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CONVERGENCE OR CONSEQUENTIALISM: A STUDY OF HEALTH POLICY TOWARDS DRUG USERS IN TWO COUNTRIES

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CHAPTER ONE

Theory and Methods

Introduction

This study centres on the changes which have taken place in the area of health policy towards intravenous drug users over the past two decades; the relationship between competing perspectives in policy and the impact of AIDS on that policy. To illustrate this, policy perspectives in two countries towards the provision of needle exchanges will be examined to provide a concrete example of how different countries have dealt with the issue of drug use: normalisation versus deterrence.

It is my intention to attempt to account for these policy choices by first examining what role politics played in the providing the ideological perspective from which policies were launched; whether or not there has been convergence in policy due to internal or external forces and finally, to examine whether AIDS precipitated a consequentialist response which was unrelated to either of the previousely mentioned factors.

The two countries I have chosen are Ireland and the Netherlands. This is primarily due to the fact that historically they have been confessionally based welfare states with similar perspectives in the area of social policy. Born out of the Catholic social doctrine, the principle of 'subsidiarity[1] had been adopted in both countries; however, although policy in both countries has been launched from a broadly similar ideological platform there have been marked differences in the approaches taken in the area of health policy towards I.V. drug users, particularly with regard to the provision of needle exchanges and the participation of ex addicts in the policy process.

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[1] 'subsidiarity' - a doctrine of 'self reliance' operating within the framework of certain welfare state systems

For practical reasons, the comparative policy literature is cast mainly within the traditional set of sectoral policy categories; health, environment, social etc. (Bennett,1991). Consequently, this inquiry can be regarded as an exercise in the 'case analysis method', in which isolated configurative studies are brought together to identify common patterns and relationships.

Each individual case study will attempt to establish the factors which contributed to the policy choices in each country; examining the historical background of the 'problem' and the impacting forces which contributed to the formation of the different policy perspectives in each country.

The questions I seek to answer are: What was the impetus behind the Netherlands government adopting these very innovative and controversial programmes, when the problem was at least as big in other countries in Europe? (Anderson, 1993) Why did Ireland eventually take the model on board; was it for the same internal dynamic? Did convergence play a major role in the process? Was this adoption of a controversial programme, which took place in the aftermath of the AIDS scare, simply a consequentialist response in the tradition of 'the public health model' and not a turn around in the policy perspective of the Irish Government towards drug users? The route by which the Irish Governments arrived at its present policy towards drug users being a major issue in this inquiry.

With needle exchanges being used as an indicator of a policy based in normalisation (Wijngaart,1991), the Irish government are stating that their present policies are as a result of a swing towards a more empathic approach to this previously marginalized group and that they have now integrated into their health programmes an ethos based on respecting the individuals choices, with 'harm reduction' as their goal of intervention. Respecting a person's choice means allowing him opportunities to choose and to act upon choices he makes.(Goodin,1987)

In an attempt to illuminate aspects pertaining to the policy process, I will examine the idea that 'politics matters' (Castle,1982) and Wilensky,(1982) ; the concept of 'policy convergence' (Bennett, 1991); then finally, the consequentialist approach (Goodin,1987) .

Theoretical Perspectives in Policy

The theoretical perspectives I have chosen to review are based in the 'nowness' of the policy being examined and consequentially I will not be covering such established theories as functionalism. As, although it is widely accepted that while economic development exerts a tremendous influence in the early stages of development -of the welfare state- (Castles, 1982) it can be argued that the subtle differences in the area of health policy to be covered here, are not effected to any significant degree by marginal disparities in economic development that may exist between these two countries over the past two decades.

The three bodies of literature I have chosen, in an attempt to explain the policy process in the area of health policy towards I.V. drug users in these two countries, include: political theory; the theory of consequentialism and 'policy convergence' (Bennett, 1991); as quite distinct from that of socio-economic convergence theory.

Political theory in the area of the policy process within the framework of the welfare state has a number of theoretical perspectives which may or may not operate on a mutually exclusive basis; two such perspectives are posited by Harold L Wilensky and Frank Castles.

Castles argues that political structure and ideology are of vital consequence in the policy process and that contrary to conventional wisdom politics does matter. In putting forward his case he models welfare state development in terms of three political variables: type of political structure; the type of political leadership and the dominant political ideology. The three hypotheses leading on from a number of variables are that(1) Federal states will be characterised by lower levels of welfare state provision than unitary states; (2) States with competitive leadership styles will have lower levels of welfare state provision than those with coalescent styles; (3) States, characterised by dominance of parties of the Right, will have lower levels of welfare than those where this is not the case.

I have some misgivings with regard to the first hypothesis in the light of the present situation in Europe with regard to the Social Charter as this appears to be a case in point where Castle's hypothesis falls down and consequentially would have grave reservations in adopting this part of his theory as a way of explaining aspects of the policy process. The second of these three; coalescent leadership existing when leaders of opposing groups perceive that there are advantages to be derived from mutual accommodation leading to the creation of formal or informal coalitions to achieve a particular goal. However, it is in the third of these hypotheses that I believe that the strongest case for the theory that 'politics matters' is propounded; that the political ideologies espoused by political parties are likely to be reflected in the policies they adopt when in office. Castle makes a very good case for the fact that generally, the Left is associated with a set of political beliefs which favour greater economic and social equity and that they see welfare state reforms as a crucial element in achieving social justice. The Right on the other hand, he sees as being associated with opposition to such beliefs. Castles further argues that these differences in the nature of political beliefs are firmly grounded in the material interests of groups within the society. Whether the last point is a given or not may provoke some debate in certain quarters however the main point at issue has also been expounded in some detail by Wilensky.

Wilensky started by putting forward a hypothesis based on the political role of the working class in welfare state development and lead on to consider the ideological stance and power of two mass-based types of political parties - Left and Catholic. In his definition 'Catholic Parties', he refers to anticollective, antiliberal themes in party ideology. His aim was to integrate political party dominance into a model of democratic corporatism and thereby come closer to an understanding of how and whether political parties influence social policy. In an attempt to do this he devised measures of left party dominance and Catholic party dominance and in a retrospective longitudinal study of nineteen rich democracies examined the political response to spending and taxing , measured by tax-welfare backlash from 1965 to 1975. The three dimensions of dominance focused on are: (1) the degree of control or influence Left or Catholic parties have had in their countries' government (2)the number of times such parties have been thrown out; and (3) the total number of years of Left and Catholic power. By distinguishing between continuity as long duration and continuity as few interruptions of tenure, Wilensky attempts to determine whether the sheer number of years in office is more important than the security of office. To measure Left and Catholic party dominance , Wilensky determined the positions of parties on a scale of Leftism to Catholicism, similar to Castles scale of Left to Right party positioning.

Wilensky concludes that, in general, Catholic power shapes welfare state development much more than left power. However, both have surprisingly similar effects on the structure of modern political economies in that they both foster corporatism. In pointing to the large diversity operating within Catholic party programs, Wilsensky suggests that to be better understood they should be defined mainly in terms of what they oppose.

He further points out that although Catholic parliamentary groups, drawing on medieval and romantic themes, have often been conservative or reactionary, the rise of social Christian and particularly Catholic workers movements (in the Netherlands) pushed European Catholic politicians towards the Left.

Castles, while placing the power of political leverage in the context of socio-economic development argues that based on the table below, that there has to be a pronounced difference in per capita gross domestic product before any one type of political system attains the same level of commitment to public welfare as a country with a type of political system which is higher up the hierarchy. "We find our most satisfactory conclusion not in arbitrating between the relative merits of political versus non-political (economic) explanations, but in combining these two sets of factors.....it is clear that differences on political structure and ideology, play a critical role in explaining differentials in commitment to public welfare in advanced democratic states." And that " the dynamic role of economic development only becomes apparent once we have taken political factors into consideration".

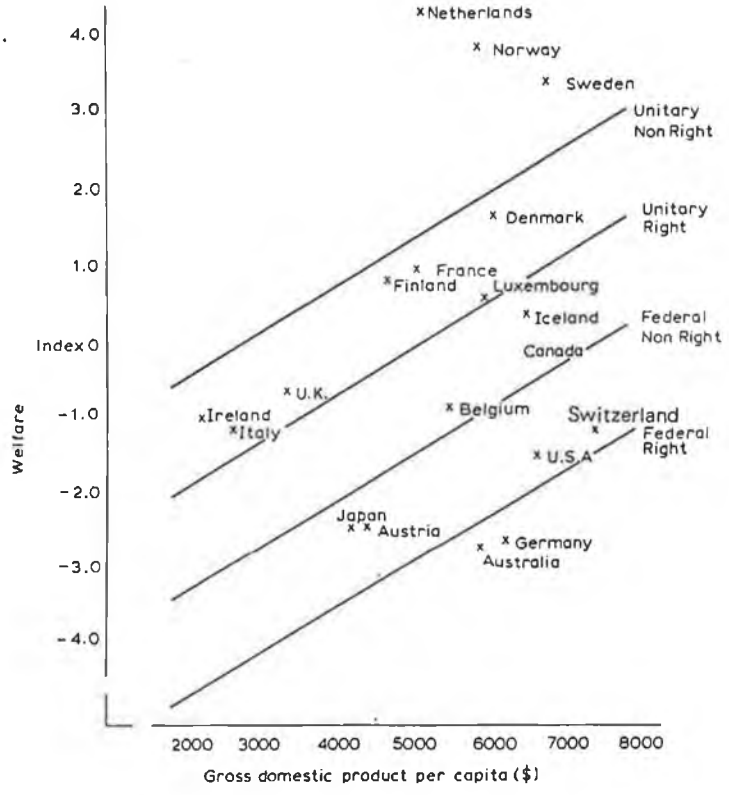

Fig. 1. Welfare index by political organization and per capita gross domestic product.

While Wilsenky argues that the strength of Catholic power counts insofar as it manifests itself in terms of the overall development of the welfare state, Castles puts that case that the degree of commitment to egalitarianism which is evident in outputs (programs) is strongly influenced by political factors; where he sees the Left as pursuing more liberal programmes. However, y these are not necessarily mutually exclusive arguments.

Policy convergence, many would argue, may also be put forward as a case in light of the fact that while the Netherlands was a leading innovator in the area of health policy towards I.V. drug users that Ireland did in fact ultimately adopt the Hep B[2] model (the core of which was the provision of needle exchanges) which had proved to be so successful in the prevention of the spread of this and other infectious diseases; AIDS being one such disease. To establish whether this may in fact have been the case we need to examine what it is that constitutes 'policy convergence'

While the general convergence theory suggests that, as societies adopt a progressively more industrial infrastructure, certain determinate processes are set in motion which tend over time to shape social structures, political processes and public policies in the same mould, Bennett makes a clear distinction between 'societal convergence' and 'policy convergence'. It is the latter that may or may not have had appropriate application in this particular policy process. Bennett argues that it is not enough to say that comparable conditions produce comparable problems which produce comparable policies, that there are also different political mechanisms, operating at the level of middle-range theory through which policies might converge. All deal with domestic policy questions; all concern cases of policy innovation.(Bennett, 1991)

It is widely accepted that convergence means moving from different positions towards some common point and that there must be a movement over time, consequentially the essential theoretical dimension is temporal rather than spatial. This latter caveat may be more significant than we realise in that often convergence is used as a synonym for similarity which is why the idea that an incremental process must be observed to establish whether convergence has taken place or not, it so vital to any inquiry.

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[2] Hep B - The decision to provide needle exchanges for I.V. drug users in the Netherlands was first proffered as a remedy to the spread of Hepatitis B , an infectious disease transmitted similarly to HIV/AIDS

In his attempts to determine whether 'policy convergence' is still a useful idea, Bennett posits that 'policy convergence *probably* means one of five things: (1) The convergence of *policy goals*; a coming together of intent to deal with common policy problems. (2) *Policy intent,* defined as more formal manifestations of government policy, such as statues. (3) *Policy instruments*; instrumental tools used to administer the policy such regulatory provisions.

(4) *Policy outcomes*, impacts or consequences; the results of implementation.(5) *Policy style*, a more diffuse notion signifying the process by which policy responses are formulated; consensual or conflictual, proactive or reactive. In the light of the consequentialist theory put forward by Goodin,(see p9) I find it hard to concur that policy outcomes are in fact an indicator of policy convergence in themselves but rather that a much more complicated issues which involve a number of moral and ethically questions is operating in the dynamic.

Bennett expands on his concept of policy convergence by further defining it conceptually as a series of processes. In his framework he identifies four processes: emulation, harmonization elite networking and penetration. Harmonization having a number of similarities with diffusion.

To establish emulation it requires evidence of conscious copying, lesson drawing or adoption which should not be confused with diffusion, which occurs at an international level and is the result of imitation of social policy programs *amongst* nations. The observation of a pattern of successive adoptions of a policy innovation means simply that the same policy has spread internationally. (Collier , Messick, 1975). A variety of hypotheses have examined this particular phenomenon and the overall conclusion reached by the majority is that those states that tend to adopt based on international influences tend to have a more anticipatory or reactive approach to problem solving.

The crux in establishing emulation is the utilization of evidence about a programme or programmes from overseas and a drawing of lessons from that experience.In the emulation of policy goals , the policy of another country is employed as an exemplar or model which is adapted.

The case at issue would appear to be the while there may *appear* to have been a case of emulation it is very hard to establish conclusively that diffusion has not been responsible for this *apparent* copycat policy or that observed outcomes,the consequences in themselves have not play a leading role in the policy adoption. That it is in fact the mere wish to reproduce the desired results, to act on the premise that the consequences are the be all and end all of the process and not that the evidence of good or appropriate policy as the driving force.

Finally, an examination of one perspective on consequentialism is required to provide for an alternative possibility to the above stated forms of 'policy convergence' as an explanation for the resulting decisions in the area of health policy towards drug users in Ireland and the Netherlands.

Goodin argues against the traditional moral dogma which he suggests is founded on the premises that *What* happens is deemed morally far less significant than *how* it happens and *who* causes it to happen. In the context of classic 'conscience' issues, Goodin argues that the things we clearly should not do, whatever the consequences, - such as killing- are things we should not do *because* of the consequences. For the consequentialist, an outcome is an outcome and it does not matter whether it was produced by our acting or by our failing to act. However, he notes that "some omissions create just as strong a probability of death as their corresponding acts" (Glover, 1977) In support of a consequentalist view, Goodin states that he does believe that a satisfactory solution to the problems of political morality can be found in the shadow of utilitarianism. He expands on his view of utilitarianism by added that although dignity and self-respect are incorporeal, protecting them is implicit in the utilitarian principle itself. While the former view may hold in respect of a consequentialist stand point, the addendum to it may present particular issue in the area of policy which is being examined in this paper.

What this inquiry hopes to unravel is what role, if any, did political forces play in the policy process, particularly with regard to policy innovation in the Netherlands; and in Ireland, was 'policy convergence' the sole factor or were subsequent policy decisions taken by the Irish government based on clear-cut and radical consequentialist approach to the problem at hand.

To further examine the hypotheses that 'politics matters, or the Left party power had any significant influence on policy in this area and to attempt to establish why Ireland eventually adopted needle exchange programmers, we need to examine both the size of the problem and the history of policy response in both countries over the past two decades.

Methods

"*A case study is both the process of learning about the case and the product of our learning*"

(Robert Stake,1995)

With this inquiry I have chosen to pursue a qualitative approach over a quantitative one for a number of reasons; of which two hold greater sway: (1) my concern with the possible exclusion of meaning and reason which can occur in with a quantitative approach. I concur with Guba and Lincoln (1994), that human behaviour, unlike that of physical objects, cannot be understood without reference to the meanings and purposes attached by the human actors to their activities. Qualitative data, it is asserted, can provide rich insight into human behaviour. (2) Any inquiry into the intricate and complex realms that are the responses of the human collective must, I feel, be considered in the fullness of the context in which they are acted out. Context stripping is one of the negatives attributed to the vast majority of quantitative research, for while increasing the theoretical rigor of the study, this approach tends to detract from the relevance; its applicability. Qualitative data on the other hand provides a contextual framework. In designing a research framework for this inquiry probably the most difficult decision to make was that regarding the *inquiry or interpretative paradigm,* as it defines for the inquirer what it is they are about, and

what falls within and outside that limits of legitimate inquiry(ibid) The *interpretative paradigm* has been described as a net which contains the researcher's epistemological, ontological, and methodological premises; an interpretative framework; a basic set of beliefs that guides action.(Guba,1990) That it has this weighty dimension makes it all the more difficult a choice. After some consideration I have chosen a *Constructivist or naturalist paradigm* to inform and guide this inquiry, with the following as allies to my decision: *Constructivists* are deeply committed to the view that what we take to be objective knowledge and truth is the result of perspective. That knowledge and truth are created, not discovered by the mind. (Schwandt,1994) *Constructivists* are concerned above all with the *production* and *organisation* of differences, and they therefore reject the idea that any essential or natural givens precede the process of social determination. (Fuss,1989) According to Schwandt, " In a fairly unremarkable sense, we are all constructivists if we believe that the mind is active in the construction of knowledge. In this sense, constructivism means that human beings do not find or discover knowledge so much as construct or make it ". - Perspective is all. In the area of both drug use and drug policy an example of this might be seen in the degree to which attitudes towards these issues are morally judgmental and value laden, with each individual having his or her own personal issues impacted perspectives.

As *strategies of inquiry* put paradigms of interpretation into motion (Denzin et al, 1994), the next priority in preparing a research design is to ensure that there is a *fit* between the former and the latter. *Strategies of inquiry* are further important because they connect the researcher to specific methods of collecting and analysing empirical materials. (ibid) The strategy I have opted for is one which has an acknowledged *fit* while at the same time fulfilling the requirements of this particular inquiry, *the case study.*

Of the three types of *case study* available I would say that without doubt that the *intrinsic case study* is the appropriate and predetermined choice driving this for this particular inquiry.

According to Stake(1995), study is undertaken because one wants better understanding of the particular case; the immediate, if not ultimate, interest is intrinsic. Both observations are applicable to this inquiry.

As the majority of researchers report their cases as cases that will be compared with others (ibid), I have chosen to present two such *case studies* as part of this inquiry in the hope that this may aid the learning process about each to a greater extent than each would singly. However, as comparison is a powerful conceptual mechanism, fixing attention upon the few attributes being compared and obscuring other knowledge about the case, I have a degree of reticence about the degree of responsibility I would wish to take for the finished product as the so-called definitive word on the subject. Consequently, I will attempt to concentrate on describing the present cases in sufficient detail so the reader can make good comparisons, only occasionally pointing to where comparison might be made. However, while researchers seek out both what is common and what is particular about the case, the end result regularly presents something unique and that 'uniqueness ' is often pervasive. I further wish to draw the attention of the reader to a caveat, that "the interpretative practice of making sense of one' findings is both artful and political, there is no single interpretative truth." (ibid)

To study these two particular cases the data collection methods will be in the main from secondary sources; this is mainly due to the two major constraints of both time and finances. I will concentrate on assimilating data from a number of authentic documents and reports and augmenting this where possible with personal interviews with key actors and informants.
To study the cases, I intend to collect data on the following: historical background; physical setting; economic, political and legal contexts and other cases through which the case can be recognised.

CHAPTER TWO

Two Case Studies

Background

Ireland - It is generally agreed that the period between independence in 1922 and end of the second World War in 1945 marked a time in which the development of social policy in Ireland was stagnant. During this period, the main historical influences were to be found in the link with Britain and a strict adherence of the Church to the principle of 'subsidiarity'.(O'Cinneide, 1970) It has been stated that up to the 1960's in Ireland, there was a distinct lack of Left / Socialist influence on either the development of the welfare state or more specifically on the major policy issues of the day; in fact ideological cleavages of any kind were scarcely found in the political arena prior to this time.

It is only since the 1960's that the Irish Welfare State has shown signs of expansion; this paralelled a period of sustained economic growth which lasted up until the mid-seventies. Coinciding with the world recessionary period, from 1973 onward Irish Social Services were under pressure to consolidate. Resulting in a halt to expansion after the 1987 general election and resulting change in leadership. Expenditure did continue to show clear signs of continued growth, however this was mainly to keep in line with the high rate of inflation which characterised the period.

Historically Irish politics have not been endured the polemic of the Left / Right ideology and consequently have not seen Liberal trade-offs in policy which have existed in other countries, Therefore, it is vital at this juncture not to underestimate the power and influence exerted by the Catholic Church, in all issues pertaining to both the development of the welfare state and all aspects of social policy. To reiterate, Catholic party programs should be defined mainly in terms of what they oppose. (Wilensky, 1986)

The Netherlands - Similar to that of welfare state development in Ireland, the Dutch system showed no significant signs of growth in the period 1920 to 1945. A number of suggestions have been put forward as the reason for this lack of commitment to a discernible system of welfare provision, these include: the sustained political alliance of the of certain groups (pillars)[3] in which the confessionalist based forces rallied opposition to the Liberal / Socialist lobby; and in particular the preoccupation of the Catholic leadership in consolidating its previously held significant influence - 'pillarisation' having the dominant role in Dutch politics until in the 1960's.

It was not until World War Two that a statutory system of social security was developed in the Netherlands and there is evidence of a strong growth there afterwards right up to the mid-seventies when the Dutch Welfare state was deemed to be one of the most successful in Europe. (Roebroek, 1986) A large amount of this growth took place in the period 1966 to 1975, when the percentage of expenditure to GDP rose by almost 18% and statutory provisions were enacted which directly resulted in the cessation of the operation of social services on the Catholic principle of 'subsidiarity'.

The above timeframe is the period which saw what is commonly referred to as the 'depillarization ' of the Netherlands and a sharp decline in support for Catholic parties. This latter feature culminated in the radical break of the Catholic labour union with the Catholic party and their subsequent alliance with the Socialist Union in 1981. This final nail in the coffin of the, until then previously weighted, confessionalist welfare state may prove to have had far reaching effects on certain areas of welfare state provision in the '80's. However, the merging of the three main religious parties to form the Christain Democrats the previous year resulted in the maintainance of a leading role for the Right in Dutch politics.

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[3] Pillarisation is a system of societal devision which has been developed to describe the many religious and political groups which operated completely independently of one another in the provision of all aspects of social service sin that country.

The Netherlands and Drugs

Historically, both the Dutch and the British have operated, as part of their colonial enterprise, a very successful trade in opium; to the extend that in the 1860's the Dutch state profits from opium rose to a level of 800-1600%. However, 'home grown' opium was forbidden as the state was afraid of losing its monopoly. Up to the mid 1800's opium use to restricted to the indigenous Chinese population; a colony had established itself in Amsterdam. However, as a result of the spread of opium use to the upper classes and within the military, in both Britain and the Netherlands, moral resentment towards opium use was growing. In 1890 the Netherlands Anti-Opium League was established and in 1894, the so-called Opium Direction was started by way of governmental effort to control the supply and distribution of the drug.

As the problem of opium use had spread considerable within the Dutch, British and American European populations, the first national conference on narcotic drugs - the Opium Commission - was convened in Shanghai in 1909. This brought together 19 nations and led to the signing of the first international drug-control treaty; The Hague Convention of 1912. However, as late as the 1930's 3-5% of the Dutch national income came from opium revenues.

Traditionally, opium was taken orally by the Chinese however it was noted that while the local opium smoker was able to abstain from his habit with some degree of control, his well-educated European counterpart proved unable to refrain from the use of morphine injections. (Vanvught, 1985) So, it is in the tradition of the intravenous use of the opiate morphine that heroin was introduced, however this did not prove to be in much evidence until about 1972.

During the summer of 1972, the supply of opium was quite restricted then quite suddenly , heroin became available in large quantities on the Dutch market. One reason given for this was that with the departure of the American forces from Vietnam, an important market had been last for dealers and in search of new markets they looked to Western Europe.

In 1977 the number of heroin addicts was estimated at 5,000.(Wijngaart,1991) However, in the early part of 1975, there was a scarcity of heroin on the Dutch market and prices rose to 200-300 guilders for an average daily 'dose'.(ibid,P23) This situation caused two things to occur; a strong reaction by the Dutch law enforcement authorities, which resulted in a number of successful 'drug hauls' and the addition of a two new groups to heroin use; Surinamese immigrant workers took to smoking heroin and a number of people with psychotic disorders began taking heroin. At the same time a parallel group of habitual 'hashish' users had emerged and by the end of the 1960's the estimated number of users was between 10,000-15,000. With the number of drug addicts in the Netherlands estimated at between 15,000 - 20,000 by 1990.

It is therefore clear to see that while the tradition of opium use may have laid the foundations for familiarity in the area of government intervention via attempts at drug control, it was not until the middle of the 1970's that the Dutch government recognised that it had 'a drug problem', with serious societal implications, where wide spread use of drugs was concerned.

At this point it might be prudent to mention that while it is not my intention to ignore the fact that the history of the Dutch trade in opium paved the way for both familiarity in terms of drug using and tolerance by a government that had 'legally' profited from it or that the Dutch population was considerably more ethnically heterogeneous from 1948 onwards (ibid) and as a result more accepting of culturally diverse practices, there is no evidence that this operated as a key factor in policy choices towards drug use; more that it assisted in the smooth transition and implementation of programmes such as needle exchanges they met with less personal resistance from government officials and those involved in the implementation process.

Drug Policy - a legal perspective

After the Hague Convention, the first Dutch Opium Act was enacted in 1919; this has had a number of amendments, the most recent being in 1976. In 1961 the Netherlands ratified the

Single Convention on Narcotic Drugs in New York, which criminalised such activities as trafficking and possession drugs of any kind making them punishable offences. However, by the end of the 1960's a reconsideration of the prosecution policy was advocated by a growing number of experts and official agencies. They insisted on a decrease in punitive measures for the use of cannabis (hashish) or the deletion of these products from the Opium Act. Their recommendations were based on the theory that protecting people from the danger of certain substances by means of punishment is an insufficient motive for interfering with an individuals privacy.(Wijngaart,1990)

Here we see our first sign of the fact that 'politics matters' where drug policy in the Netherlands was concerned. So while the history of attitudes towards drug use in most Western countries, including the Netherlands, from the early 1900's was inclined towards that of 'deterrence, the political shifts in the 1960's contributed to the resulting evaluation of this perspective and may be seen as the first step in a turnaround in policy towards drug use in that country. A further contribution was also made by the various interest groups who actively lobbied for change.In 1980 two prominent groups emerged that were to have considerable effect on the policy process: The Foundation for Parents of Drug Addicts' and 'The Junkiebond'; (Junkie League, a kind of union for drug users by a group of 'hard drug' users) Local groups were set up in most major cities and from time to time local representatives meet to deliberate at national level; their main aim being the development of a policy directed towards the acceptance of 'hard drug' users and the promotion of their civil and social rights. Here again it might be worth noting that had these highly organised pressure groups arrived in a vacuum, they may well have had little or no impact on the policy process *however* as they were in a position to appeal to the, by then well established 'new Liberal' parties, they were more likely to find acceptance of their ideas based on Libertarian principle of 'freedom of the individual.

The starting point of the 'Junkiebond' was to look after the interest of drug users; their philosophy being that drug users themselves know best what their problems and needs are.

Their aims included improving the housing and general situation of the drug user and their approach toward this was to attempt to develop ideas to improve the welfare system overall. The 'Junkiebond' has made it known that they think that it is wrong that heroin users be singled out for special management unlike users of alcohol and tranquillisers, who generally do not evoke the same degree of judgmental, moralistic intervention.

Drug policy - a health perspective

In 1970 the Dutch government appointed experts from various disciplines to investigate the drug problem; The Working Party on Drugs. The WDP's recommendations were published in 1972 and have largely determined the direction of present day drug policy in the Netherlands. "Since that time Drug policy has had two main aspects: the enforcement of the Opium Act on the one hand and a policy of assistance to addicts on the other; the central perspective being to prevent and deal with risks that drug abuse presents to the addicts themselves, their immediate environment, and society as a whole" (Wijngaart,1991)

In 1974 an Interdepartmental Steering group was set up to co-ordinate on a national level the activities of the various ministries involved; the main responsibility lying with the Minister of Welfare and Public Health. The first government policy document specifically focusing on aid to drug addicts appeared in 1977 - the same year that Irish Government enacted The Drugs Misuse Act - The policy principles which have emerged over time in the Netherlands, based on this document, include:

- that a multifunctional network of medical and social services be built up at local or regional level to provide assistance appropriate to the problem.[3]

[3] Research into the lifestyles of heroin addicts (Jassenet al, 1983) has shown that from the point of view of addicts, the use of drugs has certain functional significance; that drugs are used primarily as a coping mechanism to deal with deeply personal and social problem occurring in their everyday lives.

that assistance be made more accessible

that 'social' rehabilitation of both addicts and former addicts be promoted

that greater and more efficient use be made of non-specialist facilities, such as primary health care and youth welfare facilities.

that the various aid facilities be co-ordinated more effectively

that, since there is more to prevention than just publicity campaigns, the role of information should not be overestimated.

(Wijngaart, 1991)

Since 1978, there has been a decentralisation of powers, with municipal authorities drawing up policy plans and submitting them to the Alcohol, Drugs and Tobacco Branch of the Ministry of Health, Welfare and Cultural Affairs. The ADT branch, as the central co-ordinating body has been the one which considers all requests for funding on behalf of the Dutch government.

Needle Exchange Programmes

In 1984, the Amsterdam municipal health service, prompted by the 'Junkiebond', set up the first successful needle and syringe exchange to combat the spread of Hepatitis B amongst intravenous drug users. (Anderson,1993). This was in-line with the Junkiebond's welfare objectives to focus on 'harm minimisation' and the right to a *normal life* for drug users.

The clients of the exchange received one needle and syringe for each set they returned; the procedure was anonymous.The programme was so popular amongst users that in 1985 over 100,000 needles and syringes were handed out.(Anderson, 1993)

The advantage of this low-threshold care programme was that it opened the way for 'secondary prevention'; including educational outreach, counselling and condom distribution. In 1986 the Municipal Health Service decided to make the exchange of needles and syringes available on the methadone buses.[4]

Besides HIV incidence, acute hepatitis B incidence among I.V. drug users is also an indicator of unsafe drug use. The number of reported cases has decreased considerably since 1985. (Ibid,p42) It would be fair to say that in 1984, it is highly unlikely that HIV/Aids was in any way part of the impetus for such programmes, since the 'AIDS Scare' had not yet taken a grip of the population in Europe; in fact by 1985 there were only two recorded cases of AIDS among I.V. drug users in the Netherlands.(Wijngaart, 1991)

In conclusion, the primary aim of the drug policy pursed in the Netherlands is the safeguarding of health. The central objective is to restrict as much as possible the risks that drug abuse present to drug users themselves, their immediate environment and society as a whole. A realistic and pragmatic approach has been opted for and so far, the Dutch experience has shown that an approach aimed at seeking solutions for concrete problems is more effective than a policy that is dogmatic,emotional, and based on prejudices.(Ibid,p43)

Ireland and Drugs

Nowhere have any connections with the 'drug trade' or extensive use of opiates by any group within the population been chronicled in the history of Ireland prior to 1966. According to the first major policy document on drugs; the 1971 Report of the Working Party on Drug Abuse, the drug problem at that time in Ireland was negligible In the chapter entitled 'Extent of Drug Abuse in Ireland', it states that the results of a survey carried out the previous year based on a random

[4] Since 1983, the AMHA used a mobile unit to distribute methadone to so-called" extremely problematic addicts". The idea behind 'the bus' was to ensure that the services were accessible to all while residents of any one area were not singled out to be subjected to a constant flow of addicts into their vicinity alone.

sample of 14 Dublin post-primary schools, covering a total of 5,483 pupils showed that only 2.3% "claimed to have taken drugs".[5]

The Report further states that information gathered during the examination of cases attending student health clinics in universities during the years 1967-68 and 1968-69, showed that the proportion who admitted having taken drugs appeared to remain constant. In most cases the drug taking consisted of the occasional and often single incident of taking cannabis. Nevertheless, there was an increase in those who admitted taking cannabis habitually, and also in those who had taken LSD occasionally. The most notable statement in this section of the Report was that "no student patient admitted to taking an opiate(e.g. heroin or morphine) or any other 'hard' drug while at University."

Figures furnished by the Gardai (see table 3) in the Report, show that in 1970 the total number of persons charged with drug offences where the use of opiates was concerned only totalled 10 in number. However, the number of persons charged with drug offences in all categories had risen from 250 in 1969 to 940 in 1970; and if a factor based on the experience of the Gardai was applied to the figure of 940, the new estimated total would be closer to 2,000 - 2,500 cases of usage. This section of the Report concludes by stating, "There is no evidence of any significant use of heroin ....."

1980 - 1985 'The Opiate Epidemic'

From 1979 onwards 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' from the first time in Ireland, as intravenous drug use became the norm. (Butler, 1991) One of the reasons given for this somewhat sudden increase in heroin use was the huge influx of heroin on to the world market consequent of the Iranian revolution of 1981.

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[5] The term 'drugs' at this time was almost entirely synonymous with 'Cannabis' (hashish) - not hard drugs like opiates (heroin)

In a detailed study[6] commissioned by the Minister for Health and undertaken by The Medico-Social Research Board 1982-83, it was stated that in the Dublin area, the definitive prevalence of heroin abuse among those aged 15-24 was found to be 10%; with figures for females aged 15-19 at 13%. "These Irish prevalence figures are in some respects slightly better, in other respects a good deal worse, than equivalent 1970 figures for New York black ghettos. In particular, the figure for females aged 15-19 and aged 20-24 were markedly worse" (Fr. Lavelle, 1983) The report was one of the first Irish studies to state quite unequivocally that drug use was not simply a matter of deviant behaviour but instead a result of very definite social problems. "It is difficult not to think that these young people in North Central Dublin are the victims of society. They live in a dirty, squalid, dispairing area; education seems to provide no mode of escape; unemployment is to be their most inevitable lot; their parents are quite often separated or else dead; abuse of alcohol is a common problem; crime the societal norm .... heroin taking is regarded as commonplace". The report further comments that "current treatment and rehabilitation facilities seem to hold little in the way of answers to their heroin abuse."

A second report in 1984 by the MSRB reiterates the above in terms of the profile of the majority of drug addicts and recommends that, "clearly, all these matters call for remedial action aside from any association they may have with drug abuse.

It was around this time, and coming from these underprivileged areas that the first Irish action group on drugs was founded, Concerned Parents Against Drugs. The group's primary concern was the prevention of drug pushing, a huge problem in their area, however ultimately, its tactics were generally disapproved of by other members of the community because they alleged crossed the line into vigilante type behaviour.(Cullen,1990) Unlike the 'Junkiebond' in the Netherlands, the CPAD did not involve ex-addicts in their initiative - other than to give evidence against accused pushers- and their goal was not the 'normalisation' of drug use but the eradication of 'the problem' from their areas.

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[6] Often referred to as The Bradshaw Report

Although some of the CPAD action was putting pressure on the government to act in the area of 'community care', ultimately this amounted to very little more than rhetoric.(Butler,1991) Two attempts to run a Youth Development Project failed due to lack of official funding. One of the main reasons put forward for this was the widespread perception that the then minister for health equated CPAD with Sinn Fein;(Cullen,1991) Sinn Fein has been alledged to have links with the IRA terrorist group.

Here again the complete lack of political axis allowed for little or not real solutions to be found. With the CPAD coming from a traditional working class background, entrenched in a conservative based ethos where the rights of individual are traditionally tied to property rights and to issues pertaining to human right and freedom of the individual.

Drug Policy - a legal perspective

One of the recommendations made by the 1971 working party was the amendment of the 1934 Dangerous Drugs Act. The newly named, Misuse of Drugs Bill was circulated in early 1973, immediately before a general election which resulted in Fianna Fail being displaced by Fine Gael/Labour coalition government and subsequently did not get a second reading until 1975. The bill was finally introduced in 1977; however it was not in force until 1979 by which time the problem had taken root.(O'Hare, OBrien,1990)

In 1982 the CEO of the Eastern Health Board set up a committee which became known as the Task Force on Drug Abuse which confirmed the sudden and dramatic rise in the number of young people misusing drugs. As a result of this report the government established an Inter-ministerial Task Force !983 to examine the question of drug misuse.(ibid,1990)

Directly arising out of their recommendations, made later that year, several changes were made to legislation. The Misuse of Drugs Act 1984 was introduced: "This act facilitates the easier enforcement of the provisions of the 1977 Act and in addition provided for ....."

A combination of this and the new Criminal Justice Act 1983, allowed for the following: -

a streamlining of the procedure for investigation of allegations of irresponsible prescribing by practitioners

an increase in the **maximum prison sentence** for a convicted drug pusher from **14 years to life imprisonment.**

a redefinition of cannabis to capture some types of the plant which were not covered by the previous definition.

This heavy handed approach was based very much on the U.S. style 'War on Drugs' legislation; not only did it include all drugs, making no attempt to differentiate 'hard' from 'soft' drugs, what it ultimately allowed for was the conviction of a student for having 3 Ecstacy tabs.

While the more recent amendment to the Bill in July of this year,(1995) goes even further in its provisions for the summary detention for seven days of any persons suspected of dealing drugs. Prolonged detention periods without being charged have only ever been used once before in attempts to prevent terrorism - The Special Powers Act of 1976 - and reactions are so strong that both the Green Party and the Irish Council for Civil Liberties believe that this amendment is in breach of the Constitution and international human rights. *(Irish Independent newspaper, 11th July '95)*

Drug Policy - a health perspective

In 1969 Ireland's first major treatment centre for drug users was established at Jervis Street Hospital (later designated the National Drug Advisory and treatment Centre) and a small rehabilitation unit at the Central Mental Hospital in Dundrum; taking most of its clients from the prison system. However between 1971-77, in general there was little evidence that mainstream health services hand any great interest in drug problems. (Butler, 1991)

One of the working parties recommendations in 1971, was that the whole question of drug education should be considered by a specialist committee; this lead to the establishing of the Health Education Bureau in 1974. While advocating that drug education should be developed as an integral part of the school curriculum, it 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 early by the Commission of Inquiry on Mental Illness,[7] that drug treatment and rehabilitation services should be specialised rather than delivered as part of primary health care services. (ibid, 1991) - at the time of the 1966 Commission Report recommendations included compulsory commitment to a mental facility for up to one year, if the person was classified as an addict.

In 1973 the first major voluntary body which addressed itself to the problems of drug users, the Coolemine Therapeutic Community, was established in Dublin. The Coolemine approach to rehabilitation , which has continued to be of influence in the intervening years, is derived from the American ' concept- based' programmes and utilises the experience of former addicts in the provision of a highly-structured residential care service. The most fundamental belief 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 defects. (Butler, 1990)

As a result of the Inter-ministerial Task Force 1983, a National Co-ordinating Committee on Drug Abuse was set up to advise the Government on an on-going basis on general issues regarding prevention and treatment of drug misuse. Its First Annual Report 1986, which would appear to have been precipitated by 'The European Parliament Inquiry into the Drugs problem in the Member States of the Community', requesting that all member states respond with a detailed report of the situation in their country by mid-January 1986.

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[7] The first discussion of drug problems in an official Irish policy document.

In this report, the section headed 'addiction' is almost completely taken up with reference to the legal provision made to deal with the problem in terms of treatment.

"Under existing mental health legislation, there is specific provision for the admission of a drug addict as a temporary patient to a district mental hospital and for his detention for maximum period of one year." It further states that while the power to detain addicts compulsorily is rarely used, the "facilities for the treatment and care of addicts are available as part of the general services provided for the mentally ill."

It would appear that up to this point the policy towards drug users in Ireland was based on a model of 'deterrence' and not normalisation; with even the voluntary bodies taking the view that of the drug users as being physiologically disturbed and that total abstinence was the only goal of intervention. However, 1991 The Government Strategy to Prevent Drug Misue was published. It reflected the recommendations of WHO for setting up strategy committees (Duffy,1992) and was seen as significant in the shift to a policy based on 'nomalisation'

The 1986 document is also the first official document to mention HIV/AIDS - no doubt prompted by the EP questionnaire specifically requesting information on that subject. In a paragraph at the beginning of the document it states that Dr.J.H. Walsh, the then Deputy Chief Medical Officer in the Department of Health, who was co-ordinating the response to AIDS was invited to apprise the Committee of the current situation. The figures compiled from screening patients at the Drug Clinic at Jervis Street Hospital had shown that of 636 drug abusers tested in 1985, 27.8% were HIV positive.

In 1987 the first major campaign was initiated by the Irish Government and a booklet was published, entitled *AIDS* was published. Under the heading of 'Groups at high risk from AIDS' in which five categories were mentioned, including 'Intravenous drug abusers, particularly those who share needles' and 'Sexual partners of any of the above'

This publication was changed two years later to cover four ways in which HIV can be passed and included: 'Sharing injection needles with an infected person.' (Duffy,1992)

However, it was not until 1989 that the first Dail debate on 'the AIDS epidemic in Ireland' was convened (ibid), which coincided with opening of the first needle exchange that same year. During a debate on health issues in November that year, Ivan Yates of Fine Gael stated that,
"The rate of increase in the number of patients contracting AIDS is doubling every seven months" and "no provision is being made for this catastrophe of epidemic proportions".
Clearly, there was a strong inclination towards alarmism around the AIDS issue in the political arena in Ireland at this time.

As a result of these public debates in 1989, various initiatives were undertaken by the Government and governmental agencies, such as the Outreach Programme in the AIDS Resource Centre in Dublin, which provides a walk-in clinic for IV drug users.(ibid)
The degree of Government commitment to overcome the spread of AIDS can been seen in the that fact that in 1992 a walk-in clinic for gay men was also established. This was an interesting innovation, since male homosexual activity was still a criminal offence at that time. (Duffy,1992)

Needle Exchange Programmes

The first needle exchange centre was established in Dublin in 1989 by the Eastern Health Board; to date two programmes running which operate out of seven centres within the city.
As these services were only provided on a limited and specialised basis, this meant that drug workers had to go out into the neighbourhoods where drug use was common in order to establish contact with drug users who were unwilling to attend centralised services.

The first facility was opened by the Eastern Health Board as part the AIDS Resource Centre in Baggot Street, it came under a budget allocated for AIDS prevention and was an initiative launched in the traditional public health model aimed at the prevention of the spread of contagious diseases.

In an article in DrugLink (Jan/Feb '91), 'Syringe exchanges; has it worked ?, Donoghoe states:
"Syringe exchanges have developed as low threshold points of contact for drug injectors, *characterised by a user-friendly operating philosophy with no requirement of referral, no waiting lists, no criteria for entry other than evidence of injecting...*" (emphasis added)

In striking contrast to the above, in an article in *The Irish Independent* newspaper July '95 on the drugs issue, Catherine Cleary interviewed recipients of these services with different story,
"I went to the family doctor and asked him to help my son. He said he couldn't. They told me 'there was a two-year waiting list at your clinic' " The women had had to buy the heroin substitute, Methadone, on the black market having been reportedly refused by 14 doctors.
In the July article, Dr Joe Barry, Aids and drug services co-ordinator for the EHB, said that the Baggot street clinic was under-resourced to deal with the numbers it attracted. He was further reported as having said that there was too much concentration on the criminal justice side of drug abuse and added that compulsory treatment of addicts via the courts was not satisfactory.
However, judging by recent proposals put forward by Fianna Fail this may become the norm in the future. 'Drug addicts should be treated in specialist detention centres' proposed FF spokesman for Justice, while also demanding that consumption of drugs should be a crime.(*Independent)* In short, FF would like <u>all</u> 'drug use' outlawed.

CHAPTER THREE

Analysis

Based on the empirical data that has been documented in the previous chapter, and in conjunction the body of theory put forward in Chapter, I will now attempt to establish what w factors influenced the policy decisions taken by each country in relation to drug use.

Politics Matters

While Wilensky(1982) makes a good case for Catholic influence on the development of the welfare state in terms of spending (see table 1); in his classification of political parties he determines that while there was strong Catholic party power in the Netherlands, Catholic party power in Ireland was weak (see table 1.1). This classification is probably due to the fact that while all major parties in Ireland were strongly influenced by the predominant Catholic ethos of the country, none defined themselves as 'Catholic' parties. The nearest we may get to defining them might be : Fianna Fail/Secular Conservative; Fine Gael/Christian Democrat(Gallagher et al,1994) This was probably due to the fact that it was not necessary for any of the parties to articulate themselves as 'Catholic', as they did not face strong Protestant or secular opposition; such as was the case in the Netherlands. Due to this rather incongruous state of affairs it is somewhat difficult to show any causal effect between a strict adherence to Catholic party ideology and a historically negative policy response towards drug users in Ireland or alternately positive policy response in the Netherlands. However, this is not to say that the 'Catholic ' ethos did not play a major role in other areas of social policy. The influence that Catholic ideology had on education in Ireland is said to have had a profound impact by way of a knock-on effect; as the vast majority of present day decision-makers were indoctrinated into it.. (Peillon,1990)

On examination, Castles theory that political structure and ideology are vital in the policy process does not appear to be mutually exclusive to that of Wilensky's theory..

In Castles classification of states he focuses on the Left/Right continuum and illustrates that in 1982 (the date of the data) that States exhibiting more Left tendencies were spending more than those on the Right. So it may still be plausible to say that Catholic party power had considerable influence on the development of the Welfare State over a period of time, while parties of the Right may, more recently, be less committed to the Welfare State.

According to Lipset and Rokkan(1967),in the 1960's discernible shifts in traditional political affiliations appeared. Political cleavages became to emerge and shifts in the Left /Right continuum were evident; the most notable of these was the shift from the traditional Left to the Post Materialist/ Liberal perspective, resulting in a more Libertarian overlay. In 1963 the combined Left in the Netherlands held 35.8% of the vote with the traditional Liberal vote at 10.3 (see Table 2). By the middle of the 1960's, around about the time when drug use was emerging as a social problem, the traditional Left was making the transition to a more 'new Liberal' position - the Irish political shift occurring about the same time was from a more traditional Right to Materialist/Authoritarian position.(ibid).Clearly,evident in recent legislation.

However, Castles by inference is handing considerable *kudos* to the Left which presents us with another snag in our attempts to seek casual factors for policy towards drug use in Ireland; in that, the Left in Ireland, albeit historically weak, is also somewhat anomalous. Because Labours[9] only route to government was via coalition, it therefore tailored its policies to avoid conformation with any perspective partners; notably Fianna Gael with whom the Left has been in government on a number of occasions. This was further complicated by the fact that any attempts to take up the baton handed on by the CPAD in the early 80's would have been seen as tantamount to aligning themselves with a radical militant party, Sinn Fein - Workers Party - political suicide.

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[9] The Labour party is historically the largest and best supported of the small group of parties on the Left in Ireland; holding 9% of the vote in 1982
SinnFein - the Workers Party only held 2.2% in the same year.

This may account for the fact that at no time up to 1990, did Labour (O'Connor, 1995) or any other party of the Left, beside Sinn Fein publish any formal policy statement on the drugs issue.

So, while in the Netherlands we not only had the influence of the strong Catholic parties which may have contributed significantly to the development of the welfare state in that country, we also have a historically strong Left - holding over 56% in 1982 - which, if we are to concur with Castles, was more likely to propound the cause of social justice and egalitarianism.
An example of which may be found in the policy adopted towards drug users, evidenced in the amendment of the Dutch Opium Act in 1976; where issues pertaining to the privacy and rights of the individual were deemed to be responsible for this statutory response in the area of drug use. (p14) In 1981 the traditionally Catholic labour Union allied itself to the Socialist Union, giving working class support to the new 'Libertarians of the Left, augmenting their already considerable political clout, to introduce the innovative programmes in the mid-eighties; most notably of these being needle exchanges. The direct contribution of political forces on the drugs issue can be seen in the fact that a strong interest group made up of addicts and ex-addicts in the Netherlands, the Junkiebond, was in a position to lobby a sympathetic and powerful Left into action while in Ireland the CPAD, had it been lobbying for drug users rights - which it was not- was in effect lobbying into a vacuum; as no major political party was prepared to take its issues on board.

Statutory responses in Ireland were also of a more repressive nature and took their queue from the belief that the preservation of law and order was paramount to all other concerns, including respecting the rights of the individual. Examples of this may be seen both the Misuse of Drugs Act 1984; which outlaws <u>all</u> drugs other than those provided for by authorised medical prescription and the draconian measures provided for in the Criminal Justice Act 1983, allowing for 14 years to life imprisonment for convicted drug pushers.There is evidence to this day that this approach remains unchanged, with the present Minister for Justice, Nora Owen, attempting to legislate for the seven day detention of suspected drug pushers.

This latest proposal not only flies in the face of the 'rights of the individual' to due process but is also hugely flawed in that it does not take into account the all encompassing scope of the Drugs Misuse Act; which in its present provisions allow for the arrest and summary detention of a teenager found in possession of a few Ecstasy tablets. (Hanahoe,1995)

The degree to which this action was a proactive sweep by the Right at political level may be seen in the fact that an article in the *Irish Independent* newspaper in July '95 reported that:

'it is understood that the Gardai did not press for the seven-day period which caused problems when last in force under the Emergency Powers Act in 1976' - an act against terrorism !

It would appear that, so as not to left out of the action, the other main party of the Right, Fianna Fail had more to add to the seven-day detention proposed by Fine Gael. In an article entitle "FF wants drug addicts taken off the streets", which appear a week later on 17th July this year (1995), it was reported that,

'Fianna Fail advisors are contemplating anti-drug measures much more radical than those under discussion by the Government. They are considering introducing in the next session of the Dail a private member's bill which would empower the Garda to take heroin addicts off the streets and out of their dwelling places and compel them to undergo six months treatment in rehabilitation centres.' ....' Senior party sources admit that the '*clean the streets* ' proposal could create civil liberties and constitutional difficulties.' The FF spokesman for Justice is further reported as saying that' drug use as well as possession and supply,be made a criminal offence and resources should be allocated to building drug-detention centres.(*Independent, 21July '95)*

Conclusion

What we appear to have witnessed is policy of 'normalisation' nurtured by a strong Left and a policy of 'deterrence' rigidly imposed where there was a strong and/or unopposed Right.

Perhaps it might be as straightforward as just that, if it were not for the fact that the Irish government did, in fact, eventually bring in needle exchanges as part of their health programmes aimed at drug users which appeared to indicate that they may have had a shift in the policy perspective. To verify this as a true indicator of policy change, we need to examine 'policy convergence' and establish whether convergence took place or not

Policy Convergence

The two routes to convergence that we will examine here are that of 'emulation' and 'diffusion' via 'harmonisation'. With either of these, it is important that we acknowledge Bennett's observation, which underlies any attempts at establishing convergence, 'In comparative research the essential theoretical dimension is temporal rather than spatial'.

As previously stated, in the emulation of policy goals, the policy of another country is employed as an exemplar or model which is adapted. To establish that Ireland engaged in a process of emulating the policy goals of the Netherlands in the area of health policy towards drug use we need to first look at the policy models operating in both countries over a period of time.

Models of Drug Use

According to Wijngaart, there are three basic elements in the use of any substance - legal or illegal, medical or non-medical: the substance ('drug'), the individual who takes it ('set') and the social and cultural context in which the drug use occurs ('setting'); and any approach should take account of all three factors.

There are four major points of view with regard to drug use and its three interacting components (drug, set, and setting): the moral/legal model, the medical or public health model, the psychosocial model and the sociocultural model.

Each of these models varies in its assumptions about the nature and relative importance of drugs, of people, and of social and cultural contexts; each has implications for prevention, education, social action, treatment, legalisation and policy making. (Wijngaart,1991)

In the context to the two main competing perspectives on drug use and policy directed towards this issue, namely, 'deterrence' and 'normalisation', the four models are split equally; with the moral/legal model and the medical /public health models been seen are deterrent in nature(ibid)

The moral/legal model

The traditional moral/legal model places major importance on the substance. The primary goal is to keep specific substances away from people; with drugs assuming to be the active agent. Protection occurs via legal controls on processing, manufacture, distribution and sale; where the major deterrents are considered to be control of availability of the drugs; punishment or the threat of it; and warnings of great physical, psychological and social harm. Emphasis is placed on the dangerous effects of drugs and in order to deter use, and on educational programmes based on these assumptions.(ibid)

The disease or public health model

In the public health approach, which has been considered as an alternative to the moral/legal model, 'drug', 'set', and 'setting' are translated into 'agent', 'host' and 'context', following the model developed for infectious diseases. The substances causing concern are defined as dependence-producing - rather than simply dangerous, as in the moral/legal model - but both models emphasis the substance as the active agent. Drug users are to be treated and cured as though they had a medical problem and drug use is to be prevented as a public health problem just as any infectious disease. (ibid)

The psychosocial model

This models puts major emphasis on the individual as the active agent. Drug use and drug users are the complex, dynamic factor and the primary site for intervention. This approach views drug use as behaviour that would not persist unless it serves some function for the individual. It is concerned with the context, in terms of the influence of the perceived attitudes and behaviour of other persons individually or in social groups such as families, peer groups and communities. The context is a contributor to both use and the problems associated with use. This model recognises that the decision to take drugs is influenced only marginally by information

The sociocultural model

The sociocultural model goes beyond the social and psychological factors emphasised in the psychosocial model, to highlight socio-economic and environmental conditions as the reasons for the psychological stress and therefore as the primary site of intervention. Poverty , poor housing , lack of opportunity discrimination, urbanisation and industrialisation are seen as the breeding ground of the more personal factors the sociocultural model emphasises; factors such as broken homes, lack of parental guidance, large impersonal educational and work institutes, and breakdown in social controls. This view also recognises that many of the social ills being highlighted are linked with phenomena that are approved of and valued: conformity, competition, achievement and productivity. (ibid)

The Netherlands

Aspects of the moral/legal model operating towards drug use in the Netherlands began to disappear as early as the 1960's. Evidence of this can be seen in two specific areas: legislation and education. The term 'health education' was introduced in the 1960's and it encompassed all activities undertaken to influence in a deliberate and systematic way the relationship between health and behaviour.(ibid); in itself, one of the primary elements of the prevention strategy exhibited by the psychosocial model.

The Dutch government took the view (Ministry,1985) that the significance of information as a means of preventing drug abuse should not be overestimated. It further objected to publicity that oversensationalised drug use as it was deemed likely to be too one-sided and ineffective to the degree that it may even encourage drug use.(ibid)

In the area of legislation, the kind and degree of surveillance required was at a certain point no longer acceptable to the society because of other 'higher' values and priorities; such as privacy or individual freedom.(Wijngaart,1991) This was evident in the decrease of punitive measures for the use of cannabis and the deletion of these products from the Opium Act in 1976.(p14)

Between the years 1983 to 1985 the Dutch policy towards drug use was moving on a stage from the psychosocial model born in the late 1960's to sociocultural model that it operates today. Prevention strategies adopted by this model suggest that aspects of the context should be adapted to the individual and his/her needs, rather than emphasising the adaptation of the individual to the social environment. Evidence of this first appeared in the innovative and large scale methadone programmes started in 1983,(first,1978) including the methadone bus and the needle exchanges programmes started in 1984. Both of these low-threshold care programmes opened the way for 'secondary prevention', while at the same time made allowances for respecting the rights of the individual to the freedom of personal choices. This last statement is supported by comments made by the then Minister for Justice, as recorded in Altes in 1987,

"In the Netherlands we give high priority to services directed primarily at improving the health and social functioning of the addict, without necessarily ending addiction, because a lot of addicts are not, or not yet, capable of kicking the habit. Addiction involves a lifestyle which cannot be changed easily or quickly. We note that the majority of addicts have in some way contact with medical and social services which we appreciate as a very positive development. This approach may be characterised as harm reduction"

Ireland

On examination, it would appear that up until 1989 at least and even possibly up until 1991, when the 'Government Strategy to Prevent Drug Misuse was published, the Irish Government has operated a policy based on the traditional moral/legal model. On 5th February 1984, in an address by the then Minister for Health and Social Welfare, Barry Desmond T.D, at a seminar on 'Drugs in Ireland', it was stated that , "The decision not to experiment with hard drugs is one which any individual can make before he becomes hooked" and that "The drug problem, now effects young people particularly, without any reference to intellectual or educational attainment. No social class and no district in this area is exempt."

This statement was made in the height of the 'Opiate Epidemic'(1980 -1985) and after not one but two detailed reports[10]quite categorically stated the opposite.

"It is difficult not to think that these young people in North Central Dublin are victims of society. They live in a dirty, squalid, architecturally dispairing area; education seems to provide no mode of escape; unemployment is to be their almost inevitable lot; their parents are quite often separated or else dead; abuse of alcohol is common place" (Lavelle, 1983)

While details are unavailable on the content of the then newly proposed 'provision of comprehensive education programmes as an integral part of school curricula', it is not unreasonable to assume that they were most likely in line with the views expressed by the Minister at that time "I would like to make a special appeal to parents to ensure that children are aware of *the terrible consequences of becoming addicted to drugs*". (emphasis added)

While detailing the achievements and future intentions of the government with regard to the legal aspects of government policy towards drug use, the Minister stated, " The Department of Health introduced a licensing scheme in 1969 under which amphetamines were withdrawn from ordinary channels of distribution."

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[10] 'Drug Misuse in Ireland 1982-83, and 'Characteristics of Heroin and Non-Heroin Users in a North Central Dublin Area 1984 - The Medico-Social Research Board.

As a response "to the need to bring our laws and regulations on drugs up-to-date', ' this was done with the introduction of the Misuse of Drugs Act, 1977. This Act contains extensive provisions for controlling the production, distribution and possession of certain drugs which are liable to abuse, particularly narcotics."

The Minister mentions the Criminal Justice Bill 1983 when referring to the progress that has been made so far. As previously stated, this Bill increase the maximum prison sentence for a convicted drug pusher from 14 years to life imprisonment.

As the 1986 National Co-ordinating Committee on Drug Abuse, First Annual Report confirmed, compulsory committal to a mental institute for persons deemed to be 'drug addicts' was still an option at that time.

Other than a possible overlay with the public health model in terms of the introduction of the first Methadone maintenance programme in 1987, Irish Government policy towards drug use shows all the elements of the traditional moral/legal model. These were operated on a specialised basis from centralised location and not threshold in nature. As previously stated, in 1989 the Irish Government opened its first needle exchange programme as part of its drive against AIDS and not as a result of a cross over to a health model based on normalisation.

Conclusion

While attempting to establish 'emulation', Bennett points out that "emulation should not b inferred from the successive adoption of similar polices by different states in the absence of any empirical evidence of conscious copying" and that "the other country's policy(should) serve as a blueprint that pushes a general idea on to the political agenda".

The only documented evidence of a direct reference to policy towards drug users in the Netherlands has been found in a report by The Medico-Social research Board 1985, "The gloomy epidemiological picture which AIDS present world-wide has prompted suggestions of adopting Amsterdam's pragmatic non-moralistic approach to drugs and the distribution of clean needles and syringes to drug users" (Fr.Lavelle,1985) The reference for this information was a Commentary from Westminster which appeared in *The Lancet.* No reference of the Netherlands policy towards drug use appears anywhere else in either European funded research -the Medico-Social Research Board- or in any Government policy documentation.

It is apparent therefore, that the Irish Government's policy towards drug use did not mirror that of the Netherlands incrementally or even ultimately and nor was Dutch drug policy a motivating factor in driving the policy agenda in Ireland; in short 'emulation' did not take place.

On examination there may be a case for policy convergence where diffusion via harmonisation is concerned. Europe may well have been the impetus behind the apparent policy shift in Ireland; as exhibited in the Government Strategy to Prevent Drug Misuse 1991. To verify if this, we need to look at how elements within the framework of the European Union may have effected Irish drug policy.

Diffusion is defined as, 'any pattern of successive adoptions of *a policy innovation'* (Bennett,1991) Collier and Messick augment this definition be adding that the international or diffusion explanation focuses on 'the imitation of programs *among* nations.' (ibid) In the European context, since the early seventies, diffusion of policies has usually occurred via efforts to harmonise policies on a Europe-wide basis.

One of the first groups formed in Europe specifically to deal with the drugs issue was the Pompidou Group, named after Georges Pompidou the then President of the French Republic The aim of the Pompidou Group, formed by the European Community in 1971, was defined as 'an examination, from a multi-disciplinary point of view of the problems of drug abuse and illicit trafficking'. Since 1980 it has continued its activities within the framework of the Council of Europe, while remaining open to countries which were not members of the Council. An epidemiological sub-group was set up by the 6th Ministerial Conference in November 1981. One of the decisions made at the conference was to further, 'the development of administrative monitoring systems for the assessment of public health and social problems related to drug abuse'.(O'Brien, O'Hare, 1990) The Irish Times reporting on the Conference at that time, wrote that the then Minister of State at the Department of Health, Donal Creed and Assistant Secretary, Joe O'Rourke, had told the Pompidou Group that *the heroin problem had 'stabilised'* in Ireland. One can only assume that the Irish officials were out to make a good impression with their European counterparts, as this statement was quite obviously either very misinformed for its time or contrived as a propaganda exercise.

Only two weeks previous the Fianna Fail spokesman on Justice, Gerard Collins, concluded in a Dail debate on drugs that, "Anyone who does not believe that the usage of heroin is growing has his head in the sand." (Bultler,1991)

One of the most valuable contributions of the Pompidou Group was the provision of funding for research to such bodies as the Medico-Social Research Board, who received almost all its funding from Europe. Subsequent to these funding arrangements being put in place after the 1981 Conference, the board began in earnest its detailed and invaluable work in the area of research into drug abuse as part of a European multi-city study covering the period 1980-1991.

In the Minister for Health's 1984 Conference address in Dublin, he refers to the co-ordination of international action, "In my view there is an urgent need for various Ministers for Public Health at European Community and W.H.O. level to co-ordinate their policies in this area. Ireland will assume the Presidency of the Community in the second half of this year and I intend to sponsor, for the first time since 1978, an informal meeting of Public Health Ministers." The Minister further stated that, "The new National Co-ordinating Committee on Drug Abuse will be established later this year.[11] It is perhaps coincidental that the news of the formation of the European committee of inquiry on the drugs problem was being circulated at this time.

In fact the National Co-ordinating Committees First Annual Report, published in 1986, was a direct response to a request by this same European committee of inquiry to answer a detailed questionnaire on the issues pertaining to drug abuse and provisions made therefore. Although published in 1986, the request for information from Europe was for submission by mid-January of that same year; one assumes therefore that the document was completed sometime prior to Christmas 1985 - data collection being the bug bear that it is !

One other group which has been instrumental in adding to the impetus for harmonisation in European drug policy is the European Committee to Combat Drugs (CELAD) formed in 1989 and composed of representatives of the twelve member states.

'The consequent need for effective action by each member state, supported by joint action by the twelve, has been voiced by the EC.' (O'Brien, O'Hare,1990)

[11] The Committee was not in fact formed until March 1985

As part of its role (obligation) in developing an appropriate drug demand reduction programme, the Irish Government re-constituted and strengthened the National Co-ordination Committee on Drug Misuse in 1990 which was charged with the responsibility of developing a policy to prevent drug misuse. Its report was adopted to become the Government Strategy to Prevent Drug Misuse 1991. (ibid)

In fact there is an entire section in this document entitled 'International co-operation' (Ch.V) which leads in with, " It is recognised that the question of drug misuse cannot be tackled as an exclusively internal matter and that improved international co-operation is central to the success of any anti-drug strategy"; going on to list over 10 bodies in which the Irish Government participates at international level - over half of which are specifically instruments of the EU.

In the appendix (C) of the document there is tantamount admission that the Misuse Drugs Act 1984 was encoded " in consequence of implementation of the U.N. Convention against illicit Trafficing in Narcotic Drugs and Psychotropic Substances 1988 and of E.C. Regulations"

Conclusion

There would therefore appear to be evidence of not only a pull factor involved where Europe and the international fora is concerned but perhaps also a certain degree of push factor; the latter perhaps being exhibited in the agendas of those involved in the process. In short, diffusion via harmonisation has been a major element in the apparent shift in policy perspective.

Consequentialism

To use an old and weary maxim, Consequentialism has a lot to do with the 'end justifying the means' and to establish it in this particular case we need to be able to show that the traditional 'means' were thrown out in favour of those that would achieve the much sought after end result - a cessation of the spread of the deadly AIDS virus.

To get a clearer picture of how AIDS was being dealt with in the political area in Ireland at the time; in an attack on the government by Fine Gael, T.D. Ivan Yates in November of 1990 during the debate of a private members bill on AIDS policy, he stated that,

"It is predicted by conservative estimates that there will be 20,000 people in Ireland who will be HIV positive by the end of this decade, the year 2000. This epidemic needs a similar response to that of the health programme dealing with tuberculosis in the forties and fifties. *This means a departure from normal public health programmes.* Unless *a radical approach* is adopted Dublin may become the AIDS capital of Europe. (emphasis added)

In a response to this attack on the lack of coherent policy on AIDS in Ireland, the then Minister for Health, Dr.O'Hanlon stated that, "The Government's AIDS strategy consists of monitoring; prevention through health education strategies aimed specificaly at the young and at at-risk groups; the protection of the blood supply; the provision of services to reduce risk, such as outreach and methodone maintenance and provision of condoms and needle exchanges aimed specifically at risk groups and linked to counselling at individual level."
The Minister when on to further state that,
"When zero-prevalence monitoring became possible in 1985, it was apparent that the HIV virus was indigenous in the country and that a particular problem existed in relation to the spread of HIV infection in intravenous drug abusers."

"The percentage of intravenous drug-related case in now 36% of all cases as compared with 20.5% in 1986 in the twelve EC countries." "Almost 60% of the persons known to be infected with HIV virus are drug abusers. The movement of the epidemic towards the drug abusers has lead to an increase in the number of heterosesexual cases."

At European level, Pompidou Group, of which Ireland had been a member since in the 1970's held an 'Extraordinary Ministerial Conference in May '89, in which it noted:
'that in those countries where injecting drug misuse was seen as a significant route for the spread of HIV infection particular priority was being given to measures designed to bring an many misuses as possible into contact with health and counselling services '.

However, while health and counselling services were technically present, surveys[8] carried out among drug users have shown that attitudes exhibited by service providers at these facilities were in no way indicative of any real ideological shift from the original perspective, having been sent down from the top. One HIV-positive woman described the service at Trinity Court, one of the centres distributing syringes to drug users, 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 is hard to get on the maintenance programme and it seems even harder now." (Butler et al,1992)

Conclusion

Perhaps conflict and ambivalence of this kind would not have been so obvious in drug services if there had been a clear and unequivocal policy statement committing the services to 'harm reduction'. The 1991 Government Strategy, while formally endorsing the concept, its overall tone was that of an administrators report rather than a policy maker's report; with the phrase 'harm reduction' appearing only once in the main body of the text. (ibid)

[8] Butler and Woods,'Women, Drugs,HIV and the Perpetuation of Powerlessness'

CHAPTER FOUR

Conclusions

On reflection, this inquiry set out to cover too great a scope in theory; any one of the three bodies of theory chosen would have done justice to the subject matter. However, as with most *intrinsic case studies,* it was the intrinsic interest in the case itself that drew me in originally and thereafter the case content evolved in the writing; the first case being that of Irish drug policy, its process and progress. It is therefore, with the full realisation that this inquiry has only grazed the surface of a considerable volume of information that I make the following conclusions which are, by their very nature, tentative.

Political Factors

From the outset I had a somewhat naive view with regard to this particular variable, only to discover that it carried considerably more weight than I had originally perceived. Even from the very basic précis that this inquiry has allowed, it is nonetheless clear that one of the most profound forces impacting in the area of drug policy has been that of the political ideologies operating in the two countries studies; with particular reference to the *balance of power.*

Power in the cases studied comes in many forms: the power that can be exerted by a fully mobilised, organised and cohesive *interest group,* as in the case of the 'Junkiebond'; the political party power that can be directly utilised to produce results, as in the case of the Left in the Netherlands demanding amendments in legislation that they saw as *interfering with the rights of the individual* to personal life choices; the bludgeoning power of a single ideologically weighted government, which is evidenced in Ireland where major changes to the legal process have recently been instigated by a government with a strong Right element receiving support from a Right-wing opposition, without the request of the police force and in direct opposition to the Council for Civil Liberties and a number of MEP's; particularly in the Irish Green Party.

How any political ideology conceptualises the whole issue of 'rights' would appear to be reflected in the policies they initiate and with what underlying goals in mind. The whole issue of 'negative' and 'positive' rights come to bear, almost without exception, on all areas of social policy. According to Goodin(1982), "Dignity and self-respect might be incorporeal but they are hardly immaterial to the concerns of the morally sensitive policy-maker. Indeed, protecting them is implicit in the utilitarian principle itself". The ideal of a society in which each individual takes responsibility for his or her own choices, having regard for their implications for others, is undermined every time government and police lay down the law on how individuals many or may not live. (Wijngaart,1991) An example of this perspective on the rights of choice would would acknowledge that people who choose to use drugs as a coping mechanism should have that 'right'.

Clearly, the driving force behind some of the draconian legislation we have encountered in this inquiry have been driven by the perceived need to maintain order in society; prevent crime. However, it is the process of criminalisation of drugs that has created that associated crime and not the use of them. The possession of heroin, for example, is illegal in almost every country and it is therefore only possible to acquire it as an illicit drug. As a result, quality is questionable and the price is disproportionately high. Usually, money has to be acquired in the margins of society and consequently, the user gets more and more isolated from the mainstream of society. So long as drugs are illegal, heroin users may deteriorate into 'junkies', because of the fact that heroin is illegal. (ibid) The drugs are not the problem, it is how we perceive them in the context of how we view *'individual rights'* in our different societies.

Policy Convergence

One of the powers I neglected to mention in the previous section was the power of a federal entity, in this case the European Union.

While there is some evidence that independent international bodies have influence to encourage 'policy convergence' via diffusion, the degree of enforceability cannot be overlooked here. In the case of the EU, the considerable power of coercion may be utilised via funding mechanisms to bring policies in line for harmonisation; particularly on smaller countries such as Ireland or the Netherlands. This is clearly the case with Irish Drug policy. There is evidence that almost all progress in the area of drug policy in Ireland which occurred in the ten years prior to the 'AIDS epidemic' can be attributed to outside influences, mainly European. However, this is not to say that progress would not have been made otherwise; it is the direction that this progress would have taken, in the light of recent events, which is in question.

Consequentialism

On reflection, there appears to be little doubt that AIDS played a huge role in the introduction of the first steps towards 'normalisation' in the area of drug policy in Ireland and that without it there is no guarantee that 'harm reduction' would have surfaced before the end of this century. "The provision of wider and more accessible services for drug users is seen as an essential element in the prevention of HIV".(Geoghegan, 1994)

It is hard to say which one of the variables studied has had the most impact on drug policy; doubtless a combination of all three in varying degrees has produced the end result. Attempts to weight the importance of any one of these variables is beyond the scope of this inquiry.

Bibliography

Anderson,W.(1993) *The New York Needle Trials,* in Berridge, *AIDS and Contemporary History,* Cambridge University Press, Cambridge, England.

Bennett, C.(1991) *What is policy Convergence and What causes it?* British Journal of Political Science. Vol. 21. No2

Bradshaw,Dr.J.(1983) *Drug Misuse in Ireland 1982-1983,* The Medico-Social research Board, Dublin.

Brady,T., 15th July 1995, *Drugs probe new Powers 'not sought by Gardai'* Irish Independent Newspapers, Dublin.

Butler,S.(1991) *Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed,* The Journal of the Institute of Public Administration 39/3, Sage Publications

Castles, F.(1982) *Does Politics Matter: An Alalysis of the Public Welfare Commitment in Advanced Democratic States* , European Journal of Political Research, 7(1979), P169-86

Cleary, C. 21st July 1995, *Other Options* , Independent Newspapers, Dublin.

Collier,D. and Messick,R.(1975) *Prerequisites verus Diffusion,* American Pollitical Science Review, 69 (1975), 1299-1315

Commission of the European Communities, (1990) *Report on National Programmes for Drug Demand Reduction in the European Community, Nov. 1990 Brussels.*

Council of Europe, Pompidou Group (1989) *Report of the Extraordinary Ministerial Conference - London May 1989,* Council of Europe, Brussels.

Cullen,B.(1990) *Community Action in the Eighties: A Case Study* in *Community Work in Ireland: trends in the 80's, Options for the 90's,* Combat Poverty Agency, Dublin.

Dail Debates (1990) *Private Members Business, AIDS Policy, 27 Nov.1990,* Government Publications Office, Dublin.

Dean.G. et al.(1985) *The Opiate Epidemic in Dublin 1979-1983,* Irish Medical Journal, April 1985, Vol 78, No 4.

Department of Health (1991), *Government Strategy to Prevent Drug Abuse,* Eastern Health Board, Dublin.

Desmond,B.Irish Minister for Health and Welfare (1984) *'Drugs in Dublin' Seminar address.*

Donoghoe,M.(1991) *Syringe Exchange: Has it Worked?* DrugLink Jan/Feb 1991, The ISDD, London

Downey,J. 19th July 1995, *FF wants drug addicts taken off the Streets,* Irish Independent Newspapers, Dublin.

Duffy, M.(1992) *Positive Proof,* The Sociological Association of Ireland, Dublin.

Gallagher,M., Laver,M., Mair,P. (1991) *Representative Government in Western Europe,* McGraw-Hill, New York and London.

Geoghegan, T. (1994) *Drug Treatment Services,* in the periodical *AIDS Inform,* The AIDS Liaison Forum, Dublin.

Goodin,R. (1982) *Political Theory and Public Policy,* Cambridge University Press, UK.

Guba,E and Lincoln,Y(1994) *Competing Paradigms in Qualitative Research,* Sage Publications, Inc, London, UK.

Inter-ministerial Task Force Report (1983) *Developments in relation to the implementation of the Recommendation of the Task Force,* Government Stationary Office, Dublin.

Lavelle,Fr.P.(1986) *Heroin Misuse in a North Central Dublin Area 1985,* The Medico-Social Research Board, Dublin.

Lipset, S. and Rokkan, S.(1967) *Party Systems and Voter Alignment,* in the *International Yearbook of Political Behavioural Research,* Vol.7,P519-522. New York Free Press.

Medico-Social Research Board (1984) *Characteristics of Heroin and Non-Heroin Users in a North Central Dublin Area,* Dublin.

National Co-Ordinating Committee on Drug Abuse (1986) *First Annual Report,* Dept. of Health, Dublin.

O'Brien,M. , O'Hare,A.(1990) *Treated Drug Misuse in The Greater Dublin Area,* The Health Research Board, Dublin. (Formally known as the Socio-Medico research Board.

O'Cinneide,S.(1970) *A Law for the Poor: A study of Home Assistance in Ireland,* Reseach Series, The Institute of Public Administration (3) Dublin.

O'Neill,L. 11th July 1995, *New moves to fight drug crisis set for Cabinet.* Irish Independent Newspapers, Dublin.

Peillon, M.(1982) *Comtempory Irish Society: An Introduction,* Gill & McMillian, Dublin.

Report of the Working Party on Drug Abuse, (1971) Government Offical Publications, Dublin

Roebroek, J.(1986) *The Netherlands,* in Flora, *Growth to the Limits,* Transaction Inc. NY

Ryan,T. 18th May 1995, *FF in Call for Specialist Drug Centres,* Irish Press Newspapers

Stake,R..(1994) *Case Studies,* Ch.14 The Handbook of Qualitative Research edited by Denzin and Lincoln, Sage Publications Inc. London, UK.

Schwandt,A.(1994) *Constructivist, Interpretivist Approaches to Human Inquiry,* Ch.7 the Handbook of Qualitative Research edited by Denzin and Lincoln, Sage Publications Inc, UK

Wijngaart,van de, F.(1991) *Competing Perspectives on Drug Use: The Dutch Experience,* Swet & Zeitlinger B.V. Ameterdam / Lisse

Wilensky,H. (1982) *Leftism, Catholicism and Democratic Corporatism* in Flora and Heidenheimer's *The Development of Welfare States in Europe and America* , Transaction Inc. New Jersey, New York.

APPENDIX

Table 1 General Elections

Year	Fianna Fail	Fine Gael	Labour	Other Parties	Independent Candidates	Year
			Percent distribution of votes			
1944	48.9	20.5	8.8	13.5	8.4	1944
1948	41.9	19.8	8.7	21.1	8.5	1948
1951	46.3	25.7	11.4	7.0	9.6	1951
1954	43.4	32.0	12.1	6.9	5.7	1954
1957	48.3	26.6	9.1	9.4	6.6	1957
1961	43.8	32.0	11.6	6.7	5.9	1961
1965	47.7	34.1	15.4	0.7	2.1	1965
1969	45.7	34.1	17.0	-	3.2	1969
1973	46.2	35.1	13.7	2.0	3.0	1973
1977	50.6	30.5	11.6	1.7	5.6	1977
1981	45.3	36.5	9.9	4.2	4.2	1981
1982 (Feb.)	47.3	37.3	9.1	3.3	3.0	1982
1982 (Nov.)	45.2	39.2	9.4	3.3	3.0	1982
			Percent distribution of seats			
1944	54.5	21.6	6.0	11.2	6.7	1944
1948	45.9	21.2	9.6	15.0	8.2	1948
1951	46.6	27.4	11.0	5.5	9.6	1951
1954	44.5	34.2	12.3	5.5	3.4	1954
1957	53.4	27.4	7.5	5.5	6.2	1957
1961	48.9	32.9	10.5	3.5	4.2	1961
1965	50.3	32.9	14.7	0.7	1.4	1965
1969	51.7	35.0	12.6	-	0.7	1969
1973	47.6	37.8	13.3	0.0	1.4	1973
1977	57.1	29.3	10.9	0.0	2.7	1977
1981	47.0	39.2	9.0	1.8	3.0	1981
1982 (Feb.)	48.8	38.0	9.0	1.8	2.4	1982
1982 (Nov.)	45.2	42.2	9.6	1.2	1.8	1982

Table 1[illegible].1

Strong Corporatism and Strong Catholic Power
Each Foster Strong Welfare Effort in 1971.
Tax Visibility Has No Independent Effect.

Strong Corporatism					Weak Corporatism			
Strong Catholic Power 1919-76*		Weak Catholic Power 1919-76*			Strong Catholic Power 1919-76		Weak Catholic Power 1919-76	
High Tax Visibility	Low Tax Visibility	High Tax Visibility	Low Tax Visibility		High Tax Visibility	Low Tax Visibility	High Tax Visibility	Low Tax Visibility
No case	Belgium 20.7	Denmark 24.0	Israel 11.8		No case	Germany 21.3	U.S. 11.7	Japan 6.3
	Netherlands 24.0	Finland 16.4	France 17.8				Switzerland 11.4	Ireland 12.7
	Italy 22.8	Sweden 23.8	Norway 19.6				UK 14.5	
	Austria 23.1						Australia 9.3	
							Canada 15.8	
							New Zealand 10.5	
Av. SS as % of GNP	22.7	21.4	16.4			21.3	12.2	9.5

*Catholic power for 1919-76 or for 1946-76 yields an identical classification. If we substitute 1965 tax visibility in this Table, the results are very similar.

Table 2

Results of Elections

(% of votes and number of seats)

	1948		1952		1956		1959		1963		1967	
	%	n	%	n	%	n	%	n	%	n	%	n
Political Reformed Party	2.4	2	2.4	2	2.3	3	2.2	3	2.3	3	2.0	3
Reformed Political Union			0.7		0.6		0.7		0.7	1	0.9	1
Reformatoric Political Party												
Evangelist People's Party												
Anti-Revolutionary Party	13.2	13	11.3	12	9.9	15	9.4	14	8.7	13	9.9	15
Christian Historical Union	9.2	9	8.9	9	8.4	13	8.1	12	8.6	13	8.1	12
Catholic People's Party	31.0	32	28.7	30	31.7	49	31.6	49	31.9	50	26.5	42
Catholic National Party	1.3	1	2.7	2								
Roman Catholic Party												
Radical Political Party												
Labour Party	25.6	27	29.0	30	32.7	50	30.4	48	28.0	43	23.6	37
Communist Party	7.7	8	6.2	6	4.7	7	2.4	3	2.8	4	3.6	5
Pacifist Socialist Party							1.8	2	3.0	4	2.9	4
Democratic Socialists '70												
Liberal Party	7.9	8	8.8	9	8.8	13	12.2	19	10.3	16	10.7	17
Farmers Party									2.1	3	4.8	7
Democrats '66											4.5	7
Middle Class Party												
Centre Party												
Others	1.7		1.3		0.9		1.2		1.6		2.5	
		100		100		150		150		150		150

1971		1972		1977		1981		1982	
%	n	%	n	%	n	%	n	%	n
2.3	3	2.2	3	2.1	3	2.0	3	1.9	3
1.6	2	1.8	2	1.0	1	0.8	1	0.8	1
						1.2	2	1.5	2
						0.5		0.7	1
8.6	13	8.8	14	Christian Democratic Appeal					
6.3	10	4.6	7	31.9	49	30.8	48	29.3	45
21.8	35	17.7	27						
0.4		0.9	1	0.4					
1.8	2	4.8	7	1.7	3	2.0	3	1.6	2
24.6	39	27.3	43	33.8	53	28.2	44	30.4	47
3.9	6	4.5	7	1.7	2	2.1	3	1.8	3
1.4	2	1.5	2	0.9	1	2.1	3	2.2	3
5.3	8	4.1	6	0.7	1	0.6			
10.3	16	14.4	22	17.9	28	17.3	26	23.1	36
1.1	1	1.9	3	0.8	1	0.2			
6.8	11	4.2	6	5.4	8	11.0	17	4.3	6
1.5	2	0.4							
						0.1		0.8	1
2.3		0.9		1.7		1.1		1.6	
	150		150		150		150		150

TABLE 1

Social Security (or Welfare) Spending as a Percent of GNP at Factor Cost for 22 Rich Countries in 1966** and 1971

Welfare state leaders			Middle rank spenders			Welfare state laggards		
	SS/GNP			SS/GNP			SS/GNP	
Country	'66	'71	Country	'66	'71	Country	'66	'71
Austria	21.4	23.1	United Kingdom	14.3	14.5	USSR	10.6	12.1
Germany (FR)	19.6	21.3	Denmark*	13.9	24.0	Switzerland	9.5	11.4
France	19.3	17.8	Finland	13.1	16.4	Canada*	9.4	15.8
Italy	19.2	22.8	Norway*	12.6	19.6	Australia	9.2	9.3
Belgium	18.6	20.7	New Zealand	12.0	10.5	Israel	8.0	11.8
Netherlands	18.3	24.0	Ireland	11.2	12.7	United States	7.9	11.7
Sweden	16.5	23.8				Japan	6.1	6.3
East Germany	15.8	–						
Czechoslovakia	15.5	17.2						

*Countries whose relative welfare effort had drastically moved up by the early seventies. For instance, the percent increase for Denmark is 72.1, for Canada, 68.2, and for Norway, 55.6. Based on unpublished data supplied by ILO (forthcoming). The French figure is our own estimate derived from French sources, all of whom agreed that the French trend from 1966 to 1971 was not up.

**The last year for which reasonably comparable data are published. For details on the uses and limits of these data, see Wilensky (1975: 121-28).