

Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed

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INTRODUCTION

The recent publication of the *Government Strategy to Prevent Drug Misuse* twenty years after Ireland's first major policy document in this area, the 1971 *Report of the Working Party on Drug Abuse*, suggests that drug problems and policies aimed at their alleviation have now become a permanent feature of Irish society.¹ There has, however, been relatively little analysis of this area of Irish social policy and the aim of the present paper is to fill this gap by reviewing the major developments which have taken place over the past twenty five years. Given the lack of a descriptive literature on Irish drug problems and policies, the bulk of this paper will consist of a chronological presentation of material, with the period concerned being broken down into three distinct phases. From an analytical perspective, however, the following four questions will be addressed continuously throughout this historical review.

Firstly, how clearly and explicitly have drug problems been defined and which societal institutions have been given 'ownership' or responsibility for their prevention and management? This question reflects the international experience that drug problems may be perceived either as health issues, which are legitimately managed by the health care system, or alternatively as criminal matters to be controlled by the criminal justice system. In practice, health care and criminal justice internationally have tended to share responsibility for drug problems; thus drug policy studies which focus on a particular society at a particular time are most likely to be concerned with determining where the balance lies between these contrasting institutional approaches.

Secondly, what have been the major external influences on Irish drug policy? The twentieth century has seen the creation of an international system of agreements and conventions governing all aspects of the production, distribution, possession and use of psychoactive drugs.² Despite a high level of international collaboration (and Ireland is currently involved in this context with such bodies as the United Nations, the World Health Organisation, the Council of Europe's Pompidou Group and the European Community's CELAD Group), there are still significant policy differences and it is of interest to consider these differences and to attempt to assess which countries have had the strongest impact on Irish policy making and practice. The most obvious external influences have come from English-speaking countries, particularly Britain and the United States of America, but in the period since our accession to the European Community there has been increased exposure to the drug policies of our non-English-speaking European partners.

Thirdly, have causal relationships been sought or accepted between drug problems and other social problems, such as poverty, unemployment and urban decay, or have policies been based on the

view that drug problems constitute a discrete phenomenon with no significant structural or cultural linkages in Irish society? Critical studies of drug policies in other countries have generally concluded that drugs have been *demonised*, that is they have been regarded in an exaggerated way as corruptors of otherwise well-functioning societies. Specifically, such studies have argued that neither an increase in use of the criminal justice system, of the American ‘War on Drugs’ type, nor an increase in the provision of treatment and rehabilitation services is likely to make a substantial impact on drug problems, and that much wider societal and cultural interventions are required.³

Finally, regardless of the content of Irish drug policies, what policy-making structures have evolved over the years in this country? The drug scene in Ireland, as in other countries, is prone to change and it might reasonably be expected that drug policy making would be an on-going process, involving constant evaluation and adaptation. Policy-making structures may take a variety of forms: in Britain, for example, a major role has been played by the Advisory Council on the Misuse of Drugs which was established in accordance with Section One of the 1971 Misuse of Drugs Act; while in the United States of America, since the Nixon era, policy making has been drawn closer to the executive, with recent presidential advisers being dubbed ‘drug czars; and in the Netherlands, which is generally regarded as having extremely innovative albeit controversial drug policies, a unified Alcohol, Drugs and Tobacco division within the Ministry of Welfare, Health and Cultural Affairs has contributed significantly– and more publicly than would be the norm in Britain and Ireland with their tradition of the ‘faceless bureaucrat’ – to the development, implementation and evaluation of such policies.⁴

1966-1979: THE EARLY YEARS

The first discussion of drug problems in an official Irish policy document is almost certainly that which is contained in the 1966 *Report of the Commission of Inquiry on Mental Illness*.⁵ It is understandable that a mental health report of this era should touch upon the subject of drug problems; the commission carried out its work during the 1960s, a decade which more than any other is associated in the popular mind with drug use as part of a burgeoning youth culture. The overall conclusion of the commission, however, was that Ireland had as yet avoided such problems, although a cautionary note was sounded: ‘the Commission considers that drug addiction could reach serious proportions in this country unless a constant effort is maintained to prevent the abuse of habit-forming drugs’.⁶ The main reason why the Commission of Inquiry on Mental Illness considered this topic was that under the Mental Treatment Act 1945 drug addiction was deemed to be a condition which might appropriately be treated by psychiatric services and indeed on occasion might warrant compulsory hospitalisation. The commission accepted that the treatment and rehabilitation of drug addicts was a legitimate function of the mental health services, although it favoured the creation of a centralised, residential treatment unit rather than advocating that drug problems should be dealt with by generic, community mental health services.

Two years later, following the establishment of a special Drug Squad in the Garda Síochána and considerable media interest in drug problems in Dublin, the Minister for Health, Sean Flanagan, appointed a Working Party on Drug Abuse with the following terms of reference:

To examine the extent of drug abuse in Ireland at present; to advise the Minister on the steps which might be taken to deal with the problem, including measures to discourage young persons from starting the use of drugs (e.g. publicity, education, example, etc.); to advise on the action to be taken to assist in the rehabilitation of persons who have acquired the drug habit.⁷

The *Report of the Working Party on Drug Abuse* was completed and made public in 1971 and for the remainder of that decade it continued to be an important point of reference in all public debate and policy making in this area.

The 1971 *Report* was, on the face of it, a balanced, caring document, taking its cue perhaps from the Minister’s prefatory comments, which included the opinion that ‘persons who have become dependent on drugs ... should be regarded as sick people in need of medical care to be treated with sympathy and understanding’.⁸ It recommended, among other things, that statutory controls to be

contained in comprehensive, new, anti-drug legislation should not unduly infringe on individual civil liberties; that there should be a system of scaled penalties for varying types of drug offence; and that the courts should have the power to commit convicted drug abusers to a treatment facility rather than to a conventional prison.

However, when one reads the *Report* with the wisdom of hindsight what is obviously missing is any discussion of what exactly is meant by ‘drug abuse’ or any attempt at defining this concept. It is assumed throughout that drug abuse is a self-evident social problem and, furthermore, that it is a problem which can only be tackled by policy measures which are aimed at controlling the supply of illicit drugs and, where this fails, insisting that individual drug users should become abstinent. What is notably lacking is an explicit discussion of the long-standing policy divergence between Britain and the United States, and the implications of this policy divergence for countries, such as Ireland, which were starting afresh in the whole business of drug policy. In the US the passage of the Harrison Act 1914 had given ‘ownership’ of drug problems to the criminal justice system and only a very limited role was allowed for the health care system. Drug use was seen as an unusually deviant, criminal phenomenon which was so threatening to society that it had to be dealt with in a tough, uncompromising way. By contrast, the ‘British system’, which was established by the Rolleston Committee in 1926, took a more pragmatic line in allowing all medical practitioners to prescribe addictive drugs (including heroin and cocaine) on an indefinite or ‘maintenance’ basis for dependent drug users who either could not or would not become abstinent. The rationale underlying the Rolleston recommendations was that maintenance prescribing of this kind would allow drug users to become socially stable, while at the same time keeping them out of the criminal drug supply network.⁹

In fairness to the Working Party on Drug Abuse, it should be stated that these policy differences between Britain and the USA had diminished considerably by the late 1960s. Methadone maintenance was now being practised widely in the US, and, following the Second Brain Report of 1965, the British authorities had established their ‘clinic’ system and had restricted the prescribing of heroin and cocaine to specially licensed doctors in these new clinics.¹⁰ In suggesting that Irish policy makers might have benefited from an examination of this historical divergence between British and American policies, the intention is not to argue prescriptively that one policy approach is right and the other is wrong; rather is it suggested that an explicit acknowledgement of conflict and ambiguity might alert Irish policy makers to the need for subtlety and an avoidance of dogmatism. Interestingly, the working party displayed precisely this kind of subtlety in its discussion of drug education for schoolchildren, where it recognised the need for a cautious approach to drug education and the risk of increasing drug experimentation amongst young people by the use of crude, anti-drug educational tactics.¹¹ The working party recommended that the whole question of drug education should be considered by a specialist committee and this, in turn, led to the establishment in 1974 of the Health Education Bureau.

However, while advocating that drug education should develop as an integral part of the school curriculum, being taught by teachers in the context of religious education, health education or civics, the working party did not apply similar ‘normalisation’ principles to its recommendations on treatment services for drug users and drug addicts. Instead, it followed the line, which had been taken earlier by the Commission of Inquiry on Mental Illness, that drug treatment and rehabilitation services should be specialised rather than delivered as part of primary care services or within the newly-developing community mental health services. Ireland’s major treatment centre for drug users (later to be designated the National Drug Advisory and Treatment Centre) was established at Jervis Street Hospital in 1969, following discussions between this hospital, the Dublin Health Authority and the Department of Health.¹² The Jervis Street unit was initially run on out-patient lines only, and the Dublin Health Authority opened a small in-patient unit at St Brendan’s Hospital at the same time. This latter unit, known as St Dymphna’s, catered for both alcohol and drug problems but, within a year, it was decided that the practical problems involved in looking after both groups were insurmountable and it was decided to discontinue its service to drug users. A small rehabilitation unit at the Central Mental Hospital in Dundrum, taking most of its clients from the prison system, was operated by the Eastern Health Board (the successor of the Dublin Health Authority) between 1971 and 1977, but in

general there was little evidence that mainstream health services had any great interest in drug problems. An editorial in the *Irish Medical Journal* during 1971 was quite explicit:

The treatment of the established drug taker is extremely frustrating and therapeutically unrewarding. The task is usually given to our psychiatric colleagues. They can get patients through the acute withdrawal phase which follows their admission to hospital and get them back to reasonable physical health. Subsequent management varies but psychotherapy has not been demonstrably successful and psychiatrists are not willing to claim more than a small percentage of cures. As Dr Brandon of the Manchester University Department of Psychiatry pointed out in a paper in our last issue, psychiatry cannot and does not claim to cure all the ills of a society.... One of the most heartening features of health care in Ireland over the last twenty years has been the great revival of voluntary effort in dealing with the handicapped members of our society.¹³

At the time this editorial was written there was no major voluntary body in Ireland which addressed itself significantly to the problems of drug users, but in 1973 Coolemine therapeutic Community was established in Dublin. The Coolemine approach to rehabilitation, which has continued to be influential over the intervening years, is derived from American 'concept-based' programmes and utilises the experience of former addicts in the provision of a highly-structured, residential service. The most fundamental belief (although not a belief which is scientifically proven) which underlies therapeutic community programmes is that addicts / abusers suffer from personality defects and that their recovery, of necessity, demands the confrontation and elimination of these effects.¹⁴

The other majority development of the 1970s in this area was the enactment of the Misuse of Drugs Act 1977. It was generally accepted that the Dangerous Drugs Act 1934 was obsolete and that comprehensive new legislation was required, but the delay in the enactment of this new legislation may be largely explained in terms of the quiescence of the Irish drug scene. After the initial sense of a drugs crisis and the flurry of activity in the late 1960s, there followed a period of relative stability; drug use was almost entirely confined to the Dublin area, the drugs being used (as reflected in data from Jervis Street and the Garda crime statistics) were little evidence of intravenous use. The Misuse of Drugs Bill was circulated in early 1973, immediately before the general election which resulted in Fianna Fáil being displaced by a Fine Gael/Labour coalition government, but did not have its second reading until February 1975. In general, the debate on this subject was marked by consensus and there was widespread agreement that the issues involved were apolitical. Perhaps the clearest evidence of this political consensus is to be found in the decision, at the committee stage, to have the bill considered and amended by a small, all-party committee rather than through the usual adversarial procedure which involves the whole Dáil acting in committee. The overall content of the legislation reflected the views of the Working Party on Drug Abuse: a reasonable balance appeared to be struck between *care* for those experiencing drug problems and *control* measures which were aimed at limiting the supply or availability of drugs. The self-satisfaction of the legislature with its handling of this problem was expressed most succinctly in the Seanad by Michael D. Higgins:

The point that has struck me most forcibly listening to this debate has been the difference between the debate in the Dáil and the Seanad and the usual debate which takes place among the public on the subject of drugs and drug abuse. The public discussion is often crude in a number of important ways.¹⁵

On the question of the social and cultural correlates of drug use, it is difficult to find explicit policy debate which focuses on this area during this first period. The Working Party on Drug Abuse generally tended towards the view that drug use was a feature of youth culture and this also appeared to be the perception of politicians and administrators. It is noteworthy that the two 'youth' representatives on the Working Party came respectively from the Students' Representative Council of University College Dublin. During the second reading of the Misuse of Drugs Bill, a Fine Gael deputy, Dr Hugh Byrne, attributed most of Dublin's drug problems to the influence of foreign students in Trinity College: 'it is here we should look for it — in the areas of advanced study where we have

the highest percentage of overseas students'.¹⁶ Little attention was paid, however, to the possibility that drug problems might occur disproportionately among disadvantaged young people, although there were early indicators that this might be the case.¹⁷

Finally, it should be noted that, following a recommendation of the Working Party on Drug Abuse, a permanent advisory body known as the Inter-Departmental committee on Drug Abuse was established. This committee — which included representatives from the Garda Drug Squad, the Jervis Street centre, the Probation and Welfare Service, the Pharmaceutical Society of Ireland and Coolemine Therapeutic Community — was based in the Department of Health and met intermittently during the decade 1972-82, with the aim of apprising the Minister for health and his department of changes in the drug scene and suggesting how such changes might be responded to.

1980-1985: THE OPIATE EPIDEMIC

The authorities might be forgiven for a certain amount of complacency with regard to their handling of drug problems in Ireland towards the end of the 1970s. legislation had been enacted, treatment services had been created, the Garda Drug Squad had a uniquely good public image and the Health Education Bureau was beginning to address drug problems in the context of its wider health education brief. The air of crisis which had existed a decade earlier was no longer in evidence, as reflected for example in the fact that the Misuse of Drugs Act 1977 (which had already had a leisurely passage through the Oireachtas) was not put into effect until 1979. From that year onwards, however, there was a dramatic upsurge in the use of opiates, particularly heroin, in the Dublin area; this new wave of drug use saw the emergence of a 'needle culture' for the first time in Ireland, as intravenous drug use became the norm. Another unwelcome change was the advent of organised, commercial drug pushing.

To give some indication of the escalation of heroin use, it is worth pointing out that in 1979 five persons were charged with heroin offences: in 1980 this number rose to 47 and 1981 to 177. Similarly, the Jervis Street centre had treated 55 heroin users in 1979: in 1980 this rose to 213 and in 1981 to 417.¹⁸ These figures continued to rise until 1983 when the situation stabilised. The response of the authorities, both at central government level and at local level, was not as immediate or coherent as might have been expected, and both sets of authorities appeared for a couple of years to be unconvinced that any real change had occurred in the Dublin drug scene. In November 1981, the Fianna Fáil spokesman on justice, Gerard Collins, spoke at length on this topic a Dáil debate, concluding: 'Anybody who does not believe that the usage of heroin is growing has his head in the sand'.¹⁹ Two weeks later, however, *The Irish Times* reported that the Pompidou Group of the Council of Europe had been told by Donal Creed, Minister of State at the Department of Health, and Joe O'Rourke, Assistant Secretary at that department, that the heroin problem had 'stabilised'.²⁰

It was not until 1982 that specific attempts to assess and respond to this new wave of drug use were made. The chief executive officer of the Eastern Health board set up a committee which became known as the Task Force on Drug Abuse; this committee, which consisted of Eastern Health Board officials and outside experts, concluded its work in late 1982, but its report contained no major new strategy and had no discernible effect on the Dublin drug scene. Of greater importance was a prevalence study, which was commissioned by the Minister for Health and carried out by the Medico-Social Research Board between September 1982 and April 1983. This study, usually referred to as the *Bradshaw Report*, revealed that in the north inner-city community which was studied, 10 per cent of those in the 15-24 age group had used heroin in the year prior to survey. Other findings were that:

- 95 per cent of identified heroin users in this area were less than 24 years of age.
- 93 per cent of heroin users said that they had regularly taken heroin at least once a day.
- 74 per cent of heroin users said that intravenous use was their preferred mode of use.²¹

These findings, and the manner in which they were highlighted by the media, led to the establishment in April 1983 of the Special governmental Task Force on Drug Abuse, a committee consisting of six ministers of state under the chairmanship of Fergus O'Brien, Minister of State at the Department of Health. The most obvious result of their task force was that the existing legislation was amended by

the Misuse of Drugs Act 1984, which introduced higher fines and harsher sentence (including a symbolic ‘life’ sentence for drug pushing) for drug offences.

One of the most interesting and radical sections of the report of the task force — and perhaps the main reason why the report was unpublished, although it was later leaked — concerned ‘Community and Youth Development’. This section made by Irish policy makers that drug problems in Dublin were largely explicable in terms of the poverty and powerlessness of a small number of working-class neighbourhoods. It proposed that by using a number of indicators — prevalence of drug abuse, a high crime rate, a high unemployment rate, poor and overcrowded housing, low levels of educational attainment and lack of social and recreational amenities — certain urban areas should be identified and designated as Community Priority Areas. The task force went on to recommend that areas thus designated would become eligible for additional financial resources and for youth work services, all of which would be co-ordinated by a new body to be called the ‘Youth and Community Development Forum’. No additional funding was made available for youth work or community development, however, and the press releases issued by the Department of Health on the report of the task force gave no hint of the radicalism of these views which had been rejected by the government. On the contrary, the press releases reverted to the customary suggestion that drug problems were randomly distributed in society and could be explained in terms of individual personalities and individual choices:

It cannot, however, be too strongly stressed that in this area, above all others, it is individual decision which counts most. The decision not to experiment with hard drugs is one which any individual can make before he becomes hooked.²²

The political debate on the Misuse of Drugs Act 1984 reflected a preoccupation with law and order and drug control, rather than care for the health and well-being of drug users. In addition to the increased fines and jail sentences mentioned above, the new legislation dropped the requirement that justice should defer sentencing convicted drug offenders pending the completion of medical and social reports. Despite the fact that it was heroin which was uppermost in the public anxiety, a good deal of discussion focused on cannabis, and the legislators appeared to feel a strong need to persuade the electorate that they were resolute and unequivocal on the whole question of drug problems. The most hard-line, though not unrepresentative, speech in the Dáil was that of Deputy Brendan McGahon who remarked wistfully:

As far as drugs are concerned, liberals should not be allowed to be heard because surely nobody in his right mind can condone the taking of drugs, soft or hard. In other countries, drug pushers are dealt with summarily by being shot and there is little or no drug pushing. I am not advocating that penalty here because it would not be accepted but, unfortunately, there will be commissions and inquiries and the problem will worsen and get out of control, as in the case of law and order.²³

The most sustained and coherent critique of the legislation came from Senator Brendan Ryan who argued against the view that there was a causal connection between cannabis use and hard drug use, worried that he newly-created ‘advocacy’ offences might stifle serious discussion of drug problems, and finally concluded that it would not be ‘possible to deal with drug abuse on a universal scale or completely, if we leave areas of this city with dreadful housing, poor education and virtually no employment prospects’.²⁴

During these years in which Dublin experienced its so-called ‘opiate epidemic’, treatment and rehabilitation services continued to be confined to the Jervis Street centre and to Coolemine Therapeutic Community, both of which insisted on total abstinence as the only acceptable goal of intervention. The Eastern Health Board, as though confirming the lack of interest of its mental health services in drug problems, transferred administrative responsibility for these problems from its Special Hospitals (i.e. psychiatric service) Programme to its Community Care Programme in 1979. The rationale underlying this transfer was apparently that the administrator who had most experience of

drug issues had move from Special Hospitals to Community Care and it was considered best that she continue to retain responsibility for the Eastern Health board's drug services.²⁵ Among other things, this formal abandonment of drug problems by the Eastern Health Board's psychiatric service rendered the polity recommendations on community-based drug services in the Department of Health policy statement, *The Psychiatric Services: Planning for the Future* (1984), largely meaningless.²⁶ In Britain the Advisory Council on the Misuse of Drugs (ACMD) in its 1982 *Treatment and Rehabilitation* report had recommended the establishment of multidisciplinary, community drug teams which would operate on a different philosophical model to the medical model of the existing drug dependency clinics.²⁷ The ACMD recommendations were not referred to or discussed in the Eastern Health Board's 1982 task force report, and the preference for centralised services was continued.

The transfer of responsibility for drug problems to the Eastern Health Board's Community Care Programme did not result in any discernible change of attitude or work practice in relation to drug users by existing community care personnel, and it was not until 1983 that a number of 'addiction counsellors' were appointed to some community care teams. These counsellors tended to be in temporary positions, with no clear job descriptions, and while no formal evaluation of the margins rather than become fully integrated into the wider community care teams.

A number of Dublin communities which were experiencing the most severe drug problems had attempted to create local responses of both a preventive and rehabilitative nature. Their attempts to co-operate with the statutory bodies — the Eastern Health Board, the Jervis Street centre and the Health Education Bureau — were often fraught with tension. Not only were the community groups making financial demands at a time when resources for this purpose were quite restricted: philosophically they posed a threat to the *status quo* through their insistence that drug users should be seen, understood and helped in the context of their families and neighbourhoods, rather than seen as having a clinical condition with warranted treatment at a centralised facility at a considerable remove from their usual environment.

Conflict between the Eastern Health Board and such local groups was most pointed in the north inner-city, in St Teresa's Gardens in the south inner-city, and in Ballymun. In the latter area the conflict was highly publicised in early 1985 when the Ballymun Youth Action Project took umbrage at the appointment of an Eastern Health board addiction counsellor in its area; the Youth Action Project, which had been in existence for four years, had just received Department of Labour funding for its own first full-time worker and saw the appointment of a health board counsellor, without consultation, as an attempt to undermine its position. In the course of a long letter to *The Irish Times*, the committee of the Youth Action Project expressed criticism of the Eastern Health Board which undoubtedly was shared by other community groups:

The [Eastern Health] Board's statement that they are interested in working together would be more credible if this had been a joint decision. Far from helping our project to develop, this leaves us with a new set of circumstances to deal with — what are the Health Board's plans for the area? Are local people to be totally excluded from those plans? How are we supposed to work together ...it would seem there are differences in perceptions of what constitutes resources being 'community based'.²⁸

In the St Teresa's Gardens area, conflict between local people and a range of authorities led to the establishment of the Concerned Parents Against Drugs, a group which was primarily concerned with the prevention of drug pushing and which was generally disapproved of for its alleged use of vigilante tactics.²⁹ In overall terms, it can be said that neither by direct service provision nor by its co-operation with voluntary groups in communities badly affected by drug problems, did the Eastern Health Board's activities match up to the rhetoric of 'community care'.

In concluding this account of the period 1982-85, it should be pointed that the Inter-Departmental committee on Drug Abuse had been blamed, even if mildly so, by the Special Governmental task force on drug Abuse for its failure to monitor the emergence of the 'opiate epidemic' and to help orchestrate a swift and effective response. It was recommended that a new National Coordinating Committee on Drug Abuse, with formal terms of reference, should be

established. This National Coordinating Committee was established in early 1985, with terms of reference which included an obligation to submit an annual report to the Minister for Health. The new committee was to be 'housed' in the Department of Health and had no independent secretarial or other research staff. Several members of the previous Inter-Departmental Committee to whom this writer has spoken have refuted the suggestion that they were in any way culpable for the slow response to the changed drug scene in Dublin; instead, they have argued, the delay could be attributed to the Department of Health, which had no great expertise or continuing interest in the area of drugs problems and which ignored the evidence it had receive from the committee from 1979 onwards.

It can certainly be said that drug policy making in Ireland during this period continued to reflect the administrative, 'common-sense' perspective which had been the norm during the earlier years. No effort was made to establish clear conceptual and practical distinctions between drug control policies, which are the responsibility of the criminal justice systems, and health and welfare policies which operate on a radically different value system and are the responsibility of health and social welfare institutions. Such distinctions had been at the heart of Dutch drug policy since 1972, as they were in the 1982 British ACMD recommendation that drug-using clients of health and welfare services should be referred to by the relatively neutral phrase 'problem drug users' rather than the more value-laden terms 'addicts' or 'abusers'. Lest it appear that these are merely semantic points, it should be made clear that their practical implication was that health and welfare services should treat their drug-using clients in the courteous, morally-neutral way that they would all other clients; the Dutch were particularly clear that while it was desirable to assist client to become drug-free, it was equally valid to assist them to reduce the harm associated with their drug use if continued drug use was their choice. It would not be accurate to say that this 'harm' reduction' perspective was rejected by Irish policy makers; rather would it be more accurate to say that there is no evidence that it was ever discussed at nay level, that policy makers may have been largely unaware of it, and that American ideas of the need for an all-out 'War and Drugs' were taken as self-evidently right and sufficient.

1986-1991: THE AIDS CONNECTION

Acquired immune deficiency syndrome, more commonly known by its acronym AIDS, is a medical condition which was first identified in the early 1980s. There was general, though not universal, agreement that it was caused by a virus, the human immunodeficiency virus (HIV), and in the absence of an effective prophylactic or treatment for those already infected, medical attention focused on preventing the transmission of HIV.³⁰ It quickly emerged that HIV was transmitted in only a number of ways, all of which involved an exchange of body fluids between an infected and a non-infected person. Such exchanges of body fluids occur during certain forms of sexual contact, in blood transfusions, in mother-to-child contact (across the placenta, through the birth canal or in breast milk) or through the sharing of non-sterile needles and syringes between intravenous drug users.

In Ireland, three high-risk groups were identified during the early 1980s —haemophiliacs, male homosexuals and intravenous drug users —and data published by the Department of Health in 1986 showed that 33 per cent, 9 per cent and 30 per cent respectively of selected samples of these groups had tested positive for HIV.³¹ From the beginning of 1985 all blood products used in the treatment of haemophilia were rendered safe by heat treatment, and health education concerning 'safe sex' (including financial assistance for a voluntary groups known as Gay Health Action) was directed at the homosexual community. Particular concern was felt, however, about the transmission of HIV between needle-sharing drug users and the remainder of this section will consider the changes which occurred in Irish drug policy and practice as a result of this AIDS connection.

The newly-established National Coordinating Committee on Drug Abuse, which might have been expected to debate the implication of HIV for Irish drug policy, failed signally to do so or to lay down clear policy guidelines. The 1986 annual report of this committee contained a single page of desultory material on AIDS, while an equivalent amount of space was devoted to an address to the committee by a visiting American, Carla Lowe of Californians for Drug-Free Youth Inc., whose concern with cannabis now seemed rather less urgent.³² This annual report was to be the first and last such report, however, and meetings of the committee became increasingly infrequent, perhaps

confirming the arguments of those members of the previous committee that there was no continuing interest in, or commitment to, drug policy among Department of Health officials. The committee was 'reconstituted' during 1989 and this effectively created a two-tier system, with those who were directly and voluntarily services, being consigned to an advisory or consultative position the new committee, which was to produce the 1991 *Government Strategy to Prevent Drug Misuse*, consisted mainly of officials from various government departments, with some Garda and health board representation.

Despite the premature demise of this committee, a number of important changes took place in drug treatment practice in Dublin during this period, and an important role in introducing these changes was played by the Department of Health's National AIDS Coordinator, a public health doctor with no previous involvement in drug problems. In 1987 the Jervis Street centre began to offer methadone maintenance to some of its opiate-dependent clients; that is, these clients were given a daily dosage of oral methadone, a synthetic opiate, on an indefinite basis in order to dissuade them from using illicit drugs and, in particular, from sharing needles. This practice was continued when, following the closure of Jervis Street Hospital, the National Drug Treatment Centre was moved to a new and much larger premises known as Trinity court. The other major development which occurred was the opening by the Eastern Health Board of an AIDS Resource Centre at Baggot Street Hospital in 1989. This new centre was intended, among other things, to provide a needle exchange programme for drug users who continued to use illicit drugs, and to act as a base for 'outreach' work with drug users. The creation of this latter service literally meant that drug workers went out to neighbourhoods where drug use was common, in order to establish contact with drug users who were unwilling to attend centralised services.

The establishment in Ireland of services which were aimed at harm reduction rather than total abstinence corresponded in many ways to similar developments in other countries,³³ the important difference being that most other countries had some previous history of harm reduction and so did not experience this as such a major ideological shift. It was also significant that in these other countries there was a tradition of debate, where all interested parties could participate and where the existence of alternative viewpoints was obvious. In Ireland, however, the lack of debate and the consensus of the previous twenty years on the validity of total abstinence made these changes rather difficult for some of the traditional services. While harm reduction practices had been imposed by the Department of Health, it was not always clear that these new practices were being delivered in what the British tended to describe as a 'user-friendly' way. This attitudinal shift in Britain was described rather more formally by Edwards as follows:

The central change is perhaps that the balance of power between treatment agency and person treated has been sharply re-adjusted. Agencies have less capacity than previously to demand, challenge, set contracts or exclude from treatment, while patients or clients are now likely to secure treatment (including prescribed opiates) much more on their own terms.³⁴

It seemed, to some extent at least, that the National Drug Treatment Centre at Trinity Court had not made this attitudinal shift and that staff were ambivalent about the new work practices which had been imposed from outside. A 1989 paper by Comberton, a senior social worker at Trinity Court unequivocally rejected harm reduction practices, described the 'addict' in a negative, stereotyped way reminiscent of American therapeutic communities, and suggested that: 'it would appear there are too few people expert in the field of addiction involved in analysing the situation and AIDS prevention planning'.³⁵ Not surprisingly, there were also indications that some drug users attending Trinity Court were unconvinced that there had been any philosophical change on the part of that centre's staff; one HIV-positive woman described the service to a research interviewer in the following terms:

The only reason they are concerned about us is because they think that if they keep us from using [drugs] then we won't spread the virus ... It was hard to get on the maintenance programme and it seems even harder now. I don't know if it's that they're too busy and can't

cope. There are no fresh ideas. That place! ... When you can stand up for yourself, they can't stand that...³⁶

Perhaps conflict and ambivalence of this kind would not have been so obvious in the Dublin drug services if there had been a clear and unequivocal policy statement committing the services to harm reduction. In Britain, for instance, the ACMD had set down admirably clear principles which it felt should underlie drug services in the HIV/AIDS era, based on the premise that: 'The spread of HIV is a greater danger to individual and public health than drug misuse'.³⁷ In Dublin, however, the Minister for Health appeared to disapprove of the measures being taken by his own National AIDS Coordinator³⁸ and this must have added to the confusion felt by those workers who dealt with drug users on a day-to-day basis.

The recent Government Strategy does contain new ideas; it formally endorses the newly-introduced harm reduction practices and, in its recommendations for a wider role for general practitioners and for the establishment of community drug teams, appears to have signalled an end to the dominance of centralised services. Viewed in the context of Irish drug policy and practice over the past twenty-five years, this report cannot be seen, however, as marking a radical departure. It is, in its overall tone, an administrator's report rather than a policy maker's report. It is, even more than the 1971 *Report of the Working Party on Drug Abuse*, concerned with closing down rather than opening up a debate, and with making arrangements rather than considering alternative policy positions. Given that for more than twenty years Irish drug policy was concerned with total abstinence and the achievement of a drug-free society, one might expect a full discussion of the policy changes which are contained in this new strategy. No such discussion is provided, however, and the phrase 'harm reduction' appears just once in the main text. The establishment of a national drug misuse database, which is endorsed in the new Government Strategy report, may be helpful for policy making and may arguably be necessary, but it is certainly not sufficient. Drug policy making does not merely reflect pharmacological, epidemiological or other scientific data, but consists ultimately of value judgements. One rather extreme policy option which is increasingly advocated internationally is that all drugs currently illicit should be decriminalised; this proposal is considered, for instance, in the Minority Report of the European Parliament's 1986 *Committee of Inquiry into the Drugs Problem in the Member States of the Community*.³⁹ There is no reference whatever to this debate on decriminalisation in the *Government Strategy*, nor is there any reference to the argument of some policy analysts that society is damaged more by the 'war on drugs' than by drug problems.⁴⁰ The discussion concerning the detention of individuals suspected of concealing drugs in 'body cavities', for instance, contains no reference to civil libertarian issues or to the general sensitivity of this issue.

CONCLUSION

Bruun and his colleagues⁴¹ characterised the cosy and inward-looking world of those involved in international drug control systems as a 'gentlemen's club' and, while acknowledging the work of some redoubtable Irish women in this arena, it is tempting to apply this image to the Irish drug policy-making scene of the last twenty-five years. In *Health: The Wider Dimensions*, a consultative document on health promotion issued by the Department of Health in 1986, there is a brief statement that: 'In Ireland the problem of drug abuse provides a good example of intersectoral collaboration working successfully in practice'.⁴² This is in contrast to an immediately preceding discussion of alcohol abuse, which is described in less happy terms of conflicting interest groups and of cultural ambivalence. It is suggested, in concluding this review, that the consensus which has been a feature of Irish drug policy making has been superficial, that it has been achieved and maintained by ignoring many real policy dilemmas, and that such consensus-seeking may in the long run be of less societal value than an open acknowledgement of institutional conflict and cultural ambivalence.

The advent of HIV has admittedly shaken this consensus, and the introduction of harm reduction practices implicitly accepts that drug use per se is not the ultimate evil which it has sometimes been portrayed. However, when one looks at policy-making structures, it is far from clear that there has been real change. The failure of successive governments to create a statutory policy-making body has given the Department of Health undisputed dominance in this arena. Drug problems

have been an episodic and peripheral irritant over the years for that department's Public Health Division, and it can be argued that the civil servants who have responsibility in this area are so caught up in the daily administration of a wide range of health services that they lack the time, detachment, and perhaps the expertise, to become involved in formal debate on the subtleties of drug issues.⁴³ The membership list of the reconstituted National Coordinating Committee on Drug Abuse generally suggests 'sound', administrative common sense rather than expertise in, and enthusiasm for, the drugs field.

The *Government Strategy* report began by boldly defining drug misuse as:

The taking of a legal and/or illegal drug or drugs (excluding alcohol and tobacco) which harm [sic] the physical, mental or social well-being of the individual, the group or society.⁴⁴

Ten years earlier, the World Health Organisation had concluded that:

... 'abuse' and 'misuse' are unsatisfactory concepts within a scientific approach. Because the terms involve value judgements they are impossible to define so that they are appropriate for different drugs in different contexts.⁴⁵

All this may seem pedantic, but the final point to be made is that while drug controls may be implemented by a body which is absolutely clear in its definitional stance, harm reduction policies demand acceptance of relativism and ambiguity.

NOTES TO ARTICLE

- ¹ Government Strategy to Prevent Drug Misuse (Dublin: Department of Health, 1991); Report of the Working Party on Drug Abuse (Dublin: Stationery Office, 1971).
- ² For a detailed study of the international legal framework, see S. Stein, *International Diplomacy, Stale Administrators and Narcotics Control* (London: Gower, 1985). An earlier and more critical study from a broad, social policy perspective is K.. Bruun, L. Pan and I. Rexed, *The Gentlemen's Club: International Control of Drugs and Alcohol* (University of Chicago Press, 1975).
- ³ See, for instance, S. Wisotsky, *Breaking the Impasse in the War on Drugs* (Westport Connecticut: Greenwood Press, 1986).
- ⁴ For an example of a published paper by a Dutch civil servant, see E. Englesman, 'Dutch Policy on the Management of Drug-Related Problems', *British Journal of Addiction*, 84 (1989), 211-18.
- ⁵ Report of the Commission of Inquiry on Mental Illness (Dublin: Stationery Office, 1966).
- ⁶ *Ibid*, 84.
- ⁷ Report of the Working Party on 'Drug Abuse, 9. It is worth noting that within the Department of Health responsibility for drug problems was assigned to the Food and Drugs Section (later renamed the Public Health Division) rather than to the Mental Health Section; the effect of this, consciously or otherwise, was to ensure an emphasis on drug control systems rather than care systems.
- ⁸ *Ibid*, 59.
- ⁹ For a detailed comparison of British and American policies from the 1920s to the 1970s, see A. Trebach, *The Heroin Solution* (New Haven: Yale University Press, 1982).
- ¹⁰ J. Strang, "'The British System": Past, Present and Future', *International Review of Psychiatry*, 1 (1989), 109-20.
- ¹¹ The whole question of drug education in Ireland and the fate of the Health Education Bureau's 'lifeskills' programmes are not dealt with in this paper, since it would merit detailed consideration in a separate paper.
- ¹² 'Report on the Proposed Drug Addiction Clinic Sited at Jervis Street Hospital' (unpublished report. May 1969).
- ¹³ 'Care for the Drug Addict', *Irish Medical Journal*, 64 (1971), 148.

- ¹⁴ For a description of the Coolemine programme, see J. Comberton, *Drugs and Young People* (Dublin: Ward River Press, 1982).
- ¹⁵ Seanad Debates, 86 (1977), col. 742.
- ¹⁶ Dáil Debates, 278 (1975), col. 938.
- ¹⁷ See, for instance, P. Carney, M. Timms and R. Stevenson, 'The Social and Psychological Background of Young Drug Abusers in Dublin', *British Journal of Addiction*, 67 (1972), 199-207.
- ¹⁸ For a detailed description of the escalation of heroin use, including its link with social deprivation, see G. Dean et al., 'The Opiate Epidemic in Dublin 1979-1983', *Irish Medical Journal*, 78 (1985), 107-10.
- ¹⁹ Dáil Debates, 330 (1981), col. 1384.
- ²⁰ *The Irish Times*, 18 November 1981.
- ²¹ G. Dean, J. Bradshaw and P. Lavelle, *Drug Misuse in Ireland 1982-1983: Investigation in a North Central Dublin Area* (Dublin: Medico-Social Research Board, 1983).
- ²² 'Drug Abuse and the Task Force' (press release issued by the Government Information Services on behalf of the Department of Health, 22 September 1983).
- ²³ Dáil Debates, 351 (1984), col. 1146.
- ²⁴ Seanad Debates, 104 (1984), col. 1119. 'Advocacy offences' which were created by this new legislation referred to publications or audio-visual materials which appeared to condone or promote the use of illicit drugs.
- ²⁵ This explanation was offered to me by Michael Walsh, Programme Manager (Special Hospitals Programme), Eastern Health Board and confirmed by Aine Flanagan, Senior Administrative Officer (Community Care Programme), Eastern Health Board, the official concerned.
- ²⁶ *The Psychiatric Services: Planning for the Future* (Dublin: Stationery Office, 1984).
- ²⁷ *Advisory Council on the Misuse of Drugs, Treatment and Rehabilitation* (London: HMSO, 1982).
- ²⁸ *The Irish Times*, 4 February 1985.
- ²⁹ For a detailed account of drug problems in this neighbourhood and the emergence of the Concerned Parents Against Drugs, see B. Cullen, 'Community Action in the Eighties: A Case Study', in *Community Work in Ireland: Trends in the 80s – Options for the 90s* (Dublin: Combat Poverty Agency, 1990), 271-94.
- ³⁰ J. Green, 'The Facts About AIDS', in J. Green and A. McCreaner (eds.), *Counselling in HIV Infection and AIDS* (London: Blackwell, 1989).
- ³¹ *AIDS: General Information for Doctors* (Dublin: Department of Health, 1986).
- ³² *National Coordinating Committee on Drug Abuse, First Annual Report* (Dublin: Stationery Office, 1986).
- ³³ For a general review of AIDS prevention programmes for drug users, see D. Des Jarlais, 'AIDS Prevention Programmes for Intravenous Drug Users: Diversity and Evolution', *International Review of Psychiatry*, 1 (1989), 101-08.
- ³⁴ G. Edwards, 'What Drives British Drug Policy', *British Journal of Addiction*, 84(1989), 223.
- ³⁵ P. Comberton, 'Drug Addiction and AIDS', *Irish Social Worker*, 8(1989), 9.
- ³⁶ S. Butler and M. Woods, 'Women, Drugs, HIV and the Perpetuation of Powerlessness', in N. Dorn, S. Henderson and N. South (eds.), *AIDS: Women, Drugs and Social Care* (London: Falmer, forthcoming).
- ³⁷ *Advisory Council on the Misuse of Drugs, AIDS and Drug Misuse (Part I)* (London: HMSO, 1988), 75.
- ³⁸ *The Irish Times*, 18 November 1988, carried the following passage:
 'There is insufficient evidence to support the introduction of free condoms or needle exchange for drug abusers, the Minister for Health, Dr O'Hanlon, said at the opening of a major new drugs treatment unit in Dublin yesterday ... Dr O'Hanlon's remarks seem to cut across those made by the head of the Government's AIDS programme, Dr James Walsh, who earlier in the day had come out in favour of free condoms and needles for drug abusers.'
- ³⁹ *Committee of Inquiry into the Drugs Problem in the Member States of the Community* (Luxembourg: Office for Official Publications of the EC, 1987).

- ⁴⁰ R. Barnett, 'Curing the Drug-Law Addiction: The Harmful Side Effects of Legal Prohibition', in R. Hamowy (ed.). *Dealing With Drugs: Consequences of Government Control* (Lexington, Massachusetts: Lexington Books, 1987), 73-102.
- ⁴¹ K. Bruun, L. Pan and I. Rexed, *op. cit.*
- ⁴² *Health: The Wider Dimensions* (Dublin: Department of Health, 1986), 26.
- ⁴³ It could, of course, be argued that, in the *Devlin* sense, the entire Department of Health is an *Aireacht* and that the health boards are executive bodies. However, the Eastern Health Board has not to date displayed much policy-making capacity in the drugs area and there has been constant contact between voluntary bodies and the Department of Health in relation to drugs.
- ⁴⁴ *Government Strategy to Prevent Drug Misuse*, 4.
- ⁴⁵ 'Nomenclature and classification of drug and alcohol-related problems: A WHO Memorandum', *Bulletin of the World Health Organisation*, 89 (1981) 225, cited in *The Psychiatric Services: Planning for the Future*, 115.