

# **A Tale of Two Sectors: A Critical Analysis of the Proposal to Establish Drug Courts in the Republic of Ireland**

**SHANE BUTLER**

## **Abstract**

*It was formally recommended in 1998 that dedicated drug courts, similar to those which have been operating in the USA, should be established in the Republic of Ireland in order to cope more speedily and effectively with the large numbers of drug-using offenders coming before Irish courts and being processed through the criminal justice system as a whole. This policy recommendation was accepted, and planning for the introduction of drug courts in Ireland is now at an advanced stage. The philosophy which underpins the drug courts concept is essentially of a treatment or rehabilitative nature; it is accepted that simple imprisonment of convicted drug users is generally unsuccessful, involving a high degree of recidivism, so, as an alternative, dedicated courts are created with a view to diverting offenders into intensive outpatient treatment which is supervised closely by the court. The proposal to establish such courts in Ireland is reviewed critically here against the background of the evolving Irish drug treatment system, and it is argued specifically that its proponents have failed to acknowledge or address the cultural differences and strategic conflicts which continue to characterise relationships between the two relevant governmental sectors – the criminal justice and healthcare sectors – in their attempts at collaborating on the management of drug problems.*

## **1 Introduction**

### **1.1 The Proposal to Set Up Drug Courts in Ireland**

In line with most other countries, Ireland has tended over the past thirty years or so to describe its public policy on illicit drugs as one which seeks to combine tough criminal justice sanctions with a humane therapeutic response. This has proven to be a difficult balance to achieve both philosophically and practically, and frequently it has involved the use of rhetoric which categorises offenders somewhat stereotypically into “innocent” victims and “evil” drug dealers. For example, in his introductory address to the Working Party on Drug Abuse, Ireland’s first official committee to study drug use and related problems, the Minister for Health of the day distinguished between addicts, who “should be regarded as sick people in need of medical care to be treated with sympathy and understanding and be helped in every way possible to overcome their dependency on drugs”, and drug dealers, who “deserve no sympathy and should be punished to the full extent permitted by the law” (Report of the Working Party on Drug Abuse, 1971, p. 59).

Despite the difficulties which have consistently characterised health-care/criminal justice collaboration in relation to drug use and related problems, and which will be looked at in some detail later in this article, the decision to explore the establishment of dedicated drug courts in Ireland in the mid-1990s was the first major public policy initiative to address this issue explicitly. There are a number of factors and events which explain why the drug courts initiative should have arisen at this time. The sense of moral panic surrounding drug use, which had waxed and waned over the years in Ireland, reached an unprecedented high in 1996 with the murder of Veronica Guerin, a well-known journalist, apparently by criminals involved in drug dealing; the sense of public revulsion which followed this murder accelerated and strengthened legal developments, including the creation of increased police powers, which were intended to deal severely with drug offenders. At the same time, research conducted by O’Mahony (1997)

confirmed the admittedly complex link between drug use and crime, with 66% of a sample of prisoners surveyed in Mountjoy, Ireland's largest prison, reporting that they were heroin users, while research by the Garda Síochána (the Irish police force) revealed that of 7,757 individuals charged with indictable offences in the Dublin Metropolitan Area over the course of a year 3,365 (43%) were identified as hard drug users (Keogh, 1997).

The increased volume of drug-related work being processed by the courts, the probation service and the prison system had not been matched, however, by structural or institutional innovations within these systems, and a sense of frustration began to emerge amongst criminal justice professionals at what appeared to be the inability of the system to respond rationally or effectively to drug-related crime. Irish public sector management, which had been largely unchanged since the establishment of the State in 1922, was reviewed during this period and major reforms were recommended under the rubric of the Strategic Management Initiative (SMI), all with a view to introducing modern management systems into the public sector. A major element in the SMI was its recognition of the fact that the attainment of important public policy objectives is frequently dependent upon the co-operation of two or more sectors of government, and drug problems were identified early on in this process as constituting such a "cross-cutting issue" (Boyle, 1999). It was not surprising therefore that the question of clarifying and rationalising the respective roles of health and justice in the management of drug-using offenders should be raised at this time, and in late 1998 the Minister for Justice, Equality and Law Reform requested the Working Group on a Courts Commission (a committee which had already made significant strides in reforming the administration of courts in Ireland) to investigate and report on the establishment of a drug courts system in Ireland. The working group tackled this task with what by bureaucratic standards seemed almost indecent haste, reporting in February 1998 (Working Group on a Court Commission, Fifth Report: Drug Courts, 1998) with a positive recommendation for the introduction of this concept to Ireland.

## 1.2 The Origins Of the Drug Courts Concept in the USA

Comparative drug policy research, particularly that which contrasts British and American policy, has tended to emphasise the degree to which American policy throughout the twentieth century has favoured criminal justice over health service interventions (Trebach, 1982; Strang & Gossop, 1994). The rhetoric of American drug policy has consistently portrayed illicit drug use as though it were the ultimate evil, to which no public policy response could be too harsh, and since the Nixon presidency of the late 1960s there have been periodic declarations and re-declarations of a "war on drugs". Towards the end of the Reagan administration, in 1988, American policy became even tougher with the introduction of the concept of "zero tolerance", which involved the extension of heavy criminal justice sanctions from commercial drug dealers to ordinary users, even casual users; understandably, this led to even higher numbers of drug users being processed through the criminal justice system and ending up in prison.

It would be erroneous to suppose, however, that in giving primacy to the criminal justice sector American policy makers totally ignored or excluded the therapeutic dimension. On the contrary, there is a long tradition in the USA of diverting drug-using offenders into treatment systems prior to adjudication, just as there is a tradition of coercing convicted offenders into various forms of residential or non-residential treatment (Inciardi et al., 1996). Outcome studies of treatment systems for convicted drug offenders were generally disappointing, however, and Martinson's review of these systems in the early 1970s – which, broadly speaking, concluded that "nothing works" – appears to have been particularly offensive to American sensibilities (Martinson, 1974).

It is against this background that the development of dedicated drug courts from 1989 onwards must be understood. The courts, as a result of the zero tolerance philosophy, were more burdened with recidivist drug-using offenders than ever, while their collaboration with the

healthcare or treatment sector seemed confused and ineffective. While numerous variants of the drug courts concept were to emerge during the early 1990s, there were some underlying beliefs and fundamental characteristics which were common to all of these new systems and which should be enumerated here:

- it was recognised, drawing on the concept of “differentiated case management”, that since not all cases coming before the courts were the same they should not all be processed in precisely the same way, and on this basis it was argued that it might be more rational and efficient to create special courts which would deal exclusively with drug-using offenders;
- it was reaffirmed that the threat of criminal justice sanctions might be used as leverage to motivate offenders to make good use of treatment services and facilities, but that this might be best facilitated by a process which was non-adversarial, consisting of judges, prosecutors, defenders and treatment providers collaborating towards this end;
- it was proposed to assign a new role to judges in these drug courts, a role which involved the judge in a therapeutic function rather in the more traditional punitive capacity and which consisted of intense and continuous monitoring of the defendant’s attendance at and performance within the treatment system.

### 1.3 Intersectoral Collaboration in the Public Management of Drug Problems

From a theoretical perspective this analysis of drug court concepts and practices, both in their country of origin and in Ireland, is primarily informed by the sociological writings of Joseph Gusfield (Gusfield, 1996), who has devoted a lifetime to the study of the social construction of alcohol problems in the USA. In summary, Gusfield’s work has focused on the way in which different societal institutions have at different times succeeded in claiming “ownership” of this social problem. What Gusfield means by this is that at certain times a particular institution, such as the medical profession, the legal profession or a church, may succeed in having its own cultural definition of a phenomenon accepted as being valid either scientifically or morally, so that the institution is then seen as having a legitimate claim to play a dominant role in the societal management of that problematic phenomenon. He also points out, however, that despite the appearance of solidity and consensus which may practically and philosophically surround such claims to ownership of a specific public or social problem, the meanings are frequently contested and there may be, quite close to the surface, political or economic conflict between two or more institutions concerning the ownership of the problem.

Public sector management may simply view drug courts as pragmatic initiatives to achieve better collaboration between the two sectors which are mainly involved, all with a view to achieving a common goal. Applying Gusfield’s ideas, however, one is alerted to the possibility that the two sectors may have quite fundamentally different and conflicting cultural perspectives on what constitutes “drug abuse” and also that the notion of a common goal may be illusory.

### 1.4 The Aims of This Article

The aims of this article, therefore, are to look critically at the proposal to create drug courts in Ireland, bearing in mind the possibility that this initiative may not simply be a matter of public sector strategy or administrative common sense, but that it may be complicated by differing philosophical or ideological positions as well as by conflicts over status or access to scarce public resources.

## 2 Drug Treatment Systems in Ireland

### 2.1 The Evolution of Drug Treatment Systems in Ireland From the Mid-1960s

The enactment of the Dangerous Drugs Act 1934, the first anti-drugs legislation since the achievement of self-government in 1922, appears to have been prompted solely by Ireland's accession to the Geneva Convention of 1931, and it was not until the mid-1960s that the Irish authorities became convinced of the necessity to develop policy in this area. The Working Party on Drug Abuse, which has already been mentioned, conducted its business between 1968 and 1971 and made wide-ranging recommendations for legislative change and other policy developments in this field. Statistics on the extent of drug use and related problems, which at this time were primarily derived from the reports of the Garda Síochána, suggested that drug use was largely confined to the Dublin area and consisted in the main of soft drug use; opiate use and intravenous use were practically unknown (Report of the Working Party on Drug Abuse, 1971, pp. 10-15). However, the structure of treatment services for problem drug users in Dublin was decided quickly and pragmatically, without reference to the Working Group, when at the initiative of the Department of Health a centralised treatment facility was set up at Jervis St. Hospital in Dublin's city centre in 1969. This facility, which soon was designated the National Drug Advisory and Treatment Centre, reflected developments in Britain at this time, when drug dependency units (DDUs or "clinics") were being established in the wake of the Second Brain Committee, and when the role of the general medical practitioner was being seen as relatively unimportant if not actually counterproductive. Voluntary treatment services for problem drug users were slow to emerge in Dublin, and it was not until 1973 that the first (and, for the next decade, the only) such service was established: this was the Coolemine Therapeutic Community, an American-style "concept house", which applied a confrontational approach to behaviour change within a residential setting and which saw total abstinence as the only valid goal of treatment.

There are perhaps just two main points to be made about Irish drug treatment services in the light of this early history. In terms of treatment models, it became established that services for drug users should be centralised and delivered by specialist caregivers and therapists, with no credence being given to the idea that such services could be normalised by being delivered by primary caregivers in localised or community-based settings. Furthermore, the treatment models which became the norm in Ireland also tended axiomatically to the view that total abstinence was the only acceptable goal of therapeutic interventions. The second point to be made about Irish drug treatment services refers to the policy-making process rather than to content or substantive issues involved here, and what emerged from this early period was a tradition of making decisions without public debate or discussion of alternative treatment models; it was as though the decisions to be made about treatment and rehabilitation were based on such a clear consensus that no public debate was necessary. No formally constituted drugs policy advisory body was set up and the task of evaluating treatment services appeared to rest somewhat ambiguously with the Department of Health (Butler, 1991).

Although "drug abuse" was discussed politically and by the media during these early years in the customary language of moral panic, the enactment of new legislation was a relaxed and relatively leisurely affair. The resulting statute, the Misuse of Drugs Act 1977, was enacted nine years after the Working Party had been set up to advise on this matter, and the Commencement Order which brought the new legislation into effect was not made until 1979.

Section 28 of the Misuse of Drugs Act 1977 deals specifically with the provision of treatment options, as an alternative to incarceration, for convicted drug-using offenders. The policy intent of this section seems quite clear: the legislators wished to have such offenders (although offenders who were deemed to be commercial dealers were dealt with in a less favourable way) medically assessed prior to conviction and, where it seemed appropriate, to have

prison sentences suspended subject to conditions laid down by the courts. Much of the content of this section of the legislation may be seen as being broadly similar to what the Irish criminal courts had been doing generally, in terms of suspending sentence where the probation or the healthcare system monitored and reported upon the progress of offenders within therapeutic or rehabilitative services. However, Section 22 authorised the Minister for Health to designate an appropriate institution as “a designated custodial treatment centre”, and the courts were empowered to detain convicted offenders in this centre as opposed to ordering their detention in conventional prisons.

Following the introduction of the Misuse of Drugs Act 1977, the courts continued to collaborate with the healthcare system in the management of convicted drug-using offenders, but this collaboration was largely based on traditional lines, with the Probation and Welfare Service playing a mediating role. However, the designated custodial treatment system never became an operational reality. Following the enactment of the legislation, there was no continuing political commitment to the implementation of this specific aspect of the new law and, in the absence of such political commitment, neither the healthcare nor the criminal justice sector displayed any interest in developing this intersectional initiative.

## 2.2 The Opiate Epidemic, HIV and Harm Reduction

Quite dramatically, during 1979 and 1980, the drug scene in Dublin changed and intravenous heroin use became prevalent in a number of deprived inner-city areas and in some of the outer suburbs (Butler, 1991). Policy responses to this style of problem-drug use were slow to emerge and initially it seemed as though political and administrative systems were totally denying this new reality, which was so at odds with how Irish people wished to view themselves and their country. However, what had originally been described colloquially as an “opiate epidemic” was eventually accepted as an ongoing reality, and policy measures to cope with it were gradually devised. The existing treatment system, which was inflexibly centralised and insistent on abstinence as the only legitimate therapeutic goal, became even more problematic from 1983/84 onwards when the role of needle-sharing amongst intravenous drug users in the transmission of HIV was clearly identified. Equally problematic was the perception previously alluded to that debate on drug treatment issues was unnecessary, and the absence of formal policy-making structures.

Irish health policy makers faced a similar range of problems as in other countries (Klingemann & Hunt, 1998) in deciding upon the style of treatment service provision for problem drug users, but understandably it was public health issues – originally just HIV/AIDS issues but later hepatitis C issues – which dominated for much of this period. As was the case elsewhere, the dilemma for Irish policy makers was whether they should continue to insist that, since “drug abuse” was such a self-evident social evil, treatment must have abstinence as its sole aim, or whether they should opt for more pragmatically based treatment systems, such as methadone maintenance and needle and syringe exchange.

In summary, what happened in Ireland was that between 1985 and the end of the century drug treatment policy and practice changed towards harm reduction, which included not merely the introduction of specific strategies such as methadone maintenance but also a decentralisation of services and the creation of outreach services. These changes were made within the Irish healthcare system in an incremental and covert style, largely without either public debate or official announcement; this served to avoid public controversy, but it also appears to have resulted in a somewhat confused situation where other sectors of government – including the criminal justice sector – were unclear as to what was happening on the treatment and rehabilitation side. By way of contrast, the introduction of harm reduction services within neighbouring Britain could be seen as reverting ideologically to the traditional “British system”, but in any event these changes were debated in a relatively public style and were justified by the

much-quoted conclusion of the Advisory Council on the Misuse of Drugs that: “The spread of HIV is a greater danger to individual and public health than drug misuse” (Advisory Council on the Misuse of Drugs, 1988, p. 75).

By 1997, therefore, when the Working Group on a Courts Commission was asked to consider the possibility of introducing the drug courts concept to Ireland, the Irish healthcare sector had shifted radically towards the use of harm reduction models, although this shift had occurred so gradually and so quietly that the criminal justice sector may not have appreciated its full extent or been philosophically in tune with it. While it could be argued that this covert style of policy making was functional in that it allowed for the introduction of liberal-seeming drug treatment policy into a relatively conservative political culture, it could not in management terms be seen as entirely helpful or as exemplary as regards intersectional collaboration.

### **3 The Drug Courts Proposal in Ireland**

#### **3.1 The Report of the Working Group on a Courts Commission**

As mentioned above, the report (which will be referred to hereafter simply as Drug Courts) recommending the setting up of drug courts in Ireland was completed in early 1998. The Working Group which drew up the report was chaired by a Supreme Court judge, as well as having five other judges among its members, and was almost entirely representative of the criminal justice sector, with no representation from the Irish healthcare sector. In preparing its report, the Working Group had drawn heavily on the American experience and this had included a visit to Ireland by visiting drug court experts from the USA for the purposes of a special conference on this topic. This influence from the American drug courts system does not seem to have been balanced by an equal degree of contact with the Irish treatment services, and reading the report in the context of the changes which have occurred in these services in recent years, it would seem that the Working Group was relatively unfamiliar with them. Instead, the philosophy implicit in Drug Courts and at times the explicit rhetoric of the report is that of the American “war on drugs”. Nowhere is this more apparent than in the report’s melodramatic opening sentences which declare that: “Drug abuse is a cancer in our society. It destroys individuals, families and communities” (Drug Courts, p. 11).

The report does admittedly refer to policy developments in countries other than the USA, and looks in particular at Germany, Sweden, Australia, and England and Wales. In its summary of developments in England and Wales, which deals with legislative proposals to create “Drug Treatment and Testing Orders”, the report quotes from a policy document to the effect that: “The success of any new legislation will depend on the availability of treatment and the resolution of cultural differences between the criminal justice system and treatment providers, underpinned by strong interagency arrangements” (cited in Drug Courts, p. 27). However, the Working Group does not seem to have taken this principle seriously in its own analysis of the Irish scene, in the sense that it makes no explicit effort to identify cultural differences which might impede collaboration between the two sectors in the creation of drug courts in Ireland.

Chapter 5 of Drug Courts describes the complex network of statutory and voluntary drug treatment services which currently exists in Ireland, referring to it as “the supporting infrastructure”, a phrase which could be read as implying that treatment systems have a subordinate relationship to the criminal justice sector, which might not be the most tactful way to initiate new collaborative relationships between the two sectors. What is also striking in this chapter, however, is that it does not advert explicitly to the dominance of harm reduction philosophy and strategies in the Irish healthcare sector or discuss the implications of this for the criminal justice sector. In fact, it is only in its recommendations section (Chapter 7) that the Working Group has a short paragraph on methadone maintenance which says that “while total abstinence is the optimal object of a drugs treatment programme the alternative system of

methadone maintenance should not be excluded” (Drug Courts, p. 64). Ironically, the report, which is dated February 1998, was only published and made widely available in September 1998, just before the introduction of a new “methadone protocol” which was intended to regulate and normalise methadone prescribing by Irish general medical practitioners. It is made clear in Appendix D, which is the text of an overview of American drug courts prepared for the conference held on this topic in Dublin in early 1998, that maintenance prescribing of methadone is not seen as an acceptable treatment modality by most drug courts in the USA (Drug Courts, p. 87).

Another item in the report which suggests that it reflects a traditional criminal justice perspective on illicit drug use, rather than the perspective of healthcare workers, is its insistence on making categorical distinctions between “addicts” and “dealers”. It is argued of drug courts that: “These are courts for drug addicts, not drug dealers” (Drug Courts, p. 15), a contention which is repeated later in the report. This distinction is the same as that made by the Minister for Health thirty years earlier when Irish drug policy was in its infancy, but it is not one which healthcare professionals (or indeed practising lawyers) find persuasive. Illicit drugs tend to be relatively expensive and for many users there are limited means of raising the money necessary to sustain their habit; one of these means is to do some small-scale drug dealing themselves so that many – if not most – users are also dealers. Within the criminal justice system offenders are categorised as “addicts” or “dealers” on the basis of the market value of drugs found in their possession, and the Working Group refers to the proposal (since implemented) to have mandatory prison sentences for offenders convicted of having possession of drugs with a market value in excess of £10,000. The Working Group does not favour this development, commenting that “mandatory sentencing is the antithesis of the philosophy behind the Drug Court process” (Drug Courts, p. 40), yet it seems clear that its strict enforcement would exclude from treatment and incarcerate many users who could not realistically be described as large-scale commercial dealers. Healthcare workers who have ongoing therapeutic relationships with drug users, particularly within harm reduction services, tend to accept philosophically that, however undesirable it may be, drug-dealing is part of the overall lifestyle of their clients; Drug Courts does not appear to acknowledge this, but retains the traditional stereotypical distinction between users and dealers.

Finally, it is striking that in its review of treatment services (“the supporting infrastructure”) the Working Group does not advert to the potential for conflict with the healthcare sector, which has built up its own services and facilities slowly and expensively and might view the drug courts proposal as a hijacking of healthcare resources for criminal justice purposes. It is clear that diverting offenders into treatment rather than prison will save money for the criminal justice system- it is noted that the cost of building a prison place in Ireland is approximately £100,000 per inmate and that the cost of maintaining a person in prison is approximately £46,000 per annum (Drug Courts, p. 53) – but it is not clear whether there will be a transfer of resources from the criminal justice to the healthcare sector as a kind of dowry to facilitate this process.

## **4 Discussion and Conclusion**

### **4.1 Drug Problems as Cross-Cutting Issues within Irish Public Sector Management**

It was suggested earlier in this article that in the language of modern public sector management drug-related problems may be seen as “cross-cutting issues”; what this means is that their management transcends any one sector of government and calls for the collaboration of a number of governmental sectors. Two of the most important sectors in this area are health and justice, the two which have been looked at here in relation to the proposal to set up dedicated drug courts in Ireland, but many other sectors – such as education, housing or employment – also may be seen

as having a part to play in the management of drug issues. It has been argued here that it is superficial and ultimately illusory to see the establishment of drug courts as nothing other than a practical management tool to co-ordinate the workings of two sectors; instead, it is argued, that fundamental cultural differences have arisen between health and justice and that policy developments must acknowledge and deal with these differences.

It is made clear in Drug Courts that this is a preliminary document and that another committee will have to take charge of the implementation of the proposed new courts. However, the Working Group, which was so impressive in terms of the speed with which it tackled the task set by the Minister for Justice, might have been better advised to co-opt representatives of the healthcare system and to recognise and engage with the ambiguity which characterises harm reduction, although to do this would undoubtedly have delayed the process of reporting.

#### 4.2 The Ownership of Drug Problems

To return to Gusfield's theoretical work which was referred to above, it would seem that despite the clarity and strength of the rhetoric with which drug problems are sometimes discussed and indeed denounced, there is no longer – if indeed there ever was – a cultural consensus on this subject. Ownership of drug problems has always been shared, primarily between health and justice, but with the gradual emergence of harm reduction within the healthcare sector in Ireland, as elsewhere, the process of sharing has become more fraught. What appears to have complicated the shared ownership of drug problems in Ireland is the surreptitious introduction of harm reduction into a healthcare system which had previously been abstinence-based. Some countries debated this issue and decided for harm reduction, while other countries debated it and decided against it; in Ireland there was virtually no public debate and the introduction was such a covert and incremental process that other sectors – in particular the justice sector – were slow to realise the extent and significance of this change. The meaning of illicit drug use, which was traditionally clear and unambiguous, has become increasingly contested. To some at least within the criminal justice system it remains a “social cancer”, while to many within healthcare its meaning has become more subtle and ambiguous. Perhaps what this study of the Irish drug court proposals suggests is that policy developments which are essentially concerned with shared ownership cannot make progress without at least some acknowledgement of these contested meanings.

#### References

- Advisory Council on the Misuse of Drugs *AIDS and Drug Misuse (Part 1)*. London: Her Majesty's Stationery Office, 1988
- Boyle R. *The Management of Cross-Cutting Issues*. Dublin: Institute of Public Administration, 1999
- Butler S. *Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed*. Administration, 39, 210-233, 1991
- Gusfield J. *Contested Meanings: The Construction of Alcohol Problems*. London: The University of Wisconsin Press, 1996
- Inciardi J., McBride D., Rivers J. *Drug Control and the Courts*. London: Sage, 1996
- Keogh E. *Illicit Drug Use and Related Criminal Activity in the Dublin Metropolitan Area*. Dublin: An Garda Síochána, 1997
- Klingemann H., Hunt G. (eds) *Drug Treatment Systems in an International Perspective: Drugs, Demons and Delinquents*. London: Sage, 1998



Martinson R. *What works? Questions and Answers About Prison Reform*. *The Public Interest*, 35, 22-54, 1974

O'Mahony P. *Mountjoy Prisoners: A Sociological and Criminological Profile*. Dublin: Stationery Office, 1997

*Report of the Working Party on Drug Abuse*. Dublin: Stationery Office, 1971

Strang J., Gossop M. (eds) *Heroin Addiction and Drug Policy: The British System*. Oxford: Oxford University Press, 1994

Trebach A. *The Heroin Solution*. London: Yale University Press, 1982

Working Group on a Courts Commission *Fifth Report: Drug Courts*. Dublin: Stationery Office, 1998

Correspondence Address:

Shane Butler,

Department of Social Studies, Trinity College, Dublin 2, Ireland

Tel: +353 1 608 2009, FAX: +353 1 671 2262, e-mail: [sbutler@tcd.ie](mailto:sbutler@tcd.ie)