

**An Evidence-Based Policy in a Moral Panic:**  
*Linking Local Drugs Task Forces to Drug Treatment Data*

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## ***Abstract***

*This dissertation considers the case of Irish drugs policy in 1996 which saw a change in established government thinking on drugs misuse to take account of social causality. This study seeks to investigate the extent to which this policy was evidence-based using drug treatment data by exploring all the mitigating factors. This research is grounded in theories of evidence-based policy making and models of the relationship between research, policy and practice.*

*The methodology was from a mixed methods approach including a case study of the 1996 Irish drugs policy which is single-case embedded design study. The embedded unit of the design takes a look at Blanchardstown Local Drugs Task Force. Investigation for this study was carried out using qualitative interviews, quantitative data analysis, documentary analysis and extended literature reviews.*

*The study finds that three major dynamics contribute to the change in government drug strategy in 1996, presenting a special case of evidence-based policy. The three dynamics are political imperative, political incentive and political legitimation. The drug treatment data is used to legitimate the government's policy decision.*

*Raging a war on drugs is rejected in favour of context-based evidence-based drugs policies. Such responsive evidence-based policies, which would unleash the potential of Local Drugs Task Forces, call for an interactive model of linkage and exchange between researchers, policy makers and practitioners in the area of drug misuse in Ireland*

## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BLDTF	Blanchardstown Local Drugs Task Force
CPA(s)	Community Priority Area(s)
CSO	Central Statistics Office
CDT(s)	Community Drug Team(s)
DARP	Drug Abuse Reporting Programme
DDTRS	Dublin Drug Treatment Reporting System
DED(s)	District Electoral Division(s)
DIS(s)	Drug Information System(s)
DMRD	Drug Misuse Research Division
EBM	Evidence Based Medicine
EIS	Epidemiological Information System
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FÁS	Foras Áiseanna Saothair (Training and Employment Authority)
GP	General Practitioner
HEB	Health Education Bureau
HIV	Human Immunodeficiency Virus
HRB	Health Research Board
LDTF(s)	Local Drugs Task Force(s)
LSD	Lysergic Acid Diethylamide
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NIDA	National Institute on Drug Abuse
PG	Pompidou Group
RCT(s)	Randomised Controlled Trial(s)
RDTF(s)	Regional Drug Task Forces
TDI	Treatment Demand Indicator



# 1 Introduction

‘The accumulation of data is all very well, but data left to its own devices tends to mumble in low tones rather than speak with a clear voice [in the absence]...of the authoritative and integrative scientific review which seeks purposely to make the connection with policy needs’

(Edwards, 1993: 7).

The crux of research is to provide a quality knowledge base to guide policy developments and practice change. The context of this study is how research is utilised in evidence-based policy and practice. Within this context, a case-study of Irish drugs policy in 1996 will be presented, and the implications of research using drug treatment data for this policy will be explored. The practice end of this policy will also be considered by looking at the example of Blanchardstown Local Drug Task Forces, one of the original eleven Local Drug Task Forces established as an outcome of this policy in 1996. This study seeks to investigate the link between Local Drug Task Forces and Drug Treatment Data. Was this a perfect case of evidence-based policy making linking research, policy and practice? Clearly, there were other mitigating social and political factors and this study will seek to examine the case of evidence-based drug policy in a moral panic.

This chapter will introduce the background to this research, highlight the aims of the study as well as explain the history behind data collection on drug misuse in Ireland with the establishment of the Drug Treatment Reporting System.

## 1.1 Background

The case of Irish drug policy in 1996 merits special attention in this study as it signalled a move away from established government responses to drug misuse and presented a pro-active agenda to tackle the drug issue at local level. Within the 1996 policy document, Irish epidemiological research using drug treatment data<sup>1</sup> is recognised as identifying ten ‘black spots’ in Dublin which translated into ten areas

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<sup>1</sup> O’Higgins, K. 1996. *Treated Drug Misuse in the Greater Dublin Area: A Review of Five Years 1990 – 1994*. Dublin: Health Research Board

from which the highest proportion of drug users seeking treatment resided. Subsequently, in 1997, ten Local Drugs Task Forces were established in each of these ten areas in Dublin (along with one in North Cork city) as part of a national structure to tackle the drugs issue. There are presently fourteen Local Drugs Task Forces in operation; thirteen of these are in the Greater Dublin Area.

## **1.2 Aims of the Study**

- This study aims to explore the link between research, policy and practice and investigate the evidence-based policy debate in the area of drugs misuse
- A case study will be presented of Irish Drug Policy in 1996 and will assess the use of drug treatment data, why there was a change in government response and the nature of this change
- A subunit of this case will consider the practical level changes of this policy with the example of Blanchardstown Local Drugs Task Force.

## **1.3 The Irish Treatment Demand Indicator**

The Drug Misuse Research Division (DMRD) of the Health Research Board (HRB) was established in 1989. It operates the National Drug Treatment Reporting System (NDTRS), which ‘aims to provide reliable information on the number and characteristics of people who are treated for problem drug use; and to examine patterns and trends of problem drug use’ (O’Brien et al, 2002).

The collection of statistical and epidemiological data on treated drug misuse in Ireland began with the participation of the Health Research Board in a Multi-city study initiated in 1984, which used comparable procedures and criteria to collect a standard set of core data from drug treatment centres on a routine basis (O’Hare and Hartnoll, 1989). The Drug Treatment Reporting System was set up in Ireland in 1990 and initially covered treatment demand in the Greater Dublin Area. The Dublin Drug Treatment Reporting System (DDTRS) was extended in 1995 to cover other areas of the country and hence, became the National Drug Treatment Reporting System (NDTRS). The NDTRS was initially based on the PG’s (Pompidou Group’s)

Definitive Protocol and was subsequently refined in accordance with the TDI (Treatment Demand Indicator) Protocol of the European Monitoring Centre on Drugs and Drug Addiction (Roland, 2000). The NDTRS is co-ordinated by the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children.

### **1.3.1 The National Drug Treatment Reporting System (NDTRS)**

Data is collected for the NDTRS on treated drug misuse in the Republic of Ireland and analysis of the data is used in certain different ways. Data analysis for service providers shows treatment status by each variable. Trends can be analysed considering person, place, time and type of drug used. The data is useful for policy-makers and planners and is used to inform local and national drug policy and planning. The next chapter will discuss how, in 1996, National Drug Treatment Reporting System data were used in identifying a number of local areas experiencing problematic drug use (Ministerial Task Force, 1996). Previous research using the treatment data undertaken by the Drug Misuse Research Division has looked at; trends in route of heroin administration in Dublin 1990-1996; service needs and provision for adolescents; links between deprivation and drug misuse and modelling patterns of drug use.

### **1.3.2 Reporting to the NDTRS**

Compliance with the NDTRS requires that one form be completed for each person who receives treatment for problematic drug use at each treatment centre in a calendar year. For the purpose of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems’ (O’Brien et al, 2003: 1). Those excluded from the NDTRS are those clients who attend needle-exchange programmes and those who report alcohol as their main drug of misuse.

Data falls into two main categories; “all treatment contacts” refers to information provided to the NDTRS from drug treatment agencies on all individuals who contact

them for treatment. “All treatment contacts” provide data for period prevalence. The second category is “first treatment contacts” which refers to a subset of clients who, during the year in question, demanded treatment for the first time, never having had previous treatment anywhere else for problem drug use (Moran et al, 1996). The top copy of the form is kept for the centre/service records and the carbon copy, whereby the identity of the client is kept anonymous, is sent to the Drug Misuse Research Division of the Health Research Board.

The data, which is collected on the form, relates to treatment contact details, socio-demographic information, problem drug-use and risk behaviour (see Appendix X).

The socio-demographic details provide valuable information on gender, age and importantly, area of residence (by way of a code), nationality, employment status, education and living status as well as details of whether or not the client lives with other drug misusers. Details on problem drug-use provide information on the clients’ main drug of misuse as well as subsequent drugs misused. Age of initiation of drug misuse is recorded, as well as duration of drug misuse, frequency of use in the past month and also important information on route of drug administration (e.g. injecting, smoking, sniffing etc). Information is also collected on risk behaviours relating to injecting behaviours and sharing practices.

#### **1.4 Organisation of Research:**

Each phase of this research will be divided into chapters. The following chapter, Chapter Two, will be a review of the literature relevant to this study including research using drug treatment data and the policy implications.

Chapter Three will present the methodology utilised in this research and discuss the research design which was most relevant for each research objective. Data collection and analysis will be examined and limitations of the research will also be discussed.

Chapter Four will investigate evidence-based policy making which will be the context of this study. The chapter will consider the link between research, policy and practice and also examine the research/policy relationship in the area of drug misuse.

Chapter Five will examine the chronology of Irish drug misuse policy tracing government responses from the 1970s to the 1990s and thus setting the scene for the policy under review.

Chapter Six will present the case study of Irish drug policy in 1996 and examine why a change had taken place in government strategy towards a targeted, local response and the nature of these changes

Chapter Seven will analyse a sub-unit of this case and present the practical level change of this policy with the example of Blanchardstown Local Drugs Task Force. This example is presented around interviews and reviewed documentation.

Chapter Eight will present an analysis of drug treatment data from the NDTRS for drug users seeking treatment between 1998 and 2002 who were residing in the Blanchardstown area to give an indication of changes to the profile of drug users in this area since the inception of the Blanchardstown Local Drugs Task Force

Chapter Nine will discuss the findings of this research by linking together the various strands of analysis in the previous chapters and attempt to draw conclusions from this research in line with the objectives purported at the onset of this dissertation.

## **2 Literature Review**

‘What does the knowledge enable us to do or to decide that would be impossible or impracticable without the knowledge?’

(Rickman, 1977: 189)

The question posed by Rickman above was developed from Wilkins (1965) who emphasised that the concept of information has meaning only with a purpose.

Little international research has investigated the influence of drug treatment demand data on policy and practice. In Ireland, this is the first time a study will examine the implications of treatment demand data in the context of evidence-based drug policy and practice development. This review of literature will detail studies focusing on policy-makers and their views on research, international papers looking at the implications of drug treatment data for policy and Irish studies using treatment demand data as well as literature on community action and communities organising. Chapter 4 will present a comprehensive analysis of literature on evidence-based policy formation.

### **2.1 Policy-makers perceptions**

A number of studies have considered the perceptions of policy-makers and practitioners perceptions of their use of research evidence.

Marmot (2004) contends that readiness to take action sways the view of the evidence and looks at this in relation to alcohol. He sees ‘people’s willingness to take action influences their view of the evidence, rather than the evidence influencing their willingness to take action’ (2004: 906).

Goldstein et al (1998) conducted a national survey of 284 HIV prevention programme managers in the United States. It was found that the majority of the programme managers surveyed did not seek out research and actually perceived research to be an unimportant source of information. While scientific findings were at the bottom of the list, peers and colleagues topped the list of information resources that influenced

policy decisions. Oakley and Peerson (2001) observe however, that very often interactions with colleagues and peers may include discussion of relevant research and thus, research may be used indirectly.

Elliot and Popay (2000) undertook a qualitative study to identify factors that facilitate or impede evidence-based policy making at the local level of the National Health Service (NHS) in the United Kingdom. The study consisted of a literature review and case studies of social research projects using content analysis and in-depth interviews with policy makers as to how they used research they deemed relevant to their own work. It is noted that three threads implicate the relationship between research and policy. The first thread is communication whereby; research is more likely to influence policy through an extended process of sustained dialogue between researchers and policy makers. The second thread relates to the presentation of research and how the application of research within specific contexts should be considered. A third thread is also discussed as to how ‘social research has a part to play in interpreting for people in one environment what it is like to inhabit another’ (Elliot and Popay, 2000: 463). Consequently, research is more likely to have an indirect influence on policy by shaping policy debate. The predominant argument, therefore, is for continuous communication between those conducting research and those involved in decision-making.

## **2.2 International studies on the implications of drug misuse research**

Hall (2004) describes collaborative research on heroin dependence undertaken between 1991 and 2001 by researchers at the National Drug and Alcohol Research Centre (NDARC) and discusses the contribution that this research may have made to the formulation of policies towards the treatment of heroin dependence.

Hall (2004: 566) contends that ‘good, policy-relevant research necessarily emerges from an interplay between investigator, curiosity, policy maker interest, the availability of funding, political interest and a good leavening of serendipity and happenstance’. In Hall’s view, there is a need to be realistic about the impact of research on policy. He describes the inevitable lagging response to research on new drug problems as it joins the queue behind other issues vying for political attention. It

is also possible that research may be pulled apart and used selectively by supporters of opposing policies. Hall asserts that good drug research evidence can best make a difference to policy over the long term.

### **2.3 International Studies on the Implications of Drug Treatment Data**

An early paper in the United States by Rickman (1977) was forward thinking in its focus on the implications of treatment demand data for policy. Rickman (1977) addresses the uses of drug treatment data in epidemiological methodology and their potential contribution to policy formulation. Programmatic relevance is referred to in relation to treatment data as being characteristic of the information that is needed to inform planning and evaluation. 'Treatment programs must be focused on demographic subgroups or geographic areas as well as being directed toward goals of definable changes that can be objectively evaluated' (Rickman, 1977: 189).

Patients in treatment for drug addiction must remain anonymous on data systems. However, as Rickman notes without reference to a geographic area of residence, it is impossible to compare the profiles of those in treatment with the demographic composition of the area in which they live.

Rickman argues that epidemiological information must 'enable policies and strategies to be based on adequate problem definition' as well as specifying groups and circumstances where intervention is needed and thus enhance decision making for programme priorities and allocations (Rickman, 1977: 190). Thus, it is contended, that an epidemiological perspective is needed to detail the location and nature of drug misuse problems that require information.

### **2.4 Irish research using drug treatment data**

Two studies are reviewed below in which drug treatment data from the NDTRS are analysed and subsequent policy recommendations highlighted.



### **2.4.1 The dragon in sheep's clothing**

Smyth et al (2000) examined trends in treated opiate misuse in Dublin and highlighted factors associated with route of heroin administration. Patterns of drug use tend to change over time in terms of the socio-demographic profile of users, the type of drug used and the route of drug administration (Smyth et al, 2000: 1217). Opiate misuse has been identified as a problem in Dublin since the 1970s at which time heroin injecting was the predominant behaviour. This study utilises data from the NDTRS, which included individuals who were residents of Dublin between January 1991 and December 1996, were seeking treatment for the first time and were reporting an opiate as their main drug of abuse.

The findings show that 77.5% of the sample was male and the mean age was 21.5 years. The mean age for commencing opiate use was 18.7 years. The six-year period subject to analysis saw a 330% increase in the number of new attenders. There were substantial socio-demographic changes in the profiles of the new attenders. There was an increase in the proportion of females. There was a decline in the mean age of initial opiate misuse as well as a decline in the mean age of first treatment as attenders began to present for treatment earlier in their drug career.

There was also a significant shift in drug use characteristics most notably heroin users were more likely to chase the dragon rather than inject after 1994. At the outset, an increase in chasing the dragon is seen as a positive finding in terms of harm reduction<sup>2</sup>. However, the findings from this project show that the sample had commenced heroin use quite recently, with 75% of the chasers using for two years or less. Ominously, this study quotes Cassin (1998) who found that 93% of opiate injectors smoked prior to injecting and that the mean time spent smoking was about two years. Strang (1997) also warns how the more acceptable nature of chasing may invite increasing numbers to try heroin. This study indeed hints at that suggestion as the rise in chasing concurred with a substantial rise in the number of new attenders for treatment. The authors conclude that 'chasing may prove to be a dragon in sheep's clothing' (Smyth et al, 2000: 1223).

Recommendations from this study point to the need of addiction treatment services to monitor and adapt to the changing profile and patterns of drug misusers. It is also recommends that future research measures the rate of transition to injecting by heroin chasers and pinpoint the factors associated with easing or impeding transitions in route of administration.

#### **2.4.2 Children treated for drug misuse**

Smyth et al (2004) use drug treatment demand data to address the problematic level of drug use among children in the greater Dublin area and highlight the need for a dedicated service for child drug users in Dublin

The definition of a child in this study is in line with the Children's Act 2001, which defines a child as a person who is aged 18 years or younger. Comparatively, Ireland has among the highest rates of substance misuse among children in Europe. This is mirrored in the increases in the number of young people seeking treatment for drug misuse in Ireland (Smyth et al, 2004).

Analysis of the data was confined to first treatment contacts and only residents in the greater Dublin area were included. Significant trends in children presenting for drug treatment emerged between 1990 and 1999. An analysis of the data shows that nearly 20% of clients presenting for drug misuse treatment during the 1990s were children. Of children seeking treatment, 28% were aged between 10 and 15 years. In nearly half of the cases the primary drug was an opiate. Over the decade the female to male ratio had increased and there was an increase in the number of children using heroin. Children were also increasingly more likely to report daily drug use and experience injecting.

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<sup>2</sup> Strang, J., Griffiths, P. and Gossop, M. (1997) Heroin smoking by 'chasing the dragon': origins and history. *Journal of Addiction*, 92, 673 – 683

This research underlines the insufficient age-specific programmes available to meet the need of the large numbers of children presenting for drug treatment in Dublin. This has been identified as an important issue in the 2000 National Children's Strategy.

## **2.5 Critiques of Irish Drug Policy**

According to Butler (1997), criticisms of conventional drug policy tends to be based on either abstract philosophical grounds or on more practical arguments as to the ineffectiveness or counter productivity of drug prohibition.

Many authors suggest that the struggle and debate with understandings and interpretations of the drug issue has been hampered by the importation of ideas about the nature of drug addiction in international settings (Quin, 1999; Butler, 2002). Butler (1991) criticised Irish drug policy for failing to create any structure which facilitated critical debate and, accordingly, policies axiomatically reflected the central tenets of the war on drugs. The concept of a 'war on drugs' has come to dominate national and international policy debates, adopted from the American catch cry aimed at the prohibition of a range of psychoactive drugs. The concept implies that those in a society who use drugs are in direct conflict with those who do not and therefore should be criminalised; in essence it is as much a 'war on drug users' as a 'war on drugs' (Dillon, 2001). It is argued that this policy is a form of social exclusion. Buchanan and Young (2000) considered a policy based on a war on drug in the U.K. and found that consequently a sample of problematic drug users were subjected to a process of stigmatisation, marginalisation and social exclusion. Critics of the war on drugs argue that there is no cultural consensus on the evil of psychoactive drugs, the 'war' damages society as much as, if not more than the drugs themselves and that ultimately society should try to live in peaceful co-existence with that which are inanimate substances not demons (Butler, 1997).

*Rethinking the War on Drugs in Ireland* (Murphy, 1996) combines both philosophical and practical criticisms of Irish drugs policy. Murphy (1996: 3) attacks existing policy on the basis that it is morally wrong,

'I regard prohibition as ineffectual, irresponsible and illegitimate; it is ineffectual because it is falling far short of its objectives; it is irresponsible because it is contributing directly and indirectly, to the creation of greater social problems to those which is directed against; and it is illegitimate because it employs incarceration and other criminal sanctions in an improper and excessive manner'.

Murphy's argument is developed around the framework of Drug, Set and Setting (Zinberg, 1984). In his study, Zinberg (1984: 5) theorised that 'in order to understand what impels someone to use an illicit drug and how that drug affects the user, three determinants must be considered: drug (the pharmacologic action of the substance itself), set (the attitude of the person at the time of use, including his personality structure) and setting (the influence of the physical and social setting within which the use occurs). Using this framework, Murphy (1996) objects to the disinclination of Irish drug policies to address the socio-economic factors which leaves some sections of the population predisposed to drug problems.

Butler (1997: 160) maintains that

'epidemiological studies of treated drug misuse in Dublin have consistently revealed that serious drug problems are not randomly distributed in geographic or socio-economic terms but that they cluster in neighbourhoods characterised by poverty and general disadvantage; these studies have also shown that problem drug users tend to be educationally disadvantaged and unemployed, and that this complex package of personal difficulties cannot reasonably be attributed to drug use alone'.

Taking Irish drug policy then in the context of Zinberg's thesis, it has been argued that policy has concentrated on 'drug' and 'set' to the almost total exclusion of 'setting' (Butler, 1997; Murphy, 1996). Supply reduction policies have aimed at abolishing the drug trade in the country while policies aimed at the 'set' have been preventative orientated educating individual decision-making to 'just say no', while ignoring the structural factors which influence such decision-making (Butler, 1997; Butler, 1994; Dorn and Murji, 1992).

Butler (1997) reviews Murphy's (1996) *Rethinking the war on drugs* with the 1996 *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (referred to as the Rabbitte Report). Butler (1997) describes the Rabbitte Report as a document produced in the heat of battle, undertaken during Ireland's six month Presidency of the European Union and in the wake of moral panic surrounding the murder of journalist Veronica Guerin by drug traffickers. Although there are measures concerned with reducing the demand for drugs, there is no desertion of the supply reduction policies, 'and it is this retention of the basic philosophy of the war on drugs which largely explains why the Rabbitte Report, despite containing some important new policy approaches, cannot be seen as initiating a radically new era in Irish drug policy making' (Butler, 1997: 164).

Butler (1997) criticises the Rabbitte Report for failing to deal with three important topics; the definition of drug problems, the dynamics of local community partnerships and the concept of harm reduction. He concludes that from these indications it is clear that 'the Irish policy climate is not yet ready for the rationality and the radicalism of Murphy's critique; change is taking place in Irish drug policy, but it is cautious and gradual change which seeks to avoid the impression that a war has been lost' (Butler, 1996: 174).

McCann (1997) is critical of the report in a number of ways. She comments on the lack of clarity in the policy document to differentiate between the new proposed national structures and the existing but non-functioning National Co-ordinating Committee on Drug Abuse. McCann (1997: 12) also criticises the lack of analysis on why mechanisms initiated following the 1991 National Strategy to Prevent Drug Misuse had not led to fuller integration, as 'without such analysis it runs the risk of also failing to achieve this goal'.

## **2.6 Community Action Literature**

Duggan (1999) contends that in relation to poverty and social exclusion, Irish social policy has centred on the three principles of 'partnership', 'local' and 'targeting'. The 'compounding effect of localised concentrations of poverty is acknowledged within

official documentation’, according to Duggan (1999: 59) who gives the example of 1996, when all major policy documents referred to the spatial dimension of poverty, though precedents of spatially focused policy to combat poverty and exclusion go back to the early years of the state. Within this was the recognition of local interventions and initiatives.

Community action can be seen to be empowering to the extent that members of the community see themselves ‘acquiring a capacity to take greater control over their own affairs’ (Varley, 1998: 392). In Ireland, it was clear that many of the problems faced by communities were not ones they could realistically solve by their own efforts and so it was at the ‘bottom’ (Zappone, 1998) that the idea of partnership between the community sectors, statutory bodies and business was promoted in the late 1980s. In the context of the 1980s recession in Irish society, the social partners and a new government negotiated the Programme for National Recovery which ran from 1987 to 1990. This was to be the first of a line of agreements of negotiated economic and social governance. The Programme for Economic and Social Progress (PESP), which ran from 1990 – 1993, devolved social partnership to the local level with the establishment of twelve Area-Based Partnerships extending to thirty-eight in 1993. The Strategic Management Initiative was introduced in 1994 as a cross-cutting exercise in Departments, and this was used to conceptualise partnership arrangements. According to Sabel (1996), Area-Based Partnerships were created explicitly to address economic disintegration and its consequences, mainly in terms of unemployment. The partnerships act as ‘conduits for local involvement in formulating strategies, channelling resources and implementing policies to deal with the issues of local concern’ (Sabel, 1996: 4). Zappone (1998: 53) wonders whether ‘top down’ designs intend to facilitate or control the ‘bottom up’ dynamic as structures for local development should facilitate, not block or control radical energy for significant change which is central to a bottom-up approach. Otherwise there will be little room for empowerment.

## **2.7 Calls for action**

Reviewed literature suggests that Dublin communities experiencing the ravages of heroin have consistently made the case from the early 1980s onwards that strategies for drug prevention must respond to the problem in its social context. O'Hare and O'Brien (1992) maintain that heroin hit the North inner city in 1981 over a year after it had gripped Dublin's Southside communities, and in a matter of weeks it had devastated the area (Flynn and Yeates, 1985). By the summer of 1984, it was clear that the drugs epidemic and the problems it spawned had reached a peak. The drugs issue, in stark contrast to the situation a decade earlier, was now dominating the news headlines and as Flynn and Yeates (1985: 324) observed 'Dublin became a byword for heroin in the international press'. Community activism took hold as *Concerned Parents Against Drugs* (CPAD) and other local groups began campaigning against drug pushers.

### **2.7.1 Case Study on a Community Organising**

A case study by Cullen (1989) focused on the experiences of one CPAD drugs which was formed in an inner-city community. The CPAD first formed in the summer of 1983 in response to the escalation of illicit drug use, particularly heroin, in mainly working class communities. According to Cullen (1989) as early as 1978, doctors and social workers working in the communities were making strenuous but vain attempts to raise the issues of problem drug use with the public authorities. Indeed the CPAD was not the first attempt by the community to respond to the problem. In the case of St. Teresas Gardens, the local development committee had instigated repeated efforts in conjunction with other community groups to generate a statutory response but failed. Cullen (1989: 279) notes that 'within months of the first meeting of the CPAD in St. Teresas Gardens in June 1983, the whole of the inner-city was alive with mass meetings, protests, marches and the catch-call of the CPAD "pushers out"'. While the local development committee would have come together for various important local issues, including the drug problem; the CPAD united around the issue of heroin. The main features of the early years of the CPAD were mass participation, democratic and non-violent action. In St. Teresas Gardens weekly public meetings were held in

which patrols of the flats were organised and any problems were discussed. Once here was evidence of drug pushing, the pusher had the opportunity to respond. The measure of success could be seen in the first four months of the CPAD campaign in St. Teresas Gardens as each alleged pusher either decided to leave the estate or conceded guilt in front of a public meeting (Cullen, 1989: 281). All this had been achieved peacefully, without any resort to violence. St. Teresas Gardens CPAD became a source of inspiration to other communities across the capital and by the end of 1983, CPAD were being formed in other working class neighbourhoods of the city. In February 1984 a central committee of the CPAD was formed. A mass demonstration of CPAD on government buildings was organised, with a considerable turnout which received a great deal of media attention.

Despite these successes, Cullen (1989) contends that there were a number of factors that impeded the potential of the CPAD to achieve real change. Firstly, there was avoidance among established community groups to become involved with the CPAD which could have otherwise resulted in a more effective action plan. Secondly, a general fear and suspicion of community based developments by the government is noted which is reflected by the lack of a statutory response. This problem was no doubt compounded by the third problem which was the increasing domination of the CPAD central committee by Sinn Féin as well as another problem, the infiltration of violent factions in the central committee parading as CPAD activists. Cullen (1989: 293) concludes that the 'CPAD provided a temporary respite from much of the alienation that surrounded and contributed to heroin-use in the first instance and its methods also provided practical evidence that mobilised local action has a place in developing a response to threatening social conditions'.

## **2.8 Communities Organising in the 1990s**

A community group ICON was established in 1992 with the objective of serious and focused co-ordination of prevention and treatment services with its Inter-Agency Drugs Project as well as the objective of supporting local tenants groups in conducting street marches and public campaigns against the open dealing in the north inner city (ICON, 1999: 13-14). This second objective saw their action day in



October 1995 attracting 1,000 protesters and also saw the establishment of the Dublin CityWide Drugs Crisis Campaign. But according to Murphy-Lawless (2002: 102),

‘It was not until the publication of the First Ministerial Task Force Report in 1996 that the state finally began to seriously engage with arguments about the need for extensive resourcing at community level to aid community development as a strategy in prevention. There is no question that the marches and the circumstances of journalist Veronica Guerin’s murder contributed in a major way to this change of direction’.

## **2.9 Conclusion**

A number of issues are clear from the literature reviewed for this study. Firstly, evidence-based policy formation is a complex concept and the entire next chapter of this study will consider the intricacies of this debate. Secondly, drug treatment data has not been solely used as part of research on drug misuse in much international literature and recommendations arising from the two Irish studies reviewed that have analysed drug treatment demand data from the NDTRS have not been explicitly translated into policy change and developments. Thirdly, many authors have critiqued Irish drugs policy; of special interest to this study have been those critiques of Irish drug policy circa 1996, and critiques of the 1996 policy document itself. Fourthly, the case of community action has a myriad of theories and a comprehensive examination of these is beyond the scope of this study. The literature above is merely a piece of what is relevant to the context of this study detailing the rise of community action and how communities organise in the face of a drug problem. The end quote above from Murphy-Lawless (2002) will be explored in detail as part of this study to ascertain this change to established government response in 1996 and to explore the implications of research evidence for this policy as well as the influence of community activism and established political initiatives. The following chapter will present the methods used which enabled this exploration.

### **3 Methodology**

The design of this research was from a mixed methods approach. The nature of the research enquiry is exploratory. The source of the data is from both primary and secondary data. The method of data collection is from face-to-face and telephone interviews and e-mailed correspondence, secondary data analysis, database searches and documentary analysis.

#### **3.1 Research Objectives**

The aim of this study is to consider the link between research, policy and practice in the area of drug misuse.

The main objectives of this research are set out thus;

1. To examine evidence – based drug policy and practice considering the uptake of drug misuse research into policy and practice as well as the barriers to the uptake of drug misuse research into policy and practice
2. To assess whether drug treatment data has been used in research to influence policy formulation and practice change and development in the Irish context using an Irish case study.
3. To explore, within this Irish example, what developments and changes took place at the practical level

#### **3.2 Research Design**

The research is designed around the research objectives outlined above. ‘Because different study designs answer different research questions, it is worth identifying the type of question the research is needed to answer and then specifying what *type of research design* it needs to be able to answer the question’ (Harden, 2001: 48 – original emphasis).

At the outset, therefore, Harden’s simple advice was followed and thus, the research objectives were kept to the fore throughout the study. In identifying what type of questions the research needed to answer the author referred to the objectives of the

study. From these objectives it was possible to ascertain what needed to be answered by breaking down each objective into a set of questions. From this dissection it became clear what type of research design was needed.

Taking each of the objectives above, a set of clear questions were formulated which intended to address the issues encased in each objective. This formula facilitated the formation of an approach which could best deal with the decision-making around research design and delivery.

### **3.3 Objective 1**

*How can this study examine evidence-based drug policy and practice considering the uptake of drug misuse research into policy and practice as well as the barriers to the uptake of drug misuse research into policy and practice?*

#### **3.3.1 Nature of the research enquiry**

Objective 1 was broken down into a set of manageable questions which aimed to direct the nature of the research enquiry. The questions identified were as follows;

- What is the research/ policy relationship?
- What is evidence-based policy formation?
- What are the barriers to the uptake of research into policy/practice?
- What are the facilitators of the uptake of research into policy/practice?
- What is the drug misuse research/policy relationship?
- What is evidence-based drug policy formation?
- What are the barriers to the uptake of drug misuse research into policy/practice?
- What are the facilitators of the uptake of drug misuse research into policy/practice?

### 3.3.2 Research Design

‘A research design is the logic that links the data to be collected (and the conclusions to be drawn) to the initial questions of study’ (Yin, 2003: 19). From the questions formulated above it was clear that descriptive research was required to define the issues involved. The most appropriate method for this research was secondary research which would necessitate the review and analysis of documents relating to evidence-based policy formation and evidence-based drug policy formation.

### 3.4 Objective 2

*How can this study explore specifically whether drug treatment data has been used in research to influence policy formulation and practice change and development in the Irish context using an Irish example?*

#### 3.4.1 Objective 3

*How can this study explore, within this Irish example, what developments and changes took place at the practical level?*

#### 3.4.2 The Nature of the Research Enquiry

The second and third objectives of this study were to be taken together to form one important research inquiry as part of this study. The best way to answer the above research questions was to explore a case in the Irish context in which drug treatment data was used to influence policy formulation and practice change and development. For the second objective the following questions required attention:

- What was the history of drug misuse in Ireland?
- What was the history of Irish Government drug policy?
- Was drug treatment data used to influence policy in Ireland?
- If so, when was it used?
- If it was used, what facilitated the uptake of research using drug treatment data?

- What policy was formulated in this case?
- What were the practice changes and developments of the Irish case?

The third objective required an enquiry which would differ to the first three objectives. While the nature of the first three objectives called for documentary analysis and literature reviews, this objective was a social enquiry which could not be addressed through the pages of a book. The following set of questions was formulated:

- What was the practical change that took place if research influenced policy in this Irish example?
- Why did it come about?
- What was happening prior to this?
- What was the nature of this change and development?
- What is happening at the practical level?
- How is this funded?
- Who is involved?
- What is ongoing?

There are a myriad of questions that were formulated and it was clear that the answers would need to be found at the ground level.

### **3.4.3 Research Design**

Philliber, Schwab and Samsloss (1980) note, that a research design can be seen as a blueprint of research dealing with at least four problems: what questions to study, what data are relevant, what data to collect and how to analyse the results. Taking the final two objectives together, it was clear that the nature of the research enquiry would be best addressed through case study research. This case study would focus on Irish drugs misuse policy in 1996. Platt's (1992a) words are chosen to illustrate the importance of case study design for the context of the current study. She notes that the case study strategy begins with a logic of design...a strategy to be preferred when circumstances and research problems are appropriate rather than an ideological commitment to be followed whatever the circumstances' (Platt, 1992a: 46). The second objective of this study necessitated the application of similar social research

skills to the first two objectives. The nature of the research enquiry was descriptive. These questions could be best answered through secondary analysis which would enable an analysis of policy documentation, literature on drug misuse in Ireland and research conducted in Ireland using drug treatment data.

For the third objective, the questions of study were many and so it was clear that exploratory research was required. As Local Drugs Task Forces were the practice level change that took place as a result of policy developments, one LDTF was to be selected as an embedded unit of analysis as part of the Irish case in order to answer to questions pose above.

#### **3.4.4 Theory development**

The case study will show how and why evidence-based drug misuse policy making took place quickly in response to a crises in Ireland in 1996, leading to a shift in established government response towards social causality and the establishment of local, integrated responses in the form of Local Drugs Task Forces.

The case study will also show, by selecting Blanchardstown, one of the Local Drugs Task Force Areas, how local community campaigns for action in this area, was a catapult for change in addition to the evidence-base which pointed to the intertwining drugs/social disadvantage problem within this community.

As these two ‘initial ingredients’ are elaborated, the stated ideas will increasingly cover the questions, propositions, units of analysis, logic connecting data to propositions, and criteria for interpreting the findings which, according to Yin (2003: 29) are the ‘five components of the needed research design’.

### **3.5 Case Study Design**

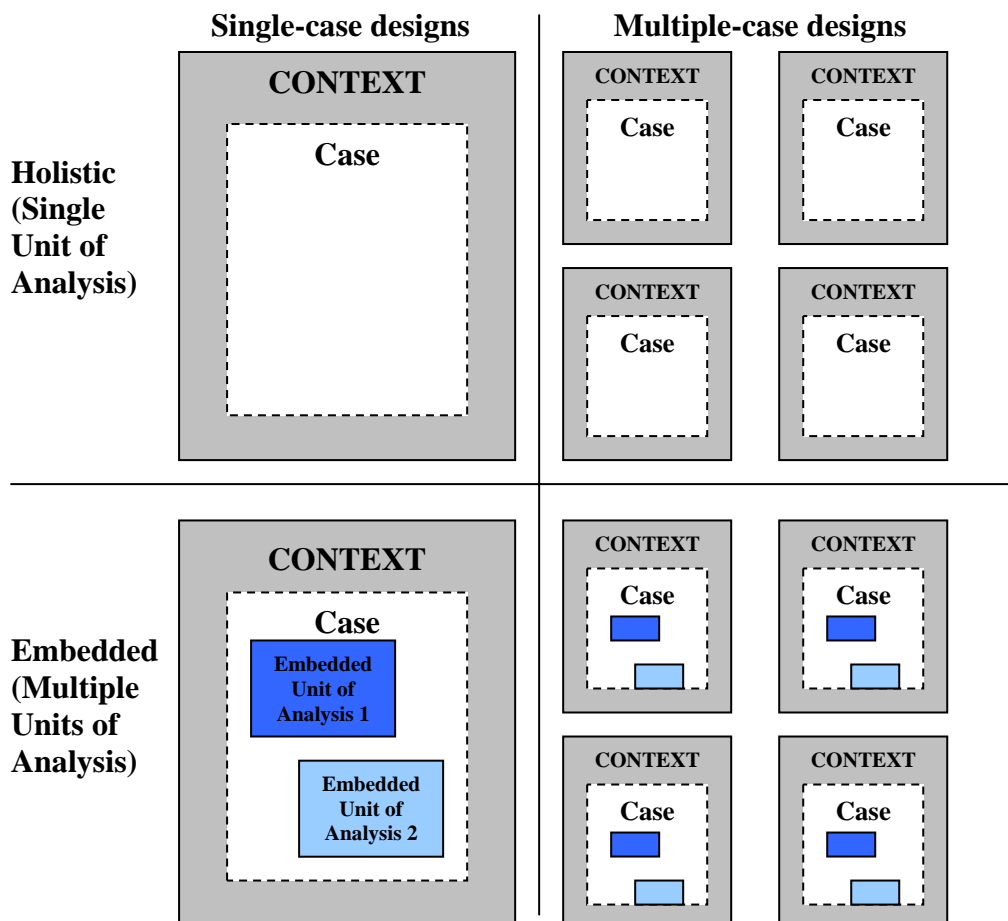
Figure 3.5.2 below depicts the four basic case study designs; single-case holistic designs, multiple-case holistic designs, single-case embedded designs and multiple case embedded designs (Yin, 2003). The design of this case study will take the form

of a single-case embedded design. The case study of the 1996 Irish drug misuse policy was under consideration within the broader context of this overall study and the embedded unit of analysis within the case was the Blanchardstown Local Drugs Task Force (see Figure 3.5.3 below).

### 3.5.1 Design Rationale

The rationale for this single case embedded design is that this case of Irish drug misuse policy in 1996 represented a unique case in the history of Irish drug misuse policy as a turning point in the Irish government’s response to drugs misuse. This will be illustrated within the overall context of the study. The subunit of analysis, the Blanchardstown Local Drugs Task Force was one of the original eleven Local Drugs Task Forces (there are presently fourteen Local Drugs Task Forces in Ireland) which was set up as an outcome of this policy.

**Figure 3.5.2 - Basic Case Study Designs**

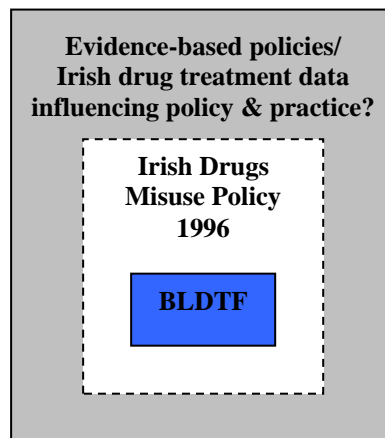


(Source COSMOS Corporation in Yin, 2003: 40)

- Embedded Unit of Analysis 1
- Embedded Unit of Analysis 2

The design of this case study was conducive to an exploration of the 1996 drugs misuse policy from a consideration of the use of drug treatment demand data in policy within the overall context of evidence-based policy making, to the operational detail of the policy with the Blanchardstown Local Drugs Task Force (BLDTF) example. While a holistic design could be criticised for being conducted at an abstract level, the embedded design serves as an important device for focusing this case study inquiry (Yin, 2003).

**Figure 3.5.3 - Case Study Design**



### **3.6 Sources of Data and Method of Data Collection**

For the first part of this study, the source of data was from reviewed literature and previous research on:

- Evidence-based policy making/evidence-based drug misuse policies
- Drug treatment data/drug treatment demand/drug treatment trends

A systematic search of the relevant internet and library databases was carried out using the above key words for each topic to determine what literature was available.



The National Documentation Centre in the Drugs Misuse Research Division of the HRB (Health Research Board) was a valuable resource while researching literature on drugs. Journal articles were the major source of information and the most popular journals used in this study were the BMJ (British Medical Journal), Journal of Addiction, Journal of Social Science and Medicine and Journal of Epidemiology. At the outset, sifting through the myriad of information, helped to identify the specific issues relevant to this research as well as guiding the formulation of the research questions as set out earlier.

The case study was divided into two parts. The case itself was Irish drug misuse policy in 1996, and the embedded unit of analysis was the Blanchardstown Local Drugs Task Force. Data collection on the case took the form of database and library searches to trace the history of Irish drug misuse policy up to 1996 and to document the change in policy response in 1996. Policy documents relating to the drugs issue from 1971 - 1999 were a major part of data collection as well as books and journal articles on the drugs issue in Ireland.

The method of data collection on the Blanchardstown LDTF was varied. The author visited Blanchardstown and conducted a one hour face-to-face interview with the BLDTF co-ordinator Mr. Joe Doyle. The visit also enabled the author to review available BLDTF literature on BLDTF submissions, action plans, funding and projects. A one hour telephone interview was also conducted with Mr. Fergus McCabe who is the National Drug Strategy Team (NDST) liaison person on the BLDTF. Both of these interviews were taped for transcription purposes. An additional source of information came from e-mailed correspondence in the form of an open-ended questionnaire with Sinéad Wiley LDTF co-ordinator for Dublin North East. The questionnaire covered similar questions to those on the BLDTF interview schedule and the perceptions of a co-ordinator in a different LDTF area added a fresh angle to the study.

Another source of data on Blanchardstown came from drug treatment demand data from the NDTRS (National Drug Treatment Reporting System, see Chapter 1) for those seeking drug treatment between 1998 -2002 who were residing in the Blanchardstown area.

### **3.7 Data Analysis**

The review of the above literature enabled a greater understanding of the issues involved in drug treatment demand, in the Irish drugs context and in the Irish drug misuse policy responses as well as the evidence-based policy debate. Once the research questions were kept to the fore, the analysis of the literature became a feasible task and this documentary analysis facilitated the identification of appropriate documentation with which to address the issues under investigation.

The interviews which were conducted were transcribed and analysed. Though the interview schedule for each interview differed, many of the same issues emerged and it was possible to ascertain some important factors. In addition, the interviews which were conducted complemented one another as they were highlighting the policy perspective and the practical perspective and this offered a unique insight into the intricacies involved, which cannot be read from a book or journal article.

The author visited the Drugs Misuse Research Division of the HRB and was provided with syntax on drug treatment demand data for the Blanchardstown area for the period 1998 - 2002 from Dr. Jean Long (co-ordinator of the NDTRS). This data relates to persons seeking treatment between 1998 – 2002 who were residing in Blanchardstown and can be analysed in terms of demographics, drugs of misuse, drug misuse practices and risk behaviours. This data was then analysed according to similar variables for 1995 NDTRS data for Blanchardstown used in a submission from BLDTF in order to compare and contrast results. This analysis could facilitate a discussion on changes to the profile of treated drug misusers residing in the Blanchardstown area since the inception of the BLDTF and subsequent implications for services and targeted interventions.

Taken together, the interviews, secondary data analysis and documentary analysis all contribute to the BLDTF jigsaw and this entire embedded unit of analysis is discussed in relation to the case of Irish drug misuse policy in 1996, all within the broader exploration of evidence-based policy making and, specifically, the influence of treatment demand data in drug misuse policy making in Ireland.

### **3.8 Limitations of the Research**

There are a number of limitations to this research design which undoubtedly affect the research outcomes.

Firstly, within the overall context of this study, considering the implications of drug treatment demand data for policy and practice change is limiting in itself. It may be argued that a more comprehensive study would consider how a number of indicators of drug misuse (e.g. drug seizures, drug convictions) intertwine to influence policy and practice development. However, drug treatment demand was chosen as the indicator for consideration as evidence existed which pointed to it as having a role to play in evidence-based drug policy making in Ireland in 1996. This study then sought to explore the nature of this role, and thus drug treatment demand data was chosen as a sole indicator for this reason.

Selecting the case study method of research as part of this study may be seen as a limitation of this study as ‘the case study has long been stereotyped as a weak sibling among social science methods’ (Yin, 2003: xiii). However, despite this stereotype, case study research continues to be used extensively in the social sciences. It was the preferred method for this research as it was deemed to be the best design in which to address the specific research objectives cited above. This research hopes to challenge this prevailing stereotype by presenting the case study as a rigorous method of social inquiry.

Due to time limitations and word restrictions this research only focuses on one subunit of analysis i.e. the Blanchardstown Local Drugs Task Force. Indeed, the ideal case study design would contain eleven embedded units of analysis (the original eleven LDTFs). This could be seen as a limitation of this design, as including a number of other subunits of analysis (some of the other original eleven LDTFs) would increase the internal validity of the study enabling pattern matching and explanation building between LDTFs. In addition, though the Blanchardstown LDTF, as the only subunit of analysis, may be seen as being representative or a typical unit of analysis of the eleven original LDTFs, this is by no means inferred. Each of the original eleven priority areas identified by the Ministerial Task Force in 1996 for a targeted response

to the drugs issue in their local communities were given a common title 'Local Drugs Task Force Area', however beyond this, generalizations are not implied nor intended with the presentation of the Blanchardstown LDTF within this study. It is indisputable that the other LDTF areas have their own stories to tell and this study does not propose to generalize unless a certain statement is explicitly noted as referring to all LDTFs.

### **3.9 Conclusion**

The methodology detailed above was chosen as the most appropriate to deal with the research enquiry of this study. The research design facilitated the collection of relevant data to make the connection between the stated research objectives and research outcomes. There were a number of limitations to this study as explained above. However, it was possible by following the research design closely to undertake an exploration of a case of evidence-based policy making in a moral panic and to thus consider a possible link between Local Drugs Task Forces and drug treatment data.

## **4 Evidence-Based Policy Formation**

‘The Greenwich clock earned the honour of sitting astride the zero meridian because it never told anyone which way to go, it simply offered the truth’.

(Valliant in Jaffe, 1993: 344).

Valliant analogises that a scientist presents findings without endorsing any policy, therefore, not setting out to add value judgements. It is necessary, therefore, to look at the relationship between research and policy to understand the formation and development of evidence-based policy and practice.

### **4.1 Theories on the relationship between research and policy**

Innvær et al (2002) present two predominant theoretical perspectives in literature relating to the research/policy relationship. The first perspective is known as the ‘two cultures’ thesis that analogises between the researcher/policy-maker relationship and the natural sciences/humanities relationship. From this perspective researchers and policy-makers are from two different cultures or communities and lack the ability to take account of the realities of one another. The second perspective centres on the concept of the ‘use of research’ and how the word ‘use’ may be conceptualised in different ways. The most frequent categories of the different types of use found in the literature review by Innvær et al (2002) were, direct use (‘instrumental’ or ‘engineering’); selective use (‘symbolic’ or ‘legitimating’) and enlightening use (‘conceptual’). The degree to which research is used either directly, selectively or in an enlightening way may vary according to different types of decision-makers, from those at the upper echelons to those at the lower level, it may also vary according to the different type of policy questions and also according to the different issues (adoption versus implementation, or decision versus action) (Innvær et al, 2000).

While many authors describe a number of different models of the relationship between research and policy, there seems to be little evidence of a direct link between research and policy. Weiss (1978) advocated an ‘enlightenment model’ in which ideas from research infiltrate policy decisions indirectly. This model has since been expanded to

view different uses of research for policy as data, ideas and arguments. The approach that policy research is a producer of data is a relatively simple model of engineering knowledge. The contrasting notion of research as ideas is a more humanistic, flexible model. The view of research as argument, however, is close to a biased, controversial model. Wittrock (1991) makes similar distinctions between enlightening, technocratic, bureaucratic and engineering models. A number of authors enter the debate from a wider philosophical standpoint. Rein and Schon (1991) work from theories on discourse and constructivism arguing for 'frame reflective' policy discourse. Majone (1991), interestingly, distinguishes between the policy core, which is deeply ingrained and irrefutable, and the protective policy belt, which is easier to influence in light of research, and may over time lead to transformations to the policy core.

## 4.2 Models of the research-policy relationship

Several authors have identified a number of models of the research-policy relationship.<sup>3 4 5 6</sup> Berridge (2004) identifies four theories of how research gets used in policy and practice; the rational model – the EBM or evidence-based policy movements; the enlightenment theories; journalism – 'delay and blame', heroes and villains and the science policy/political science model.

### *Rational*

The rational model sees research being used for developing evidence-based policies, planning interventions, allocating resources, targeting resources, amending legislation and so on.

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<sup>3</sup> Berridge, V. (2003) Epidemiology and policy: the post war context, UN Bulletin on Narcotics, 54, 1&2, 143-151

<sup>4</sup> Cohen, P.D.A. (1997) 'The relationship between drug use prevalence estimation and policy interests' in Estimating the prevalence of problem drug use in Europe, Chapter 2, 27-34. EMCDDA and Pompidou Group

<sup>5</sup> Stimson, Gerry V. (1997) 'Estimating the scale and nature of drug problems: the relationship between science, policy and drugs strategy' in Estimating the prevalence of problem drug use in Europe, Chapter 1, 19-26. EMCDDA and Pompidou Group

<sup>6</sup> Reuter, P. (1993) Prevalence estimation and policy formulation. Journal of Drug Issues, 23, 167-184

### *Enlightenment*

In the enlightenment model research influences policy in a more diffuse manner reflecting a ‘trickling’ effect over time and thus, becomes part of a climate of opinion which is familiar to people and can contribute to a shift in policy paradigm. Hartnoll (2004) presents the example of the contribution of epidemiological and sociological perspectives to broadening drug policy paradigms beyond disease or repression-based approaches. Thomas (in Berridge 2004) described this model, as the ‘limestone effect’ comparing research to the action of water and it was not possible to predict where it would come out.

### *Journalism*

The journalism model relies on blame. In relation to public health issues if something is not put in place it is someone’s fault. This model is seen to be quite common for HIV/AIDS (Berridge, 2004).

### *Sociology of science*

The political science and sociology of science models have emphasised theories focusing on networks in policy-making and actor networks.

Hartnoll (2004) presents further models of the research/policy relationship

### *Legitimation*

In the legitimation model of the relationship between research and policy, research is used selectively to legitimate and justify existing policy decisions.

### *Economic: who benefits?*

In this model, economic and commercial interests influence the impact that research has on policy. The alcohol, tobacco and pharmaceutical industries fund prevention and treatment research, which may subtly influence research processes and results.

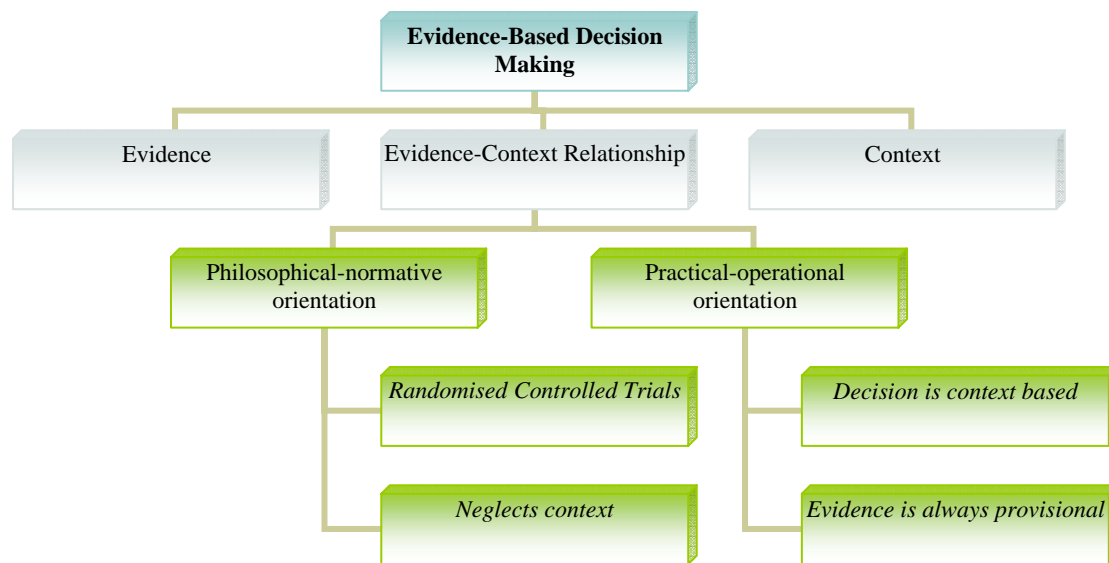
### *Stakeholder partnership*

Martin Buechi (discussion paper for PG conference) proposes this model, which suggests three-way collaboration between government, science and the market place, which could facilitate exchange of knowledge and policy development.

## 4.2 What is evidence – based policy formation?

The idea of evidence-based decision-making centres on the justification of decisions. In the shift from evidence-based medicine at the individual-clinical level to evidence-based decision-making at the population level, decision-making becomes more variable and complex.

**Figure 4.1 Evidence-based decision making framework**



(Dobrow et al, 2004)

Dobrow et al (2004) proffer a conceptual framework addressing what constitutes evidence, how evidence is utilised and how context has implications for evidence-based decision-making, as depicted in Figure 4.1 above. The two central components of an evidence-based decision are evidence and context. There are two fundamental orientations regarding the evidence-context relationship; the philosophical-normative orientation and the practical-operational orientation. The philosophical-normative orientation is unconstrained by context, focusing instead on what ought to be considered as evidence based on the quality of the evidence reviewed. This orientation presents certain restrictions as it is concerned with narrowly defined scientific evidence i.e. Randomised Controlled Trials (RCTs), and also it is limiting as it neglects to take account of context (Dobrow et al, 2004).



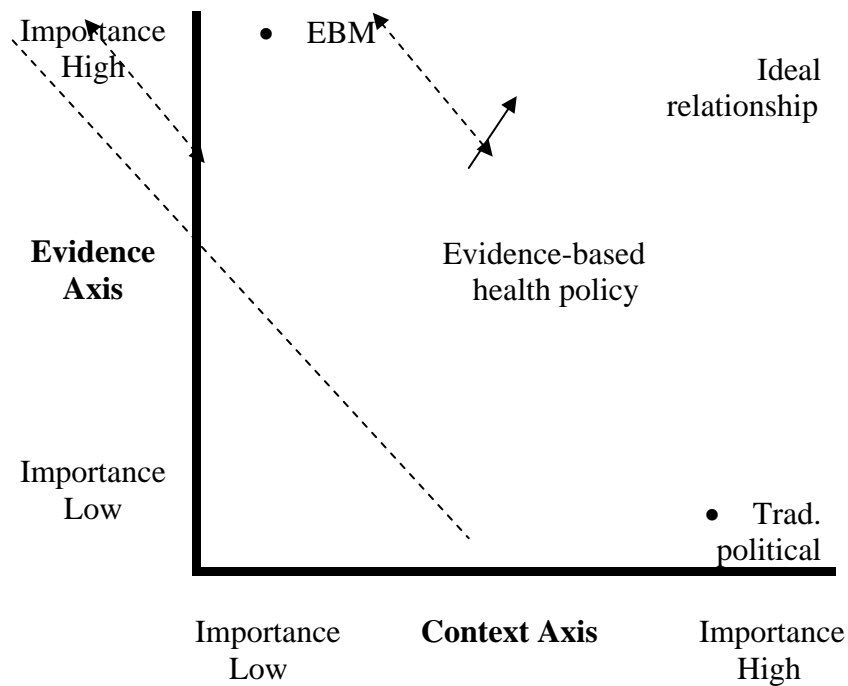
The practical-operational orientation is context based and evidence is defined in relation to specific decision-making contexts. Evidence is regarded as provisional and so is incomplete. This orientation, therefore, takes account of a multitude of factors in decision-making. Thus, the RCT may be the primary source of justification for a decision; however, consideration would be given to other forms of evidence.

The decision-making context itself is awash with complexity. It has been suggested that two categories exist in which context implicates evidence-based decision-making. They distinguish between the internal decision-making context and the external decision-making context. The internal decision-making context describes the environment in which a decision is made which includes factors such as the purpose of the decision-making ('The Why?'), the role of the participants in the decision-making process ('The Who?') and the process employed to arrive at the decision-making outcome ('The How?'). (Dobrow et al, 2004). It is possible for these internal contextual factors to be manipulated and controlled.

The external decision-making context relates to the environment in which the decision is applied which includes disease-specific factors, extra-jurisdictional factors and political factors. In contrast to the internal context, external contextual factors are uncontrollable and cannot be manipulated by decision-makers. In some cases the external context can provide constraints for a decision or in other cases it can play an evidentiary role to justify a decision.

To explicate how evidence-based decision-making differs in the move from evidence-based medicine (EBM) to evidence-based health policy, Dobrow et al (2004) forward the concept of 'axes of evidence-based decision-making'. This comprises of an 'evidence axis' and a 'context axis' as shown in Figure 4.2 below. EBM is positioned high on the evidence axis but low on the context axis, consistent with a philosophical-normative orientation towards evidence. Traditional political decision-making is positioned high on the context axis but low on the evidence axis. Evidence is regarded as only one of a number of factors affecting traditional political decision-making, which is swayed by internal and external contextual factors. The question arises then as to what constitutes a middle ground for evidence-based health policy?

**Figure 4.2 Axes of evidence-based decision-making**



(Dobrow et al, 2004)

Evidence-based health policy-makers face conflicts when trying to apply the highest quality evidence to population-wide health decisions. Dobrow et al (2004) suggest that evidence utilisation is critical in the development of evidence-based decisions. They identify three main stages in evidence utilisation; introduction of evidence, interpretation of evidence and application of evidence. These three stages are influenced by both internal and external contextual factors. The authors conclude that ‘thinking needs to shift from evidence-based decision-making to context-based evidence-based decision-making’ (Dobrow et al, 2004: 215).

### 4.3.1 Evidence – based policy formation

Grant (1993: 126) notes that ‘of all the partnerships that need to be built the most important is between the scientific community, which is committed to expanding our understanding, and the policy-makers, committed to enhancing our well-being’.

Marmot (2004) believes that evidence-based policy making is a simple prescription whereby the scientific evidence that would make a difference is reviewed; policies are then formulated and implemented. According to Black (2001) it is difficult to refute the case for evidence-based policymaking. It is often assumed that the relationship between research and policy is linear, lying within a positivist model of science; whereby a problem is defined and research provides policy options. In this way 'research is used to fill an identified gap in knowledge' (Black, 2001: 275).

According to Lomas (2000: 140), the positivist model can be likened to 'a retail store in which researchers are busy filling shelves of a shop-front with a comprehensive set of all possible relevant studies that a decision-maker might some day drop by to purchase'. Black argues that the implicit assumption of a linear relationship between research and policy needs to be replaced with a more interactive model.

The point is often made that the two sides of the science-policy connection need to strengthen their understanding of each other's position. However, the relationship between the two will never lead to unity of purpose and there will always be a rightful tension, as Edwards (1993: 13) contends, 'science has to have a larger vision of itself than it being merely a biddable management tool'.

#### **4.4 What hinders the uptake of research into policy and practice change?**

During the 1990s, the idea of evidence-based decision-making became a touchstone of health care. Lomas (2000) maintains that the reality does not live up to the rhetoric and there is an overriding sense of disconnection between researchers and policy-makers. Saul Feldman (1999) is noted as comparing researchers and practitioners to 'strangers in the night, dimly aware of each other's presence'. The idea abounds from much of the literature reviewed, that researchers and policy makers are separated by different work cultures one being isolated from the work and agendas of the other.

Haines and Jones (1994) reviewed the reasons for 'unacceptable delays in the implementation of many findings in research' in relation to evidence-based medical practice. They argue that the problem with implementing research findings lies in the existence of a cultural divide between researchers and policy-makers and advocate an

integrated system of research dissemination rather than any single approach, which they conclude to be ineffective. This would necessitate a shift in attitude of health professionals towards a more evaluative culture.

#### **4.4.1 Barriers in the research arena**

Hartnoll (2004) suggests a number of reasons for gaps in knowledge. Some issues fall outside the governing paradigm, may threaten the established structure or vested interests or may not be feasible for ethical reasons. More commonly, research may have been done but ignored because of irrelevance or due to its failure to propagate among a wider audience. Another common finding is that the presentation of research evidence is not conducive to translation into meaningful policy or practice and thus researchers are criticised of suffering from 'ivory tower syndrome' (Hartnoll, 2004: 71).

#### **4.4.2 Barriers in the policy arena**

Conversely, the argument exists that policy makers do not understand the scientific method or how research works. Elliot and Popay (2000) contend there are a number of dynamics that mitigate the direct influence of research evidence on policy making such as fiscal constraints, shifting timescales and the pragmatism of decision-makers.

Jaffe (1993: 333) comments that all too often policy in the short-term, develops on the basis of 'emotional appeals' with little logical thought regarding the expected effects over the long term and so 'such outcomes are often galling to scientists who have made careful and logical analyses of the likely results of policy options, but whose presentations did not have the emotional charge to win the day'.

Jaffe recommends that looking at the history of links between science and policy shows the lag time between major scientific findings and policy changes and how these lag times have decreased over the years. Two lessons can be observed from an historical analysis of the science-policy connection according to Jaffe. It can take some time for even obvious policy changes to be made and also the policy impact of a

scientific finding cannot be measured outside a time frame reference. According to Edwards, 'science may need to pull policy along, slowly' (in Jaffe, 1993: 334).

Rothman (1985; 340-1) argued in an editorial of the American Journal of Public Health that 'having focused on a research area...scientists should ignore policy questions to persevere in pursuit of their objective which is knowledge...the time for a scientist to be a political and social mover is after hours'. Teret (2001), however, refutes this assertion and contends that scientists should not eschew from discussing the policy implications of their research, as it would seem counterproductive to silence their voices.

#### **4.4.3 Barriers in the practice arena**

Hartnoll (2004) contends that there are a lot of barriers to research and practice. Practitioners may be threatened by research for example, evaluation research or research on resource allocation, or may feel that research is unnecessary and cannot reveal 'real understanding' for clients.

#### **4.5 What is the potential of research to be taken into account in the formulation of policies and practice development?**

Two major themes run through the reviewed literature regarding how research can enhance its potential uptake into policy. The first major factor relates to the relationship between researchers and policy makers and the need for greater communication between the two sides. The second major factor relates to the research itself and how it must be presented and disseminated to be attractive to policy-makers.

### 4.5.1 Communication

The first reoccurring theme discussed by numerous authors is the concept of communication between researchers and decision-makers. Oakley and Peerson (2001: 33) contend that 'increasing the use of research requires multiple strategies at multiple levels'. For evidence-based policy and practice implementations to occur may often require changes in the way professionals work as well as change in the operation of organisations.

Lomas (2000: 236) describes his philosophy of 'linkage and exchange' to increase the relevance and use of health services research. The idea of collaboration consistently presents itself as one of the most efficient ways to transfer research. It is argued that exchanges between researchers and decision-makers allows for 'nuances and interrogation' (Lomas, 2000: 237).

Teret (2001) maintains that while policy will probably never be determined exclusively by scientific evidence, policies that are based on reliable scientific findings are preferable to those that are not. The author continues that 'in order for policy to be informed by science, there must be some exchange of information, either directly or indirectly, between scientists and policy makers' (Teret, 2001: 374).

It is suggested that a 'policy community' needs to be created to better facilitate the influence of research. Researchers need a better understanding of the policy process, as the consequences of confusion are clear: 'so long as researchers presume that research findings must be brought to bear upon a single event, a discrete act of decision making, they will be missing those circumstances and processes where, in fact, research can be useful' (Rist, 1994: 546). It is necessary for researchers to recognise that there are other forces at play which sway policy such social, electoral, ethical, cultural and economic influences and thus, as Black (2001: 277) proposes research is most likely to persuade policy through 'an extended process of communication' as for research to have an impact it is necessary to target the values of policymakers. At the same time funding bodies must change their conception of how research influences policy while policy makers must become more involved in the conceptualisation of research and communicate their needs better to researchers.

#### **4.5.2 Presentation of research**

The second major factor in facilitating the uptake of research into policy and practice is related to the research itself, its presentation and propagation. There are a number of ways in which striving for the uptake of research into policy can be advanced. Keeping the agenda for research policy-relevant is necessary according to McKinlay (1993) who argues for methodological pluralism, embedding research within a conceptual framework and phrasing research in the language of institutional analysis to facilitate its ready translation into policy.

#### **4.6 The relationship between drug misuse research and policy**

‘By any objective reckoning, science has made many and varied contributions to policy formation in relation to the health and social problems set by misuse of mind-acting substances over the post-war decades’ (Edwards, 1993: 3-4). In some cases the link between scientific findings and policy formulation has been direct, in that research has been an exercise in problem solving while in other cases the link is complex and research can be seen to provide an angle on an issue, ‘science illuminating our general way of seeing an issue’. In relation to drug treatment issues, the research policy connection illustrates the need for critical scrutiny of the link between research findings and policy application.

Stimson and Strang (1993) note that since the AIDS epidemic came to light in the 1980’s, a research agenda was formed contributing greatly to the understanding and response to the epidemic in the 1990’s. However, rather than research taking place independent of policy, it was usually driven by policy. The authors draw attention to the alliance between science and policy, which is crucial to developing national responses to AIDS and drug injecting. The tendency for scientific findings to be exploited for political expediency is noted while in other countries ‘the obstacles are not the lack of scientific evidence, but the lack of political will to apply the findings from scientific work’ (Stimson and Strang, 1993: 144).

#### **4.7 Evidence – based drug policy formation**

To understand how research can influence drug policy we must appreciate the nature of policy and what it entails. This is achieved by looking at the national context of social policies. As well as this, the research environment and its sphere of influence must be considered. ‘Many of the decisions that influence drug using behaviour are difficult to modify by government actions, but are often readily influenced by the climate of scientific ideas and beliefs’ (Jaffe, 1993: 335).

Edwards notes that over the past number of decades research on the misuse of drugs has had implications for policy particularly in relation to dependence as a learnt drug-seeking behaviour; drugs and social context and dependence liability testing (Edwards, 1993: 9). This list exemplifies how research has progressed from looking at addiction as a purely physical condition to understanding dependence in psychobiological terms and then looking at drug taking in its specific social context.

#### **4.8 What hinders the uptake of drug misuse research into policy and practice change?**

Some literature documents the success of science as making a positive contribution to policy making, while other literature is a collection of case studies where the transfer of knowledge was not so successful. Room (1993) argued that analysing such case studies would extract a lot of valuable information.

The focus of Room’s discussion is on the science side of the science–policy interface and maximising its use. There are three major types of organisational arrangements for research namely ‘investigator-initiated research’, contractual research and academic research. A number of deficiencies in current US research are identified which may result in the fact that ‘the organisation and content of the major US research programmes in the drug field may be seen to fall short of being of optimum usefulness from the perspective of providing results useful in policy making’ (Room, 1993: 29). Many research programmes are in agencies operating under the medical model and the notion of their priority for research reflects the public mind set as health problems being solely medical in their nature and consequence (Room, 1993).



#### **4.9 What is the potential of drug misuse research to be taken into account in the formulation of policies and practice development?**

The predominant deliberation around drug misuse research and its implications for research involve international comparisons. Much of the reviewed literature on drug misuse research promotes the need for cross-national exchange of information on how best to facilitate the uptake of research on drug misuse into drug policy formulation.

There is a need to ensure that comprehensive, accurate and updated exchange of information between countries takes place in relation to research, policy experiences and the translation of science into policy. 'There often seems to be only minimal communication of experiences across countries. We have not made adequate use of information technology, nor faced up to the language problems. There is again an initiative waiting to be born, and one must hope that some country or some agency will take the lead' (Edwards, 1993: 13).

The trend in the present era of global communications whereby researchers and policy makers attend international scientific conferences on drug abuse infers that 'policy makers and scientists are recognising that there exists a wealth of policy relevant information available to be shared if only we invest the effort' (Jaffe, 1993: 342).

Global scientific interchanges on standard terms and epidemiological measurements have presented opportunities for comparison analysis and learning from the experiences of other nations.

Though much is to be learned from international exchange of information and comparative research on drug misuse, Room (1993) contends that research should focus on drug problems as largely local issues and should include case studies, evaluations and meta-analyses across these case studies at the local level to thus inform policy and practice.

#### **4.9.9 Conclusion**

This chapter has documented the various theories and models which seek to explicate the complex relationship between research and policy. Indeed the area of drug misuse,

presents a vast debate on the how research is used to influence policy, barriers to the uptake of drug misuse research on policy and ways to facilitate the uses of research in policy. The various models, frameworks and arguments above provide a compelling context in this study for the case of Irish drugs policy.

## **5 History of Drug Misuse and Policy Response in Ireland**

### **5.1 Introduction: The evolution of Irish drugs policy**

The evolution of Irish drugs policy can be seen to have taken place through a number of major phases. A comprehensive review by Butler (1991) identifies three distinct phases in Irish drugs policy over the period 1966-1991; The Early Years (1966-1979), The Opiate Epidemic (1980-1985) and the AIDS Connection (1986-1991). An update of Butler's analysis with an additional phase from 1995-1997 was depicted as 'The Period of Moral Panic' (Kiely and Egan, 2000 cited in Ruddle, Prizeman and Jaffro, 2001). It was this latter phase that witnessed the greatest activity in the area of drug policy development in Ireland. It wasn't until Kiely and Egan's (2000) period of moral panic in the mid-1990s that policy began to focus on reducing demand at the community level and social and environmental factors were taken into account.

This chapter will attempt to track the political approaches and developments in Irish drug policy in response to drug misuse in Ireland, traced from the 1960s through to the mid-1990s.

### **5.2 The beginning (or so it seemed...)**

The late 1960's marked a change in the traditional Irish 'sweep under carpet' mindset. Prior to this drug use and addiction were not recognised as constituting a problem in Irish society. This is evidenced by the lack of any formal acknowledgement of illicit drug use in Ireland. The 1966 *Report of the Commission of Inquiry on Mental Illness* gave a token few lines to the subject of drug use and drug addiction and concluded that there was no evidence of a drug scene in Ireland at this time but warned, however, that drug addiction could reach serious proportions if the situation was not carefully monitored. There was no formal establishment of a drug monitoring system by the Department of Health in the wake of this recommendation, nor were there any policy developments initiated. There was an increasing drug misuse problem which was not going to disappear, was going to worsen following the lead of international standards and it was imperative that it had to be addressed in the open.

### **5.3 The first government inquiry**

O'Hare and O'Brien (1992) contend that the first alleged media reference to the drug problem in Dublin in *The Irish Press* newspaper in 1968 instigated an enquiry into the extent of drug misuse in the country by a Working Party established by the Minister for Health in 1968. The interim report of the Working Party in November 1969 detailed a significant drug problem in Dublin with 350 regular users known to the Gardaí. This figure rose to 940 by December 1970, which was attributed to a real increase rather than increased Garda activity (Butler, 2002). The report noted evidence of drug use in some of the larger towns throughout the country; however, it found that there was no appearance of a drug problem in the smaller towns and rural areas at that time. The drugs involved were primarily stimulants (amphetamine) and sedatives and hypnotics (barbiturates and tranquillisers) usually obtained from chemist larceny as well as Lysergic Acid Diethylamide (LSD) and cannabis smuggled into the country (O'Hare and O'Brien, 1992).

#### **5.3.1 Working Party Report 1971**

The final report of this Working Party in 1971 contained recommendations, which were balanced evenly between treatment and prevention, covered statutory controls through proposed legislation dealing with unauthorised possession of certain drugs and security of drugs. It also recommended other preventive measures including one concerning the availability of hypodermic needles and the development of the out-patient facility for drug users in Jervis Street Hospital, which had been initiated by the Department of Health in 1969, two years before the Working Party reported. The Working Party highlighted abstinence as the only acceptable goal for a treatment programme and underlined the need for centralised, specialised drug treatment. The Coolmine Therapeutic Community was established in 1973 as the first voluntary body to deal exclusively with drug addiction. The treatment programmes available were based on the ethos that a client must be totally committed to abstinence before treatment could begin (Dillon, 2001).

The Working Party also recommended the establishment of an Inter-Departmental Committee on Drug Abuse to act as an advisory body, and this was subsequently established in 1972, as well as a Committee on Drug Education established in 1972, which in turn led to the setting up of the Health Education Bureau (HEB) in 1974.

The Misuse of Drugs Bill was presented to the Dáil in 1973, introduced in 1977 and not in force until 1979, by which time the drug problem had grown firm roots.

#### **5.4 Dublin's heroin problem**

The use of synthetic opiates was first introduced to Dublin in the summer of 1970, though intended for oral consumption, were ground down, mixed with liquid and injected intravenously (Kelly, 1972). The drug most commonly used in this way was dipipanone (Dicanol). Along with the obvious health risks of overdose, this method of administration introduced added risks of contaminating blood through injection and sharing unsterilised needles and syringes. It is noted, however, that though the practice of using Dicanol and other synthetic opiates in this way persisted, it involved a seemingly small group of drug users, it did not result in any large-scale social or behavioural problems and cannabis was still reported to be the predominant drug of use (Butler, 2002).

The heroin epidemic has its origins in the early 1980's. A drastic change had occurred in the Dublin drug scene, which saw the increased availability of heroin "which was now being 'pushed' for the first time on a commercial scale and was being used intravenously by increasing numbers of young people in some of the most disadvantaged inner-city and peripheral working-class neighbourhoods" (Butler, 2002: 134). The Garda Commissioner Crime Reports verify the emergence of a heroin problem in Dublin in the 1980's, though increased Garda activity may be a factor in increases in seizures and convictions. At the same time, the National Drug Advisory and Treatment Centre at Jervis Street were treating significantly more drug users, and in particular more heroin users were being treated (Dean, O'Hare, O'Connor, Kelly and Kelly, 1985).

#### **5.4.1 The scale of the epidemic**

Opiate abuse was primarily, and still is today, a Dublin phenomenon, in which heroin prevails as the drug of choice. The health risks associated with heroin use were physical dependency and overdose, as well as the indirect health problems associated with sharing injection equipment such as hepatitis, abscesses and toxæmia. There were also behavioural problems associated with the emerging heroin epidemic notably acquisitive crime to feed drug habits, as well as prostitution, which was becoming a common activity to fund drug careers. These medico-social problems were seen to be of concern to Irish society as a whole but ‘appeared to engulf those already deprived urban areas in which they were disproportionately prevalent’ (Butler, 2002: 167).

#### **5.5 The policy response (or lack thereof...)**

The Inter-Departmental Committee on Drug Abuse, was set up in 1972 as a result of a recommendation by the Working Party on Drug Abuse, but failed to orchestrate a speedy response to the heroin epidemic and was disbanded in 1983. Investigation by Butler (2002) included interviews with key informants on the Committee who unanimously agree that detailed information on the changing drug scene in Dublin was fed to the Department of Health; however, they argue that the Department viewed much reporting of heroin problems as gross exaggeration; ‘It seems as though the culture of the Department of Health encouraged it’s officials to look inwards and to treat with scepticism any externally-generated information, ideas or policy recommendations which did not coincide with their own conventional wisdom on drug problems’ (p, 145).

Even by the end of 1981, the Department of Health still refused to acknowledge publicly the change in the drug scene and the emerging heroin epidemic, which was sweeping the Capital’s inner city. Butler (2002) concludes that the tardiness of the Department in responding to the heroin problem, or drug use in general was due in part to structural nuisances such as the high turnover of Health ministers in the period 1979-1982, but more specifically faults the poor networking skills of departmental

officials outside the political circle as well as their lack of expertise to analyse and respond effectively to this emerging multifarious medico-social problem.

### **5.5.1 The ‘Bradshaw Report’**

An important initiative taken by the Minister for Health in 1982 was to commission a prevalence study of drug-use among residents of Dublin’s North inner city. This study became the famous ‘Bradshaw Report’ after the lead author and senior researcher in the study Dr. John Bradshaw, under the direction of Dr. Geoffrey Dean, Director of the then Medico-Social Research Board (now the Health Research Board). The report found that 9% of 15 – 24 year olds in North Central Dublin were estimated to be using heroin (Dean et al, 1983). This prevalence study became the catalyst by which drug issues would finally be placed on the agenda for national policy.

### **5.5.2 Post-Bradshaw**

In the immediate aftermath of the ‘Bradshaw Report’ the Minister for Health appointed a *Special Governmental Task Force on Drug Abuse* in 1983. The Task Force recommended amendments to the 1977 Misuse of Drugs Act, as well as developing treatment facilities, community and youth development as well as education and research recommendations. The Special Government Task Force on Drug Abuse also recommended the establishment of a new National Co-ordinating Committee on Drug Abuse, with specific terms of reference to replace the demised Inter-Departmental Committee.

The policy recommendation relating to community and youth development was a radical step insofar as for the first time the government would be recognising the causal importance of environmental factors instead of following the traditional biomedical approach to heroin use and heroin addiction.

### **5.5.3 A radical recommendation!**

The 1983 Task Force suggested the identification of ‘Community Priority Areas’ (CPAs) through the use of a number of indicators, such as, prevalence of drug abuse, the crime rate, levels of educational attainment, the unemployment rate and the general state of social and recreational amenities. These areas would receive special consideration for resource allocation, training schemes and job creation with special funding for all CPAs and further funding for youth services development. However, the Government rejected these recommendations. Indeed the 1983 Task Force recommendations were never sanctioned in policy, or even published, and the CPAs rhetoric would be ignored for the next decade in favour of the traditional treatment of the individual model

## **5.6 The virus**

In the period 1985-1996, the Irish government were faced with the biggest challenge to the drug policy climate in light of the public health crisis generated by the human immunodeficiency virus (HIV) and its related acquired immune deficiency syndrome (AIDS). The connection between sharing needles and transmission of HIV became clear in the mid 1980’s. The Irish Government were now forced to deal with abandoning an all out war on drugs, as drug use was seen as a lesser evil when AIDS was brought into the picture. As a consequence, newer thinking on drug policy began to emerge, as new answers were needed. The Department of Health used epidemiological research, which monitored the incidence of HIV infection in Ireland, as a basis for planning preventive strategies. The switch of focus to HIV prevention amongst intravenous drug users and homosexual men catapulted policy makers into a moral debate.

### **5.6.1 Policy revision for harm reduction?**

There was no indication that any revision of Irish drug policy would be undertaken. However, a dilemma had arisen between preventing the transmission of HIV and



staunch adherences to the unequivocal prohibitionist ideology inherent in the recent Irish drug policy. Within the gay community, HIV prevention revolved around safer sex with the use of condoms rather than sexual abstinence. The extended argument advocated safer drug use instead of the traditional therapeutic goal of total abstinence. The concept of harm reduction described this emerging public health approach. Harm reduction included strategies such as methadone maintenance and the new needle exchange schemes, which were specifically introduced in response to HIV. Heroin itself was no longer seen as the major health risk (apart from the risk of overdose) by harm reductionists who were now targeting drug practices and routes of drug administration.

A harm reduction approach to the Irish context would require a total rearrangement of health services for drug users in which services would be decentralised, methadone maintenance and needle/syringe exchange would be introduced and power would be shared with drug users in outreach and peer-led service initiatives (Butler, 2002). This liberal seeming inclination would come under fire in the political climate of the time swarming with victory from religious groups lobbying pro-life (Referendum 1983) and anti-divorce (Referendum, 1986).

## **5.7 Government strategy and discreet change**

The National Co-ordinating Committee on Drug Abuse, which had been set up in 1985, published a report in 1986 which side-stepped a lot of the emergent drug issues at the time, with random comment on the implications of HIV/AIDS and no reference at all to the ensuing harm reduction debate. The National Co-ordinating Committee on Drug Abuse was reconstituted with different members in 1989 and in 1991 it published the policy document *Government Strategy to Prevent Drug Misuse*.

Incremental changes had been taking place in the Dublin drug treatment system, which saw the introduction of harm-reduction services, and facilities that were not overtly discussed or explicitly acknowledged at the time (Butler, 2002). Tracking the precise developments of this change towards harm reduction is difficult due to its covert nature. The advent of HIV/AIDS in Ireland saw a subsequent shift to a more

comprehensive inclusion of substitute prescribing in the Irish treatment services. Although small-scale substitution services have been provided since the 1970s, up until 1998, there were no restrictions on GPs prescribing methadone to patients (Dillon, 2001). However, from 1987 the availability of methadone was increased with the formal introduction of a methadone maintenance programme at the National Drug Treatment Centre (Trinity Court) and from 1989 an AIDS resource centre established by the Eastern Health Board initiated needle exchange and outreach work programmes.

The 1991 *Government Strategy to Prevent Drug Use* reflected the central role of the advent of HIV and its prevalence among injecting drug users and the difficulty in separating drug misuse policies from the HIV/AIDS problem (Department of Health, 1991). The strategy calls for a 'multiplicity of treatment approaches' to ensure that services were appropriate to individual users needs. Programmes were not only to be involved in harm reduction strategies but were also to move away from the previous centralised specialist model. The role of community based service providers i.e. general practitioners together with local pharmacies were seen as critical in achieving this decentralised model (Dillon, 2001). The report contained recommendations on effective roles for General Practitioners in the medical management of problem drug users. One proposal was for the establishment of Community Drug Teams (CDTs). A pilot CDT was established in Ballymun in 1992, but was dissolved in 1995 owing to mutual recriminations between both sides of the Health Board/local drug group partnership (Butler, 2002). Between 1991 and 1996, local community groups instigated serious lobbying for action.

An Expert Working group of General Practitioners convened in 1992 under the auspices of a National AIDS Strategy Committee to consider methadone prescribing by general practitioners to treat drug users. As with the covert initiation of earlier harm reduction strategies into Ireland, GP treatment of opiate addicts was introduced quietly without impassioned debate in the public arena.

## **5.8 Conclusion - What had changed?**

The above documents the history of drug misuse in Ireland and subsequent Government apathy, response, report recommendations, rejections, inactivity and piecemeal change. The period 1986-1996 saw a change in the Irish healthcare system where discreet policy changes were introduced from small organisational networks rather than from the work of the National Co-ordinating Committee of Drug Abuse with its formal terms of reference for policy making in this sphere. As Loughran (1999: 308) comments, however, 'the presence of policy documents does not ensure the resolution of the drugs problem'.

## **6 The Impact of Drug Treatment Demand Data on Policy and Practice – The Irish Case**

### **6.1 Drug Policy in the 1990s**

As the previous chapter has illustrated, drug misuse policy in Ireland developed through a traditional ‘treat-the-individual’ filter, which discounted the environmental approach and social causality. Loughran (1999) contends that the early years of Irish drug policy were at best reactive and at worst restrictive, while in contrast, the 1990s began one of the most active phases in the government’s attempts to tackle the problem of drugs in Ireland.

The pre –1990 Irish model had a prevailing individualistic paradigm, which promoted prohibition with the criminalizing of drug use, drug manufacture, drug distribution and drug supply and also advocated abstinence as *the* treatment response (Loughran, 1999). Murphy (1996) describes how this approach by the Irish Government from the mid 1960s until the 1990s proved unsuccessful and this is evidenced by the escalation of the drug problem during this time (O’Hare and O’Brien, 1993; O’Higgins, 1996; Moran et al, 1997).

### **6.2 Government Strategy to Prevent Drug Misuse 1991**

- *What was the impact of treatment demand data on policy and practice?*

-

As mentioned in the previous chapter, *Government Strategy to Prevent Drug Misuse 1991* was a policy document published by the reconstituted National Co-ordinating Committee on Drug Abuse. The goal of the strategy was to ‘implement realistic and achievable objectives in the areas of supply reduction, demand reduction and increased access to treatment and rehabilitation programmes coupled with a comprehensive co-ordinated structure geared towards their effective implementation’ (Department of Health, 1991: 2).

### **6.2.1 The impact of treatment demand data**

One of the major concerns of the strategy was the location and characteristics of drug misusers where ‘all the evidence here points to a concentration of the problem in specific areas of Dublin with poor housing and high levels of unemployment’ (Department of Health, 1991: 8).

Information on treated drug misusers was provided by the Dublin Drug Treatment Reporting System (see Chapter 1).

The treatment data used in the 1991 Strategy also shows that ‘a high proportion of clients live in the inner city area, Ballymun and Ballyfermot’ (Department of Health, 1991: 6).

Data analysed from the Dublin Drug Misuse Reporting System showing demographic and drug practice percentages is presented in Appendix B to the Strategy. The appendix is explicitly referred to in the text of the Strategy as the data on employment status and area of residence from the treated drug users are evidence of the association between a concentration of the drug problem and high unemployment and poor housing.

### **6.2.2 Evidence-based policies?**

It was clear from the data presented in the Government Strategy that there was a strong association between the social marginalisation of particular communities and drug misuse. This epidemiological evidence from the treatment reporting system presented an obvious case for evidence-based policies which would target these identified areas with extra resource allocation, training and education schemes, and youth and community projects. However, as Loughran (1999: 311) notes, ‘The social marginalization of sectors of society, of communities and neighbourhoods was acknowledged but unchallenged by the strategy document’. The evidence from the data used in the Strategy had little effect and went virtually ignored. In fact, statistics in 1994, three years after the Strategy was instigated, show that eighty to ninety per cent of treated drug users were unemployed and the same socially and economically deprived areas were over-represented in the statistics (O’Higgins and O’Brien, 1995; Moran et al, 1997: 34).

### **6.3 What Happened in 1996?**

In 1996, a change had taken place in the political mindset which saw a greater willingness for the policy process to be more visible and for action to be taken quick on the drugs issue. The Government had now become acquiescent to strategies to reduce the demand for drugs at community level and was thus, moving away from focusing on the individual drug misuser which had characterised policy decisions on the drugs issue over the previous two decades.

### **6.4 The Government Response**

The government response was two-fold. The first was supply-reduction orientated involving a range of legislative and criminal justice measures. The second response was to focus on demand reduction at the community level involving the establishment of a Ministerial Task Force.

A ‘Ministerial Task Force to Reduce the Demand for Drugs’ was established which produced two reports (October 1996 and May 1997). Both of the reports focused on treatment generally and more specifically dealt with moves towards a more decentralised approach as was alluded to in the 1991 Government Strategy. In the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* in October 1996 (colloquially referred to as the ‘Rabbitte Report’ after the chair and Minister of State to the Government at the time; Mr. Pat Rabbitte), the Irish Government Ministerial Task Force reviewed measures to reduce the demand for drugs and as a consequence recommended changes in policy, legislation and practice to facilitate more effective drugs reduction strategies.

The report in 1996 identified Ireland’s drug problem as mainly an opiates one and was predominately a heroin misuse problem. The report saw the heroin problem as principally a Dublin phenomenon. There were actually three problems distinguished within the heroin problem: addiction, AIDS/HIV and Hepatitis C/B.

The Rabbitte Report validated earlier concerns about the relationship between drug use and socio-economic deprivation. In the preface to the report Pat Rabbitte,

chairman of the Ministerial Task Force, highlights the fact that '[addicts] are concentrated in communities that are also characterised by large-scale social and economic deprivation and marginalisation. The physical/environmental conditions in these neighbourhoods are poor, as are the social and recreational facilities' (Ministerial Task Force, 1996).

#### **6.4.1 Epidemiological Analysis**

The epidemiology of drug use in Ireland, primarily in Dublin, shows that 'drug misuse spreads in communities according to a discernible pattern' (Ministerial Task Force, 1996). The best data available was from the Health Research Board's Dublin Drug Treatment Reporting System (DDTRS, which had been extended to National Level to become the NDTRS in 1995), which would be an invaluable base for epidemiological analysis. The Task Force commented that epidemiological research was necessary to assist in targeting drugs services over the long term, to ensure appropriate services were to be provided based on need, to monitor progress and measure effectiveness and to determine levels of funding needed (Ministerial Task Force, 1996: 9).

#### **6.4.2 The scale of drug misuse**

Preliminary data for the Greater Dublin Area in 1995 showed that the number of cases presenting for treatment had increased by 21% since the previous year, totalling 3,593 drug users. Caution, of course, is advised as to the analysis of these figures as it may also be related to increased service provision rather than increased service demand. Also, drug treatment demand data is only one part of the story and the 'dark figure' of the true scale of the problem is obviously in excess of the numbers presenting for treatment.

### **6.4.3 The pattern of drug misuse**

The report from the Task Force presents a pattern of drug misuse from analysis by the Health Research Board. The main predictors of heroin addicts presenting for treatment are being male, aged mid-twenties, living with family of origin, with some level of secondary education, unemployed, initiated heroin use between 15 years and 19 years of age and taking heroin at least once a day (Ministerial Task Force, 1996: 10). Gender differences were apparent with a declining proportion of females presenting for drug treatment and a corresponding increase in the number of male drug addicts seeking treatment. Also, a higher proportion of females were living with a partner who was also misusing drugs. There is also evidence that the drug problem is a youth problem with a declining average age.

A close correlation was found between addiction and social and economic disadvantage. The Task Force explicitly reports that

‘Statistics produced by the Health Research Board on the areas of residence of those receiving treatment for drug misuse in the Greater Dublin area in 1995 are set out in map form at Appendix 3 to this report. There is no reason to believe that this geographical distribution is not broadly similar to the underlying pattern of drug misuse. There is a high correlation between the areas where the problem is most acute and the areas which have been designated, on the basis of objective criteria, as economically and socially disadvantaged under the Operational Programme for Local and Rural Development 1994 – 1999’. (Ministerial Task Force, 1996: 27).

Ten districts of prevalent heroin abuse in the Greater Dublin Area were identified based on these maps produced by the HRB showing areas of residence of those receiving treatment for drug misuse in the Greater Dublin Area in 1995 as well as evidence supplied in submissions to the Task Force. According to the Task Force, these submissions had consistently ‘identified the same underlying causes of problem drug use as had already been identified by the Group’ (Ministerial Task Force, 1996: 5). The ten areas identified in Dublin were parts of the North Inner City; South Inner City; Ballyfermot; Ballymun; Blanchardstown; Clondalkin; Coolock; Crumlin;



Finglas/Cabra; Tallaght. North Cork city was also identified as a problem drug misuse area.

The Task Force concluded that ‘in view of the link between social and economic deprivation and drug misuse, strategies to deal with the problem need to be focused on these areas’ (Ministerial Task Force, 1996: 28). One of the main recommendations arising from this report was the establishment of Local Drugs Task Forces comprising of statutory, voluntary and community representatives, in each of the eleven worst – affected areas. It was also concluded that, due to the evidence of the increasing levels of drug misuse among younger people, targeted measures around treatment, rehabilitation and prevention needed to reach this particularly vulnerable cohort.

According to Butler (2002), ‘the Rabbitte Report had an immediacy and a directness which was unusual in drug policy documents, and its authors appeared to be genuinely committed to doing something – and doing something quickly – to address Dublin’s opiate problem’.

## **6.5 Rabbitte Recommendations**

The recommendation arising from the Ministerial Task Force report included proposed structures at national, regional and local level, which will be described in detail below. In addition to these structures there were a number of other important recommendations in relation to information/research, treatment/rehabilitation and education/prevention for the identified priority areas.

## **6.6 Structural recommendations**

The most significant recommendations in the First report were in relation to structures. Arising from these recommendations a Cabinet Drugs Committee, National Drugs Strategy Committee and Local Drugs Task Forces (presently fourteen) were established.

### **6.6.1 Cabinet Drugs Committee**

A Cabinet Drugs Committee was established to give political leadership to the new action on drugs. It was to be chaired by the Taoiseach and comprise the Ministers for Health, the Environment, Education and Justice and the Minister of State to the Government. This committee was to review all trends in the drug problem, assess the progress of the strategy to curb the supply and demand of drugs and also resolve any policy or organisational issues, which may inhibit effective developments in the response to the drugs issue. The Cabinet Drugs Committee was later reconstituted as the Cabinet Committee on Social Inclusion and Drugs.

Once the link between drug abuse and social exclusion had been recognised, it was necessary to reconstitute the Drugs Committee in order to address disadvantage in the broadest sense.

### **6.6.2 National Drugs Strategy Team**

It was recommended that a National Drugs Strategy Team be set up to report to the Cabinet Drugs Committee. This Strategy Team would be cross-departmental comprising experienced personnel from the relevant areas in the main departments involved and their agencies. The idea of cross-departmentalism was heavily influenced by the Strategic Management Initiative in the Public Services which would describe the drugs problem as a 'cross cutting' issue requiring a sustained co-ordinated effort across Departments and agencies (Ministerial Task Force, 1996).

The National Drugs Strategy Team was set up on two levels;

- The Inter-Departmental Group on the National Drugs Strategy, comprising Assistant Secretaries from those Departments represented on the Cabinet Committee, to review the progress of the strategy implementation and to address any policy issues which may arise
- The National Drugs Strategy Team (NDST) comprising representatives from the same Departments as those represented on the Cabinet Committee.

The mandate of the NDST was to implement the Government's Strategy in relation to drugs and in particular to maintain close links with the eleven areas which were identified in the report as having the most acute drug problems and to ensure that their problems and priorities are under constant monitoring by central government. This would involve an ongoing review of the need for LDTFs in disadvantaged urban areas, particularly having regard to evidence of localised heroin misuse. The Strategy Team were also mandated with identifying and considering policy issues and ensuring that policy was informed by the work of and lessons of the LDTFs.

## **6.7 Local Drugs Task Forces**

The Local Drugs Task Forces were to be the ground level force of the new structures. They were set up in 1997 to provide a strategic, locally based response by the statutory, voluntary and community sectors to the drugs problem in the worst affected areas and 'to develop and implement a drugs strategy for their areas which co-ordinates all relevant programmes and addresses any gaps in services' (Department of Tourism, Sport and Recreation, 1999: 9).

### **6.7.1 LDTFs – A closer look**

The Local Drugs Task Forces (hereafter LDTFs) serve a three-fold purpose

- To ensure effective co-ordination of drug programmes and services at local level;
- To involve communities in the development and delivery of locally based strategies to reduce the demand for drugs;
- To focus actions on tackling the problem in the communities where it is at its most severe (Moran et al, 2001).

Funding of £10 million was made available for the LDTFs service development plans, which were expected to respond to the problem of drug misuse in the identified areas and include costed proposals of how best to address the issue. LDTFs were set up originally in eleven areas identified as priority areas by the 1996 Rabbitte Report:

- Dublin North Inner City

- ❑ Dublin South Inner City
- ❑ Ballymun
- ❑ Finglas/Cabra
- ❑ Blanchardstown
- ❑ The Canal Communities (Rialto/Inchicore/Bluebell)
- ❑ Ballyfermot
- ❑ Crumlin
- ❑ Tallaght
- ❑ Clondalkin
- ❑ North Cork City

The areas of Dun Laoighaire/Rathdown, North East Dublin and Bray were identified as priority areas subsequent to the Rabbitte Report and LDTFs were set up in these areas thereafter.

### **6.7.2 Composition of the LDTFs**

The LDTFs have representation from the Health Boards, the Garda Síochána, the Probation and Welfare Service, the relevant Local Authority, the Education/Youth Service and FÁS (Training and Employment Authority) as well as community representatives nominated by the relevant community groups, a chairperson, nominated by the local Partnership Board and a co-ordinator provided by the relevant Health Board.

### **6.7.3 LDTFs mandate and activities**

The mandate of the Local Drugs Task Forces (LDTFs) is to oversee and monitor the implementation of projects approved under their existing action plan and to ensure the formal evaluation of these projects with a view to their successful 'mainstreaming' which will see their continued funding through State Agencies rather than through the Local Drugs Task Forces themselves. In addition, the task forces are to update their area profile keeping account of any changes to the drug problem as well as certain other specific terms of reference around networking and consultation. There were

over two hundred separate community-based initiatives funded to complement existing services and programmes under the themes of education, prevention, treatment, aftercare, rehabilitation and reducing supply (Department of Tourism, Sport and Recreation, 1999).

The type of projects receiving support as part of the LDTFs include local information, advice and support centres for drug users and their families; Community Drug Teams; special projects aimed at children involved in drugs or at risk; the production of drug awareness materials; drugs training programmes for community groups, teachers, youth workers and other professionals and rehabilitation programmes and initiatives to allow local communities to work with the State Agencies in addressing the issues of supply in their areas (<http://www.irlgov.ie>).

#### **6.7.4 Evaluation of LDTFs**

An independent evaluation of the LDTFs was reported in October 1998 by PA Consulting Group and concentrated on the processes and structures associated with the drugs initiative, 18 months after their introduction. The evaluation found that the LDTFs had achieved a considerable degree of success in the short term since they were established and that ‘their very existence had provided a strong focus for tackling drug issues in the target areas, often reducing the feeling of isolation felt by local communities and preventing a potentially critical situation from developing further into a continuing downward spiral of economic deprivation, addiction and crime’ (PA Consulting Group, 1998: ii).

The evaluation found that the LDTFs were the most critical factor in the success and credibility of the drugs initiative as they provided the most direct knowledge of what was happening at local level.

In light of the 1998 review of the operations of the LDTFs, certain changes were made to the composition of the LDTFs. Additions were made to representations from the State sector to include the Departments of Education and Science, and Social,

Community and Family Affairs. Voluntary representation was also strengthened with local elected representatives, vocational groups. Drug users would also be consulted by LDTFs through the setting up of drug user forums.

In addition to the evaluation of the overall initiative, individual projects are evaluated with a view to mainstreaming those that are operating effectively (Department of Tourism, Sport and Recreation, 1999).

Ruddle et al (2001) were commissioned by the NDST in 2000 to undertake an evaluation of the projects implemented by the LDTFs. They found that of the 142 projects involved in the evaluation; 51% were education and prevention projects, 36% treatment and rehabilitation, 7% providing services in both education and prevention and treatment and rehabilitation, 3% were involved in supply control and 3% were involved in research and information. The evaluators also found that the most frequently mentioned guiding principle (20% of projects) for a project was that it was 'needs driven' (Ruddle et al, 2001: 31).

#### **6.7.5 Achievements of the LDTFs**

The Local Drug Task Force initiatives were established in response to a serious drug problem, which manifested itself most acutely in a number of deprived communities (Moran et al, 2001) The measure of success for the LDTFs has been the 'mainstreaming' of projects. Mainstreaming ensures the continuity of projects and a transfer of budgetary responsibility from government departments to agencies/project promoters for specific piece of work (Moran et al, 2001). The National Drug Strategy Team governs the mainstreaming of projects through a set of protocols. Between April and June 2000, one hundred and forty LDTF projects were evaluated and one hundred and twenty two were subsequently mainstreamed (Moran et al, 2001).

The Department of Tourism, Sport and Recreation (1999) assert that eight hundred stabilised drug users are participating in specifically designed Community Employment projects which were developed by the LDTFs, in conjunction with FÁS which will help improve the employment potential of drug misusers. It is also noted

that LDTFs have contributed to greater awareness around the drugs issue by educating young people about the dangers of drug misuse as well as creating greater awareness in communities about the needs of drug users and how best to respond to those needs (Moran et al, 2001).

In 2002, the LDTF model was expanded to cover the entire country through Regional Drug Task Forces (RDTFs) based in each of the ten Regional Health Board areas. Each RDTF is conducting initial research to establish the extent, nature and pattern of drug misuse in their respective regions. Based on the findings of this research, each RDTF is charged with developing regional action plans for their areas to address the gaps in service provision (<http://www.irlgov.ie>).

The Young Peoples Facilities and Services Fund was established in 1998 aiming to divert at risk young people away from possible drug misuse by developing sporting and other recreational facilities. It operates in the 14 LDTF areas in Dublin, Cork and Bray and also in four other urban areas (Limerick, Waterford, Carlow and Galway).

## **6.8 Why the change in 1996?**

A fundamental enquiry of this study was to uncover the reasons why, in 1996, the Irish government were amenable to a major change in Irish drugs policy. For the first time in the history of the state, the socio-economic context of drug misuse was responded to by the establishment of appropriate structures from national to local level to target priority drug problem areas and thus moving away from the treatment-of –the-individual model to take account of social causality.

This study has found that two principal dynamics played a role in the change in government response in 1996. The first dynamic was that of political imperative while the second dynamic was that of political incentive.

### **6.8.1 Political Imperative**

The political imperative dynamic was largely due to the effect of the social climate in Ireland in 1996. The social climate could be best described as one of ‘moral panic’ with three major factors contributing to this panic. Firstly, communities had taken to the streets in organised marches again in the 1990s, campaigning for action within their localities.

*“Agencies were seen as having neglected the needs of disadvantaged communities over the years or of having imposed solutions without local consultation”*  
(Sinéad Wiley, Dublin North East LDTF Co-ordinator, e-mail correspondence)

The second factor which has been argued as causing a moral panic was the HIV/AIDS issue and its association with intravenous drug use and the third factor identified was the public outcry at the murder of the high profile journalist Veronica Guerin, allegedly by organised criminals involved in drug trafficking.

*“By the ‘90s and as the community groups were campaigning again, they had died down a bit, but then they were back and people were saying look this has got a lot worse in areas, there isn’t a response...the quality of life in communities was going down and there was AIDS and HIV and despite these massive problems which were concentrated in a relatively small number of urban areas, the areas we’ve talked about, there seemed to be very little in the way of concerted or integrated government response”* (Fergus McCabe, NDST, telephone interview)

In a face-to-face interview, Blanchardstown Local Drugs Task Force Co-ordinator Mr. Joe Doyle referred to three possibilities for the change in government response in 1996;

*“I guess if I was to prioritise them the first is the public support behind the local community marches so it was a response to that. Secondly the issue of crime...within crime then it’s organised crime and I guess the Veronica Guerin [murder] is a symptom of that. And thirdly, the HIV issue”* (Joe Doyle, BLDTF co-ordinator, face-to-face interview)

### **6.8.1 Political Incentive**

The second principal dynamic, the political incentive, was affected by the political climate at the time which was conducive to such a change in Irish drug policy



response in 1996. There were a number of political factors at play which enabled the ball to start rolling quickly on the issue. The first factor was the Strategic Management Initiative (SMI) which was introduced into government departments in 1994.

*“They realised there was a need to have an integrated response and SMI, Strategic Management Initiatives needed to be adopted because these were cross-cutting issues that you couldn’t solve the drugs thing by treatment alone, you certainly couldn’t solve it by policing alone and you needed to integrate policing and treatment and rehab and to get communities involved”* (Fergus McCabe, NDST, telephone interview)

The second motivating factor was the existing social partnership model. According to Butler (2002), the political approach from the late 1980s onwards was broadly described as one of social partnership. The success of the social partnership model can be seen in the dramatic boom of the Irish economic and the emergence of the ‘Celtic Tiger’. Instead of autonomous state actions, the government co-ordinated a network of the most prominent social and economic stakeholders and framed government policy around this concept of social partnership (Butler, 2002). As this idea became popular and evidently successful, it became apparent that addressing community drugs policy issues would only be possible within this framework. Local Drugs Task Forces would be a natural extension of the social partnership model and would include both vertical partnership between statutory authorities and local voluntary agencies and community interests, and horizontal or intersectoral partnership between different sectors of the state (Butler, 2002).

Butler (2002) also alludes to another factor likely to have facilitated this government policy response in 1996; the healthy state of the country’s finances in the mid 1990s meant that an undertaking of large-scale community development projects were an option for the Government. This option was not available for a country steeped in recession in the 1980’s. In addition, two secondary factors are indicated as having impacted on the speed at which the policy on local drug response was implemented; one was the fact that Ireland was, at the time, holding the EU presidency for six months and the second was the upcoming general election and the political concern over public votes (Butler, 1997; 2002).

It can be seen, then, that two intertwining political dynamics in 1996 ushered in a new wave of Irish drug policy and an immediate implementation of recommendations on local, priority area response.

*“There was both an institutional recognition that the current approach wasn’t working plus you had the political imperative of people campaigning out on the streets” (Fergus McCabe, NDST, telephone interview)*

## **7 Blanchardstown Local Drug Task Force**

Blanchardstown was one of the original eleven priority areas identified in the 1996 report of the *Ministerial Task Force on Measures to Reduce the Demand for Drugs*. (see chapter 6). This prioritisation translated into the establishment of a Local Drugs Task Force, which aimed to significantly reduce the harm caused to individuals and the specific community to provide an integrated response to the problems posed by drug misuse through a concerted effort involving the statutory, community and voluntary sectors. This chapter will consider the mechanisms, dynamics and operations of the Blanchardstown Drugs Task Force since its inception to the present. The next chapter will consider the changing profile of the Blanchardstown drug users seeking treatment by analysing drug treatment data on drug users residing in Blanchardstown 1998 – 2002 and comparing this to 1995 treatment data, prior to the establishment of the BLDTF.

### **7.1 Profile of Blanchardstown**

The Blanchardstown area is situated in North West County Dublin and is part of the Dublin 15 postal area. The area embraces eight electoral wards of Fingal County Borough namely; Abbotstown, Blakestown, Coolmine, Delwood, Mulhuddart, Roselawn and Tyrellstown (see map of area, Appendix X). However, the six designated Task Force Areas in Blanchardstown are Corduff, Mulhuddart, Huntstown, Hartstown, Blakestown and Mountview (see analysis of treatment data by area, Chapter 8)

#### **7.1.1 Population and the Socio-Economic Implications**

In 2000, the Greater Blanchardstown Response to Drugs (GBRD) estimated that the population of Blanchardstown had reached 70,000 from 3,000 in the early 1970s, and the 1999 county development plan stated that the ultimate target population is 100,000 (D'Arcy, 2000). The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported an explosive growth in the population of Blanchardstown over five years (42% from 1981 – 1986) which resulted

in large residential areas with high unemployment, high levels of social exclusion and marginalisation, very poor levels of public utilities and social facilities, poor quality of life and high social stress. Development features in the past for Blanchardstown has been large scale construction of local authority housing which has meant that inevitably, due to housing shortages in recent times the first tenants of new public housing are usually unemployed and thus surviving on low incomes. It has been reported by the GBRD that the entire wards of Tyrrelstown, Mulhuddart, Coolmine and Corduff are either entirely or mostly comprised of housing estates with very high levels of social and economic disadvantage (D'Arcy, 2000).

### 7.1.2 Age Profile

As Blanchardstown can be seen as a new town, with its recent explosion in population, it has a significantly younger age profile compared with the rest of the state with relatively few senior citizens. The young age profile creates a special demand on social services.

**Table 7.1: Age Profile of Blanchardstown Wards**

Area of Blanchardstown	Age		
	Under 15 years	15 – 24 years	Over 65 years
<i>Abbotstown</i>	19%	17%	24%
<i>Blakestown</i>	34%	13%	2%
<i>Coolmine</i>	33%	23%	2%
<i>Corduff</i>	32%	24%	2%
<i>Delwood</i>	22%	27%	4%
<i>Mulhuddart</i>	50%	18%	1%
<i>Roselawn</i>	22%	24%	8%
<i>Tyrrelstown</i>	51%	12%	2%

(Source: D'Arcy 2000; GAMMA and Small Area Statistics from 1996 Census)

Table 7.1 above shows a large proportion of the population from Tyrrelstown, Mulhuddart, Blakestown, Coolmine and Corduff under the age of 15 years. The wards of Mulhuddart and Tyrrelstown have large concentrations of local authority

housing, much of which has been constructed relatively recently (1980s/1990s). D’Arcy (2000) notes that subsequent Census data shows that a lone parent heads many of the houses in those wards.

Roselawns relatively high senior citizen figure and relatively low under 15 figure depict the maturity of the mostly private housing estates in this ward, dating back to the 1970s. Similarly, the Delwood ward also encompasses mostly private housing. The unusually high senior citizen figure for the ward of Abbotstown can be by the presence of Cappagh hospital, and so without the hospital D’Arcy (2000) reports that the overall figure for senior citizens would be even lower at 2%.

The population and age profile of the Blanchardstown area has specific implications for the level of drug misuse in the area and thus, affects the particular interventions required to respond appropriately. An analysis of drug treatment data from the NDTRS in the next chapter illustrates some of the implications for targeted interventions by considering the profile of drug users seeking treatment who were residing in Blanchardstown between 1998 and 2002.

## **7.2 Prior to the BLDTF**

In order to appreciate the role of the BLDTF in the area, it is important to establish what was happening in Blanchardstown prior to its inception. This will include looking at life in the community, the drug treatment services that were in place and the actions that were being called for to respond to the drugs problem in the area.

### **7.2.1 Life in the community**

Prior to the establishment of the BLDTF, Blanchardstown indeed showed outward signs of being a disadvantaged area. As the BLDTF co-ordinator, Joe Doyle, comments in Box 7.2 below, there were no structures in place to seriously address the combined issues of social disadvantage and drug misuse.

#### **Box 7.2: Ghettoisation**

*“If you look at the whole social policy of the state they were all contributing factors to the I guess ghettoisation with lack of amenities and facilities and then*

*there's the whole issue of early school-leaving, poor educational attainment..we didn't seem to have a strategy back then to deal with the variables, as I call them, that possibly lead to drug misuse. I guess research has proven that it's not just one variable, it's how a number of variables interlink that cause people to make certain decisions so by looking at a disadvantaged area there's a probability that more of those variables are there". (Joe Doyle, BLDTF Co-ordinator)*

### **7.2.2 Services in Blanchardstown pre-BLDTF**

There were a number of limited social responses in existence in Blanchardstown prior to the establishment of the Task Force including a Youth service; Health Board funded programmes and the Blanchardstown Area Partnership as well as a community development project.

The Eastern Health Board was providing some community care programmes with health centres in Blanchardstown; childcare and family support services and the Neighbourhood Youth Project. In relation to drug misuse, the Eastern Health Board supported the Coolmine Therapeutic Community, which provided the services of two addiction counsellors, an outreach worker, a shared HIV counsellor and an education officer.

Blanchardstown was declared a partnership area due to high levels of unemployment and in May 1995 the Blanchardstown Area Partnership was established. Its aim is to counter unemployment and disadvantage by providing community based sustainable response to needs in an integrated way.

### **7.2.3 Local calls for action**

The two predominant sides of the drug misuse debate in Blanchardstown were the prohibitionists, who were anti-drugs, and the harm reductionists who were pro-services.

➤ **In the red corner: The Anti-drugs**

Calling for action on a red light to drugs, the anti-drugs side organised under the auspices of *Concerned Parents Against Drugs* (see Chapter 2), which was set up in Blanchardstown in 1987.

**Box 7.3: Concerned Parents Against Drugs tarred with vigilantism**

*“The Concerned Parents Against Drugs differed in different areas. In the North Inner City the Concerned Parents Against Drugs was rather a broad coalition of groups and included what you may regard as conservative politicians from Fianna Fáil and Fine Gael as well as the left wing Tony Gregory, Sinn Féin and Labour. So it was kind of broad, you had the clergy and youth workers as well as local people. In some areas it was local people who wanted to have a very law and order, populist, vigilante maybe type approach. So in a way, the government kind of tarred the whole Concerned Parents thing with maybe one bit of it i.e. the vigilante end of it and to be fair too there obviously were people involved with the Concerned Parents who adopted illegal things and there was blitzes and so forth and there were people who were involved in IRA and INLA and different people who might be involved in what would be called now terrorist type of activities, so there wasn't a coming together”.*

(Fergus McCabe, NDST liaison for Blanchardstown)

However, this group later disbanded (see Box 7.3 above) and in 1993 a group called *Blanchardstown Against Drugs* was established. Anecdotal evidence suggests that the activities of this group was organised through their own networks.

*“They had an unwritten agreement with Fingal County Council that they would stop people who were evicted in other areas moving into Blanchardstown for drug dealing..so people say from Finglas would find that a certain family was being evicted and pass on the names to the local group”* (Joe Doyle, BLDTF co-ordinator)

As well as this type of activity, anti-drugs activists were organising marches to demand action in loud unison. These marches were similar to larger marches being organised across the city and were receiving increasing media attention.

➤ **In the green corner: The harm-reductionists**

Calling for action on a green light to drugs services, the harm-reductionists were organising in Blanchardstown since 1992 when the *Greater Blanchardstown Response to Drugs* (GBRD) was set up. This organisation was concerned with

bringing more services in for drug users, not battling to make the problem go away. The GBRD was the first community-based initiative around education, training and information to be delivered in the Greater Blanchardstown area.

*“Addicts are not aliens from outer space, who have suddenly appeared out of nowhere. They are brothers and sisters, sons and daughters, our neighbours. As a community we need to take ownership of the issue, in a rational, democratic and peaceful manner”* (GBRD, Dublin 15 community website)

### **7.3 The BLDTF is born**

The Blanchardstown Drugs Task Force was established on the 7<sup>th</sup> February 1997. In line with the Government's drugs policy the aim of the BLDTF is to provide an integrated response to the problems posed by the misuse of drugs. The key objectives of that policy make up four pillars consisting of:

- *Education and Prevention:* To reduce the number of people turning to drugs in the first instance through comprehensive education and prevention programmes
- *Treatment and Rehabilitation:* To provide appropriate treatment and aftercare for those who are dependent on drugs
- *Supply reduction:* To have appropriate mechanisms in place aimed at reducing the supply of illicit drugs
- *Information:* To ensure that an appropriate level of accurate and timely information is available to inform the response to the drug problem.

### **7.4 Staffing and Composition of the BLDTF**

Staffing wise the BLDTF has a co-ordinator and a semi part-time administrator (half a part-time administrator) released from the Advocacy Group. The appointment of a part-time co-ordinator was secured in May of 1997 and this position was made full-time on 5<sup>th</sup> August 1997. In Box 7.4 below, the current co-ordinator Joe Doyle, describes his role within the Task Force.



#### Box 7.4: BLDTF Conductor

*“Conductor! I look upon it as an orchestra! Ensuring that actions that come out of Task Force meetings are actually moved on. So to that end what we’ve decided this year is that we’ve monitored every action that we’ve made at every Task Force meeting and we would hope then in December, like on average about twenty actions come out of a Task Force meeting so we reckon by the end of December it will be 140 actions so I’ll be able to give an update on progress..this is how many we’ve moved on this is how many we didn’t. These are the groups responsible for moving them on and so on so we can form an analysis of how we’re functioning. So when you look at it, it seems to be very structured. So it’s my job to ensure that all the subgroups are meeting regularly, that information is flowing to Task Force and from Task Force, supporting Community Reps. It’s like any co-ordinators job description if you look at it, it’s as broad as it’s narrow.” (Joe Doyle, BLDTF Co-ordinator)*

In terms of composition the Task Force is made up of the following representatives:

- Representative from the Area Partnership Company
- Voluntary Representatives including a representative from Blanchardstown Youth Service
- Representative from the Community Drug Team
- Representative from eight other funded projects outside the Youth Service and Community Drug Teams
- Six community representatives
- Political Representatives
- Statutory representatives: Gardaí, Health Board, Probation and Welfare, Department of Education, FÁS, Fingal County Council, County Dublin VEC (Vocational Education Committee) and liaison person from the NDST

There is currently a vacancy for an Advocacy representative on the BLDTF which the Task Force are close to filling. However, as the BLDTF co-ordinator contends,

*“That’s a lonely place to be and it’s a ballsy place to be because effectively you’re standing up and saying I’m a drug user you know, the fact that you’re an Advocacy rep.” (Joe Doyle, BLDTF Co-ordinator)*

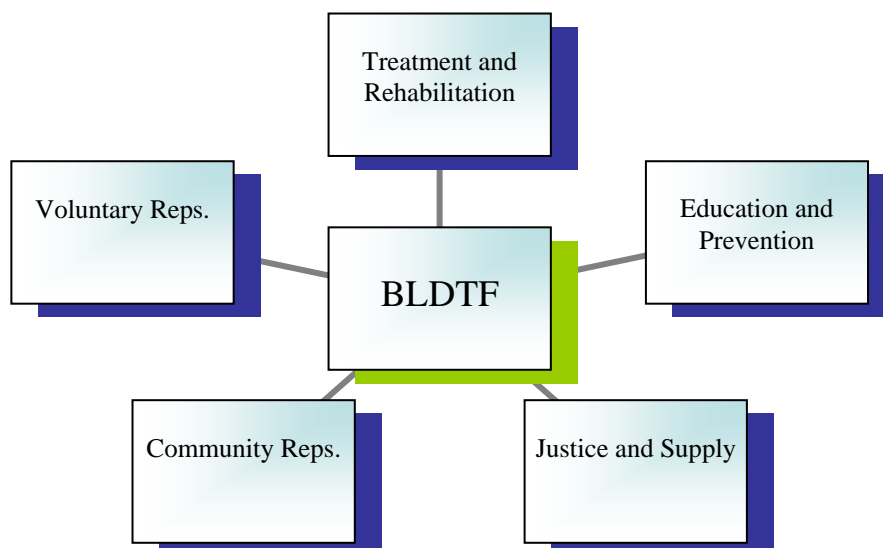
The current NDST liaison for Blanchardstown, Fergus McCabe, describes below how his role on the BLDTF is about trying to solve problems that arise and also disseminating information in relation to what's happening nationally.

*“I would tend to go to as many [meetings] as I can and at the particular meetings what you would try to do is number one you would try to reflect some of the policy discussions that are going on nationally and you would give information about development for example, but you would also then be a conduit for bringing up the information so if the Task Force has a problem that it can't resolve between itself and projects or itself and agencies I'd raise them then at the National Drugs Strategy Team Level and we'd try and resolve them”.* (Fergus McCabe, NDST liaison for Blanchardstown)

#### 7.4.1 Dynamics of BLDTF composition

The business of the BLDTF is conducted through a number of sub-groups illustrated in Figure X below. The sub-groups are in line with three of the four pillars of the National Drugs Strategy. There's a treatment and rehabilitation sub-group, education and prevention, justice and supply and the Task Force also has a planning and evaluation subgroup. In addition there's a voluntary representatives sub-group and a community representatives subgroup.

**Figure 7.5: Subgroups of the BLDTF**



The maximum number of Task Force members on any of the subgroups is two so as to facilitate a broader and more specialist knowledge. The subgroups meet monthly, two weeks prior to the Task Force meeting, and subsequently send reports to the Task Force so issues arising can be raised on the Task Force agenda. At certain times also, the subgroups themselves have their own Task Groups, a subgroup of the subgroup in essence. In terms of the operations of the BLDTF, the Task Force designates the work to the subgroup and the subgroup does the work.

## **7.5 Mechanisms of Funding**

The Task Force itself does not administer funding (see Chapter 6), apart from a family support budget which they are administering as part of their second action plan (2001 – 2005).

### **7.5.1 Interim Funding**

Under the current plan, there are 17 interim funded actions. These actions relate to nine projects receiving funding. Projects apply to the BLDTF for funding. The BLDTF approves them for interim funding. The BLDTF then writes to the NDST looking for continued interim funding for the project/action. When that is approved, the BLDTF writes to the particular funding channel (e.g. Dublin VEC, Northern Area Health Board) requesting a release of the project.

### **7.5.2 Mainstreamed Projects**

There is a tripartite arrangement in relation to mainstreamed projects. Projects from the first action plan (1997 – 2000), which were evaluated and approved for mainstream funding, are now accountable to the funding agency. In turn, the funding agency is accountable to the Task Force for those projects. Whereas the interim funded actions are the direct responsibility of the Task Force who are accountable to

the funding agency, mainstreamed actions are the direct responsibility of the funding agency who are in turn accountable to the BLDTF.

There are other issues present, which are causing complexities and tensions in terms of funding status, as Joe Doyle explains below.

*“There’s issues arising with the benchmarking and the issue there is that the Northern Area Health Board has agreed to pay benchmarking subject to productivity negotiation and the NDST hasn’t so in essence you might have a worker who’s funded through interim funding who financial provision won’t be made for benchmarking but yet their co-worker who’s funded through mainstreamed [has financial provision made for benchmarking] and also they can only be offered six month contracts because that’s the term of the form so there’s issues around the interim. But last year there were cut backs made, I think they were 2% cutbacks from the mainstream action whereas the interim funding remained constant so there was more security being interim funded that mainstreamed which is ironic” (Joe Doyle, BLDTF Co-ordinator)*

## **7.6 BLDTFs Local Strategy**

The Task Force is currently delivering the second action plan of its local strategy (2001- 2005), the first round of actions was evaluated and subsequent recommendations fed into the second plan.

### **7.6.1 BLDTFs First Plan**

In the first action plan of the BLDTF (1997 – 2000), the Task Force sought to coordinate the integration and extension of existing projects and programmes and develop a range of new projects, as well as identifying gaps in service provision. The first plan, therefore, aimed not just to deal with the immediate needs of active chronic drug misusers in the short term, but also to compliment and integrate drug prevention services in the community. An important part of the first strategy was the development of a partnership-based approach, which would harness the relevant strengths of the local community, statutory and voluntary organisations.

In the first three years the BLDTFs plan was centred more on education and prevention programmes rather than addressing the treatment issue. Joe Doyle, the current BLDTF co-ordinator, comments in Box 7.6 that the first plan did not have same structure in place as there is presently yet there were some valuable developments initiated in the early years of the BLDTF.

#### **Box 7.6: Plan A - Keep them off the Streets**

*“The interesting thing about Blanchardstown the first time is it was very education/prevention led with elements of treatment...keep them off the streets sort of intervention..from talking to people, I wasn’t here in those days, there was an acknowledgement that there was a problem but yet when the Task Force drew up its first plan it was education/prevention orientated. But I think that’s mainly because the structure wasn’t there and in fairness to them they did set up three Community Drug Teams and they were built on quite extensively in the second plan.” (Joe Doyle, BLDTF Co-ordinator)*

The following projects were approved under the first plan of the BLDTF and received funding through the National Drug Strategy Team (NDST):

- ◆ Three Community Drug Teams  
(Corduff/Mulhuddart; Blakestown/Mountview; Hunstown/Hartstown)
- ◆ Blakestown/Mountview Neighbourhood Youth Project
- ◆ Blakestown/Mountview Youth Initiative
- ◆ Pilot Peer Drug Prevention Programme
- ◆ Blanchardstown Early School Leavers Programme
- ◆ WEB Project (Working to Enhance Blanchardstown)
- ◆ GBRD Drugs Research Project
- ◆ GBRD Roadshow
- ◆ Drug Information and Community Education (DICE)
- ◆ Coolmine Community Support Group
- ◆ Combined Secondary Schools Drug Education Prevention Programme
- ◆ Community Action on Drugs Course (CAD)

### **7.6.2 Evaluation of the First Plan**

In 2000, the National Drug Strategy Team initiated a comprehensive external evaluation of all the above listed projects save the latter two. The schools project was evaluated locally by the Task Force while the CAD project was still under review by the Task Force at that time. Overall, it was found that the nature of project interventions were heavily skewed in the direction of education/prevention while at the same time clear rehabilitation and treatment needs were being identified and significant development and resource investment in that area were required. All the projects from the first plan, which were evaluated, were mainstreamed.

### **7.6.3 BLDTFs Second Plan**

In response to recommendations made from the evaluation of the first plan, BLDTFs second plan, the current strategy (2001 – 2005) is more drug treatment and rehabilitation orientated than the first plan. The three community drug teams were built on considerably in the second strategy. Some of the Interim funded projects for the second plan include:

- ◆ Mulhuddart/Corduff CDT: Outreach Worker, programme expansion
- ◆ Blakestown/Mountview CDT: Team Leader, Peer Education Programme, Siblings Project
- ◆ Hartstown/Huntstown CDT: Project Worker
- ◆ Blakestown/Mountview Youth Initiative: Family Support Worker
- ◆ Local Family Support Programme (BLDTF)
- ◆ Sessional Psychotherapist (Corduff Counselling)
- ◆ The River Rehab Project: Project Manager

*“It’s all evolving, there’s constantly movement, nothing is remaining static”.*  
(Joe Doyle, BLDTF Co-ordinator)

The BLDTF has also been involved in Equal Inter-Agency Protocol, which is concerned with how agencies work together. This has involved setting up protocols for agencies in Blanchardstown including the Rehabilitation and Integration Services

in the NAHB, the three CDTs, Coolmine Therapeutic Unit and Tolka River. They now have common referral forms so if a client is referred to another agency it is recorded as well as lead agency referrals which are concerned with the continuum of care. Therefore, a lot of developments have centred on organisational mechanisms and how people work together, which is continuously progressing.

#### **7.6.4 Issues arising in BLDTF**

Despite the emphasis on treatment and rehabilitation in the second plan, one of the major issues arising for the BLDTF is the absence of a central treatment facility in Blanchardstown. The BLDTF Treatment Position Paper outlines the strategy for treatment and rehabilitation in Blanchardstown so that the area would have a central treatment facility with progression within treatment. Drug users in treatment in Blanchardstown would progress from the central facility to primary health care and then on to General Practitioners. The strategy document also outlines certain provisions for relapse. The proposal, however, was turned down (see Section 7.7 below). Nonetheless, the need for a treatment facility for Blanchardstown still remains.

The major Justice/Supply issue is the creation of a Community Policing Forum within the BLDTF. The North Inner City Local Drugs Task Force was one of the first Task Forces to set up a Community Policing Forum, and this has been a model for the BLDTF to build a proposal on. The Blanchardstown Policing Forum would be comprised of community representatives, senior members of An Garda Síochána and the local authority. While concentrating on the drugs issue, it would open the opportunity to raise broader issues of community and agency concern.

Another pressing issue alluded to by the BLDTF co-ordinator, when interviewed, was the need for a Development Worker. One of the problems is that the second plan has not yet been implemented in its entirety. All the local projects have a community dimension to their management committees, yet in the absence of a Development Worker, Joe Doyle questions what kind of support is being given to these people. The role of the Development worker would be to liaise on the actions of the BLDTF and

work with all the committees. In the current plan of the BLDTF the Development Worker has a named role on a number of the actions, yet to date this position has not been created within the BLDTF.

## 7.7 Perceived barriers to BLDTF operations

There are a number of perceived barriers to the workings of the BLDTF which were alluded to in interview with the co-ordinator.

Firstly, the very name of the BLDTF is seen an obstacle as Joe Doyle explains below.

### Box 7.7: What's in a name?

*“I think Task Force is the wrong name for it. A Task Force is something that comes together for a period of time, produces its work and then disbands that's what a Task Force is by definition. Like the Task Forces are Local Drug Strategies that's what they should be called and I think that might link them closer to the National Drugs Strategy. You've a National Drugs Strategy Team, maybe they're Local Drugs Strategy Teams. Actually in essence that's what they are.”* (Joe Doyle, BLDTF Co-ordinator)

Other perceived barriers to the BLDTF are what are described by Joe Doyle as contradictory government policies. For example, the veto on BLDTFs proposal for a Central Treatment Facility was seen as the National Health Strategy contradicting the National Drugs Strategy. The proposed location for the treatment facility is in the grounds of James Connelly Memorial Hospital. However, the Health Board have objected with the argument that it is against the National Health Strategy for non-acute services to be based in an acute setting i.e. a hospital. However, the technicality on the side of the BLDTF is that the treatment facility will be located in the grounds of the hospital not in the hospital itself.

*“It's always going to be a question of resources”* (Joe Doyle, BLDTF co-ordinator)

The BLDTF have set out their plan of action, yet they hit a barrier when it is not all implemented. Financial restraint on behalf of the government has seen some of the



actions put on hold. This financial restraint has impeded the BLDTF moving forward with many of its actions as the NDST liaison remarks below. The position of a Development Worker has not yet being approved for Blanchardstown and this absence has limited the potential of some of these actions to achieve what they originally set out to do.

*“We’ve got to keep moving forward we’ve got to enhance the operational capacity of the LDTF’s and we’ve also got to look at new and emergent issues and respond to them in a timely fashion it doesn’t mean you just throw money at problems but that you give them the opportunity of developing sensible rational policies at a local level if they’re not sensible and rational it’s up to us our job is to slap them down and say they’re not sensible and rational come back with..but if they are it’s our job then to try and get the money to implement them that’s what we try to do here, but as I said it has become more difficult over the last couple of years..the government, like the different political elements within the government, that the more make-sure-we-have-the -economy-right-be-very-careful-about-the-spending has been the atmosphere..all these barriers now are being very very slowly dealt with and that’s the big problem”* (Fergus McCabe, NDST liaison for Blanchardstown)

## **7.8 BLDTF influencing policy?**

The Task Force has the opportunity to challenge any issue on the National Drugs Strategy. At NDST level, the Critical Implementation Plan breaks down the 100 actions of the NDS and gives them each a time frame. This enables progress to be monitored and allows Task Forces the opportunity to raise issues as depicted below.

### **Box 7.8: You can earth it and they can raise it**

*“I’m constantly writing to the NDST. I just challenged recently Action 69 and it’s to do with the Health Board providing training to the Local Authority around needle collection. So we’ve had an issue in relation to needles and Fingal has a policy in relation to parks, they’ll collect them in parks but they won’t collect them outside of parks, so if it’s on a street beside a park they won’t collect it. Now according to that Action, that’s been achieved but we know it hasn’t so at least I’m able to write and say in reference to Action... So you can earth it and then they can raise it so that’s where I see the policy being influenced.”* (Joe Doyle, BLDTF Co-ordinator)

At the local level, the community in Blanchardstown has had a major role to play in consulting, negotiating, drawing up and implementing its own response to local drug problems. This has shifted the emphasis from external professionals being consulted for resolutions to local problems. As can be seen from above, influencing national policies is dependent on the NDST receiving feedback from the BLDTF. To some extent the aims of the BLDTF continue to influence drug policy in the Blanchardstown area, however as can be seen by the refusal of the statutory sector to allocate a central treatment centre to Blanchardstown, the role of the BLDTF to influence or change official government policy is quite limited.

## **7.9 Perceived Impact of BLDTF on the community**

At the outset the perceived impact of the BLDTF can be seen;

*“If you go back to why they created the policy to begin with it was to keep people from marching on the streets. That’s been achieved”* (Joe Doyle, BLDTF co-ordinator)

The community was marching, prior to the inception of the Task Force, calling for action on the drugs issue. Since the establishment of the BLDTFs, the community have stopped marching and have become integrated into the local response, and this has seemed to work according to the NDST liaison for Blanchardstown:

*“So without saying it’s been a panacea, it hasn’t there’s been huge problems but the model I think is quite good because what you try to do is say look the people who know best in Blanchardstown are the people who work and who live in Blanchardstown. If you give them the responsibility of coming up with a drugs plan for Blanchardstown and you have all the key players together and they’re getting the go ahead from senior management within the organisations, which was the case at the start of this. That seems to be the best way.”* (Fergus McCabe, NDST liaison for Blanchardstown)

Indeed, the BLDTF co-ordinator refers to the Task Force as a cohesive group adhering strictly to its operational guidelines. A tribute to its formality in its functions is to be seen as all the other LDTFs use the Blanchardstown operational template as best practice.

### Box 7.9: Significant Progress

*“Blanchardstown started off very well, then there were issues of co-ordinators and gaps in co-ordinator changes and different chairs and it went through a dodgy sort of patch. I think in recent years it’s been very lucky that it’s had some very good people on the Task Force particularly the chairs and the co-ordinator; they’ve been very good and very focused. I think they’ve come on and they’ve made qualitative leaps in terms of looking at some of the strategy issues like how you develop protocols for projects to work together about drug use, how do you link in with some of the other local development projects, the social inclusion ones, in the sense that they’d say yes we’re dealing with the drugs issue but we’re dealing with it in the context of addressing educational disadvantage, unemployment, I think Blanchardstown is beginning to be very good at that sort of strategic approach etc. It’s been very good now, I think, in developing it’s approach in the sense of getting the group to work together, getting the community groups on board, supporting the community groups etc. So I think every area has problems, the Task Forces aren’t going to be a final solution to drugs problems but I think they have a role to play and I think the Blanchardstown one has made very significant progress in the relatively few years.” (Fergus McCabe, NDST liaison for Blanchardstown)*

#### 7.9.9 Conclusion

From what was there prior to the setting up of the BLDTF, to what has been initiated and developed since its inception, shows the significant role of the Task Force in the community. By presenting a model, which empowers the community to take control and cultivate organically, grown responses, at the minimum the Task Force in Blanchardstown has alleviated the sense of hopelessness that permeated through many communities because of the drugs problem. (Is this the main impact the BLDTF has had? Bear in mind what Doyle said, the LDTF is an interim measure by the very nature of the title 'Task Force' it is task orientated. It can be curtailed and removed. Consider this likely development in terms of the claims made for its impact.)

The first plan of the BLDTF was more education/prevention led and the second plan took on board the recommendations made from the first strategy, while all of the evaluated actions on the first plan have been mainstreamed. The current strategy is now more focused on treatment and rehabilitation and the BLDTF is pro-active in its objectives to address the issue of drug treatment and rehabilitation. Looking at the current profile of the drug misuser from Blanchardstown, it was possible to observe

changes with comparative data from the NDTRS (National Drug Treatment Reporting System) and these results and analysis are presented in section B of this chapter.

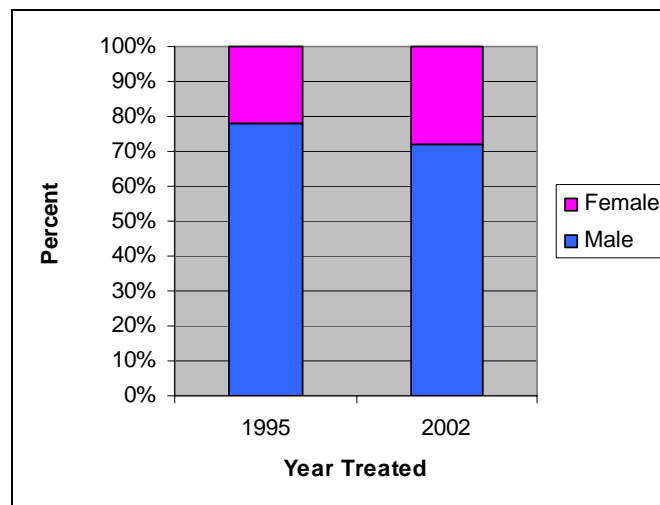
One of the talking points at the moment is the possibility of the BLDTF becoming a Limited Company. A number of the other LDTFs have already moved in this direction. If Blanchardstown Local Drugs Task Force becomes Limited it will be in a position to draw in funding from other sources to fund interim actions. This would side-step one of the barriers that has faced the BLDTF in terms of lack of resources and financial restraint.

In total, 752 drug users, residing in the Blanchardstown area, were treated for problem drug use between 1998 and 2002 (unpublished data from the NDTRS, see Chapter 1). Of the 752 drug users, 154 (20.8%) were treated for the first time. The number of new cases decreased, from 46 in 1998 (28.6% of total drug treatment demand in that year) to 27 in 2002 (18.8% of total drug treatment demand in that year). The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that 90 drug users residing in the Blanchardstown area were treated in 1995 while according to unpublished data from the NDTRS, 144 drug users were treated in 2002. This represents an increase in the total number treated for drug misuse. The increase is more influenced by the high numbers in continuous treatment or returning to treatment rather than new drug users attending treatment for the first time.

### **8.1 Gender**

Of the 733 treated drug users living in Blanchardstown between 1998 and 2002 whose gender was known, 520 (70.9%) were male while 213 (29.1%) were female. The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 78% of treated drug users residing in the Blanchardstown area were male and 22% were female, while according to unpublished data from the NDTRS, in 2002 72% were male and 28% were female. This represents an increase in the proportion of females from the Blanchardstown area treated for drug misuse as is depicted in Figure 8.1 below.

**Figure 8.1: Gender and Year Treated**



## 8.2 Age

Of the 751 treated drug users residing in Blanchardstown between 1998 and 2002 whose age was known, the majority (542, 72.2%) were aged between 20 and 29 years, this was followed by 103 (13.7%) who aged between 10 and 19 years, 92 (12.3%) aged between 30 and 39 years and finally 14 (1.9%) were 40 years or older (see Table 8.2 below). The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 40% of treated drug users residing in the Blanchardstown area were aged between 15 and 19 years and 31% were aged between 20 and 24 years, while according to unpublished data from the NDTRS, in 2002 78% were aged between 20 and 29 years and only four per cent were aged between 10 and 19 years. Although these age groups are not directly comparable, there is a clear decrease in the proportion of treated drug users under 20 years of age in the Blanchardstown area.

**Table 8.2: Age\*Year Treated**

Age	Year Treated					
	1998	1999	2000	2001	2002	Total
<b>10 - 19</b>	49†	22	17	9	6	103
<b>Years old</b>	(29.2%)‡	(19.5%)	(9.2%)	(6.3%)	(4.1%)	13.7%
<b>20 - 29</b>	99	84	138	106	115	542
<b>Years old</b>	(60.4%)	(74.3%)	(75.0%)	(74.6%)	(77.7%)	(72.2%)
<b>30 - 39</b>	15	6	25	22	24	92
<b>Years old</b>	(9.1%)	(5.3%)	(13.6%)	(15.5%)	(16.2%)	(12.3%)
<b>40+</b>	1	1	4	5	3	14
<b>Years old</b>	(0.6%)	(0.9%)	(2.2%)	(3.5%)	(2.0%)	(1.9%)
<b>Total</b>	164	113	184	142	148	751
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(Source: Unpublished NDTRS Data)

† = Number treated within that year

‡ = Percentage treated within that year

### 8.3 Living Situation

Of the 734 treated drug users residing in Blanchardstown between 1998 and 2002 whose living situation was known, 510 (69.5%) were living with their parents or family, while 93 (12.7%) were living with their partner alone and 74 (10.1%) were living with their partner and children. The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 68% of treated drug users residing in the Blanchardstown area were living in the family home and 13% were living with their partner, while according to unpublished data from the NDTRS, in 2002 66% were living with their parents/family and 12% were living with their partner alone. There has been relatively little change therefore in the proportion of treated drug users living in the family home or living with their partner.

## **8.4 Education**

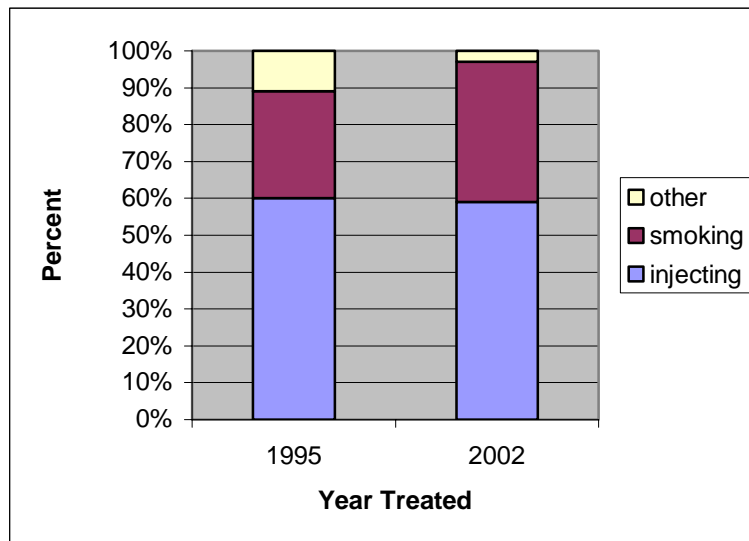
Of the 686 treated drug users residing in Blanchardstown between 1998 and 2002 whose level of education was known, 392 (57.1%) had already left school by the age of 16 years, within that 218 (31.8% of treated drug misusers) left school by the age of 15 years. The percentage to reach secondary level education was 86.1%, while 11.9% finished with school at primary level. The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 82% of treated drug users residing in the Blanchardstown area had gone on to secondary education however 69% left school before the age of 18 years, while according to unpublished data from the NDTRS, in 2002 83% had gone on to secondary education however 53% left school before the age of 16 years. In 1995 and 2002 a high proportion of treated drug users report having gone on to secondary level education; but clearly in the case of the 2002 figures, the majority would have left before completing their Leaving Certificate.

## **8.5 Main Route of Drug Administration**

Of the 752 treated drug users residing in the Blanchardstown area between 1998 and 2002, 719 (95.6%) reported opiates as their primary drug of use. The primary route of administration for the main drug of use was by injecting for 457 (61.8%) and by smoking for 239 (32.3%). The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 84% of treated drug users residing in the Blanchardstown reported opiates as their primary drug of use with 60% preferring injecting and 29% preferring smoking as their main route of administration, while according to unpublished data from the NDTRS, in 2002 95% reported opiates as their primary drug of use with 59% preferring injecting and 38% preferring smoking as their main route of administration. This represents an increase in the proportion reporting smoking as their primary route of administration, but similar numbers continued injecting (Figure 8.3).



**Figure 8.3: Main Route of Drug Administration and Year Treated**



### **8.6 Age of Primary Drug Initiation**

Of the 703 treated drug users residing in the Blanchardstown area between 1998 and 2002 who reported their age when they first used their primary drug 71.3% were between the ages of 15 and 19 years, this is followed by 15.2% who were between 20 and 24 years of age, while 8.7% were between the ages of 7 and 14 years.

For new cases (n= 140), the lag between initiation of primary drug and treatment was 3.5 years or more for 86 (61.4% of first treated drug users), less than 2 years for 32 (22.9%) and between 2 and 3.5 years for 22 (15.7%).

### **8.7 Age of First Use of Any Drug**

Of the 667 treated drug users residing in Blanchardstown between 1998 and 2002 who reported their age of initiation of any drug 52.5% began using drugs between the ages of 7 and 14 years, 43.5% between 15 and 19 years of age while 4% began using drugs in their twenties or older. The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 59% of treated drug users residing in the Blanchardstown area began using drugs aged 15 – 19 years and 22% began in their twenties, while according to unpublished data from

the NDTRS, in 2002 60% began using drugs between the ages of 7 – 14 years, 37% began drugs between 15 – 19 years and 3% began in their twenties or older. This represents an increase in the proportion of treated drug users initiating drug use under the age of 15 years.

## **8.8 Injecting Practices**

Of the 733 treated drug users residing in the Blanchardstown area from 1998 – 2002 who had reported whether or not they had ever injected, 76.3% admitted having injected drugs at some stage and 37.6% had injected in the previous month. Of those who had ever injected, 323 (64.2%) had first injected between the ages of 10 and 19 year, 25.2% had first injected aged 20 – 24 years while 10.5% had first injected aged 25 years or older. Of the 482 treated drug users residing in Blanchardstown between 1998 and 2002 who reported whether or not they ever shared needles, 79.5% admitted to having shared needles in the past. The Blanchardstown Drugs Task Force in their submission to the National Drugs Strategy Committee reported that in 1995 73% of treated drug users residing in the Blanchardstown area had injected at some stage with 48% currently injecting and 36% having injected for the first time aged 15 – 19 years, while according to unpublished data from the NDTRS, in 2002 75% had injected at some stage with 34% currently injecting and 64% having injected for the first time between the ages of 10 and 19 years. This represents an increase in the proportion of treated drug users who were under 20 years of age when they first injected.

## **8.9 Area of Residence in Blanchardstown**

A breakdown of the areas of residence of the 752 treated drug users residing in the Blanchardstown area from 1998 – 2002 is presented in Table 8.4 below. As can be seen from the table, the majority were residents of the Coolmine area 42.8%. Following this, 168 (22.3%) came from Corduff while 106 (14.1%) were from Blakestown. The remaining percentages of treated drug users residing in the Blanchardstown area came from Mulhuddart (8.9%), Tyrrelstown (4.8%), Abbotstown (3.5%), Delwood (1.9%) and Roselawn (1.7%).

**Table 8.4: Area of Residence\*Year Treated**

Area of Blanchardstown	Year Treated					Total
	1998	1999	2000	2001	2002	
<i>Abbotstown</i>	2† (1.2%)‡	4 (3.5%)	8 (4.3%)	4 (2.8%)	8 (5.4%)	26 (3.5%)
<i>Blakestown</i>	18 (11.0%)	20 (17.7%)	25 (13.6%)	22 (15.5%)	21 (14.1%)	106 (14.1%)
<i>Coolmine</i>	66 (40.2%)	57 (50.4%)	93 (50.5%)	56 (39.4%)	50 (33.6%)	322 (42.8%)
<i>Corduff</i>	47 (28.7%)	12 (10.6%)	33 (17.9%)	37 (26.1%)	39 (26.2%)	168 (22.3%)
<i>Delwood</i>	1 (0.6%)	3 (2.7%)	3 (1.6%)	2 (1.4%)	5 (3.4%)	14 (1.9%)
<i>Mulhuddart</i>	14 (8.5%)	8 (7.1%)	14 (7.6%)	16 (11.3%)	15 (10.1%)	67 (8.9%)
<i>Roselawn</i>	2 (1.2%)	1 (0.9%)	2 (1.1%)	3 (2.1%)	5 (3.4%)	13 (1.7%)
<i>Tyrrelstown</i>	14 (8.5%)	8 (7.1%)	6 (3.3%)	2 (1.4%)	6 (4.0%)	36 (4.8%)
<b>Blanchardstown</b>	164 100.0%	113 100.0%	184 100.0%	142 100.0%	149 100.0%	752 100.0%

(Source: Unpublished NDTRS Data)

† = Number within that year

‡ = Percentage within that year

Of the 150 drug users residing in Blanchardstown between 1998 and 2002 who were treated for the first time and whose area of residence was known, 44.4% were from Coolmine, 16.2% were from Blakestown, 16.2% from Corduff, 8.2% were from Tyrrelstown, 3.9% were from Delwood, 3.2% were from Abbotstown and 2.6% were from Roselawn.

### 8.9.9 Analysis of Findings

As the above analysis highlights, there have been a number of important changes to the profile of treated drug users residing in the Blanchardstown area since 1995. Indeed over the past nine years, the number of treated drug users has risen which can be attributed to both an increase in treatment provision as well as an increase in drug users in continuous treatment. Since 1995, there has been an increase in the proportion of treated drug users residing in Blanchardstown who are female. This has

consequential implications for social services, as this presents specific needs of female drug users that to be addressed regarding, for example, maternity and family planning.

Since 1995 there has been a decrease in the proportion of treated drug users residing in Blanchardstown who are aged 20 years or under. The recent figures show the highest proportion of treated drug users residing in the area are in the 20 – 29 year old category and so services should be tailored towards this target group.

The living situation of treated drug users residing in Blanchardstown has remained relatively unchanged since 1995 with the majority still living with their parents or family.

In terms of education, though a high percentage of treated drug users report having gone on to secondary education, recent figures show more than half of these have left before the age of 16 years, therefore, without completing their Leaving Certificate<sup>7</sup>.

Opiates have remained the primary drug of misuse, with increasingly higher percentages reporting an opiate as their drug of choice in 2002 compared with 1995. Similarly high proportions have reported injecting as their preferred route of administration in 1995 and 2002, while in 2002 there has been an increase in the numbers who report smoking as their preferred route of administration. This may be seen as a positive step in terms of harm reduction, however, reviewed literature has shown 93% of opiate injectors smoked prior to injection and the mean time spent smoking was two years<sup>8</sup>. Therefore, those who are currently smoking may progress onto injection and so this finding may not be as positive as it first appears. There has also been an increase in the proportion of treated drug users who are under the age of 20 when they first inject.

The lag between initiation of primary drug of use and treatment was 3.5 years or more for the highest proportion of drug user seeking treatment for the first time in 2002.

Worryingly, there has been an increase in the proportion of treated drug users who started using any drug under the age of 15 years. Indeed, unpublished NDTRS figures

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<sup>7</sup> The Department of Education does not permit students under 16 years of age to sit the Leaving Certificate Examination

<sup>8</sup> Cassin, S., Geoghegan, T. and Cox, G. (1998) Young injectors: a comparative analysis of risk behaviour. *Irish Journal of Medical Science*, 167, 234 – 237

for 2002 show that the highest proportion began using between the ages of 7 and 14 years which has important implications for targeted interventions in Blanchardstown. The breakdown of areas of residence in Blanchardstown shows that the highest proportion of treated drug users reside in the Coolmine area, followed by Corduff, Blakestown and Mulhuddart. Interventions in these areas have been initiated and expanded upon by the Blanchardstown Local Drugs Task Force. The first action plan of the BLDTF set out a strategy to establish three Community Drug Teams; the Mulhuddart/Corduff CDT, the Blaskestown/Mountview CDT and Harstown/Hunstown CDT. The Coolmine Therapeutic Unit was in existence prior to the establishment of the BLDTF, set up in 1973. The most pressing need in terms of drug treatment services for Blanchardstown is a Central Treatment Facility as alluded to by the BLDTF co-ordinator when interviewed (see Chapter 7). However, this request has not been granted and so this is a major barrier obstructing the provision of an adequate drug treatment service for drug users residing in Blanchardstown.

## 9 Discussion

The following discussion will focus on the outcomes of the three objectives of the study drawing them together in the overall context of this research.

Objective 1: *How can this study examine evidence-based drug policy and practice considering the uptake of drug misuse research into policy and practice as well as the barriers to the uptake of drug misuse research into policy and practice?*

Objective 2: *How can this study explore specifically whether drug treatment data has been used in research to influence policy formulation and practice change and development in the Irish context using an Irish example?*

Objective 3: *How can this study explore, within this Irish example, what developments and changes took place at the practical level?*

The analysis of literature on the evidence-based policy debate has created a fitting backdrop to the case of Irish drugs policy in 1996. The various models, theories and arguments on both a general level and in the area of evidence-based drugs policy have acted as a framework on which to weave the threads of the case of Irish drugs policy in 1996.

### 9.1 Traditional policy responses

Tracing the history of drug misuse in Ireland, this study has shown that for a long time problem drug use was virtually ignored and when the issue was brought to light in the 1970s, traditional interpretations of the meaning of addiction were to reign supreme. It was easier to see drug use in terms of poor lifestyle choices to be subject to the biomedical model rather than conceptualising it as a social product. Even with the onset of the heroin epidemic in Dublin in the 1980s, the legislative avenue for addressing the drugs issue did not alter in any way and the official response to the problem was one of individualism, taking drug dependency to be a disease which

affected ‘individual sufferers [who]..should be plucked from their everyday environment and taken to a centralised system, where they could be subject to the ministrations of technical experts in the condition’ (Butler, 2002: 169). In the 1990s the switch of focus to HIV/AIDS prevention and its association with injecting drug use. It was only in 1996 that a change came about in traditional government thinking on drug misuse and for the first time structures were put in place which would respond to drug misusers in their everyday environment and decentralise the system in favour of localised initiatives.

## **9.2 Why was 1996 a special case?**

As Marmot (2004: 906) is noted as saying, ‘people’s willingness to take action influences their view of the evidence, rather than the evidence influencing their willingness to take action’. These words ring true for Irish policy makers as this study has shown. In the 1991 *Government Strategy to Prevent Drug Misuse* drug treatment data from the HRB was available. The strategy utilised drug treatment data which pointed to a number of areas in Dublin from which a high proportion of drug users seeking treatment resided. However, this evidence was not acted upon. In the 1996 report of the *Ministerial Task Force on Measures to Reduce the Demand for Drugs* there was a willingness from the government to take action for a number of reasons which will be discussed below and this influenced the view of the epidemiological evidence used in the report.

## **9.3 Research Findings**

This study has found that the readiness of the government to take action in 1996 and address the social context of drug abuse through targeted local structures was due to three major dynamics:

- Political Imperative
- Political Incentives
- Political Legitimation

### **9.3.1 Political Imperative**

The moral panic that had been generated in Ireland with the threat of HIV/AIDS and its association with injecting drug use had rallied people onto the streets again in the 1990s calling for a local response. This panic was further intensified with the murder of Veronica Guerin in June 1996 by gangland criminals, whose main source of funding came from drug trafficking. Public outcry ensued demanding an immediate government response to toughen supply-reduction. This moral panic generated a political imperative and the Rabbitte Report was a response to this.

### **9.3.2 Political Incentives**

The publication of the Rabbitte Report in 1996; its subsequent structural recommendations with a framework running from national level to local level and these local level structures (LDTFs) targeting the worst affected areas as a response to the drug problem were all enabled by a number of political incentives.

Firstly, the structures which were put in place as a result of the 1996 policy were a natural extension of a tried and tested approach. The partnership model had been utilised in Ireland since the early 1990s and the local Area Based Partnerships had been set up in many of the now LDTF areas as part of a socio-economic response programme. This model could now be expanded to deal with the drugs issue and LDTFs can include representatives from their local Area Based Partnerships as the case of Blanchardstown LDTF showed.



A second incentive, as some authors have alluded to, was the healthy state of the government's purse in 1996. Major community development projects such as the LDTFs were not an option in the 1980s for a country in steep recession. However, healthy finances coincided with a political imperative in 1996 and thus funding was available to respond to this on a large-scale.

A third incentive was the possibility of 'political kudos'. There were both national and international factors involved in this. In October 1996 (publication of the Rabbitte Report) Ireland was holding a six-month presidency of the European Union and nationally, there were upcoming elections and these factors can be seen as attributing to the speed at which the policy recommendations were implemented.

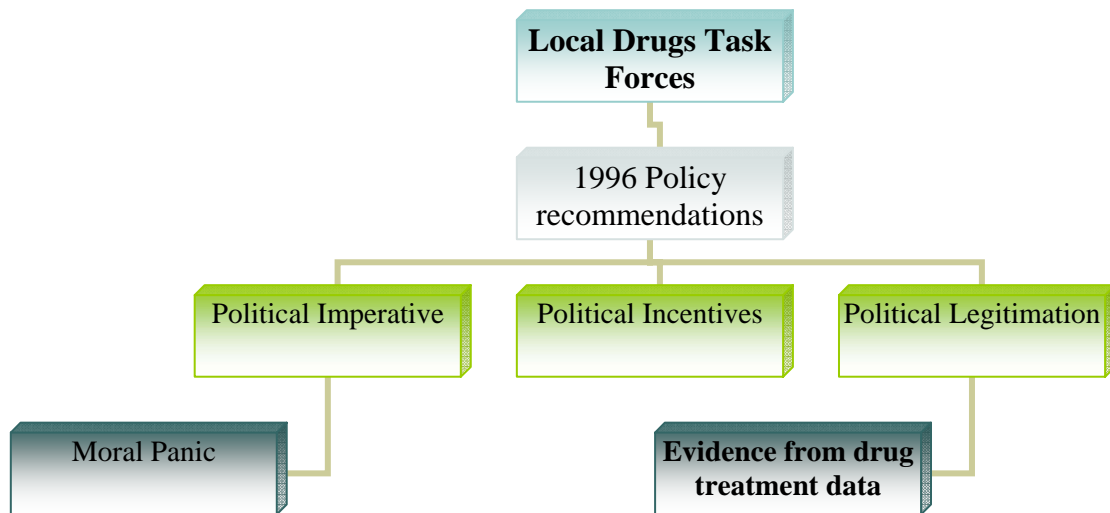
### **9.3.3 Political Legitimation**

A third dynamic was the use of drug treatment data from the NDTRS to inform this 1996 policy. An analysis of this data pointed to the worst affected areas from the area of residence codes of drug users seeking treatment. This epidemiological research mapped out ten 'black spots' in the Greater Dublin Area and these maps corresponded with areas identified as those also worst affected by social and economic disadvantage, consistent with international findings of the link between problem drug use and socio-economic disadvantage. The sound knowledge base of this research legitimated the government's decision to target these areas with extra resources and to establish a local level, integrated response in the form of Local Drugs Task Forces in each of these ten 'black spots' in Dublin. In essence, this NDTRS research verified on a national level what the locals already knew and were campaigning for and using this evidence-base authenticated the government's policy.

#### **9.4 Evidence-based policy making?**

The three dynamics above coincided to create an Irish drugs policy in 1996 which was evidence-based. The title of this study depicts the overall finding of this research, that evidence-based policy making took place in the context of a moral panic. This evidence-based policy in 1996 was not a simple recipe linking research, policy and practice. If 'evidence' is taken in its broadest meaning then it can be argued that Local Drugs Task Forces are an example of evidence-based policies translated into practice. Epidemiological evidence from NDTRS drug treatment data mapped out a number of different areas experiencing problematic drug use. However, anecdotal evidence on the scale of the drug problem came from community groups in these areas long before the establishment of the NDTRS and the collection of data on drug users seeking treatment Ireland began. This 1996 Irish drugs policy was of, what Dobrow et al (2004) called practical-operational orientation meaning it was context based, defining the evidence from the drug treatment data in relation to the specific decision-making context of these problem areas. This orientation takes account of a multitude of factors in decision-making which is clear from the three dynamics of the 1996 drugs policy. The epidemiological perspective which was employed framed policy decision – making in a particular way which saw the policy response being applied at local community level. There is undoubtedly a link between Local Drug Task Forces and Drug Treatment Data as this study has shown, but what has also been found is the complex nature of this link as Figure 9.1 below depicts.

**Figure 9.1: Linking Local Drugs Task Forces to Drug Treatment Data**



This link is an intricate and complex one, reflecting the very nature of the policy itself. It is not an ideal model of evidence-based policy making that can be replicated. The 1996 policy emerged from an interplay between several dynamics which was, as Hall (2004) would call, a serendipitous happenstance. The political will to apply the findings from research at an opportune time lead to the establishment of the Local Drugs Task Forces.

### **9.5 Local Drugs Task Forces and Policy**

The practice end of 1996 policy saw the creation originally of ten LDTFs in Dublin, and one in North Cork city. The case of the Blanchardstown LDTF in this study highlighted the operational mechanisms and action plans and strategies put in place to deal with the drugs problem within the community. The BLDTF has a formal operational plan which it closely adheres to and this allows a cohesiveness to permeate the Task Force. Through concerted community involvement, locally devised responses have alleviated the sense of hopelessness at the problem of drug misuse in Blanchardstown. Projects from the first plan have now been mainstreamed which has been a measure of success guaranteeing continued funding. Current projects have been interim funded and implemented; however, this study has found that LDTF workings have been hampered by a number of factors:

- As alluded to by the BLDTF, the very name of the Local Drugs Task Force is an interim measure which can be curtailed or removed. As suggested, this name should be changed to the Local Drugs Strategy Team bringing it closer to the National Team.
- Another ironic feature which this study found in terms of the BLDTF is the curtailment of its potential by its very support structure. Rather than the structures working in unison, it seems the BLDTF is obstructed from moving forward since the rejection of a proposal for a Central Treatment Facility in the area. While the LDTFs may be seen as empowering in harnessing local communities and statutory strengths, this empowerment is dependent on what it can do, and what it can do is decided from above. As reviewed literature on community development argues, ‘top down’ designs should facilitate the ‘bottom up’ dynamic not block significant changes.

The workings of the BLDTF take place through the subgroups with a specific focus three pillars of the government’s drug policy of education/prevention; treatment/rehabilitation and supply reduction. The fourth pillar of research, however, is not formally assigned to local level and this can be seen as an impediment to the workings of the overall structural response. The NDST, the structure above the LDTFs, is mandated with informing policy from the work and lessons of the LDTFs. Though as this study found, there is regular feedback from the BLDTF to the NDST, without routine, localised research on the changing trends of the drug problem as well as regular, evaluative research on projects and actions ongoing under the LDTFs, it is impossible to effectively inform policy.

For this study, NDTRS data was analysed for drug users seeking treatment in the period 1998 – 2002 who were residing in Blanchardstown, and this data was compared with 1995 NDTRS data. Though a sole indicator, it provided important evidence of the changing profile of drug users seeking treatment who live in Blanchardstown since the inception of the BLDTF. Indeed the indications of these data must be considered. An increase in the numbers of drug users from Blanchardstown seeking treatment could be viewed as a consequence of an increase in service provision. However, though concerns may rage, an interpretation of the finding that there are increasing numbers of drug users from Blanchardstown seeking

treatment could be attributed to a positive consequence of BLDTF project interventions into problem drug use and an optimistic sign in terms of both harm reduction and demand reduction. Of most concern, this study found an increase in the proportion of treated drug users from Blanchardstown initiating use under age of 15 years, as well as the increase in the number of treated drug users who were under the age of 20 years when they first injected. This has serious implications for targeted responses to drug use among children in Blanchardstown and prevention projects and treatment responses for children should be reviewed and strengthened in light of these serious changes.

## **9.6 Conclusion: Linking research, policy and practice**

This study has found that in 1996 Irish drugs policy marked a change of approach in government thinking and for the first time problem drug use would be responded to in its social context. An evidence-based decision was taken in a time of moral panic to target ten areas in Dublin with Local Drugs Task Forces and an eleventh area in North Cork city. The ten original LDTFs in Dublin can be linked back to drug treatment data, however, the nature of this evidence-based policy is a multifarious interchange of several dynamics and the research/policy relationship in this 1996 example reflects the legitimisation model, as the evidence justified the policy decision.

The protective Irish drugs policy belt was swayed in a moral panic in 1996 and this led to a radical change, compared with previous policies, to take account of context, thus weaving policy around an epidemiological framework. This change can be seen as an incremental adjustment to competing pressures which was legitimated by research evidence. The practice developments, the LDTFs, which have ensued could inform policy and contribute to an interactive research-policy-practice relationship if their potential is set free to be realised not constrained. This community based response empowers locals to cultivate their own strategy at local level. This empowerment is supported by the partnership based approach, which permeated from other policy initiatives at the time. This study has shown, by the example of the 1996 case of Irish drugs policy, the intricate interplay of dynamics leading to an evidence-based policy. Future research might expand on the complexities underpinning

evidence-based policy making in the Irish context through other case study research designs.

The link between research-policy-practice should not be viewed as an ideal linear progression but as an interactive relationship with policy influenced by practitioners and researchers. 'Linkage and exchange' between researchers and policy-makers, as propagated by Lomas (2001) should be encouraged in the Irish context of drug misuse and extended to include practitioners, so that these three perspectives can make links and exchange information within a policy community. Irish drugs policy should develop within a rational model and thinking should shift towards, what Dobrow et al (2004) call, 'context-based evidence-based decision making'. Perhaps then overtime, the ingrained militancy of the Irish drugs policy core will disarm in its war against drugs, and negotiate with the enemy. It is clear from the example of the Local Drugs Task Forces that the troops on the ground are the best negotiators of all.

*“Strategies which consult with and actively encourage the involvement of local people are most likely to lead to a reduction in the demand for drugs... local groups and individuals have a very valuable contribution to make to the development of national policy and can bring to the decision table a depth of local experience...some of these local groups have been involved in tackling the drugs problem in their respective areas over a number of years and, during that time, have built up considerable valuable experience which should be tapped as a resource”.*

(Submission from the Combat Poverty Agency to the 1996 Ministerial Task Force)

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