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The Making of the Methadone Protocol: the Irish system?

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ABSTRACT
Treatment service provision for problem drug users in the Republic of Ireland until the mid-1980s was centralized, specialist and ideologically tending towards abstinence models of intervention. However, in the context of continuing heroin use and its accompanying public health risks, all these features of policy and service provision changed gradually over the next decade. This paper looks in detail at the evolution of the methadone protocol of 1998, which institutionalized and regulated methadone prescribing by general medical practitioners in Ireland. It discusses the main stakeholders, lists the sequence of events and looks analytically at the policy process. It is concluded that the introduction of the methadone protocol was a pragmatic success, albeit one which departed significantly from conventional beliefs about policy transparency in democratic societies.

Introduction

On 1 October 1998 the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations came into operation in Ireland, effectively creating a licensing system for the prescription of methadone by general medical practitioners (GPs). Under the new regime, commonly referred to as the methadone protocol, methadone prescribing by GPs was restricted to those doctors who were deemed to have appropriate training and who were specifically authorized by the regional health authorities to carry out this therapeutic function. Another key element in the new scheme was the establishment of a register or `central treatment list' of patients for whom methadone was prescribed, aimed at the avoidance of multiple prescribing for individual drug users.

In introducing this new regime, health policy makers were motivated by a desire to expand the numbers of drug users in treatment, while balancing this against the risk that unfettered methadone prescribing by GPs would lead to large-scale diversion of the drug on to the black market. While there was no published survey research into the attitudes of GPs towards drug users, the situation in Ireland prior to the introduction of the methadone protocol appeared to be similar to that which obtained in the UK: impressionistically, most Irish GPs were disinterested in, if not antipathetic to, the idea that they should play a major role in the management of opiate dependency, some were enthusiastic about working with drug users and committed to doing so to a high professional standard, and there was anecdotal evidence that a small but indeterminate number of `rogue' doctors was exacerbating societal opiate problems and bringing their profession into disrepute through irresponsible prescribing of methadone.

Debate about the role of GPs and their relationship to specialist treatment providers has long been a central feature of the British drug treatment scene (Glanz,1994) and, as demonstrated in a recent issue of this journal (Gerada, 2000; Lawrence, 2000; Merrill & Ruben, 2000), it still has the capacity to create dissension in the UK. The aim of this paper is not to evaluate the success or failure of this new Irish treatment initiative from a technical-rational perspective, but rather to examine the policy process which succeeded in introducing radical change into a relatively conservative drug treatment system while avoiding any major public dispute. There will be a detailed discussion, therefore, of the key stakeholders, the main events and the overall policy process which led to the introduction of the methadone protocol; this discussion will be presented against the general background of Irish political culture and in the more specific context of Irish drug policy prior to the 1990s.

It will be argued later in this paper that the policy issues studied were highly sensitive and that the policy process was generally covert. In these circumstances, the methodological task of researching and analysing the policy process before, as it were, the dust had fully settled on the methadone protocol was also quite delicate. The primary research method used was that of documentary analysis, supplemented by relatively informal discussion with policy makers known to the researcher–and the researcher, as an academic with addiction policy interests in a small arena, knew all the key players in this process. An early version of this paper was presented in September 1999 at a seminar attended by many of those directly involved in negotiating this policy initiative, and the response of this seminar audience was then used reflexively both to correct for factual inaccuracies and to sharpen the analysis. Duke's (2002) reflective paper on researching drug policy networks, when applied to the research reported here, suggests that some other researcher could in the future rework this issue, using different methods, gathering different data and reaching different conclusions. It is not, therefore, being argued in a positivistic way that this analysis of the making of the methadone protocol represents an objective, comprehensive and final account of this process.

Since comparison will largely be with Britain, it seems important to state at the outset that Ireland has never provided its citizens with universal access to health care which is free at the point of delivery; instead, eligibility to free health care is based upon means testing, with about one third of the population having full entitlement to free health care, including free GP services. Most Irish GPs combine participation in the state-funded General Medical Service with private practice, so that distinctions which are made in the British literature between National Health Service doctors and `private' doctors (see, for example, Strang & Sheridan (2001)) have little or no meaning in an Irish context where most people are accustomed to paying their GPs.

Services for Problem Drug Users in Ireland–the Historical Context

In an earlier publication, Butler (1991) divided Irish drug policy into a number of historical periods for the years between 1966 and 1991. Borrowing from this earlier paper, what is most noteworthy is that the Irish drug scene (which effectively was the Dublin drug scene) had almost no heroin and very little intravenous drug use of any kind prior to 1979. This changed dramatically, however, with the beginning in 1979 of what local epidemiologists referred to as the `opiate epidemic' (Dean et al., 1985) involving the large-scale use of heroin in areas of socio-economic deprivation in Dublin. What became clear, with the wisdom of hindsight, was that policies and structures that had been set in place in the earlier and more innocent days of illicit drug use in Ireland were seriously deficient in the face of the problems associated with intravenous heroin use.

In 1969, a central treatment agency (designated the National Drug Advisory and Treatment Centre) was established at Jervis Street Hospital in Dublin and put under the clinical direction of a consultant psychiatrist. The establishment of this centre was clearly influenced by policy and service developments in Britain in the late-1960s when, in the wake of the

second report of the Brain Committee, specialist drug dependency units were created as a response to the perceived failure of the traditional `British system' (Strang, 1989). The beginning of treatment services in Ireland coincided, therefore, with the transition in Britain to a more conservative and centralized service system; the new `clinic' system in Britain reflected a conviction that GP participation in the management of drug dependence was inherently risky, that GP prescribing rights should be circumscribed and that the balance in this arena should now swing away from generalists in favour of specialists. These convictions were transferred, more or less axiomatically, to the emerging Irish treatment system, where the tendency to view abstinence as the usual and most desirable treatment outcome was reinforced by the opening in 1973 of Ireland's first voluntary non-medical agency–Coolemine Therapeutic Community, an American-style drug-free therapeutic community.

The extent to which heroin use became endemic in Dublin and the way in which treatment policy responded may be illustrated through a brief reference to the city's treatment statistics.
(i) In 1979, the Jervis Street clinic treated 55 heroin users; this figure rose to 213 in 1980 (Butler, 1991).
(ii) In 1990, the newly established Dublin Drug Treatment Reporting System (O'Hare & O'Brien, 1992) reported that 2037 opiate users were being treated in an expanding treatment system.
(iii) By December 2000, there were 4936 residents of the Eastern Regional Health Authority registered for methadone treatment on the central methadone treatment list (Department of Tourism, Sport and Recreation, 2001).

As already stated, the aim of this paper is to explore the evolution of harm reduction policy in Ireland through a detailed study of the negotiation of the methadone protocol. As in other countries, much of the impetus for change was provided by public health concerns about the role of injecting drug users in the transmission of the human immunodeficiency virus (HIV), and the moral and political dilemmas which this presented were not of course unique to Ireland (Klingemann & Hunt, 1998). The political culture of Ireland in the 1980s was dominated by acrimonious debate on divorce and abortion (Hesketh, 1990), which can scarcely have encouraged politicians to foster public debate on liberal-seeming drug treatment policies; furthermore, there was no Irish equivalent to the Advisory Council on the Misuse of Drugs to review the issues or to offer expert policy advice.

Key Stakeholders in the Negotiation of the methadone protocol
This section of the paper will now look in detail at the key stakeholders in the policy process; the next section will look chronologically at the main policy events which led incrementally, over the decade or so prior to 1998, to its introduction; this will be followed by a section which looks analytically at the policy process. All these sections are presented in summary form in Table 1.

National Drug Advisory and Treatment Centre/Trinity Court
This clinic, as mentioned above, had been set up at Jervis Street Hospital in Dublin's city centre in 1969 ; it was for a 20 year period the only medical drug treatment facility in Dublin, had close working links with Coolemine Therapeutic Community, and was generally perceived as subscribing to abstinence models of treatment. In 1988, following the closure of Jervis Street Hospital, the drug treatment clinic was moved to another city-centre location known as Trinity Court, where it was established on a more formal legal basis than had previously been the case. From an organizational perspective, one of Trinity Court's major tasks was to renegotiate its relationship with the Eastern Health Board, now that this statutory health authority was becoming directly involved in service provision for problem drug users.

Table 1. Summaries of the key stakeholders, the key events and the policy Process

Key stakeholders
National Drug Advisory and Treatment Centre/Trinity Court
Eastern Health Board
GPs
Pharmacists
Voluntary drug treatment sector
Department of Health
National politicians
Irish public
Key events
1990 Publication of ICGP policy statement on management of drug users in general practice
1991 Publication of Government Strategy to Prevent Drug Misuse
1992/93 Expert Group on the Establishment of a Protocol for the Prescribing of Methadone
1996 Publication of the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs
1997 Publication of Fianna Fail policy document A Radical Approach to Drugs and Drug-related Crime
1997 Methadone Treatment Services Review Group
1998 Statutory instrument and implementation of methadone protocol
Policy process
Conducted largely through organizational networking
Little involvement of political leaders
Opaque rather than transparent process

The Eastern Health Board

The Eastern Health Board (EHB) became interested in direct service provision for problem drug users once the connection between HIV and injecting drug use became apparent. Ideological clashes between the EHB and Trinity Court seemed likely in view of Trinity Court's tradition of centralized service provision favouring abstinence vis-a-vis the EHB's emerging preference for harm reduction services delivered on a decentralized basis. In these circumstances, the challenge for both agencies was to create a comprehensive and integrated service system, and to avoid conflicting parallel services.

General Practitioners

It was generally implicit in the evolving policy and service systems described above that GPs had no valid role in this area of healthcare, but this view was expressed explicitly as late as 1984 in *The Psychiatric Services: Planning for the Future* (an influential report on the development of the public mental health services (Stationary Office, 1984)) which summarily stated, `We are not in favour of the treatment by general practitioners of drug addicts.' (p. 118). It was not surprising, therefore, that Dublin GPs were generally wary of involvement with drug users, and those few doctors who took the view that they could not ignore heroin use in the communities that they served were traditionally reluctant to prescribe heroin substitutes for their patients. The response of one inner-city practice during the mid-1980s was described in the following terms: `When dealing with individual drug users, the practice's policy is one of empathy, non-prescription, referral for detoxification and continuing support.' (O'Kelly et al., 1986, p. 85). The main fear appears to have been that a willingness to prescribe substitute drugs would cause the practice to become swamped by large numbers of heroin users in search of substitute drugs. Later, during the 1990s, a small group of Dublin doctors with an interest in treating drug problems in general practice came together, ran a number of conferences and produced a handbook on this theme; this group was strongly of the view that methadone maintenance at primary care level was legitimate `evidence-based' practice that was not inherently problematic or disreputable.

At an institutional level, there were two main organizations that could be expected to feature in policy making; these were the Irish College of General Practitioners (ICGP), the professional body which concerned itself with the promotion of good practice in primary care, and the Irish Medical Organization (IMO), which as a trade union negotiated payment for doctors in the Irish healthcare system. Since serious drug problems were concentrated in just a handful of Dublin neighbourhoods, doctors with an interest in these matters were clearly in a minority and could not presume upon obtaining a sympathetic response from colleagues in either the IMO or the ICGP. One contributor to a debate on methadone maintenance and needle exchange at the IMO's annual general meeting of 1989 was quoted as arguing that

> . . . it was time we spoke about the vast majority of people who are not perverts or addicts but who were paying their taxes and rearing their children and could not get treatment. There were people who needed hip replacements, immobile by day, sleepless by night, who might have to wait three years for their operation. These were honest to God people in our community who had to do without because of the allocation to these people. (*Irish Medical Times*, 13 October 1989).

Pharmacists

It was important for the success of an expanded GP treatment scheme that community pharmacists would participate, so it was inevitable that this professional group would be drawn into the policy process. Again, there were two main bodies that might be expected to participate: the Pharmaceutical Society of Ireland (the professional registration body) and the Irish Pharmaceutical Union, which was concerned with pay negotiations. An important question for community pharmacists, as for GPs, concerned the provision of services for drug users without disruption of service provision for patients considered to be more conventional.

The Voluntary Drug Treatment Sector

As already mentioned, Coolemine Therapeutic Community was the first voluntary body to deliver a drug treatment service in Dublin. In 1982, the first Irish harm reduction agency - the Ana Liffey Drug Project - was opened, and in 1989 a second harm reduction agency - the Merchant's Quay Project - began. Each of these voluntary agencies received statutory funding and each contributed to the overall policy process in a variety of ways, although there were clear ideological differences between Coolemine, with its belief in the abstinence model, and the two harm reduction agencies.

The Department of Health

Within this central government department (which is referred to here by its title prior to mid-1997 when it became the Department of Health and Children) responsibility for drug issues rested largely with general-grade civil servants, although for 5 or 6 years from the mid-1980s one medical professional officer had a great influence and a high profile on drugs by virtue of his position as National AIDS Coordinator. The capacity of general-grade civil servants in the Department of Health to build up expertise or to deal effectively with complex issues of drug policy was adversely affected by two factors. The first of these was that, in a relatively small department, illicit drugs usually constituted just one element in a wider public health brief, thus making it difficult for staff to develop specific expertise on drug issues; the second was that, as in the British system upon which it was historically based, the Irish civil service has a tradition of frequently rotating general grade staff through different sections of departmental activity, on the grounds that career development and overall service performance are best served by such rotation. This situation was altered and improved in the 1990s by the creation of a dedicated HIV and drug misuse unit in the Department of Health and by leaving senior and middle-ranking civil servants in this unit for a somewhat longer time than would have been the norm. An important question that arises in relation to drug policy making, as it does in relation to policy making generally, concerns the extent to which civil servants directly influence the content of policy as opposed to merely facilitating the wishes of their political leader - the minister of the day. Within the Irish governmental

system (again reflecting its British origins) a department or ministry has traditionally been viewed as a *corporation sole*, which means in legal terms that all its activities are deemed to be ministerial activities and that civil servants have no independent role in the policy process. Few observers, whether through their reading of academic literature on this topic (see, for example, Connolly & O'Halpin (1999)) or by virtue of enjoying the BBC comedy *Yes Minister*, would agree with this passive vision of the role of civil servants, and in looking at how Irish civil servants dealt with methadone prescribing no such assumption of passivity will be made.

National Politicians

In Ireland, as in other parliamentary democracies, ultimate responsibility for policy, and particularly policy which is enshrined in legislation, is deemed to lie with parliament. During the early years of drug policy-making, particularly exemplified in the enactment of the Misuse of Drugs Act 1977, there was no evidence of party political disagreement on drug policy. The issues that politicians had to deal with in relation to harm reduction from the mid-1980s onwards were more contentious, since they appeared to involve a conflict between public health and criminal justice interests, as well as an abandonment of the old-fashioned rhetoric of the `war on drugs'. Furthermore, because serious drug problems were concentrated in a small number of Dublin neighbourhoods, it could not be assumed that politicians as a whole would readily sympathize with drug users or develop a critical understanding of the policy issues inherent in harm reduction. In considering the role of politicians-legislators in the specific matter of methadone programmes, decision making on this issue could be expected to involve a balancing of the research evidence on the effectiveness of methadone treatment against politicians' direct knowledge of what their constituents thought of methadone.

The Irish Public

Survey research on public attitudes towards drug users in Ireland generally suggests that this social group is perceived in very negative terms. MacGreil's (1996) study of prejudice and tolerance found, that of 59 social groups that they were asked to rate, using the Bogardus social distance scale, respondents deemed `drug addicts' to be the most socially undesirable; Bryan et al. (2000), in a survey which dealt solely with societal attitudes towards drug issues, also reported attitudes towards drug users which were largely negative, with a specific finding that two thirds of respondents believed that support for problem drug users should only be offered to those who had abstinence as their ultimate goal. Despite such evidence, there was considerable policy emphasis on and investment in `community' programmes for problem drug users (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996; Ruddle et al. 2000). Most electors lived in areas where there was not a serious drug problem and, understandably, appeared to have little or no sympathy for drug users or for subtle issues of harm reduction; on the other hand, electors who lived in areas with a high prevalence of problem drug users believed that services should be provided but were likely to object strongly to services being sited close to where they lived. The task of creating community treatment services was obviously difficult.

Key Events in the Negotiation of the Methadone Protocol

As will be made clear in the next section of this paper, the policy process which resulted in the introduction of the methadone protocol in 1998 was generally low key and incremental so that it is difficult to be definitive about the sequence and the importance of the various steps along the way. However, this section will discuss what appear to have been the major events in this process, as set out in chronological sequence in Table 1.

In 1990 the Irish College of General Practitioners (1990) produced a policy statement on the management of problem drug users in general practice. While this statement had no immediately discernible impact, it was of considerable symbolic importance in that it affirmed authoritatively that clinical work with this client group was a legitimate function of general medical practice. The following year the regularization of methadone prescribing by GPs

was taken a step further in an official policy document *Government Strategy to Prevent Drug Misuse* (Department of Health, 1991) which dealt explicitly, albeit briefly, with this topic; essentially, this document supported the ICGP position and made outline recommendations for the creation of a `shared care' system of managing drug-dependent patients.

In 1992, a further and more specific step was taken when the Minister for Health appointed a committee designated The Expert Group on the Establishment of a Protocol for the Prescribing of Methadone. This Expert Group was established in the Department of Health under the aegis of the National AIDS Strategy Committee and with representation from the EHB, Trinity Court, the ICGP and the voluntary drug agencies. The Expert Group was asked to consider three issues:
(1) methadone prescribing;
(2) registration of drug users;
(3) licensing of GPs to treat drug users.

It is clear that there was no immediate consensus on the substantive issue of methadone prescribing, with the Trinity Court representative arguing in an appendix to the Expert Group's 1993 report that `Methadone should always be regarded only as an adjunct to treatment and not treatment per se' (*Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone,* 1993, Appendix A).

Despite this tension between the perspective of a consultant psychiatrist specializing in addiction and the public health perspective apparently espoused by the remainder of the committee, agreement was ultimately reached on the first Issue - namely the value of methadone prescribing as a means of stabilizing opiate-dependent drug users. On the second issue, the Expert Group agreed that some controls were necessary, particularly in the context of expanding methadone prescribing by primary care doctors, although it was of the view that `there was widespread resistance to the term "register" ' (p. 9). The Expert Group then proceeded with a certain linguistic sleight of hand to propose the introduction of registration in all but name, recommending that patients on methadone should have an identifying `treatment card' and that there should be a centrally held `treatment list'. On the third issue, the Expert Group argued against licensing GPs because it believed that `licensing would be perceived as very much a negative step and would be opposed by the doctors and their representative organizations' (p. 14). The report did, however, go on to recommend that GPs who prescribed substitute drugs for opiate-dependent patients should do so only with the support of and in collaboration with specialist services.

The protocol recommended by the Expert Group was presented, therefore, in the form of guidelines for good practice rather than proposals for tighter statutory restriction. From an analytical perspective, it is probably more instructive to look at how the Expert Group's report was presented to the public and implemented than to look in detail at its content. The report, which was completed in March 1993, was neither published by the Stationery Office nor officially launched by the Minister for Health, and no immediate attempt was made to publicize its contents or to create a national debate on this topic. Instead, the Chief Medical Officer of the Department of Health wrote to all GPs in May 1993 and again in September 1994 informing them of these new guidelines and of the planned creation of a central treatment list. The decision not to create a more transparent policy process was presumably motivated by a perception that media coverage and public acceptance of the Expert Group's recommendations were likely to be highly critical and an impediment to their full implementation. Inevitably, news of the Expert Group's report reached the media and received some coverage. Coverage of this topic by tabloid newspapers, while relatively infrequent, was generally not helpful for those in favour of expanding the role of GPs in the management of opiate-dependent patients. *The Star* (22 November 1993), for instance, led with the headline `GPs angry at drugs for addicts scheme' and, while giving space to a spokesperson from the EHB who argued the merits of GP involvement in methadone prescribing, it also presented much highly negative comment, including a remark from a

Coolemine Therapeutic Community spokesperson who suggested that what was being proposed was `asking doctors to prostitute themselves'. In September 1994, 18 months after the report was completed, Willie O'Dea (Junior Minister at the Departments of Health and Justice) became the first politician to discuss publicly its recommendations and their implementation; this led to a contretemps between Minister O'Dea and Padraig O'Morain, a journalist who specialized in health and social service issues with the *Irish Times* (generally regarded as a quality broadsheet). The degree to which policy makers had succeeded in muddying the waters with regard to the status of the Expert Group report was reflected in O'Morain's dismissal of it on the grounds that `In no sense was it an official methadone protocol from the Department of Health or anybody else'; worse still from the Minister's perspective was O'Morain's mocking rejection of his suggestion that a mobile clinic might be utilized, in the headline `Futility of queuing for methadone from a Willie Wagon' (*Irish Times*, 27 September 1994). While Willie O'Dea replied in a spirited and coherent way, both by letter to the editor and in a fuller article (*Irish Times*, 28 September 1994 and 5 October 1994), this episode could scarcely be seen as encouraging politicians to put their heads above the parapet on this issue.

The policy process moved slowly along and in early 1996 a pilot methadone project, which was to be independently evaluated, was set up in the EHB region. Later that year, in October 1996, the proposal to expand GP involvement in methadone prescribing received public support from a committee of junior ministers in the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs. This latter report led to the creation of new policy-making structures as well as to substantially funded Local Drug Task Forces. In January 1997, another committee, the Methadone Treatment Services Review Group, was established within the Department of Health to take forward the work of the earlier Expert Group. The new Review Group was chaired by the Principal Officer in the Community Health Division of the Department of Health and, while the stakeholders remained essentially the same, there were some interesting changes in personnel. Both Trinity Court and the ICGP had a change in representation, and on this occasion there was no representative from the voluntary drug treatment system. However, the Pharmaceutical Society of Ireland, which had not been represented in the earlier committee, did have a representative on this new Review Group.

The work of the Review Group took place in the context of an impending general election and the Fianna Fail party, which was now out of government but expected to regain power, in March 1997 published a policy document *A Radical Approach to Drugs and Drug Related Crime* (Fianna Fail, 1997). This pre-election policy document did not specifically threaten the evolving methadone protocol, but it appeared to make drug treatment policy a party political issue for the first time and its general tone must surely have been discomforting to the Review Group. Fianna Fail attitudes towards methadone maintenance were presented succinctly in the document's executive summary which began with the statement `Fianna Fail view the centrepiece of current Government policy – methadone Maintenance - as very much a second best solution' and went on to say that `Fianna Fail will give absolute priority to the detoxification and rehabilitation of addicts. Methadone maintenance will play a role, but only a secondary role' (p. 3).

There was also a suggestion that an independent panel (`consisting, for example, of a Psychiatrist, a substance misuse counsellor and a parent of a rehabilitated drug addict', p. 22) might review the case of any patient on methadone for longer than 5 years and `decide whether limitations would be placed on its use for that patient in the future' (p. 22). Despite the ideological threat posed by this document, compounded by the fact that Fianna Fail succeeded in becoming the majority party in the government formed after the general election of June 1997, the Review Group was not deflected from its agenda. It satisfied itself that the introduction of a licensing system for methadone prescribing was unlikely to evoke organized resistance on the part of the medical profession; those GPs interested in working with opiate users were likely to see the new regime as offering them protection,

respectability and the promise of a lucrative payment system, while the `rogue' doctors could not expect to mount a challenge to the proposed new protocol without having their own practices dragged into the light of day. In late 1997 the Review Group completed its report, recommending *inter alia* the following:

(1) GPs and pharmacists should provide methadone treatment to opiate users who lived in their local areas.
(2) Methadone prescribing by GPs should be restricted to special prescription forms issued by the regional health board.
(3) GPs participating in the new protocol should do so through a contract with their regional health board which would involve acceptance of basic training in the management of drug problems, acceptance of registration of patients through the central treatment list, restriction on the numbers of patients for whom they might prescribe (a maximum of 15 patients was specified for doctors with a Level 1 Contract, while more experienced doctors with a Level 2 Contract could have up to 35 patients), and agreement to accept payment for this service only from the health board and not from the patient.
(4) All of these proposals should be put on a statutory footing through the making of regulations under Section 5 of the Misuse of Drugs Act 1977.

The *Report of the Methadone Treatment Services Review Group* was printed by the Department of Health and Children, with the earlier *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone* included as an appendix. This printed document, arguably containing the most important policy proposals in the 30 year history of drug treatment in Ireland, was never published in conventional format or given a publicized launch; it was undated, unavailable to the public through the Government Publications Sales Office and generally only accessible to those already familiar with the policy process. Drafting of the statutory instrument went ahead and the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 were signed into law by the Minister for Health and Children, Brian Cowen, who a year earlier had been a co-author and signatory of the Fianna Fail policy document that had been less than enthusiastic about methadone maintenance.

Reflections on the Policy Process

The introduction of the methadone protocol may be considered a pragmatic success, in that it provided structure and clarity and accelerated the flow of professionals into this complex area of primary health care. In October 1996, the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs indicated that in the Dublin area there were 55 GPs and 21 community pharmacies participating in the evolving protocol. By August 2001, the Eastern Regional Health Authority could report that there were 138 participating GPs and 167 participating pharmacies. In his defence of the evolving methadone protocol (*Irish Times*, 28 September 1994), Minister Willie O'Dea had pointed out that in Dublin there were just 180 patients being prescribed methadone by GPs in accordance with the guidelines that were emerging at this time; by August 2001, statistics for the Eastern Regional Health Authority were showing that GPs were prescribing for 1749 patients under the new methadone protocol. This achievement is all the more impressive in that it took place in a policy environment where drug users were generally unpopular and where harm reduction interventions were specifically frowned upon, and also insofar as it involved a curtailment of the previously existing prescribing rights of doctors.

From a policy analysis perspective, it is clear that rational models of policy making of the top-down variety do not match the events described above. Irish political leaders appear to have identified the conflict that existed between the research evidence as to the efficacy of methadone prescribing and popular sentiment on this topic, and on this basis to have opted to distance themselves from the policy process. The model which best ®ts what has been described in this paper is that of *organizational networks* (see, for example, Kickert et al. 1997; O'Toole (1997) and Rhodes (1997)). Organizational networks are described in the

literature as groupings of actors or stakeholders that have some structural stability, although not legal or bureaucratic stability; these networks are horizontal rather than hierarchical, and they consist of actors (sometimes at the periphery of their own parent organizations) who have an ongoing interdependence in relation to the achievement of certain policy outcomes.

Thus, the creation of the methadone protocol in Ireland may be seen as the work of a small network of actors which stuck tenaciously to its task and, with considerable skill, built a consensus, established institutional arrangements and out-flanked an array of actual and potential opponents. The network was managed, although not in a top-down style, by the public health division of the Department of Health. However focused and strategically effective this network may have been, it deviated significantly from conventional expectations as to transparency and accountability in public policy making in parliamentary democracies. The overall style of deliberation involved in this policy process was discreet, the main reports were never published and, as secondary legislation, the statutory instrument that provided a legal basis for the methadone protocol was not debated in parliament. This occurred, ironically, at a time when Irish governmental systems were generally seen to be moving towards greater accountability and public scrutiny, as a result of the Ombudsman Act 1980, the National Archives Act 1986, the Comptroller and Auditor General Act 1993, the Freedom of Information Act 1997, and the introduction of public sector management reforms under the rubric of the *Strategic Management Initiative* (Department of Health, 1996). Throughout the 1990s, the Irish political system went through a series of scandals and controversies, many of which involved a lack of transparency and accountability, and, on taking up office as Taoiseach (Prime Minister) in December 1994 in the wake of one such scandal, John Bruton (1994) had announced:

> The Government must go about its work without excess or extravagance and as transparently as if it were working behind a pane of glass. The same holds for national policy.

It seems clear, however, that if those actors committed to drawing up the methadone protocol had set about their task transparently `behind a pane of glass', they would have been thwarted and perhaps ultimately frustrated in this ambition. This dilemma is not unique to Ireland and, in their summary account of English drug treatment policy, MacGregor & Smith (1998) suggested that covert policy making in the drugs sphere has been a constant feature of the English system, referring to `the separation between the debate conducted in public and that conducted in policy networks' and to `a certain fear that too much public involvement in discussions might inhibit intelligent policy making' (p. 71).

There has to date been no specific disquiet at the style of policy making which resulted in the methadone protocol, no legal challenge arguing that the Minister exceeded his legal powers in curtailing GPs' prescribing rights as he did, and no controversy surrounding the generous capitation payments to participating professionals. There have, however, been well-publicized reports from the Ombudsman (2001a, b), in relation to other health matters, decrying the failure of the legislature to scrutinize secondary legislation, and it is possible that the making of the methadone protocol could yet come in for critical scrutiny. For the moment, however, it seems fair to conclude that drugs policy making in Ireland as exemplified by the methadone protocol is characterized by pragmatism, in terms both of its harm reduction content as well as its covert process. Previous flirtations with a high-profile American-style war on drugs would appear to have been forgotten and it could be argued that there is now a fully fledged Irish equivalent to the elusive `British System'.

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