KPIs) included in the 2001 NDS, and the revised list of KPIs included in the 2005 MTR.

Co-ordination is included in the table although it was not defined as a 'pillar'. No new KPIs were identified for Co-ordination in the MTR.

Rehabilitation was identified as a fifth pillar in the MTR. The Steering Group that undertook the mid-term review did not identify any operational objectives or KPIs for the new pillar.

Pillar	Objective	Key Performance Indicators (NDS)	Key Performance Indicators (MTR)
Supply Reduction	1. To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified 2. To significantly reduce access to all drugs, particularly those drugs that cause most harm, amongst young people especially in those areas where misuse is most prevalent.	• Increase the volume of opiates and all other drugs seized by 25% by end 2004 and by 50% by end 2008 (using 2000 seizures as a base); • Increase the level of Garda resources in LDTF areas by end 2001, building on lessons emanating from the Community Policing Forum model; • Strengthen and consolidate existing coastal watch and other ports of entry measures designed to restrict the importation of illicit drugs; • Establish a co-ordinating framework in relation to drugs policy in each Garda District by end 2001; and • Co-operate and collaborate fully, at every level, with law enforcement and intelligence agencies, in Europe and internationally, in reducing the amount of drugs coming into Ireland.	• Volume of drugs seized increased by 50% based on 2000 figures • Number of seizures increased by 20% based on 2004 figures • Number of supply detections increased by 20% by end 2008 based on 2004 figures
Prevention	1. To create greater societal awareness about the dangers and prevalence of drug misuse 2. To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.	• Bring drug misuse by schools-goers to below the EU average and, as a first step, reduce the level of substance misuse reported to ESPAD by school goers by 15% by 2003 and by 25% by 2007 (based on 1999 ESPAD levels as reported in 2001); • Develop and launch an ongoing National Awareness Campaign highlighting the dangers of drugs, the first stage to commence by end 2001; • Develop formal links at local, regional and national levels with the National Alcohol Policy, by end 2001 and ensure complementarity between the different measures being undertaken; • Publish and implement a policy statement specifically relating to education supports for LDTF areas, including an audit of the level of current supports, by end 2001; • Nominate an official from the Department of Education and Science to serve as a member of each of the LDTFs by end 2001; • Prioritise LDTF areas during the establishment and expansion of the services of the National Educational Welfare Board; • Have comprehensive substance misuse prevention programmes in all schools and, as a first step, implement the "Walk Tall" and "On My Own Two Feet" Programmes in all schools in the LDTF areas during the academic year 2001/02; • Complete the evaluation of the "Walk Tall" and "On My Own Two Feet" Programmes by end 2002; and • Deliver the SPHE Programme (Social, Personal & Health Education) in all Second-level schools nation-wide by September 2003.	• The 3 Source Capture-Recapture study estimate of opiate misusers, which will be released in 2007, to show a stabilisation in terms of overall numbers and to show a reduction of 5% of the prevalence rate based on 2001 figures published in 2003 • The NACD Drug Prevalence survey, which will be released in 2007, to show a reduction of 5% of the prevalence rate of recent and current use of illicit drugs in the overall population based on 2002/03 rate • Substance use policies in place in 100% of schools • Early school leaving in LDTF areas reduced by 10% based on 2005/06 rate

Pillar	Objective	Key Performance Indicators (NDS)	Key Performance Indicators (MTR)
Treatment	1. To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle 2. To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.	• Have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment; • Have access for under-18s to treatment following the development of an appropriate protocol for dealing with this age group; • Increase the number of treatment places to 6,000 places by end 2001 and to a minimum of 6,500 places by end 2002; • Continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and implement proposals designed to end heroin use in prisons during the period of the Strategy; • Have in place, in each Health Board area, a service user charter by end 2002; • Have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002; and • Provide stabilised drug misusers with training and employment opportunities and, as a first step, increase the number of such opportunities by 30% by end 2004.	• 100% of problematic drug users accessing treatment within one month after assessment • 100% of problematic drug users aged under-18 accessing treatment within one month after assessment • Harm reduction facilities available, including needle exchange where necessary, open during the day, and at evenings and weekends, according to need, in every local health office area • Incidence of HIV in drug users stabilised based on 2004 figures
Research	1. To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst marginalised groups 2. To gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs	• Eliminate all major research gaps in drug research by end 2003; and • Publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.	• Eliminate all identified gaps in drugs research by mid 2008 • Publish an annual report on the nature and extent of the drug problem in Ireland, drawing on available data • Publish a report on progress being made in achieving the objectives and aims set out in the Strategy every two years
Co-ordination	1. To have in place an efficient and effective framework for implementing the National Drugs Strategy.	• Establish an effective regional framework to support the measures outlined in the Report by end 2001; • Complete an independent evaluation [of] the effectiveness of the overall framework by end 2004; • Each agency to prepare and publish a critical implementation path for each of the actions relevant to their remit by end 2001; and • Review the membership, work-load and supports required by the National Drugs Strategy team to carry out its terms of reference, by end September 2001.	

Appendix 2: Irish laws enacted between 2001 and 2007 that impact directly or indirectly on illicit drugs policy[1]

Children Act 2001 focuses on preventing criminal behaviour, diversion from the criminal justice system and rehabilitation. The use of detention for a child is to be a last resort: theAct requires that all avenues be explored before it is used. The Act contains specific proposals on the responsibilities of parents. These order oblige parents to take measures to remedy whatever it is that caused them to lose control over their children, e.g. to undergo a parenting skills course or to obtain treatment for substance abuse. The Act also gives the courts power to impose a curfew on persons under 18 years of age. It can also require a child to stay away from any specified premises, place or locality during specified days or between specified times.

Mental Health Act 2001 excludes addiction from the legal definition of mental disorder. (It superseded the Mental Health Act 1945, which included addiction as a criterion for non-voluntary committal to a psychiatric hospital. This Act had not been invoked as it was no longer acceptable to detain by law people whose primary problem was addiction.)

Criminal Justice (Illicit Traffic by Sea) Act 2003 gives effect to the Council of Europe Agreement on Illicit Traffic by Sea, implementing Article 17 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The convention seeks to enhance co-operation between parties to the convention in the suppression of drug trafficking at sea. The Act makes provisions for communication and co-operation in drug law enforcement between convention states.

Criminal Justice (Public Order) Act 2003 enables persons convicted of an offence under certain provisions of the Criminal Justice (Public Order) Act 1994 to be excluded from entering licensed premises or premises (including a stall or vehicle) used for the sale of food or from areas in the vicinity of those premises. The provisions for exclusion orders under the 1994 Act include 'intoxication in a public place'. Intoxication is defined as 'under the influence of any alcoholic drink, drug or solvent or other substance'.

European Arrest Warrant Act 2003 gives effect to the EU Council Framework Decision of 13 June 2002. It provides for the application of a European arrest warrant (EAW) in Ireland. The EAW is a court decision in one member state of the EU addressed to a court in another member state of the EU for the purpose of conducting a criminal prosecution or the execution of a custodial sentence in the issuing member state.

1 This list updates the list of 'statutes related to the control of drugs with the potential for misuse' provided in Chapter 2.2 of Moran, O'Brien, Dillon, Farrell (2001). It is based on information reported in the National Report on the current drug situation in Ireland, prepared by ADRU for the EMCDDA, and on items published in *Drugnet Ireland*, between 2001 and 2007.

Garda Síochána (Police Co-operation) Act 2003 makes provision, in accordance with the Agreement between the Government of Ireland and the Government of the United Kingdom of Great Britain and Northern Ireland on Police Co-operation, done at Belfast on 29 April 2002, in relation to the appointment and secondment of members of the Police Service of Northern Ireland to such ranks in the Garda Síochána as may be prescribed, the secondment of members of the Garda Síochána to that Service, and other connected matters. The Act facilitates co-operation on drug smuggling and organised crime on the whole island of Ireland.

Taxi Regulation Act 2003 disqualifies an individual from holding a taxi licence if he or she has been convicted of a drug trafficking offence. Section 36 (e) of the Act, 2003 provides for the mandatory disqualification for holding a taxi licence on conviction for a drug trafficking offence (within the meaning of Section 3 of the Criminal Justice Act 1994). Section 36 of the Road Traffic Act 2004 makes a number of technical amendments to Section 36 of the Taxi Regulation Act 2003 (see National Report 2004). Section 36 of the Road Traffic Act, 2004 provides, *inter alia*, that a person convicted summarily, where a penalty other than a term of imprisonment (that the person serves in whole or in part) is imposed by the Court, is disqualified from holding a licence for a period of 12 months and, accordingly, the licence stands suspended for that period.

Criminal Justice (Joint Investigation Teams) Act 2004 gives effect to the EU Council Framework Decision of 13 June 2002 on Joint Investigation Teams. It provides for the setting up of joint investigation teams by EU member states, including Ireland, for a specific purpose and limited period. The teams carry out criminal investigations with a cross-border dimension, particularly investigations into organised crime such as drug trafficking.

Immigration Act 2004 provides for an immigration officer to refuse to permit a non-national coming from outside the state to enter the state, if the officer is satisfied that the person suffers from any of six conditions, including drug addiction. In 1975 these six conditions were added, as an amendment, to the Fifth Schedule to the Aliens Order 1946.

Garda Síochána Act 2005 is the first major revision of the operation of the Garda Síochána since the founding of the State. The Act reforms the legislative structure for the management of the Garda Síochána, by clarifying the role and objectives of the Force and defining its relationship with the Minister and the Government of the day, including provision for new structures including Joint Policing Committees. The Act also aims to improve the efficiency and effectiveness of the operation and administration of An Garda Síochána, by measures such as the establishment of performance targets by the Minister, including annual Policing Priorities.

Maritime Safety Act 2005 introduces prohibitions on the operation of vessels in Irish waters while under the influence of alcohol or drugs to such an extent as to be incapable of properly controlling or operating the vessel. Section 29, *inter alia*, entitles the person in command of a vessel to refuse permission to board a vessel to a person who is under the influence of alcohol or drugs to such an

extent that they misconduct themselves or cause offence or annoyance to persons on the vessel. Section 31 introduces controls and penalties in relation to the consumption of alcohol or drugs on board vessels.

Proceeds of Crime (Amendment) Act 2005 makes further provision in relation to the recovery and disposal of proceeds of crime. The Act does not make specific reference to drug-related crime, but proceeds of crime legislation has been directed against those involved in organised crime involving drug trafficking. The Act also allows proof of criminality to include criminality outside the State.

Railway Safety Act 2005 provides for the testing of safety-critical workers for the presence of intoxicants, which include alcohol and drugs and any combination of drugs or of drugs and alcohol. The Railway Safety Commission, established under the Act, has the power to approve the codes of conduct, sampling procedures and support services which railway undertakings are required to put in place. The Commission is also required to report annually on the implementation by railway undertakings of the measures provided for in the Act in relation to testing of safety-critical workers.

Safety, Health and Welfare at Work Act 2005 provides for drug testing in the work place. The legislation obliges the employee to ensure that he or she is not under the influence of an intoxicant to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any other person. Also, if reasonably required by his or her employer, the employee must submit to any appropriate, reasonable and proportionate tests, by or under the supervision of a registered medical practitioner who is a competent person, as may be prescribed. An employer may require an employee to undergo an assessment by a registered medical practitioner, nominated by the employer, of his or her fitness to perform work activities. Regulations have not yet been finalised.

Criminal Justice Act 2006 makes provision for criminal offences in relation to participation in criminal organisations, an offence in respect of supplying drugs to prisoners, a drug offenders register, and dealing with anti-social behaviour through measures such as anti-social behaviour orders. The Act also strengthens the provisions on the imposition of the 10-year mandatory minimum sentence for drug trafficking.

Criminal Law (Insanity) Act 2006 sets out clear rules in relation to the defence of insanity and the related question of a person's fitness to be tried. For the purposes of the Act, 'mental disorder' is defined as a mental illness or handicap, dementia or any disease of the mind. Intoxication by alcohol or other substances is explicitly excluded from the scope of the definition.

Europol (Amendment) Act 2006 gives force of law to protocols to the Europol Convention concerned with combating terrorism, unlawful drug trafficking and other serious forms of international organised crime. It paves the way for enhanced co-operation between law enforcement agencies across the EU member states in the fight against all forms of crime with a cross-border dimension.

Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Act 2007 provides a coherent statutory mandate for the functions and responsibilities of the Minister for Community, Rural and Gaeltacht Affairs, including the co-ordination of the implementation of the National Drugs Strategy, including matters relating to the allocation of services and facilities to counter drug misuse in areas of the State where such misuse is significantly higher than in other areas of the State. The Minister also has the power to develop, implement, maintain, expand or terminate any scheme that in her or his opinion supports or promotes the functions for which he or she is responsible.

Criminal Justice Act 2007 updates several areas of criminal law and procedure so that An Garda Síochána, the State's prosecution services and the Courts are in a position to respond more effectively to gangland crime, much of which involves trafficking and dealing in illicit drugs. The Act addresses issues in relation to detention, bail, the 'right to silence', sentencing, the taking of samples and statements from arrested persons.

Part 3 of the Act contains proposals for mandatory sentencing for offences linked to organised crime, including firearms and drug trafficking offences. Under these proposals the court must impose a sentence that is at least three-quarters of the maximum sentence permissible under the law for that offence. If the maximum term is life imprisonment, the court shall specify a term of imprisonment of not less than 10 years.

Part 5 of the Act proposes amendments to the Misuse of Drugs Act 1977, specifically in relation to the sentencing of those convicted of possession of drugs with intent to supply:

- The minimum period of imprisonment for those convicted under Section 15A or 15B of the Misuse of Drugs Act 1977 (possession of drugs with intent to supply) is to be 10 years, aside from some exceptional circumstances whereby the court determines that it would be unjust to impose such a sentence. These include for example, if the person pleaded guilty to the offence or if the person provided assistance in the investigation of the offence.
- The minimum period of imprisonment for those convicted of a second or subsequent offence under Section 15A or 15B of the Misuse of Drugs Act 1977 is to be 10 years.

The main purpose of these provisions is to ensure that mandatory sentencing for supplying drugs should be imposed in all but the most exceptional circumstances.

Prisons Act 2007 provides for the making of rules by the Minister for the regulation and good government of prisons. Such rules may provide for the testing of prisoners for intoxicants including alcohol and other drugs. Section 36 prohibits the unauthorised possession or use of a mobile phone by a prisoner, and the unauthorised supply of a mobile phone to a prisoner. There is anecdotal evidence that mobile phones have been instrumental in facilitating drug supply to prisons.

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