Governing families: State discourses and professional practices in the making of Irish drug policy 1971–2016

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Abstract

In the past two decades, families have increasingly become a focus of drug policy and professional practices. This development has received limited critical and theoretical examination with respect to the presuppositions and assumptions underpinning its rationale. In this thesis, I ask how families have been problematised in Irish drug policy. Further objectives include exploring the operation of policy discourses as they are interpreted and negotiated by professionals in the drug field; and, understanding how families are governed and the political implications of this. The study is situated within an emerging body of international drug policy research that understands realities as being constituted through policy discourses and practices. This body of work has not addressed families as a focal point for analysis, a gap that this study addresses.

This study adopts a poststructuralist perspective, drawing on Foucauldian-influenced governmentality studies as the theoretical framework. The study analyses the Irish 2009 *National Drugs Strategy* and seven other official drug policy documents, using Bacchi's (2009) 'What's the Problem Represented to Be?' approach to policy analysis. Interviews with 17 professionals in policy making, policy coordination, research, advocacy, and service provision roles are analysed using aspects of Bacchi and Bonham's (2016) 'Poststructuralist Interview Analysis' approach.

In the 2009 strategy, families are represented as different 'problems': (1) Families are constructed as victims of drug-related intimidation but, at the same time, families are called upon to take responsibility for addressing the issue. (2) Affected families are constructed as service users in their own right and as responsible and self-regulating actors and, at the same time, as a source of social recovery capital for their close relative. (3) Adolescent drug use is constructed as a 'problem' of deficits in family functioning, while families are also understood as contributing to the solution. (4) Parental drug use is represented as 'problems' of family dysfunction, deficit parenting and child protection; with the primary concern being children's future potentiality in terms of future drug use and life outcomes. Technologies of responsibilisation and risk, characteristic of neoliberal forms of rule, dominate how families are governed through problem representations in drug policy. Professional discourses largely reproduce dominant policy discourses on parental drug use, adolescent drug use and affected families. However, they also problematise the way that drug-related intimidation is represented as a 'problem', the taken-for-granted role of family involvement in treatment, and the evidence based paradigm that dominates drug policy making and professional practices. Professional discourses also draw attention to the complexities of governing 'at a distance'. The study highlights how the problem representations of drug-related intimidation and parental drug use may have unintended consequences that may produce potentially harmful effects for families.

Devaney, E. (2017) 'The emergence of the affected adult family member in drug policy discourse: A Foucauldian perspective', *Drugs: Education, Prevention and Policy*, 24(4), 359-367.

Declaration

I, Eva Devaney, declare that this thesis is entirely my own work, in my own words, and that all sources I have used are fully acknowledged. I declare that I have published one paper based on the findings of this study (Devaney 2017).

Signed: _____

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List of Abbreviations

AA	Alcoholics Anonymous
AGS	An Garda Síochána
AOD	Alcohol and Other Drugs
ATS	Amphetamine Type Stimulants
CE	Community Employment
CPAD	Concerned Parents Against Drugs
CRA	Community Reinforcement Approach
CRAFT	Community Reinforcement and Family Training
DOCRGA	Department of Community, Rural and Gaeltacht Affairs
DOCYA	Department of Children and Youth Affairs
DOH	Department of Health
DOHC	Department of Health and Children
DOTSR	Department of Tourism, Sport and Recreation
DRI	Drug-Related Intimidation
EBP	Evidence-based Practice
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESRC	Economic and Social Research Council
EU	European Union
FRC	Family Resource Centre
FSA	Family Support Agency

GNDU	Garda National Drugs Unit
HRB	Health Research Board
HSE	Health Service Executive
LDTF	Local Drugs Task Force
NACD	National Advisory Committee on Drugs
NACDA	National Advisory Committee on Drugs and Alcohol
NDRIC	National Drug Rehabilitation Implementation Committee
NDS	National Drugs Strategy
NFSN	National Family Support Network
NIDA	National Institute on Drug Abuse
NICE	National Institute for Health and Care Excellence
NPM	New Public Management
NTASM	National Treatment Agency for Substance Misuse
PIA	Poststructuralist Interview Analysis
QuADS	Quality Standards in Alcohol and Drugs Services
RDTF	Regional Drugs Task Force
SAI	Sociological Association of Ireland
SFP	Strengthening Families Programme
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WPR	‘What’s the Problem Represented to Be’

Chapter One:

Introduction

Chapter One: Introduction

1.1 Purpose

This thesis is a theoretical study of how families are thought and talked about in Irish drug policy and practices, and how families are being governed as a consequence. My overarching research question asks how families have been problematised in Irish drug policy from 1971-2016. The objectives of the study include exploring the operation of policy discourses relating to families as they are interpreted and negotiated by professionals in the drug field, understanding how governing takes place, and examining the political implications. To help answer my research question and achieve my objectives I have been guided by five specific questions:

1. How are families represented as 'problems' in Irish drug policy 1971 – 2016?[1]
2. How have professional and expert forms of knowledge contributed to policy discourses about families?
3. What knowledge about families has been produced through expert/professional discourses?
4. How do professionals interpret and negotiate policy discourses about families?
5. What are the practices used to govern families?

My study is situated within an emerging body of international drug policy research that understands realities – e.g. addiction, drugs or people who use drugs - as constituted through policies and practices (Bacchi 2009; Fraser and Moore 2011; Keane *et al.* 2011; Moore and Fraser 2013; Fraser *et al.* 2014; Lancaster and Ritter 2014; Martin and Aston 2014; Seear and Fraser 2014; Lancaster *et al.* 2015; Pienaar and Savic 2016). This is vastly different from traditional policy research, which understands policy as government's best efforts to respond to 'problems' that exist outside the policy. To date, this

[1] Throughout this thesis I use scare quotes for terms like 'problem' to highlight their contingencies (Bacchi and Goodwin 2016). This practice is commonly used in poststructuralist work that aims to challenge that which is taken-for-granted or self-evident, such as understanding drugs or drug use as 'problems' in the conventional use of the term.

body of work has not addressed the family as a reality that is constituted through drug policy and professional practices, and my study addresses that gap in the literature.

The purpose of my research is to critically interrogate and make visible the presuppositions and assumptions that underpin the way that families are represented as 'problems' in drug policy and professional practices. These problem representations are shaped by dominant expert and professional knowledges, and during the process of identifying these, I also highlight alternative knowledges that are less prominent or silenced.

Through analysing problem representations, I theorise the effects in terms of their political implications for different groups of people such as families, close relatives who use drugs and professionals who intervene with families (Bacchi and Goodwin 2016). By political implications I specifically mean power relations and the "strategies by which individuals try to direct and control the conduct of others" (Foucault 1997, p. 298). I am particularly interested in analysing the unintended consequences of contemporary drug policy. This is traditionally not addressed in conventional approaches to policy analysis.

Guided by Foucault, the purpose of my research is:

> …to acquire the rules of law, the management techniques, and also the morality, the *éthos*, the practice of the self, that will allow us to play these games of power with as little domination as possible (1997, p. 298 italics in original).[2]

My intention is that my research findings may be used by myself, researchers, professionals, policy makers and other interested individuals and groups to reflect on power relations and governing practices. Furthermore, the research findings can be a starting point for thinking about alternatives in terms of problematisations of families and in terms of governing practices where the negative effects for those being governed are minimised or disrupted.

[2] When Foucault speaks about games, he refers to "a set of rules by which truth is produced" (1997, p. 297). I interpret this to mean the dominant knowledges, discourses, institutions and forms of expertise that shape what is considered to be a 'truth'.

Interested individuals and groups may use the findings of my study to reflect on the assumptions that underpin policy and governing practices; the privileged forms of knowledge and expertise shaping drug policy and practices; and, the normalising processes shaping the way that families are problematised. This form of reflection can open up a space for further questioning; for example, how could potentially harmful effects be minimised or disrupted? Could alternative policy solutions and practices that have been foreclosed by particular ways of problematising families in policy and practices be considered? Could different conceptualisations of and theories about families, using different forms of knowledge and expertise, be used to shape policy and practices?

1.2 Background context

In the past two decades, families have received increasing attention in drug research, policy and professional practices. This suggests that families and their conduct are being governed more intensely. My study has found that this development has received limited critical and theoretical examination with respect to the presuppositions and assumptions underpinning its rationale. It is a taken-for-granted development that has not been subject to much 'troubling' in the literature.

Governing families has been a key concern for the Irish state since its foundation as a Republic, and the fundamental status of the 'family' is reflected in the Irish Constitution. Drugs were first problematised as a policy issue in 1971, when the first official drug policy document was published (Working Party on Drug Abuse 1971). Since 1971, eight key drug policy documents have been published in Ireland, the most recent in July 2017 as I was preparing the final draft of this thesis.[3] While this document is not included in my analysis, families feature prominently in the new strategy across different policy goals and objectives and are directly referred to in seven of 50 strategic actions (Department of Health (DOH) 2017). This represents an increase from families being directly included in three of 63 actions in the previous *National Drug Strategy* (NDS) (Department of

[3] *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (DOH 2017).

Community, Rural and Gaeltacht Affairs (DOCRGA) 2009). Hence, my thesis is particularly salient. The findings of my critical analysis of governing practices and their effects can be used as starting points for critical reflection on proposed policy actions as the new strategy is implemented.

1.3 Personal motivation

I arrived at the aim and objectives for my thesis about one year into my Doctoral studies. I commenced my PhD research with different research questions and a different theoretical framework. I initially wanted to conduct research *for* policy rather than *of* policy. I had proposed to examine the support needs of families affected by substance 'misuse' by a close relative with the aim of making recommendations for policy and practice in the field. My interest in the topic of families, drug policy and professional practices emerged during my term as course director for a Diploma in Drug and Alcohol Studies at the University of Limerick, a position I held from 2005 – 2014. When the 2009 *National Drugs Strategy* was published, I observed that families were referred to more frequently than in previous drugs strategies. I was also aware that several family support drug projects had been established in Limerick from 2007/2008. These developments sparked my interest at the time – why the increased focus on families and why now? Eventually I developed my thoughts, engaged with some scoping literature and prepared a research proposal on the topic in 2012.

My research aim and questions, and theoretical and methodological frameworks, took shape during the first year of my PhD studies. Coming from a health promotion background, my exposure to critical social theory had been limited. I spent the first year of my studies reading social theory, empirical research and literature on research methods, and my thinking on this topic changed significantly as a result. The tenets of poststructuralism, Foucault's theoretical perspectives, and studies of governmentality appealed strongly to me. I agreed with the critique of neoliberal forms of rule and the sceptical stance taken towards 'new and better' developments in policy and practice. I concurred with the purpose of critically interrogating that which seems natural, taken-for-granted and self-evident, such as the involvement of families in addressing drugs and drug use. I found the body of literature on

alcohol and drug use that had used this theoretical perspective innovative, different, and exciting, and my thinking about my project developed. I identified gaps in this body of literature as little attention had been paid to families as the focal point of analysis.

I found Carol Bacchi's approach to analysing policy as I delved into these new and different bodies of literature. I quickly realised that her 'What's the Problem Represented to Be?' (WPR) approach would fit my study as it would operationalise my theoretical framework (Bacchi 2009). Hence, one year into my PhD studies, I revised my research proposal, amended my research aims and questions, theoretical framework and methodology. I had originally proposed to use an adaptation of Jackson and Mazzei's (2013) approach to interview analysis by interpreting data through a Foucauldian theoretical lens. Indeed, my initial draft of the interview findings chapter drew on their ideas. However, in the latter half of 2016, I came across Bacchi and Bonham's (2016) Poststructuralist Interview Analysis (PIA) strategy. This method complements the WPR approach used in my analysis of policy, and, therefore I considered this a better fit in addressing my research questions.

1.4 Outline of thesis

1.4.1 Literature review

In Chapter Two I review the literature in the field. In section one I discuss the empirical alcohol and other drugs (AOD) research on families, and highlight gaps in terms of theoretical and methodological approaches. As this body of literature is vast, I narrow the scope of my review to the areas that reflect the emergent findings from my analysis: studies on drug-related intimidation and families; families and risk factors for drug use; family involvement in drug treatment; harm and affected families; and, in keeping with my research focus, families and drug policy research. There is a lacuna in this body of literature of research that uses critical social theory, and that aims to 'trouble' the self-evident nature of families. Here my study makes a contribution to the literature by advancing theory on families in the AOD field. Furthermore, there is a dearth of drug policy research that takes families as its analytical focus.

I also make a contribution to drug policy research. As I examine professional discourses for how policy discourses related to families are negotiated and operationalised through practices, I provide insights into the degree to which drug policy proposals and efforts to govern are enacted as imagined. The focus on the effects of drug policy for families in my study, and, in particular the unintended consequences, is also different from traditional policy research, which evaluates the extent to which pre-defined measurable outcomes have been achieved.

In section two I review AOD literature that uses a governmentality studies theoretical framework and studies that adopt the WPR approach to analysis. My study builds on the body of work that understands realities to be constituted through drug policy and practice. To date, families have not been a central focus of this research, and here my study will add a new perspective.

Furthermore, as the PIA approach for analysis of interview data has only recently been introduced, my search only found one published paper adopting this approach. Hence, my study makes a methodological contribution by building on the emerging body of literature using the WPR and PIA approaches to analysis.

1.4.2 Theoretical framework

In Chapter Three I discuss the theoretical framework that underpins my study. I draw on the work of Foucault (1972; 1978; 1979; 1982; 1984; 1991a; 1991b; 1997; 2003; 2005; 2006; 2007) and other governmentality studies scholars such as Rose (1998; 1999; 2000), Miller and Rose (2008) and Dean (2010), who have further developed Foucault's initial work on the concept of governmentality. I explain how concepts in this framework - discourse, knowledge/power, power/resistance, technologies of self, governmentality, subjectification and problematisation - are applied in my study. I also discuss how Foucault depicts families in terms of different forms of power. This theoretical framework enables me to examine the forms of power/knowledge that shape how families have been problematised, and how power is exercised, rationalised and normalised through practices that govern the conduct of individuals and groups. This allows for an analysis of how such

practices are regulated by the state, the network of sites and actors beyond the state, and by the 'self'. Furthermore, the effects of such governing practices can be theorised.

1.4.3 Methodology

In Chapter Four, I outline the methodological approach. I start the chapter by outlining the epistemological and ontological assumptions that underpin the poststructuralist Foucauldian perspective that I adopt in my study. Following this, I discuss the notion of reflexivity, referred to as self-problematisation in my Foucauldian context. My research design encompasses two phases, examining policy discourses and professional discourses respectively. First, I analysed eight drug policy documents published between 1971 and 2009. I applied Bacchi's (2009) innovative WPR approach in my analysis, which is theoretically influenced by Foucauldian concepts and governmentality studies. Second, I conducted seventeen interviews with a sample of professionals holding roles in settings such as policy making, policy coordination, research, advocacy, policing, family support, drug treatment and rehabilitation. I adopted Bacchi and Bonham's (2016) novel PIA approach to guide my analysis of interview data. The two analytic approaches are complementary as they share the same theoretical and conceptual underpinnings.

1.4.4 Discussion of findings

My analysis begins in Chapter Five where I situate my research by laying out the policy context of my study. A key premise underpinning my research is the understanding that the way that subjects and objects are problematised is contingent on time and place, and embedded in the wider, dominant and pervasive discourses prevailing during this time and in that place. Therefore, in this chapter I provide an overview of the Irish social policy landscape from the 1950s onwards and highlight influencing factors that have shaped policy, such as Catholic social teaching and significant economic and social changes. Following this, I review family policy and drug policy, and I identify key shifts and developments in these policy documents.

In Chapters Six and Seven, I present and discuss the findings of my analysis of drug policy. Here I focus on addressing the question and objectives of my

research, so I discuss how 'problems' are represented in policy; I consider the forms of knowledge and expertise that have given shape to how 'problems' are represented; I analyse how families are governed; and, finally, I discuss the political implications. My analysis identifies two dominant forms of governmental strategies – governing through responsibilisation and governing through risk – and I dedicate a chapter to each of these.

In Chapters Eight (professional discourses on responsible families) and Nine (professional discourses on 'risky' families) I describe and discuss the findings emerging from my analysis of interview data. Keeping the focus on my research question and objectives, I seek to examine how policy discourse on families is negotiated and operationalised, how governing of families takes place and the political implications of governing practices. Guided by Bacchi and Bonham (2016) I am also interested in the transformative potential contained in my interview data. Therefore, I analyse the data for possibilities of challenging dominant and pervasive discourses about families, drugs and drug use.

1.4.5 Thesis conclusion

In Chapter Ten, I conclude this thesis by providing a summary of my study, and I outline the key conclusions and the contribution that my study has made to new knowledge. I also highlight the limitations of my research. Next, I suggest directions that future research can take in order to build on and develop my study. I conclude my thesis by providing a personal reflection that includes an element of self-problematisation.

Chapter Two:

Review of Literature

Chapter Two: Review of Literature

2.1 Introduction

The alcohol and other drugs (AOD) research landscape is dominated by applied social research, which is primarily quantitative in nature and underpinned by dominant disciplines such as biomedicine and psychological sciences (Fountain and Griffiths 1999; Neale *et al.* 2005; Neale *et al*. 2013; Rhodes *et al.* 2010). Important sociological contributions have been made through ethnographic research on drug cultures and the meanings and practices of drug use; in addition, ethnography has enabled the person using drugs to become visible as a unique speaking subject (Rhodes and Moore 2001; Keane 2011; Weinberg 2011; Fraser *et al.* 2014). However, where qualitative research is published, most contributions have realist epistemological and ontological underpinnings, with poststructuralist perspectives found on the margins (Martin and Stenner 2004; Rhodes *et al.* 2010).

In a 2004 review of how families are represented in AOD literature, Barker and Hunt found a similar picture. Whilst the body of research on families and substance use is substantial, most research is underpinned by psychological science, focusses on families as a source of risk or protection with respect to young people's initiation of substance use, and it is largely quantitative in nature. Furthermore, studies are underpinned by normative assumptions about families, with few attempting to 'trouble' or problematise the taken-for-granted idea of families. The authors argue that:

> The study of family in the alcohol and drug field has not yet expanded to include contemporary social theory nor has it wrestled itself far from classic structural-functional formulations. This tardiness to shift basic epistemological or theoretical approaches to understanding family has contributed significantly to conceptual stagnation with respect to family in the substance use field (2004, p. 352).

My review of the literature on families and AOD use finds that little has changed since Barker and Hunt's review. While there has been an increased focus on drug-related impacts and harms to family members, the literature remains strongly underpinned by the psychological sciences and it is realist

in its philosophical assumptions. There is a notable dearth of poststructuralist perspectives.

In this chapter, I review a relevant body of Irish and international literature related to the topic of families, drug policy and practices. The review includes academic literature and other relevant sources such as research reports. Relevant policy developments in the Irish context are reviewed in Chapter Five. This chapter is divided into two sections. In the first section, I review how families are represented in the AOD literature. The body of empirical research on families and AOD use is vast; therefore, the scope of the review in this section is limited to the most pertinent themes that emerged as key findings in my analysis of policy documents and interview data. I consider the literature on families in terms of three policy and practice domains: criminal justice, prevention and treatment.

The second section situates my study within the governmentality literature and, more specifically, within the emerging body of international research that understands realities – such as addiction, drugs or people who use drugs - as constituted through policies and practices and considers the effects of how the realities are constructed. I also review previous research that has used the What's the Problem Represented to Be? (WPR) approach to policy analysis and the Poststructuralist Interview Analysis (PIA) approach (Bacchi 2009; Bacchi and Bonham 2016). Throughout the chapter, I highlight gaps and silences in the body of work that I have reviewed. I conclude by showing how my study will add new knowledge and address the gaps that I have identified.

2.2 Section One: Representations of families in the AOD literature

2.2.1 Families, alcohol and other drugs

In the literature on families and AOD use, some studies clearly distinguish between substances, with some research having a focus on alcohol and families, and some on drugs and families. Examples include studies examining the impacts of heroin use on family members (Murphy-Lawless 2003; Butler and Bauld 2005; Duggan 2007), or the more recent focus on

alcohol related harm to others (Room *et al*. 2010; Hope 2014; Laslett *et al.* 2015). Other research does not distinguish between alcohol and drugs in terms of the preventative, pathological and therapeutic potentials of families, or in terms of impacts of AOD use on families. For example, Orford et al. (2010b) have studied the impact on family members of living with a close relative who is using alcohol and/or drugs.

There are several possible reasons for this, such as the regulatory divide that separates legal and illegal substances. It also reflects disciplinary differences and traditions in how alcohol and drug use are problematised. According to Barker and Hunt (2004), psychological and medical sciences dominate the alcohol research field, while criminology has been more influential in the drug research field. Hunt and Barker (2001) also argue that the alcohol/drugs divide mirrors the social and political organisation of the AOD research field. For example, alcohol and drugs research may have different funding streams, and global agencies, such as the United Nations, have separate organisations dedicated to alcohol and drugs.[4] In contrast, except for substance-specific interventions such as opioid substitution treatment, clinical guidelines and psycho-social interventions tend to address both alcohol and drug use. Furthermore, family-based prevention interventions tend not to distinguish between substances. The trend towards merging alcohol and drugs in research, policy and practice fields also reflects contemporary patterns of substance use, where poly-drug use is more the norm than exception (Health Research Board (HRB) 2017).

2.2.2 Criminal Justice

Family members are governable subjects within areas of drug policy and practices that interact with the criminal justice system, for example as perpetrators, witnesses or victims in criminal law, in child welfare and protection, and in probation. According to Barker and Hunt (2004), the criminology and criminal justice literature on family and drugs is underpinned

[4] For example, in the US the federally funded National Institute on Drug Abuse (NIDA) refers to alcohol but has clear focus on drugs while the National Institute on Alcohol Abuse and Alcoholism only focusses on alcohol. The United Nations World Health Organization (WHO) has a focus on alcohol while the United Nations Office on Drugs and Crime (UNODC) addresses drugs.

by the concept of deviance. Families are thought to contribute to the problem indirectly by having certain attributes and engagement in activities that associate first with youth delinquency and, subsequently, with drug use. I return to these ideas later in the review in the section on prevention. Here, I discuss families in the context of drug-related intimidation, a key theme that emerges in my study.

Drug-related Intimidation

A drug debt is acquired and accumulated when drugs are bought on credit, a common practice in Ireland (Connolly and Buckley 2016). Credit keeps the illegal drug trade system going: dealers source drugs on credit and, in turn, supply them on credit, so dealers must pay off their own debts by collecting from smaller sellers and users. The necessity to pay a drug debt is a rule of the drug trade and drug debt intimidation has become normalised in communities where there is local drug market. A drug debt also arises if drugs are seized by the authorities. While the drugs are gone, the debt is still outstanding. If the person caught with transporting or storing drugs is imprisoned it is often families that bear the brunt of drug-debt intimidation. Hence, disruption of the drug market has unintended lived effects such as an increase in violence.

Drug-related intimidation of families, most often due to an unpaid drug debt of a close relative, is an issue that has come to attention in Ireland as a concern for drug policy, empirical research and practice in recent times. Drug-related intimidation can be considered a systematic form of drug-related crime as it is linked to activities related to the illegal drug market, and this form is generally considered responsible for the largest proportion of drug-related violence (Goldstein 1985; Connolly 2006). This form of violence is "…normatively embedded in the social and economic networks of drug users and sellers" (Goldstein 1985, p. 169). It can therefore be considered an unintended consequence of a prohibitionist approach to the regulation of drugs and drug use, in this case because there are no legal means to resolve an alleged debt.

Drug-related intimidation of families, as a specific construct, is an under-researched area. A small number of studies have examined the phenomenon in an Irish context (O'Leary 2009; Jennings 2013; Connolly and Buckley 2016; O'Gorman *et al.* 2016); furthermore, an evidence review of the Irish situation and international responses has been published by the Irish Health Research Board (Murphy *et al.* 2017). Although there is a significant international body of published work on drug-related crime, including violence and witness intimidation, my search of academic literature has not uncovered any scholarly work on this specific topic. In addition, repeated internet searches on the topic throughout the duration of my project have failed to uncover international material such as commissioned reports relating to the issue. It may be contained in the literature but constructed in different terms. My finding regarding the gap in literature has been supported by Murphy *et al.*'s evidence review, which concludes that "a body of literature evaluating interventions targeting drug-debt intimidation or drug-related intimidation specifically did not exist" (2017 p. 25). Instead, the authors of the review theoretically reinterpret the literature available on gang activity, control and desistance.

A comparison of material on the websites of the UK charity for families affected by AOD (Adfam) and the Irish equivalent (National Family Support Network (NFSN)) finds that the only reference to intimidation on the UK website relates to intimidation of family members in the context of domestic violence, while the Irish website specifically refers to drug-related intimidation of family members by those involved in the drug trade (Adfam 2017; NFSN 2017).

The lack of literature specific to the construct of drug-related intimidation of families outside the Irish context highlights that the need, or not as may be the case, for production of scientific knowledge and evidence on 'what works' to inform policy making is locally contingent. In Ireland, there has been a recent need to produce knowledge about drug-related intimidation of families and a need to try to find out 'what works' in responding to this issue. I will return to this point in Chapter Six where I trace how drug-related intimidation of families emerged as a policy priority. With the exception of Ireland, drug-

related intimidation it is not referred to in other national drug policy documents.[5] The 2013 EU Action Plan on Drugs calls for further research on drug-related intimidation, its impacts and consequences, and this recommendation has carried over in the 2017 EU Action Plan (Council of the European Union 2013; European Commission 2017). Notably, the 2013 policy was published when Ireland held the EU presidency.

A study carried out by the NFSN in 2009 surveyed family support services as a secondary source about the extent and nature of intimidation of family members (O'Leary 2009). Building on this research, Connolly and Buckley (2016) carried out an audit of 140 incidents of intimidation reported through drug projects.[6] Both studies found that intimidation of family members can take place in the form of physical damage to property, threats, verbal abuse, physical violence, sexual violence and homicide, and that the experience of intimidation impacts on victims' mental health and wellbeing.

Most commonly, the debt is paid; however, other responses include not paying, avoiding those carrying out the intimidation or relocating. A minority (17 %) reported incidents of intimidation: of those most had reported to a community organisation, with only about one-third reporting incidents to the police (Connolly and Buckley 2016). Fear of reprisal is a key barrier to reporting, but there is also the perception that the police would or could not do anything about the issue. In some cases families did not want to involve the police in what is seen as a private matter.

Drug-related intimidation is mediated by gender, place and class. Those carrying out intimidation are mainly younger males while the intimidation is primarily directed at mothers, who are more likely to pay the debt. Sometimes intimidation takes place within families by the person owing the drug debt. It is also an issue related to place and class. Because drug markets tend to be local and located in socio-economically disadvantaged working-class

[5] I have analysed contemporary European drugs strategies available on the website of the EMCDDA in English, in addition to US and Australian policies. (Accurate in May 2017).
[6] The audit was commissioned by Citywide Drugs Crisis Campaign, a community organisation founded in 1995 as a community based response to drugs. The research was funded through the Department of Health and the Health Research Board, and jointly conducted by Citywide and the Health Research Board.

communities, these communities are more affected than others (Hourigan 2011; Connolly 2016). Families may know, or know of, the person(s) who carry out the intimidation (O'Leary 2009; Connolly 2016). This concurs with Stevens' (2011) argument that drug-related criminal harms are not evenly distributed in society but experienced to a much larger degree by those socially and economically excluded.

Efforts have been made to address this issue. An intervention targeting affected families, the *Drug-Related Intimidation Reporting Programme* has been introduced in Ireland by the police service and the NFSN, and in Chapters Six and Eight I analyse this programme as a technology for governing families.

2.2.3 Prevention

There is a large body of empirical literature on families and youth criminal behaviour associated with AOD use, such as anti-social behaviour. The literature on families and drug prevention draws on this body of work, which is underpinned by psychological sciences. This literature considers attributes and activities of families, such as the quality of parenting, as risk and protective factors (Velleman *et al.* 2005). Therefore, families are considered an important component of preventative interventions. In this body of literature, families are understood to play a central normalising role as an institution for the primary socialisation of children, and underpinning this role are implicit assumptions about what comprises 'good' and 'bad' families. Parental drug use has been problematised in the literature in the previous two decades. First, it is understood as a risk factor for children's future drug use behaviour and, therefore, a concern for drug prevention. Second, the concept of 'hidden harm' emerged in the early 2000s as research on impacts on children of drug use in the family emerged. Parental drug use and the quality of parenting therefore became concerns in child welfare and protection. This section briefly reviews a vast amount of literature on these topics, starting with family risk and protective factors for children's future drug using behaviour and concluding with parental drug use.

Family risk and protective factors

Best practice reviews, such as the one published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) note the following family related risk factors to be significant:

> …drug and alcohol abuse among parents, substance use of older siblings, lack of parental supervision, low quality of family relations, family disruption and problematic economic conditions… conflict, neglect, lack of parental monitoring, lower levels of interaction between young people and their families, and social disadvantage (2017, p.1).

On the other hand, protective factors include "parental discipline and monitoring, and family cohesion" (EMCDDA 2017). In a review of family interventions, Velleman *et al.* (2005) highlight seven areas in the context of family life that are thought to be influential on future AOD use. These factors draw on a number of psychosocial theories, including social control theories such as social attachment, social cognitive learning and family interaction theory (Morgan 2001). First, relational factors (e.g. discipline, communication and cohesion) are thought to be more important than structural ones, such as family size or single-parent households. Second, strong family cohesion is understood as a key protective factor. Third, the quality and level of general family communication and communication about drugs and drug use are thought to be important influences on future drug use. A fourth area includes family management, such as consistent and contingent parenting behaviour, and disapproving parental attitudes towards drugs. Fifth, parental alcohol and drug use behaviour is seen as an environmental risk factor for adolescent initiation of alcohol and cannabis use. Sixth, parental supervision is thought to have a direct effect on keeping adolescents away from drugs and an indirect effect on keeping adolescents from peers who parents suspect may use drugs. Finally, parents are thought to have an influence on both access to and the selection of peers, who in turn are thought to be a significant influence on adolescent drug use.

Because family factors are considered to be central in the prevention of drug use, many drug prevention programmes are now family-based in addition to those based in schools and communities. Most aim to 'strengthen' family processes that are considered to be risk factors and to 'build' protective

factors such as resilience, especially among families experiencing adversity (Velleman *et al.* 2005). One such programme is the *Strengthening Families Programme* (SFP), an increasingly popular intervention in Ireland in the last decade. The SFP is a skills-based programme that adopts a three-prong strategy, targeting the adolescent, the parents and the family unit (Iowa State University 2017). I analyse and discuss this programme as a technology for governing families in Chapter Six.

Family-based drug prevention interventions such as the SFP often target families where parents use substances as they are considered high-risk. I now review the literature specific to this group,

Parental drug use

In the last decade, there has been an increasing focus in drug policy, research and professional practices on the impacts and risks to children living with parents who use substances (Horgan 2011). This is often referred to as 'hidden harm', defined as "an aspect of the harm caused by drug use that until now has remained largely hidden" (Advisory Council on the Misuse of Drugs 2003, p. 7). Concerns have been raised in relation to parenting capacity (e.g. Hogan 1998) and children's developmental outcomes (e.g. Tunnard 2002; Barnard & McKeganey 2004; Barnard 2007; Velleman and Templeton 2007). In the main, research focusses on the negative impacts of parental drug use on children such as withdrawal symptoms in new born infants, low birth weight, developmental delays, child abuse and neglect, and children's future drug use. The literature is vague about different aspects of drug use, such as type of substance used or thresholds of use. There is also a gap in the literature relating to examining the issue from the parents' perspectives (Templeton *et al.* 2006). The literature tends to focus on impact of drug use on parental capacity, while other concurrent social factors likely to impact on parenting and children's outcomes such as poverty, unemployment, homelessness, social networks and mental health issues have received less priority (Woods 2000; Velleman and Templeton 2007).

There is also a general absence of alternative accounts of parents as 'responsible' in the literature. Exceptions include Klee (1998) and Rhodes *et*

al. (2010) whose research highlights the active work that parents do to provide care and protect their children from harms of drug use when they have the resources to do so. A significant proportion of the literature on parental substance use focuses on mothers, as pregnancy and child care are key concerns (Horgan 2011; Martin and Aston 2014). Thus, this serves as a 'dividing practice': in the literature women who use drugs are represented as a group having unique needs, which legitimises special interventions (Foucault 1982; Martin and Aston 2014). Lupton (2012) argues that this focus, underpinned by a neoliberal risk discourse, promotes individualisation and maternal responsibilisation for foetal health and future potentiality of children. Consequently, women are subject to regulation and control, and contributing socioeconomic factors are overlooked.

Parents who use drugs, especially pregnant women, are more likely to experience stigma when they encounter the health and social care system (Radcliffe 2011; Lloyd 2013). The normative assumption that drug users are 'irresponsible' parents can shape parents' perceptions of themselves. It can also impact on professional attitudes towards them, which can create barriers and result in parents being reluctant to access services (Klee 1998; Rhodes *et al.* 2010; Radcliffe 2011; Lloyd 2013). Services working with these parents can only think and talk about, and act on them, as 'risky' (Chandler *et al.* 2013; Chandler and Whittaker 2014: Whittaker *et al.* 2015). Consequently, fear of children being admitted into care can act as a real barrier for parents to accessing services.

In cases of family breakdown, children of parents who use drugs are more likely to be admitted into care, especially around the time of birth, and levels of family reunification are low (McGivern and McDonnell 2015; Zhou 2015). Yet, studies show that parents who do not have custody of their children tend to do less well in terms of drug treatment and life outcomes compared to those that live with their children (National Treatment Agency for Substance Misuse (NTASM) 2012; Comiskey *et al.* 2016). In Chapter Seven, I examine how this body of literature has shaped a new governmental programme, the *National Hidden Harm Project*, which was established in 2013 as an outcome of the 2009 drug strategy. This project aims to inform service planning and

delivery for children living with substance use (Health Service Executive (HSE) 2017).

2.2.4 Treatment

Family involvement in treatment has a long tradition in the AOD literature. This spans from early representations of families as dysfunctional and pathological, to later behavioural-psychological models of families as a resource and recovery capital for the close relative in treatment. A more recent representation of families as needing support in their own right has emerged as a result of research on impacts on adult family members of AOD use by a close relative. These models currently co-exist in practice and have informed a number of family-based interventions. Apart from programmes designed specifically to support families in their own right, intervention models understand families to be contributing to both the causes of and the solution to the drug 'problem'.

Pathological families

Early models of families and AOD use draw on alcohol research and are underpinned by biomedical and psychological scientific knowledge and expertise. These view families as pathological and dysfunctional, and as contributing to both the 'problem' and the solution (Barker and Hunt 2004; Orford *et al.* 2005; Velleman 2010). Perspectives such as family pathology, co-dependency and systems models dominate, and family involvement in treatment in the form of interventions such as family therapy and self-help groups designed to address individual and family 'dysfunction' are used. These have contemporary relevance as many interventions in the AOD field continue to be based on these assumptions.

The family disease model emerged in the 1950s in the US, and can be viewed as an extension of the individual disease model of addiction. The family is often referred to as the chemically dependent or alcoholic family (e.g. Wegscheider-Cruse 1989). All the family members in the unit are seen to have a pathology, which needs to be addressed through intervention. Family disease theories refer to concepts such as co-dependency, "an unhealthy pattern of relating to others that results from being closely involved with an

alcoholic or addict" (Thombs, 2006, p. 207), and enabling behaviour, where the co-dependent "protects the alcoholic or addict from the natural consequences of substance abuse" (Thombs 2006, p. 208). Co-dependency remains a popular concept in the addiction treatment field even though it lacks empirical support (Thombs and Osborn 2013). There are stereotypical descriptions of the dysfunctional individual roles and role behaviours in the chemically dependent family: the chemically dependent person (or alcoholic), the chief enabler, the family hero, the scapegoat, the lost child and the mascot (Thombs and Osborn 2013). This model has not been empirically tested and seems to have crept into the "folk wisdom" in the addiction treatment field (Vernig 2011).

Interventions that are underpinned by the disease model include compulsory family involvement in residential programmes such as those based on the Minnesota Model, which follows the principles of the Alcoholics Anonymous (AA) fellowship (Anderson *et al.* 1999). Others include self-help groups, such as Al-Anon (the independent arm of the AA fellowship serving relatives), which was also founded in the 1950s. The Adult Children of Alcoholics movement emerged later as a 12-step fellowship in the 1970s, promoting the idea that children who grew up in households where alcohol was a 'problem' were uniquely damaged; however, research has not supported this idea (Thombs 2006).

The theoretical perspective of the dysfunctional (diseased, chemically dependent or alcoholic) family, like the individual disease model of addiction, can be seen as one that is negative, labelling and stereotypical. It pathologises or blames the family for another's substance use (Velleman 2010), and similar to the individual disease model, other family members are viewed as helpless or powerless in their situation. Orford *et al.* (2013) maintain that globally, this perspective of the family is still dominant.

Family-based interventions for adolescent substance use often include family therapy and have been extensively researched (for reviews, see Williams *et al.* 2000; Deas and Thomas 2001; Houge and Liddle 2009). Family-systems theories refer to a group of theories that explain substance misuse in terms of

family dynamics and family influences on behaviour. The theories focus on the interrelationships between family members and how a change in behaviour of one family member (e.g. starting or stopping use of substances) impacts on the system of the family and affects all family members. Hence, the starting point of family-systems therapy is the network of relationships of the family. On one hand, substance use is seen as disruptive to the family unit, causing significant chaos and conflict; on the other hand, this model also understands it as having a stabilising effect as it maintains a sense of normality (Thombs and Osborn 2013). Substance use is thought of as

> a manifestation of other concerns, such as relational conflict; and that it helps the individual to minimize, distract from, or cope with interpersonal problems (Thombs and Osborn 2013, p. 222).

Thombs (2006) cautions that despite the popularity of family-systems therapy in substance misuse treatment settings "its empirically established validity is conspicuous" (p. 228). Family therapy is a preferred policy and practice intervention for adolescent drug use, and in Chapter Six I analyse this form of intervention as a technology for governing families and individuals.

A more recent group of intervention models to emerge in the last decade are behavioural. These use similar concepts to the individual behavioural models applied to a family system. In comparison to disease and system models, which regard the family as a closed system, these view the family as a system that is open to external influences such as work, education and neighbourhoods (Thombs and Osborn 2013). Interventions often start with a functional analysis, which aims to evaluate all the systems internal and external to the family that contribute to substance use in order to target potential avenues for interventions.

As the 'recovery' paradigm has gained traction in drug policy and treatment services in the UK, US and Ireland, the concept of recovery capital has recently received attention (Cloud and Granfield 2008). Cloud and Granfield developed this concept to explain how people overcame addiction without professional intervention and define recovery capital as the "key personal and social resources [that] individuals are able to access in their efforts to overcome substance misuse" (2008, p. 1971). In this model, families are

understood as an important source of social capital.[7] This model also recognises that families may benefit from help to provide the required support to their close relative and to reduce levels of conflict (Munton *et al.* 2014).

In practice, family-based approaches to treatment in the field tend to combine two or three of the models discussed. Interventions can include skills development in areas such as coping, communication and parenting, as well as structured family activities. In Ireland, the Community Reinforcement Approach (CRA) and its variations, Community Reinforcement and Family Training (CRAFT) and Adolescent Community Reinforcement Approach (ACRA) have recently gained popularity (Smith and Meyers 2004). These interventions, imported from the USA, target significant others (such as family members or close friends) and other social 'reinforcers'. Based on behavioural psychological principles such as conditioning, the programme teaches the significant other skills and strategies to encourage their close relative to initiate and sustain change. Attention to self-care for the significant other is also a component of the programme. Although no Irish data are available, studies have found positive results of this approach for factors such as family functioning, self-improvement of the significant other, and initiation of treatment (Miller *et al.* 1999; Waldron *et al.* 2007; Roozen *et al.* 2010; Manuel *et al.* 2012).

With an increase in family-based interventions, the role and remit of AOD services are being reconfigured to also include working with families. In the literature, this reconfiguration is generally assumed to be unproblematic. However, a limited number of studies suggest that implementation of family involvement is constrained by factors such as stereotypes, stigma, concerns about the autonomy of the person in treatment, and different professional values and beliefs in relation to if and how families contribute to the 'problem' of drug use (Lee *et al.* 2012; Orr *et al.* 2014; Schanche Selbekk and Sagvaag 2016).

[7] Other parts of the construct include physical, human and cultural capital (Cloud and Granfield 2008).

Families affected by the drug use of a close relative

While 'hidden harm' to children receives significant attention in AOD research, policy and practice fields, the impact on adult family members of drug use has more recently emerged as an area of interest. One example of such knowledge production is the UK Drug Policy Commission, which published seven policy reports and evidence reviews on affected adult family members between 2009 and 2012. This has led to the representation of families as service users in their own right in the literature. In the past two decades, empirical studies have examined the impacts on adult family members of a close relative's alcohol and/or drug use. While some studies do not differentiate between alcohol and drugs-related impacts, others consider them separately.

Reported impacts include stress related conditions, general ill-health, financial difficulties, isolation, interpersonal conflict, family disharmony and domestic violence (Copello and Orford, 2002; Murphy-Lawless 2003; Butler and Bauld 2005; Duggan 2007; Orford *et al.* 2010a; Room *et al.* 2010; Orford *et al.* 2013; Hope 2014; Laslett *et al.* 2015; O'Gorman *et al.* 2016). Impacts on families are mediated by factors such as social class, age, gender, family position, place and culture (Duggan 2007; Orford 2017). For example, Hourigan (2011) argues that those who are socially and economically disadvantaged are at risk for further marginalisation and social exclusion, becoming the 'disadvantaged of the disadvantaged', and being particularity vulnerable when drug use by a family member is linked with criminality and gang feuding. The literature on stigma by association experienced by families is limited; however, Corrigan *et al.* (2006) found that families can be blamed for the onset and enabling of drug use, or be held responsible for relapse. When bereaved by a drug-related death, families can experience stigma when dealing with professionals and others (Walter *et al.* 2015; Templeton *et al.* 2017).

There is a broad absence of positive accounts of drug use in the family. Arguably, this reflects broader research concerns in the field drawn from dominant discourses such as medicine, psychology and public health that

primarily focus on risk and harms associated with drug use, which subjugates research that highlights the association of drug use with caring practices, benefits or pleasure (Duff 2008; 2015; Moore 2008; Race 2008). A recent exception is Fotopoulou and Parkes' (2017) work on Greek families' coping strategies, which highlights caring practices such as active harm reduction work, tolerance and accommodation of a close relative's drug use in the home.

A group of researchers have developed a model of families and AOD use, which is informed by health psychology theory. The stress-strain-coping-support model does not blame or pathologise families; instead, AOD use in the family is understood as a long-term stressor with potential to cause strain that relatives try to cope with (Orford *et al.* 2010b). Social support is considered key for effective coping. Quantitative instruments are used to measure impacts, social support and coping (Orford *et al.* 2010c; Toner and Velleman 2014), and an intervention has been developed for use in family support and AOD services (Copello *et al.* 2010). The 5-Step Method is designed for affected family members in their own right. Although it does not aim to help close relatives to change, Copello et al. (2010) note that this can be a possible outcome of the intervention. This model is currently being disseminated as a preferred way of supporting families in Ireland, and in Chapter Six I analyse this intervention as a technology for governing professionals and families.

2.2.5 Families and drug policy research

The body of scholarly work on families in the context of drug policy is limited. Velleman (2010) reviewed UK policy documents for the visibility of families, noting an absence of families in policy despite an increasing focus on families in research and practice fields during the 2000s. Although towards the end of the 2000s, families had become more visible, the focus was primarily on parental substance use and its effects on children. While acknowledging the importance of this focus, the author calls for the inclusion of all family members as service users in their own right and as important components of the treatment of the close relative. The work of Velleman is important because it examines the presence of families in AOD policy, but it

does not problematise how families are represented in policy or the resulting effects. My literature search has uncovered a very limited number of studies that have taken this trajectory.

One exception is a paper that examines families and the notion of parental responsibility in the context of Swedish drug prevention policy. In this article, Roumeliotis (2014) highlights the changing relationships between the family and the state in drug policy between 1981 and 2011 as Sweden moved from a welfare state to a neoliberal mode of governing. The author argues that early policy saw the family

> tied to the welfare state in a relationship in which an obligation for responsibility was placed on the family in exchange for the basic security provided by the welfare state (ibid, p. 339).

With a neoliberal shift came an increased "responsibilisation of the family" (ibid, p. 342), replacing structural and collective solutions. The contribution of this study in understanding shifting conceptualisations of families in drug policy is important. However, the focus of the paper is drug prevention and the central question is how 'the drugs issue' is problematised, not families *per-se*. My study builds on this work by studying the problematisation of families across all areas of drug policy.

2.3 Section Two: Governmentality studies and the AOD literature

2.3.1 Foucauldian-influenced literature

The latter half of the 1990s and the early 2000s saw the emergence of AOD research informed by Foucauldian concepts. Earlier studies comprise critiques of new public health, health promotion and harm reduction, highlighting these as regulatory regimes for the exercise of disciplinary power (Bourgois 2000; Miller 2001; Keane 2003). This body of literature also brings attention to neoliberal forms of governance and how these work to construct a new drug using subject. This subject is an active and responsible citizen and consumer, capable of self-regulation and rational decision making regarding their own risk and harm reduction practices (Fischer *et al.* 2004; Moore 2004; Zibell 2004).

At the same time, this critical literature calls attention to how harm reduction and harm minimisation policy works to increase surveillance as a way of disciplining and controlling people who use drugs. Examples include an analysis of the methadone clinic as a site for disciplining "the unruly misuses of pleasure and in controlling economically unproductive bodies" (Bourgois 2000, p. 165); a critical examination of heroin overdose prevention strategies (Moore 2004); and an interrogation into how supervised injection sites act as physical 'dividing practices' and sites for surveillance and discipline (Fischer *et al.* 2004).

These studies emphasise the political consequences of a drug policy approach that is thought to be progressive and generally beneficial for individuals and society. These authors insist that they are not arguing against harm reduction policy *per se*. While recognising that there are associated benefits, their critiques expose how harm reduction strategies work to maintain the status quo in society in terms of power relations. Harm reduction strategies do so as they extend mechanisms of social control and medical dominance into new sites for governing deviant subjects. Keane highlights a paradox in which the focus of harm reduction

> avoids confronting the very things that produce the most harm for drug users: drug laws, dominant discourses of drug use and the stigmatisation of users (2003, p. 231).

Governmentality studies demonstrate how harm reduction strategies shift the policy and practice focus away from material and structural factors that impact on the life experiences of people who use drugs to a focus on personal responsibility and risk (Moore 2004; Moore and Fraser 2006).

Families as a focal point of analysis has not featured in this body of literature, with one exception, which is Brook (2002) who examines how families are enlisted into governmental efforts to address illicit drug use in Australia. While briefly touching on representations of families in drugs discourse as either "dysfunctional social units" or "as a locus of support, prevention, education and rehabilitation" (ibid, p. 176), Brook is more interested in the governing of human failure. Drawing on comparisons between the governing of heroin use and family breakdown (divorce) as examples, she argues that

public debates on divorce in the 1950s and 1960s and the debates on illicit drugs in the early 2000s are broadly similar. She argues that an understanding of how shifts in the governing of divorce from a preventative approach to one of management of consequences could potentially inform drug policy.

While these earlier papers are underpinned by Foucauldian theory and governmentality studies literature, the analytic approach is usually not described in detail. However, this has changed in a body of more recently published research, which applies a specific Foucauldian-influenced method to the analysis of policy. The 'What's the Problem Represented to Be' (WPR) approach (Bacchi 2009) is applied in my research, and I now turn to review this literature.

2.3.2 The construction of realities and AOD literature

My study is situated within an emerging body of international poststructuralist drugs research that understands realities – e.g. addiction, drugs or people who use drugs - as constituted through policies and practices (Bacchi 2009; Fraser and Moore 2011; Keane *et al.* 2011; Moore and Fraser 2013; Fraser *et al.* 2014; Lancaster and Ritter 2014; Seear and Fraser 2014; Lancaster *et al.* 2015; Pienaar and Savic 2016). The purpose of such research is to make visible the normative assumptions and conceptual logics that operate behind taken-for-granted and self-evident ideas, and to open up a space for thinking differently about how governing of subjects could take place (Bacchi 2009).

Several of these studies have applied the WPR approach to policy analysis. This method was first applied in the context of gender inequality in 1999; however, it has since been applied to many different areas of social policy, including AOD policy (Bacchi 2009). Much of this work to date focuses on how policies and legal texts produce drugs, alcohol or drug use as particular types of 'problems'. Other studies examine how policy constitutes 'objects' – meaning an 'object' for thought such as addiction (Bacchi and Goodwin 2016, p. 83). I now review select papers that examine how 'drugs' are represented as a 'problem' in policy in order to illustrate the type of analyses that have been conducted.

Lancaster and Ritter (2014) trace shifts in the social construction of the drug 'problem' in Australian drug policy to certain forms of knowledge. They note an increased policy discourse on data and research evidence concurring with the emergence of the evidence-based paradigm in the late 1990s. Furthermore, the representation of drug policy 'problems' shifted from one of drug-related harms to one of drug use. The authors argue that the problem representation has individualising effects as the causes of drug use are understood to be located with the behaviour of the individual.

Pienaar and Savic (2016) analyse how drug policy in South Africa produces the 'problem' of alcohol and other drugs. They conclude that despite the rhetoric of harm reduction in contemporary policy, the representation of the 'problem' works to justify and continue a tradition of criminal justice approaches as solutions that, in turn, reproduces the marginalisation and stigmatisation of people who use drugs.

I have already referred to Roumeliotis (2014), who examines shifts in how the 'drug issue' was constructed as a political 'problem' in Swedish drug prevention policy during the years 1981 - 2011, and explores the role of knowledge in this process. His analysis points to a marked shift in the 1990s when discourses relating to social exclusion were displaced in favour of a neo-liberal discourse emphasising behaviour and personal and family responsibility. There was also an increased call for expert knowledge and evidence to inform prevention policy. He concludes that this new problem representation of drugs has made the issue "a matter for experts, rather than politicians" (ibid, p. 345), precluding the construction of 'drugs' as a political 'problem' requiring political responses at a structural level.

Fraser and Moore (2011) analyse how the 'problem' of amphetamine-type stimulants (ATS) is constructed in Australian drug policy and the forms of knowledge that shape the formulation of the 'problem'. A key finding in their study relates to the

> tension between the need to acknowledge the limits of what is known about ATS and the need or desire to nevertheless problematise these drugs" (ibid, p. 503).

The authors conclude that the evidence base around the consequences of using ATS is limited. While the drugs are poorly understood, their effects are portrayed as dangerous and a number of policy responses were proposed on this basis.

The WPR approach lends itself to cross-cultural comparisons. Lancaster *et al.* (2015) analysed how the 'problem' of drugs is represented in 'recovery' discourse using UK and Australian reports as examples for comparison. The authors identify how problem representations are contingent on institutional and cultural contexts, showing how 'recovery' is problematised differently in the two jurisdictions. Consequently, subjects are constituted in different ways: defined by a neoliberal discourse as 'responsible agents' in the UK and constituted by a medical discourse as 'patients' in Australia. The stigmatising effects and silencing of alternative accounts are also highlighted in the study. The effects of the construction of the recovering neoliberal subject emphasises responsibility and ownership of the recovery process, and carries normative assumptions about citizenship and future contributions to society thorough productive work. Lancaster *et al.* (2015) argue that the neoliberal discourse dominating the UK document is rational and ignores factors that may make it difficult for people to take up this role, for example, stigma and the reluctance of employers to employ people who have been using drugs. The medical discourse that dominates the Australian document carries ideas about the subject as one that is passive and in need of intervention. This, in turn, privileges expertise. Finally, the authors argue that both problem representations silence alternative ways of thinking about drugs, for example as a socioeconomic rather than an individual issue.

The WPR approach is also used to critically analyse how objects of thought, such as 'addiction' are produced and the consequences of these problematisations. Using data from interviews with senior drug policy makers and practitioners in Australia, Moore and Fraser (2013) critically examine how drug policy functions to "define and produce the problem of addiction itself" (p. 918), The study demonstrates how current policy in relation to a certain funding and a reporting process, known as the episode-of-care system, works to produce a particular version of the 'problem' of 'addiction'. The

authors also highlight several unintended consequences of this particular problematisation, such as encouraging a fragmented provision of services, undermining long-term support for those using the service, ignoring non-drug issues, and marginalising service users with multiple needs.

The WPR approach is also applied to legal texts in the context of drug use. Seear and Fraser (2014) conducted an analysis of criminal court cases in Australia where 'addicts' are the victims of crime, not the offenders. The authors critically examine how the cases produce particular versions of 'addicts' and 'addiction' as 'problems' linked to previous trauma, and how these are relevant to compensation outcomes. They found that these problematisations render the subject positions of 'addict' and victim incompatible and produce contradictory rationales about the 'addict's' responsibility for the 'problem' of addiction. The authors argue that "by producing and reproducing disordered, marginalised and devalued versions of subject hood" legal practices produce potentially harmful effects (ibid, p. 833). Furthermore, alternative ways of thinking about drug use, for example, in terms of pleasure are foreclosed.

In another study of legal texts, Lancaster *et al.* (2015) consider the effects and political implications of Australian laws that prohibit the distribution of needles and syringes by peers. The authors argue that the law produces a stereotypical construction of people who inject drugs as 'drug addicts', which works to constrain how provision of needles and syringes is thought about and practiced. Most importantly, the law produces unintended consequences such as the potential transmission of blood-borne viruses. However, the study also highlights how practices of counter-conduct, such as peer distribution of syringes, can potentially challenge and disrupt the current problematisation.

Taking gender as a focus of analysis, Martin and Aston (2014) analyse high-impact AOD journals for how the 'problem' of women's drug use is represented as a 'problem'. The authors conclude that women have become an important object of knowledge in drugs research and are problematised as a "uniquely vulnerable population" (ibid, p. 344) with "unique treatment needs" (ibid, p. 349). Central to their analysis is how the 'othering' of women

in the literature produces potentially harmful effects and precludes alternative accounts of women's drug use. For example, the dominant discourse in the literature on women's drug use as a means of coping with victimisation and trauma is increasingly informing treatment services for women. This can preclude other responses to women's drug use, which may be more beneficial for some groups of women. Furthermore, Martin and Aston (2014) suggest that the dominant discourse on trauma works to silence alternative understandings of women's drug use, such as one that is associated with pleasure.

Apart from an article based on findings from the current study, which examines the representation of the affected family member as a 'problem' in the treatment and rehabilitation domain of Irish drug policy (Devaney 2017), a search of the literature has failed to uncover any further studies that take families as the focus using a WPR approach to analysing drug policy.

Poststructuralist Interview Analysis (PIA) is offered as a novel approach to analyse interview data from a poststructuralist perspective and is the approach I have adopted to analyse the interview data in this study (Bacchi and Bonham 2016). Apart from one published study that uses this approach (Bonham *et al.* 2015), I have not located other published studies that adopt this approach.

2.4 Conclusions

In this chapter I have reviewed empirical literature on families in the context of AOD use and a body of critical AOD literature, which is influenced by Foucauldian concepts. The empirical literature is underpinned by normative assumptions about families and takes the idea of families as self-evident.

Drug-related intimidation of families is an issue that has been problematised in the last decade in Irish research (and policy), where families are represented as victims. I draw attention to how such knowledge production is historically and culturally contingent. The extent and nature of intimidation is mediated by factors such as gender, place and class. To date, research has not included affected family members or the offenders as participants, instead services and professionals have acted as secondary sources of families' experiences.

Where families are understood to play an important role in drug prevention and treatment of the person using drugs, the family is represented as a universal institution performing necessary social functions. It is expected that within this institution individuals are encouraged to resist 'problematic' behaviours or to return to 'normal' behaviours so that they re-socialise into becoming active and contributing citizens. There is a general absence in the literature of accounts of families that resist such normative expectations. There is also a silence in the literature about interactions and relationships between the person who uses drugs, families and professionals. Instead, these relationships are understood to be unproblematic.

Parental drug use and its impacts on children has been an area of interest in the literature for over two decades. The key focus in this body of work is a concern with parental capacity, child protection and children's future potentiality. There are lacunae in the literature regarding parents' experiences, positive accounts of parents, and the relative contributions of socioeconomic factors on parental capacity and impacts on children.

In the past two decades, empirical studies have examined the health, social and financial impacts on adult family members of a close relative's alcohol and/or drug use. This has led to the representation of families in the literature as service users in their own right. The literature draws attention to how impacts on families are mediated by factors such as social class, age, gender, family position, place and culture.

There is a lacuna in the body of empirical AOD literature that uses critical social theory, with limited studies theorising families in the context of drugs and drug use. There is also a dearth of research that examines families in the context of drug policy, in particular studies that highlight the effects and unintended consequences of contemporary drug policy.

I also identify a gap in the body of work that understands 'problems' related to drugs and drug use as realities that are constituted through policies and practices: the understanding of how families as 'problems' are constituted through drug policy and practices. My study, therefore, makes a contribution to new knowledge in terms of critically theorising families in the context of

drug policy and practices. Furthermore, my study contributes methodologically by adding to a growing body of literature employing a WPR approach to the analysis of drug policy and to a limited number of studies using a PIA strategy to the analysis of interview data. Hence, my study is addressing these gaps by expanding the epistemological, theoretical and methodological approaches to the study of families in the context of drug policy and professional practices.

Chapter Three:
Theoretical Framework

Chapter Three: Theoretical Framework

3.1 Introduction

This chapter introduces the theoretical framework that informs my research as I examine how governing of families takes place through drug policy and professional practices. Primarily influenced by the work of Foucault and governmentality studies scholars such as Miller, Rose and Dean, I draw on concepts such as discourse, power/knowledge, resistance, subjectivity, technologies of self, governmentality, and problematisation. These provide the foundation for how I approach my research in terms of aims, rationale, methodology and analysis.

My research aims are to examine how families are problematised in drug policy; to theorise the forms of governing practices that are enabled as a result; to examine the practices used by professionals to govern families, and to highlight the political implications of how families are problematised. Within this context I draw on governmentality studies in order to examine how power is exercised, rationalised and normalised through practices that govern the conduct of individuals and social groups. This allows for an analysis of how such practices are regulated by the state, its actors and by the 'self'. Such analysis also sheds light on the role of the network of sites and agents across the health, welfare, education and criminal justice institutions through which governing takes place. Governmentality studies also examine the imagined role of the responsible active citizen through engagement in self-regulating practices. Governmentality is a useful framework for examining and explaining social transformations, in particular those associated with changes in modes of government, such as the transition from welfarism to neo-liberalism (Miller and Rose 2008). These modes are associated with particular rationalities and technologies for governing. This is relevant to my thesis, which examines how families are represented as 'problems' in Irish drug policy from 1971 to 2016.

3.2 Discourse

Discourse is a term that has different meanings in different theoretical traditions, so it is essential to explain the Foucauldian meaning of discourse

as used in this study. Foucault is not interested in the formal structures of language or who the author of the text (or spoken word) is. Foucault explains his uses of the term:

> Sometimes…[as]…the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a number of statements (1972, p.8)

Bacchi refers to the Foucauldian meaning of discourses as "socially produced forms of knowledge" (2009, p.35). In following Foucault's (1991a) archaeological approach, what is of interest are the conditions of discourse (how they came about), the constraints on discourse (what can be said) and the effects of discourses (what discourses can make happen). The methodological implication is that in analysis of discourses, such as those in policy or in interview transcripts, the focus is not on language *per se*, but on how discourses came to be and what they can do.

Discourses are contingent on time and place, which means that they carry constraints as only certain things can be said at a particular point in time in the field of all things that could potentially be said (Foucault 1991a). Certain discourses carry more weight than others because of their associations with strong institutions and expertise, such as the discourses of medicine or psychiatry. For example, the dominant discourses of criminal justice and medicine/psychiatry in drug policy limit the way we think about drugs, people who use drugs, their families, the issues that policy highlights and how these should best be responded to. As a consequence, the effects of policy discourses can constrain alternative ways of responding.

Discourses are productive as they both produce meanings and have real world effects (Foucault 1991b; Carabine 2001; Bacchi 2009). They make things happen. Discourses are also productive in their interaction with other dominant discourses through which they can produce different and new ways of conceptualising issues. Carabine (2001, p. 269) notes that discourses can produce

> …shortcut paths into ideas which convey messages about, for example, 'good' and 'bad', morality and immorality…and acceptable and inappropriate behaviours…

Foucault refers to discourse as a practice, and elaborates, "…discourse is a complex and differentiated practice subject to analysable rules and transformation…" (1991a, p. 71). Discursive practices "describe those practices of knowledge formation by focusing on how specific knowledges ("discourses") operate and the work they do" (Bacchi and Bonham 2014, p. 174). These refer to the rules, or the mechanisms and processes that shape 'what is actually said' (Foucault 1991a). Bacchi and Bonham argue that discursive practice is an important analytical focus (rather than discourse itself) as it "bridges a symbolic-material division and highlights the politics, the complex strategic situations, involved in the production of "the real" (2014, p. 174). An analytic focus on discursive practices – what discourses do and their lived effects – serves to address a common critique that poststructuralist discourse analyses fail to examine how discourses impact on people's daily lives (Bacchi and Bonham 2014). In my study, I emphasise how a particular version of a 'dominant truth' about families can exclude others; hence, certain discourses produce certain effects for people who use drugs and their families.

Foucault also refers to 'non-discursive practices' and he describes these as "institutions, political events, economic practices and processes" (1972, p. 162). Bacchi and Bonham (2014) interpret this to mean a domain that is not related explicitly to knowledge, but also not separate to the domain of discursive practices. The link between the two is important because it is here that "the relationships *between* those sites *and* specific knowledges" can be explored (Bacchi and Bonham 2014, p. 188, italics in original). This leads to possible questions for analysis: What are the "*practices through which knowledge is produced*" and how do the practices operate "*within each and across the two "domains"* or sites" (Bacchi and Bonham 2014, p. 189, italics in original).

Inherent in this theory of discourse is the idea that dominant 'truths' can be challenged through counter-discourses:

> …we should not think of discourses as 'all powerful' and individuals as submissive recipients of discourse. Instead, we should think of discourses as

> constantly being contested and challenged and therefore not necessarily always omnipotent (Carabine 2001, p. 273).

It follows that analysis of discourse should always include an analysis of counter-discourses.

Discourses do not remain stable throughout history, nor do they change in a consistent or continuous manner (Foucault 1991a). Foucault's genealogical method, which I discuss later in this chapter, allows for the tracing of the history of a particular phenomenon (such as families and drug use) through analysis of discourse.

3.3 Knowledge, power and resistance

3.3.1 Knowledge/power

A fundamental assumption in this project is the intrinsic relationship between discourse, knowledge and power. Foucault describes the relationship between knowledge and power:

> There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (1977, p. 27).

McDonnell *et al.* (2009, p. 92) discuss how power and knowledge work together:

> Power circulates through the discourses (specialist languages and their specific systems of meaning), techniques (strategies for targeting those who are the objects of knowledge) and practices (routine ways in which knowledge is put into effect) generated by knowledge.

As certain discourses dominate during particular moments in history (such as moral, criminal justice or medical/psychiatric discourses in the drug field), they carry more authority. They furnish normalised, accepted and 'taken-for-granted' truths and are active in shaping the behaviour of human beings. Accordingly, the power of experts that have specific knowledges in these fields is reinforced (Foucault 1979). In this way, power and knowledge are used to regulate individual subjects and populations.

I use a Foucauldian genealogical approach to analyse the developments in the knowledge/power relationship in relation to families in Irish drug policy as part of a broader problem representation approach to policy analysis (Bacchi

2009). Foucault defines his genealogical approach as a "history of the present", where history is used to critique the present (1979, p. 31). He understands history as discontinuous and non-linear, with contests of power and battles over knowledge, through which discourses and practices emerge (Foucault 1979). Carabine explains how the philosophical ideas underlying genealogy are operationalised as a method of critique:

> Genealogy is about tracing the history of the development of knowledges and their power effects so as to reveal something about the nature of power/knowledge in modern society. It does this through the examination of discourses and by mapping the strategies, relations and practices of power in which knowledges were embedded and connected (2001, p. 277).

An important premise underpinning genealogy is the contingent nature of knowledge production. Struggles between different forms of knowledge produce the result that some forms of knowledge become more dominant and others are silenced. Genealogy can highlight the less dominant or silenced knowledges and, therefore, show that things could have been different and can again be different in the future (Bacchi 2009).

Foucault talks about these subjugated knowledges in two ways, first as

> …historical blocks of knowledges that were present in functional and systematic ensembles, but which were masked, and the critique was able to reveal their existence… (2003, p. 7).

These are erudite, scholarly knowledges, such as lesser known theories or opinions that have been closed off (Bacchi 2009). The second understanding comprises

> …a whole series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naive knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity…(2003b, p.7)

These are marginalised and different forms of knowledge that "challenge the scientific consensus" (Bacchi and Goodwin 2016, p. 22). They could be local beliefs, "unqualified or even disqualified knowledges", or "noncommonsensical knowledges", for example, the "knowledge of the psychiatrized, the patient…[…]…the delinquent" (Foucault 2003b, p.7-8). The implication for my research is that highlighting the subjugated

knowledges in policy and professional discourses can open up opportunities for challenge of pervasive discourses (Bacchi and Goodwin 2016).

Foucault does not view power as simply a repressive force; instead, he understands the effects of power relations as productive. In particular, the effects enable the production of particular kinds of subjects. The study of power relations is inherent in the study of how governing takes place. Foucault's theorises power not as a possession, but as an action: "power exists only as exercised by some on others" (2000, p. 340). Foucault links power relations with the notions of conduct and government, defining the exercise of power as a "conduct of conducts" and a "mode of action upon the action of others…the government of men by other men" (2000, p. 341-2). A key point here is that power is exercised over people's possible actions rather than over people.

Another component of Foucault's theorisation of power relations is the idea that power is "rooted in the whole network of the social" (2000, p. 345). Consequently, an analysis of power relations needs to extend beyond the state and its traditional institutions to a range of actors invoked to govern. In my research, a number of actors comprise the network that governs drugs, drug use, people who use drugs and their families: criminal justice professionals, social workers, youth workers, teachers, doctors, psychiatrists, pharmacists and counsellors among others.

3.3.2 Power/resistance

Foucault was interested in the effects of power relations, asking, "What happens when individuals exert (as we say) power over others?" (2000, p. 337). Assuming some degree of freedom, in each power relation there is always a potential for resistance and challenge. Foucault notes that "Where there is power, there is resistance" (1978, p. 125). Foucault's freedom is a freedom of conduct, in other words, where "several kinds of conduct, several ways of reacting and modes of behaviour are available" (2000, p. 342). This is linked to the concept of counter-conduct, which I elaborate on later in this chapter.

Foucault suggests that an analysis of power relations could start by examining points of resistance:

> Using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used (2000, p. 329).

Foucault understands forms of resistance as "struggles against the 'government of individualization'" and challenges to "the way in which knowledge circulates and functions, its relations to power" (2000, p. 330-331). In other words, it is a struggle against subjection. Hacking makes a similar point, noting that resistance is part of the process in which people are made into subjects, here referring to subject categories as 'kinds of people':

> Kinds of people who are medicalised, normalised, administered, increasingly try to take back control from the experts and institutions, sometimes by creating new experts, new institutions… (2007, p. 311).

I use Foucault's understanding of resistance in my analysis, as I understand points of resistance as opportunities for challenging dominant forms of governing that may have less beneficial effects for some groups of people. Points of resistance can highlight alternative power relations with different political implications. I now elaborate further on Foucault's theory of power by discussing different forms of power.

3.4 Forms of power

In tracing modern forms of rule, Foucault speaks about a triangle as "…sovereignty-discipline-government…" (1991, p. 102); in other words, these forms of power co-exist in modern societies, and one has not replaced another. For example, in my research, the exercise of sovereign power is relevant as drugs and people who use drugs are regulated through the law. Families with close relatives who use drugs are also governed through areas of law, for example through criminal law as victims or witnesses, or through child protection practices.

Foucault discussed the emergence of the disciplinary form of rule in the 17th and 18th centuries in *Discipline and Punish* (1977). Disciplinary power encompasses techniques used to regulate the behaviour of individuals such as surveillance, training and the use of the norm. The aim is to improve the

individual body so that it contributes positively to society in terms of health, efficiency, productivity and social order. Institutions at a distance from the state and disciplines associated with privileged expert knowledge such as medicine, psychiatry, pedagogy and social science play an important role in the normalisation process. Institutions and disciplines produce knowledge about individuals, and, through this knowledge, produce the norms by which individuals may be judged and come to regulate their own conduct. Normalisation thus becomes an individualising instrument of power as it works to produce subjects who, through discipline but also self-regulation, strive to adhere to what is 'normal' and belong to a "…homogenous social body…", yet are subject to normalising judgement by institutions and disciplines (Foucault 1977, p. 184).

In *The Subject and Power* (2000) and in *Security, Territory, Population* (2007), Foucault traces how an old individualising power technique concerned with human conduct with origins in Christianity, pastoral power, has taken on a new shape in modern states. Drawing on the metaphor of the shepherd who looked after the flock, but also each individual sheep, to ensure their health and survival, Foucault refers to a "new form of pastoral power" (2000, p. 334). Here, the old Christian pastoral goals of wellbeing, happiness and salvation have been re-articulated by the modern state into new secular aims of ensuring health, wellbeing and security for each individual and the population as a whole.

In this new form of power, the net of agents engaged in exerting power is cast wider than the state and public sector to include community, voluntary and private sectors and institutions like the family. As the aims and agents of pastoral power are transformed, governing involves both securing knowledge about the population as a whole and knowledge about the individual. Knowledge is concerned with surveillance and population statistics, for example, drug use incidence and prevalence, morbidity related to HIV/AIDS and Hepatitis C, and various forms of treatment data. Previous Christian pastoral guidance techniques such as confession, supervision and reflection are now used as techniques for gathering knowledge about the individual. Foucault outlined a number of agents with potential for exerting

individualising powers, including "those of the family, medicine, psychiatry, education, and employers" (2000, p. 335).

Foucault (1978) refers to this form of power, concerned with regulation of both individuals and the population as a whole, as biopower (power over life), and he considers it a main concern of modern government (Foucault 1978). While disciplinary power regulates individual lives, and new pastoral power is associated with the governing of individuals and populations, the concept of biopolitics is concerned with governing populations (Foucault 1978). Biopolitics includes "policies and technologies aiming to optimize the biological life of a population" (Larsen 2011, p. 202). It is characterised by administrative interventions such as surveillance aimed at optimising health, life and productivity of a population. In order to administrate more effectively, the population is often divided into sub groups, for example 'target groups' for policy and service provision. These 'dividing practices' serve to differentiate the population according to who is deemed normal and abnormal, and the degree to which they are deemed to contribute towards or constrain prosperity (Foucault 2000).

Taylor (2012) suggests that Foucault offers a fragmented genealogy of familial power, most prominently in *Discipline and Punish*, *The History of Sexuality*, *Abnormal*, *Psychiatric Power* and *Le Désordre des familles: Lettres de cachet des Archives de la Bastiole au XVIIIe siècle* (Foucault 1979; 1978; 1982 in Duschinsky and Rocha 2012; 2003; 2006). For the most part, the family is depicted as an institution whose sovereign power has been diluted over time by discipline and biopower. However, the family is not seen as a disciplinary institution in line with the others; instead it is conceptualised as a key collaborator with, and ally to, the institutions as it uses its sovereign power to bring family members into them. In this way, it functions as a hinge in the network of disciplinary institutions that transfers the responsibility for the 'deviant' or 'abnormal' family member to the state and its institutions (Foucault 2006).

Foucault notes that in the context of bourgeois families in the 18th century families are called on to exercise its sovereign power to hand 'abnormal'

family members over to the authorities to be 'normalised', a key function of the family in a disciplinary society:

> …the family's role at this point is to reject him in turn as incapable of being fixed to any disciplinary system, and to get rid of him either by consigning him to pathology, or by abandoning him to delinquency (Foucault 2006, p. 82).

Foucault sees the family as "the agency of the abnormalization of individuals" (2006, p. 114), and, at the same time, "as a source of normalization" (2003a, p. 254). There are mutual benefits of this exchange. The state gains a healthy and active future adult with potential to contribute to the economy, while a 'normal' individual returns to the family:

> …the family is supposed to find again, at the end of the process, an individual who has been disciplined in such a way that he can be effectively subjected to the family's specific schema of sovereignty. Being a good son, a good husband, and so on, is really the outcome offered by all these disciplinary establishments…(2006, p. 116).

The family also functions as a disciplinary institution. Foucault notes how this function of the family emerges in the middle of the 19th century:

> Disciplinary techniques are transplanted into the family. And at that point the family, while retaining the specific heterogeneity of sovereign power begins to function like a little school: the strange category of student parents appears, home duties begin to appear, the control of school discipline by the family; the family becomes a micro-clinic which controls the normality or abnormality of the body, of the soul…(2006, p. 115).

Although the family is given authority to control aspects of children's lives, the decisions that the family makes are shaped by processes of normalisation:

> All immediate power over the child's body…is given to this medicalized family that is, however, controlled externally by medical knowledge and techniques (Foucault 2003a, p. 254)

The family is also co-opted into the exercise of biopower. In *The History of Sexuality* Foucault (1978) notes how in the 19th century the family is at the centre of formation of knowledge and power with respect to sexuality. He describes four strategies for the deployment of sexuality:

> the sexualisation of children, the hystericization of women, the specification of the perverted, and the regulation of the population – all strategies that went by the family…(Foucault 1978, p. 114).

As a consequence, the knowledge and expertise of pedagogy, medicine and demography are invoked to target three units in the family- the child, women and the couple - in the exercise of biopower (Foucault 1978). Similarly, the transfer of some disciplinary functions to the family occurs in the context of the emergence of biopolitics and its objectives. As a result, the family has become a primary site for the regulation of populations (Rose 1999; Duschinsky and Rocha 2012; Taylor 2012). In my research, I draw on these Foucauldian ideas on familial power as sometimes sovereign, sometimes disciplining, and sometimes as an instrument of biopower.

3.5 Technologies of self

In contrast to technologies of power such as discipline, which seeks to regulate and control individuals in order to meet specific governmental objectives, technologies of self relate to individuals regulating their own behaviour in order to improve aspects of the self (Foucault 1978). These comprise an attitude towards self, attention turned towards self, and practices of the self as an ethical form of conduct (Foucault 2005). Individuals may turn to experts for guidance. Foucault outlines how the old Christian practice of the confession is used as a technique of new pastoral power to ensure the health and well-being of both individuals and populations (Foucault 2000; 2007). The technique of confession is pervasive in modern societies, used in disciplines such as medicine and the psychological sciences. The confession is a practice where the subject is both the speaker and the subject spoken about, and implies a particular power relation:

> …one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile…The agency of domination does not reside in the one who speaks…but in the one who listens and says nothing, but in the one who questions and is not supposed to know (Foucault 1978, p. 62).

Through disclosure and production of truth, the confession produces a subject that is self-regulating, responsible and encouraged to work on self (Foucault 2007). Technologies of self are central to the government of conduct in advanced liberal states, which I discuss later in this chapter.

3.6 Governmentality

3.6.1 Government as the conduct of conduct

Foucault introduced the concept of governmentality in *Security, Territory, Population* (2007), which has since inspired scholarly work in critically analysing contemporary social processes in a number of disciplines. The analytic focus is on the process of subjectification, rationalities and technologies of government, and the relationship between techniques of power and forms of knowledge.

Governmentality as a concept consolidates and links Foucault's different areas of work, most importantly the ethical dimension of self-government with the socio-political dimension of government (Lemke 2002; Dean 2010). Lemke (2002, p. 50) explains how it does so:

> It is a link because Foucault uses it exactly to analyse the connections between what he called technologies of the self and technologies of domination, the constitution of the subject and the formation of the state.

Foucault used the term 'governmentality' in two ways. Its first use was in relation to different types of thought or rationalities associated with different approaches to government (govern-mentalities). Second, the term was used to refer to a form of power that operates at the level of population and aims to achieve governmental objectives related to health, security and order. Foucault applied the concept of governmentality to analyse the formation of the modern state, and empirically, the concept has been applied in analyses and critiques of liberal and neo-liberal forms of government. Importantly, this critique does not assume a normative idea such as neoliberalism as a 'wrong' knowledge that needs to be replaced by a 'right' one (Lemke 2002). Instead, it examines how neoliberal rationality

> functions as a "politics of truth", producing new forms of knowledge, inventing different notions and concepts that contribute to the "government" of new domains of regulations and intervention (Lemke 2002, p. 55).

Of interest in the study of governmentality are the techniques and procedures for directing and shaping human behaviour, and in particular, how individuals are made into responsible, self-regulating subjects.

Foucault used the word 'government' in its broader and 'older' sense:

> "Government" did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or of groups might be directed: the government of children, of souls, of communities, of families, of the sick. It did not only cover the legitimately constituted forms of political or economic subjection but also modes of action, more or less considered or calculated, which were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others (1982, p. 790).

Government is here understood in a broad sense as the "the conduct of conduct" of a population, groups within a population and individuals (Gordon 1991, p. 2). Foucault's idea of conduct has two angles: "at the same time to "lead" others…[…]…and a way of behaving within a more or less open field of possibilities" (2000, p. 341). In addition to understanding 'conduct' as the practice of conducting, it should also be understood as

> …the way in which one conducts oneself…, lets oneself be conducted…, is conducted…, and finally, in which one behaves…as an effect of a form of conduct… (Foucault 2007, p. 193).

In liberal and neoliberal forms of government, this understanding is closely linked with the presupposition of freedom for the majority of those who are governed, those who govern and those who self-govern (Rose 1999; Dean 2010). The presupposed freedom comes with rights and responsibilities for those governed. Of course, forms of dominance still co-exist. For example, illicit drugs are primarily regulated through the criminal justice system, and those who traffic in drugs, or use drugs, are subject to negative forms of control and the state's tactics of sovereign power, such as policing and imprisonment.

Key to the study of governmentality is the idea that the state is not seen as a centralised structure, rather, as a "tricky combination in the same political structures of individualization techniques and of totalization procedures" and its power is "both an individualizing and a totalizing form of power" (Foucault 2000, p. 332). The population and each individual are being governed at the same time. Foucault understood this to be the result of the historical interaction and linkage of political and pastoral power. Foucault was particularly critical of the individualising forms of power, encouraging us to seek alternatives:

> The conclusion would be that the political, ethical, social, philosophical problem of our days is not to try to liberate the individual from the state, and from the state's institutions, but to liberate us both from the state and from the type of individualization linked to the state. We have to promote new forms of subjectivity through the refusal of this kind of individuality that has been imposed on us for several centuries (2000, p. 336).

It follows that the dual ideas of resistance to the exercise of power and to forms of conduct (counter-conduct) are central to Foucault's vision. Notably, Foucault's ideas of power/resistance and conduct/counter-conduct both contradict a deterministic view of individuals' agency. I now discuss the concept of counter-conduct in further detail.

3.6.2 Counter-conduct

Foucault (2007, p. 201) refers to the term "counter-conduct" when talking about resistance to the power of conducting, as "in the sense of struggle against the processes implemented for conducting others". These forms of resistance have two dimensions, how and why one is conducted by others and how one conducts oneself. Foucault explains,

> They are movements whose objective is a different form of conduct, that is to say: wanting to be conducted differently, by other leaders…and other shepherds, towards other objectives…and through other procedures and methods. They are movements that also seek, possibly at any rate, to escape direction by others and to define the way for each to conduct himself (2007 p. 194 – 195).

Davidson (2011) maintains that the idea of counter-conduct is a key "conceptual hinge" (p. 25) in Foucault's work as it combines the political and the ethical dimensions of resistance:

> On the one hand, the notion of counter-conduct adds an explicitly ethical component to the notion of resistance; on the other hand this notion allows one to move easily between the ethical and the political, letting us see their many points of contact and intersection (ibid, p. 28).

In essence, counter-conduct can be viewed as an exercise of freedom, and as a productive practice as it

> …*transforms* one's relation to oneself and to others; it is the active intervention of individuals and constellations of individuals in the domain of the ethical and political practices and forces that shape us (Davidson 2011, p. 32, italics in original).

In my research, I use the ideas of resistance and counter-conduct in my analysis to highlight alternatives to contemporary forms of governing.

3.6.3 Rationalities and technologies of government

Two key concepts underpin the governmentality analytical framework, namely rationalities and technologies of government (Miller and Rose 2008). Governmental rationalities, the political reason or mentalities of government, refers to thought:

> Any way of reasoning, or way of thinking about, calculating and responding to a problem, which is more or less systematic, and which might draw upon formal bodies of knowledge or expertise (Dean 2010, p. 24).

In other words, I ask how a 'problem' is rendered thinkable, conceivable and manageable. Multiple rationalities can underpin the proposed government of a social issue or group of people. For example, policy discourses about drugs and drug use are multiple and competing. On the one hand, drugs and drug use can be understood as a law and order 'problems' that require regulation through the law. On the other hand, they can be seen as health 'problems' to be governed through medical/psychiatric professional practices. These rationalities justify different technologies for governing people who use drugs. In this study, when applying the concept of rationalities of government I ask: What are the rationalities for governing families? How did certain ways of thinking about families come about and take hold? Which bodies of knowledge and expertise have shaped certain ways of thinking about families?

Technologies refer to different forms of interventions, or the means by which policies are implemented. Miller and Rose (2008 p. 55) refer to governmental technologies as

> …the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions.

Here, I ask, what enables authorities to shape and act upon the conduct of individuals, groups and individuals? Who are the agents and what are the materials, tools and techniques? What enables "government at a distance" (Miller and Rose 2008, p. 34)? I return to the concept of governing at a distance in further detail later in this chapter.

The analytics of government focuses on the links between different technologies of government and rationalities that justify, legitimise and make the exercise of power seem rational, and in particular the role that knowledge and expertise play in these relationships (Miller and Rose 2008; Dean 2010). Through understanding these links,

> We can begin to understand the multiple and delicate networks that connect the lives of individuals, groups and organizations to the aspirations of authorities in the advanced liberal democracies of the present (Miller and Rose 2008, p. 55).

Central to my research is an examination of the effects of the way that families are problematised in drug policy. Governmentality studies allow for analysis of the political effects of contemporary rationalities and technologies of government, which relate to families and drug use, when they are interpreted and put into practice by professionals and family members themselves.

Miller and Rose argue that "the solutions for one programme tends to be the problem for another" (2008, p. 35). This simply means that technologies of government also have unintended consequences; there are those who benefit and those who lose out. Hence, an analysis of the unintended consequences, for different groups of people, needs to form part of analytics of government and is a key purpose of my research. An underpinning assumption of the analytic framework is that failure is always a feature of political programmes (Foucault 1991b; Miller and Rose 2008). Identification and analysis of where programmes fail in their intentions are useful as it is at these points where resistance and counter-conduct can be revealed.

3.6.4 Subjectification

Much of Foucault's work addresses how "human beings are made subjects" (2000, p. 326). While Foucault is commonly associated with a 'theory of power', he states that "it is not power but the subject which is the general theme of my research" (2000, p. 327). Foucault refers to two meanings of the word subject:

> Subject to someone else by control and dependence; and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to (2000, p. 331).

Foucault (2000) suggests three modes of objectification of the subject, or, in other words, how a subject is made into an object of knowledge: 'scientific classification', 'dividing practices' and subjectification':

> … the modes of inquiry which try to give themselves the status of sciences…the objectivizing of the subject in what I shall call "dividing practices"…[and] the way a human being turns himself into a subject (Foucault 2000, p. 326-7).

Scientific classification refers to how dominant discourses and disciplines, such as medicine and psychiatry, with their associated knowledge and power have formed a particular human subject. For example, different discourses and different disciplines construct people who use drugs and their families differently as they are seen from moral, genetic, biological, medical or behavioural knowledge perspectives.

'Dividing practices' is referred to by Foucault as a process whereby "the subject is either divided inside himself or divided from others" (2000, p. 326). This process focuses on how knowledge and practices, both within and outside of the 'state', shape social classifications around normalcy and deviance. As a result, there is a physical and/or social exclusion of those deemed not normal, and the formation of a dominant group deemed normal. In the sphere where drugs and families meet, idealised images are created of how families should behave, think and feel. Those who fail to conduct themselves according to normalised ideals are encouraged to undergo normalising interventions - in the case of families, these can include parenting programmes, family therapy, counselling or coping skills training. The ultimate aim of the interventions is to shape and reorient families towards these idealised images or desired conducts.

Contemporary to Foucault, the social construction of target populations is also theorised by Schneider and Ingram (1993) referring to the two aspects of this phenomenon as "the recognition of shared characteristics that distinguish a target population as socially meaningful" and "the attribution of specific, valence-oriented values, symbols, and images to the characteristics" (p. 335). They suggest that this is a dynamic process as old groups are reconfigured and new groups created. As groups are reconstructed they can move from

being viewed in a more negative light to a more positive one, and vice versa. These are useful insights; however, other aspects of this theory are not compatible with my research. For example, there is a traditional understanding of power, where groups are seen to be either powerful or powerless, and where power is understood as held by elected officials, traditional government and the state.

Hacking also theorises how subjects are constructed, what he refers to as "making up people" (2007, p. 6). He focuses on the role of institutions, knowledge, scientific practices, surveillance and statistics, and how these influenced the formation of new classifications of people. In particular, he emphasises the efforts made to medicalise, biologise and geneticise certain kinds of people. Current dominant explanations of drug use include behavioural, medical, biological and genetic theories. These in turn make up different kinds of subjects who use drugs and different kinds of families who are seen to need different types of interventions.

Hacking (2007, p. 10) describes the process of normalisation as the "engine of practice" as interventions attempt to transform people to as close to the 'normal ideal' as possible. Of particular interest to Hacking are the dynamics around how classifications change, how they impact on 'the classified' and how, in turn, 'the classified' impact on classifications. These insights into the social construction of target populations are closely linked to the concepts underpinning my research and are useful in analysing how new categories of families may come to take hold in contemporary Irish drug policy, and in analysing the consequences of the new classifications for 'the classified'.

When new 'problems' are constructed in policy they are often associated with the construction of new subject categories. For example, it is argued that problematising drug use in the language of harm reduction in neoliberal societies produces a new drug using subject who is an active, responsible and health conscious citizen capable of making rational decisions in relation to risks (Miller 2001; Fischer *et al.* 2004; Moore 2004; Zibell 2004). The new subject categories are made visible through different sites where drug use and drug using subjects can be governed, for example the prison, the clinic or the

street. Furthermore, subject categories are made problematic by different agents, for example those who possess expert knowledge, lobby groups, politicians and the media (Miller and Rose 2008). It is important to note, however, that the creation of certain subject categories can potentially ignore important social factors. Consequently, in my study I examine if and how drug policy discourses construct new subject categories of families. I also examine the effects of such categories, for example, if they appear to ignore other potentially important aspects such as gender, age, education, income, geographical location and other factors related to social position.

The third mode of objectification of the subject – subjectification – concerns the way "a human being turns him- or herself into a subject" (Foucault 2000, p. 327). The new self-governing subject is a central figure in modern governmentality. In contrast to the other two modes, where the individual can be seen as more passive and constrained, in this mode the individual is a more active agent (Rabinow 1984). Miller and Rose observe that this form of citizenship is "active and individualistic rather than passive and dependent" (2008, p. 48).

3.6.4.1 The self-governing subject

Miller and Rose (2008) note the changes in the relationship between the individual and society that took place in the mid-80s in Western societies. This relationship moved from being anchored in the language of social responsibilities and collective solidarities to the "language of freedom, autonomy and choice [which] increasingly came to regulate programmes of government" (ibid, p. 48). The authors argue that this neoliberal discourse emphasised individual enterprise, choice and freedom, and these ideas extended into all areas of social life, such as welfare, health and education. Consequently, these ideas enabled the introduction of new types of programmes and interventions, and these became

> translated into a range of technologies to administer individuals, groups and sectors in a way that was consistent with prevailing ethical systems and political mentalities (Miller and Rose 2008, p. 48-49).

Hence, the processes of self-governing and self-regulation are key resources for modern forms of government. Political power is now less about dominance and more about producing and maintaining self-governing subjects (Miller and Rose 2008). In my research, I examine if and how families are enlisted to work towards broader political goals, such as health and productivity of the workforce, through self-regulation.

Two factors facilitate the making of people into self-governing subjects, the process of normalisation and the power of expertise. Norms are shaped by professionals through expert knowledge. People conform to norms for desirable behaviour through self-regulation, and they do this in the name of freedom and choice. Governments put in place strategies to enhance people's self-governing capacities, with experts and professionals playing an important role in guiding and prompting certain behaviours. Miller and Rose refer to a "complex net of technologies" that aim to educate citizens in how to self-govern (2008, p. 52).

Thus, governmentality helps us understand how people engage in self-constituting and self-regulating practices and how they are made into active, responsible and health conscious citizens. This conceptual tool can help us understand and explain how technologies such as health promotion work:

> …not by making social and structural changes which impeded on the health and wellbeing of the population, but rather, by inciting the desire within autonomous individuals to choose to follow the imperatives set out by health promoting agencies, and thus, take on the responsibility of changing their behaviours accordingly (Ayo 2012, p. 100).

In this view, self-regulation is a method of social control, however, it is not one that necessarily is coercive or forceful; rather, it works as individuals freely regulate their conduct in the best interest of the state and society. Self-governing thus forms part of the idea of 'governing at a distance' where "the arm of the government can rest lightly" (Bacchi 2009, p. 29). In modern societies, technologies of self are now more important than technologies of power in the governing of conduct. The idea of 'governing at a distance' is now examined further.

3.6.5 Governing at a distance

In contemporary post-welfarist neoliberal societies governments claim to intervene less directly into people's lives. However, governing of conduct still takes place. While governments aim to interfere less in people's lives, Foucault observes that the "government of individualization" has constantly been developing since the sixteenth century (2000, p. 330). Hence, there is a need to look beyond the state for attempts to govern people's conduct. The idea of 'governing at a distance' is important in understanding modern governmentality and relates to Foucault's theory of power. Power is not understood as something that is held by a central authority, such as the 'state'. Instead, authority to govern is given to agents outside the state, often on the basis that they hold expert knowledge. Miller and Rose (2008, p. 43) write on the role of experts:

> they have acted as powerful translation devices between 'authorities' and individuals, shaping conduct not through compulsion but through the power of truth, the potency of rationality and the alluring promises of effectivity.

In addition to expertise associated with the rational professional, Miller and Rose also observe the "plethora of minor and petty expertises that emerged in the interstices of life" and the importance of including these in analysis of government (2008, p. 12). It follows that analysis of government needs to see the state as only one of several actors that also include professional groups, social science researchers and peripheral groups who have an influence on the knowledge for governing. Analysis should focus on the role these experts play in influencing knowledge, rather than any direct participatory roles they may have in political processes (Bacchi 2009). It should also study shifts in different forms of knowledge; for example, how does one form of knowledge ascend while another descends? As noted in previous sections of this chapter, attention should also be paid to the role of agents and experts in subjectification processes - the way that knowledge shapes governing of self.

The community can be understood as an actor in the web of governmentality, where individuals and families are 'governed at a distance' through the community. According to Rose (2000), the space of community can be understood as a buffer zone:

> …a territory between the authority of the state, the free and amoral exchange of the market, and the liberty of the autonomous, rights-bearing individual (p. 1400).

Individuals and families self-regulate and act in certain expected and socially desirable ways, for the good of their community, and they do this because it is morally and ethically right (Rose 2000). He refers to this as ethopolitics of the community, arguing that the conduct of individuals is governed through ethics:

> …ethopower works through the values, beliefs, and sentiments thought to underpin the techniques of responsible self-government and the management of one's obligations to others (Rose 2000, p. 1399).

Ethopower works to produce individuals that self-manage and self-regulate behaviour, but they do so according to the moral norms of their community and the perceived obligations to their fellow citizens of that community. This makes individuals and families as members of communities responsible to address social issues, such as wellbeing or security, through technologies of governing such as community policing.

In the context of my research, this means that the governing of families involves a network of agents starting with the state, but also including actors placed within the public sector, with many positioned in the voluntary, community and private sectors. Places where individuals conduct their everyday lives become sites where governmental rationalities are acted out. These are targeted as legitimate sites of intervention to reach individuals in social settings such as schools, clinics, prisons, communities, streets and workplaces.

3.7 Problematisation

Miller and Rose (2008) note that the Foucauldian focus on conduct brings attention to why a certain behaviour such as drug use, or the way families deal with drug use, needs conducting. This suggests that a certain conduct appears problematic to someone. The process of problematisation, or questioning how something becomes a particular type of a 'problem', is central to the notion of governmentality. It is also important that a certain conduct becomes amenable to governmental intervention. Miller and Rose state that "to become governmental, thought had to become technical" (2008, p. 15). Hence, the

process of problematising is closely linked to the process of devising solutions or responses to remedy the 'problem'. The idea of problematisation is central to my research, as I am examining how families are problematised in drug policy and professional discourses.

Bacchi (2012) highlights two Foucauldian meanings of the term problematisation. The first points to a method of critical analysis where the purpose is to examine how a response to an issue is "questioned, analysed, classified and regulated at specific times and under specific circumstances" (Deacon 2000 cited in Bacchi 2012, p. 1). The second meaning refers to a process where two questions are asked. The first question asks "how and why certain things (behaviour, phenomena, processes) become a problem" (Foucault 1985 cited in Bacchi 2012, p. 1). The second question asks "how they are shaped as particular objects for thought" (Deacon 2000, 2006, cited in Bacchi 2012, p. 1). In following Foucault, Bacchi notes that the key purpose of the study of problematisations "is to "dismantle" objects…[…]…as taken-for-granted fixed essences…[…]…and to show how they have come to be" (2012, p. 2).

Knowledge, in the form of scientific evidence and expertise, is intrinsically linked to the construction and representation of 'problems'. As previously discussed in this chapter, knowledge is also intrinsically linked with the production and reproduction of power relations. Consequently, an examination of how knowledge enables the constructions and representations of 'problems' forms part of the analytics of power.

This perspective assumes a particular epistemological and ontological position. To highlight this, Bacchi directly quotes Foucault who states:

> Problematization doesn't mean the representation of a pre-existing object, nor the creation through discourse of an object that doesn't exist. It is the set of discursive and non-discursive practices that makes something enter into the play of the true and the false and constitutes it an object for thought (whether under the form of moral reflection, scientific knowledge, political analysis etc.) (Foucault 1988 cited in Bacchi 2012, p. 4).

The way that issues, conducts or groups of people are problematised have political implications for how issues, conduct and people are governed, and,

in turn, for how subjects are invoked to think about themselves (Bacchi 2009). It is precisely these implications that I analyse in this research.

3.8 Conclusions

The theoretical framework that underpins my research is informed by the work of Foucault (1972; 1978; 1979; 1991a; 1991b; 2000; 2003a; 2003b; 2005; 2006; 2007) and scholars such as Miller and Rose (2008), Dean (2010) and Bacchi (2000; 2009; 2012) who have developed Foucault's ideas on governmentality. In applying the concepts discussed in this chapter to my research, I aim to make "politics visible" (Bacchi 2012, p.1) by demonstrating how policy and professional discourses are productive in the governing of families and to highlight any unintended consequences of such forms of governing.

I am using theories of governmentality to examine how the families have been problematised in Irish drug policy, and consequently, how families are targeted in policy responses and professional practices. The analytical approach I adopt enables this through interrogation of power relations, including forms of resistance and counter-conduct. The approach sheds light on how subject categories have been constructed and problematised and the role played by expertise and knowledge in this process. This framework allows for analysis of how individuals are 'governed at a distance' through their interactions with institutions and non-state actors. Furthermore, the governmentality studies framework is helpful in examining how families engage in self-constituting and self-regulating practices, and in highlighting the rationalities and technologies that regulate these practices.

This framework enables me to shed light on the effects of contemporary rationalities and technologies of government relating to families and drug use as they are interpreted and put into practice, in particular, the unintended consequences for different groups of people. Perhaps the most powerful use of this theoretical perspective is in challenging self-evident or taken-for-granted positions relating to families in drug policy and professional practices. In doing so I can open up the space for alternative discourses that

could result in alternative governing practices, which may produce different effects.

As I have demonstrated in Chapter Two, a critical examination into how families are problematised in drug policy and practice and the theorisation of the political implications arising from such problematisations has been scarcely addressed in the literature, and here my research will make an important contribution.

Chapter Four:
Methodology

Chapter Four: Methodology

4.1 Introduction

I situate my research within a poststructuralist tradition, guided by a Foucauldian influenced theoretical framework as outlined in Chapter Two. It follows that certain presuppositions underpin the methodological approach that I have chosen to address my research question. These presuppositions relate to the social construction of knowledge, the social construction of the meaning of realities, and the decentralisation of the subject.

My overarching research question asks how families have been problematised in Irish drug policy from 1971-2016. The objectives of the study include exploring the operation of policy discourses relating to families as they are interpreted and negotiated by professionals in the drug field, understanding how governing takes place, and examining the political implications. To help answer my research question and achieve my objectives I have been guided by five specific questions:

1) How are families represented as 'problems' in Irish drug policy 1971-2016?
2) How have professional and expert forms of knowledge contributed to policy discourses about families?
3) What knowledge about families has been produced through expert/professional discourses?
4) How do professionals interpret and negotiate policy discourses about families?
5) What are the practices used to govern families?

I adopted an iterative approach to my research, where different phases of research were re-visited throughout the life of this project. However, operationally my research included two major phases of data collection and analysis: analysis of policy documents and field work.

The first phase consisted of an analysis of eight official drug policy documents published between 1971 and 2009. I applied a tool especially developed for analysis of public policy, the 'What's the Problem Represented

to Be?' (WPR) poststructuralist approach (Bacchi 2009). It is influenced by the theories of Foucault (2007) and other governmentality scholars such as Miller and Rose (2008) and Dean (2010). Consequently, the WPR approach operationalised my theoretical framework.

In the second phase of my study I undertook qualitative semi-structured interviews with a sample of professionals that hold drug policy making, policy coordination, research, advocacy and service provision roles. The purpose of conducting qualitative interviews was to gather perspectives from professionals with different areas of expertise and knowledge on how families are problematised in how the 'problem' of drug use is understood and addressed. I also aimed to explore how policy discourses relating to families are operationalised and, consequently, how families are governed in relation to drugs and drug use. I adopted the Poststructuralist Interview Analysis (PIA) approach, an innovative and original method underpinned by Foucauldian theory, to analyse the interview data (Bacchi and Bonham 2016; Bonham and Bacchi 2017). The PIA draws on the same theoretical framework that informs the WPR, which provided consistency in my approach to analysis across the two sets of data (Bacchi and Bonham 2016).

I used the two sets of data in dialogue as they worked to address different research objectives and questions. Analysis of policy enabled me to theorise the political implications of the problem representations I identified in terms of the limits on what can be thought and said, and in terms of the kind of subject that is produced. These are the 'discursive effects' and the 'subjectification effects' (Bacchi 2009). The analysis of the interview data complemented this by providing insights into how policy is operationalised. It also illuminated the extent to which policy works as an instrument of government (Fraser and Moore 2011).

I begin this chapter by setting out the epistemological and ontological assumptions underpinning the research. Following this, I describe the methods I used to collect and analyse data. I conclude with a discussion about the ethical issues associated with my project.

4.2 Epistemological and ontological assumptions

The poststructuralist approach I adopt makes certain epistemological and ontological claims about knowledge, truth and reality. The concept of knowledge is central to my research, and a fundamental assumption is the intrinsic relationship between discourse, knowledge and power. I have discussed the Foucauldian meaning of these concepts in Chapter Two. Hence, in my approach, knowledge about the social world, about objects of knowledge (for example, 'addiction' or 'drug-related intimidation'), and about subjects as targets of knowledge (such as 'families with close relatives who use drugs') is understood as constructed and produced through discourse and through the effects of power (Foucault 1979; Hall 2001). The knowledge constructed about a topic, object or subject is culturally and historically specific (Foucault 1991a; Hall 2001; Taylor 2001). This places a constraint on the choices available to subjects in terms of language and actions (Taylor 2001). Accordingly, the knowledge produced through this type of research is always assumed to be situated, contingent and partial (Wetherell *et al.* 2001). It follows that this form of research should be "continually aware that it constructs the very world it documents" (Hammersley 2004, p. 23) and, as such, reflexivity is an important part of the research process.[8]

My research assumes an ontological position where the meaning of reality is understood to be socially constructed through discourse and discursive practices. Foucault states that "…nothing has any meaning outside of discourse" (1972, p. 32). Hall (2001, p. 73) clarifies this position, stating that "…physical things and actions exist, but they only take on meaning and become objects of knowledge within discourse". This means that a singular reality does not exist 'out there' as an entity waiting to be discovered by the researcher. This ontological perspective also accepts that multiple truths exist. The knowledge produced is only one of many possible realities constituted through discourse (Taylor 2001; Martin and Stenner 2004). Consequently, the analytic focus of the research is on the specific ways that realities are represented.

[8] I refer to self-problematisation rather than reflexivity in this study (see 4.3).

Knowledge and reality are not separate categories; rather, they constitute each other. Fraser and Moore express this relationship:

> Knowledge, that is, acts to shape the reality it seeks to understand as much as reality shapes the knowledge we produce about it (2011, p. 501).

Thus, I am concerned not with reality, but the production of reality as it is represented as a 'problem' in policy documents and interview transcripts. Below I will draw on one example from my research to illustrate this relationship.

My analysis of the treatment pillar of drug policy found that families living with a close relative using drugs are constructed as service users in their own right, and that the 'problem' to be addressed is represented as a coping 'problem'. Particular forms of knowledge, primarily drawing on psychological discourses and positivist research evidence, have shaped this particular version of reality (that the 'problem' is represented as coping and not another type of 'problem' in the policy). In turn, the production of knowledge and research evidence has been shaped by certain assumptions about the character of the reality of being an affected family member. In this case, the assumptions about the reality of the psychosocial nature of (negative) impacts on family members have favoured how research evidence and knowledge about affected families were produced.

Thus, the poststructuralist stance adopted in my research assumes knowledge and realities as being socially constructed. Furthermore, this stance assumes that my research involved several layers of construction. When analysing policy, the version of reality that I produced was contingent on the choices I made when selecting documents and my interpretations of how a certain 'problem' was represented. In relation to my field work, several factors contribute to the production of a certain version of reality. Martin and Stenner note that

> Our interviews and observations, as ways of knowing, cease to be mere conduits to reality; they become, as techniques, one of the means by which that reality is actively constructed (2004, p. 398).

Even before the interview interaction, the design of the interview topic guide and the sampling of interviewees shaped how this version of reality was

constructed. During the interview interaction, a version of reality was jointly constructed by me and the interviewee. Following the interview, I constructed a version of reality by converting interview talk into a transcript. My version of reality was also contingent on my approaches to analyses and the way I represented the findings.

The theory underpinning my study challenges traditional, humanist views of the human being as a foundational subject - a pre-existing fixed essence that possesses knowledge, which a researcher can access (Foucault 1972). Instead, the Foucauldian position views the subject as produced and shaped through the effects of knowledge, power and discourse. The subject itself is not seen as producing knowledge. The implication for treatment of empirical data is that the focus of analysis is not on the subject and its intentions; instead, the it is on how subjects are positioned within available discourses (Martin and Stenner 2004). Bacchi and Bonham refer to this process as "a form of "de-*person*-alization"" (2016, p. 115 emphasis in italics in original).

This raises the question of individual agency. Wetherell posits that "…there is little scope for individual control over 'big' discourse" (2001, p 13). At first glance, it would appear that this perspective supports a deterministic view of subjects lacking agency, simply being trapped by dominant discourses. However, the potential for resistance and challenge to subjectification exists in every relation of power, and there is always the possibility of subjects acting differently (Foucault 2000). Furthermore, the notion of power as positive and productive in terms of its effects means that:

> The individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in doing so subdues or crushes individuals. In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals (Foucault 1980 p. 98).

Therefore, because governing processes produce rather than determine subjects, there is always a scope for "political agency" (Bacchi 2009, p. 42). However, this agency exists "within the parameters of a finite number of discourses" (Martin and Stenner 2004, p. 398). The implication of this for my research is to recognise that the data produced are contingent on the local

context of the interaction while, at the same time, being understood as immersed in broader contemporary discourses (Rapley 2004). The interviewees are immersed in dominant discourses and governing practices relating to concepts that feature in my study such as 'drug use', 'addiction' or 'families'. These assumed ways of thinking, being and doing put limits on what it is possible to say and do. However, they can also create opportunities for reflection on transformative potential - how it could be possible to think differently, become a different type of subject, and act differently (Bacchi and Bonham 2016).

4.3 Reflexivity/self-problematisation

The idea of reflexivity assumes that the researcher cannot separate the 'self' from the research. Denzin and Lincoln state that the researcher:

> …speaks from a particular class, gender, racial, cultural and ethnic community perspective…[this]…situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that he or she then examines in specific ways (methodology, analysis)… (2005, p. 21).

However, the traditional view of reflexivity assumes a humanist founding subject, which does not fit easily with the poststructuralist perspective (Mazzei 2013; Bacchi and Goodwin 2016). Instead, I, the researcher, am a particular kind of subject who is in process, and who is "immersed in the conceptual logics of our era" (Bacchi 2009, p. 19). These conceptual logics include prevailing and dominant neoliberal rationalities of rule, which shape the way I think about the world, including ideas about 'problems' and what needs to change. These conceptual logics may have shaped the way I interpreted and analysed data, for example, by purporting that a 'problem' is represented in a particular way in drug policy. The way I read and interpreted a policy recommendation as a problem representation, assigned underpinning assumptions, traced expertise and knowledges, and theorised effects was merely one way of reading the recommendation. Therefore, my analysis was always contingent and partial.

In Foucauldian-influenced research reflexivity has a specific meaning as it is closely linked with the concept of self-problematisation, with Foucault suggesting to problematise "even what we are ourselves" (2001, in Bacchi

and Goodwin 2016, p. 24). The approaches to analyses of policy and interview data that I have used contain a self-problematising 'step' where the WPR approach is applied to the one's own recommendations (Bacchi 2009; Bacchi and Bonham 2016). However, the extent that this step has been applied in studies that have used the WPR approach is unclear as it is usually not explicitly referred to in the literature I reviewed in Chapter Two.

I have applied self-problematisation in my study in three ways. First, I adopted a sceptical stance towards how 'problems' were represented in policy and in professional discourses. I did not assume that one form of representing the 'problem' was 'better' than another; rather, I viewed them as different forms of representations with different political implications. For example, drug use can be represented as a law and order 'problem' or as a health 'problem' (or both) in policy. I understand the constitution of drug use as a law and order 'problem' as producing important and potentially negative effects for people using drugs and their families. However, I also recognise that drug use represented as a health 'problem' involves forms of governing people who use drugs and their families that are equally problematic, albeit in different ways, and that result in other effects. My task, therefore, was to reveal the assumptions and theorise the effects of the problem representations.

Second, as such I did not prescribe a political position nor did I prescribe desirable futures. In other words, I did not make specific recommendations for how things should best change. Instead, I highlighted areas in policy that could be re-thought and, consequently, could result in different effects for groups of people. While not being specific recommendations, these could be thought of as proposals for change,

Third, in Chapter Nine I subjected these proposals for change to a process of self-problematisation - an examination of the presuppositions, assumptions and possible effects of my own proposals.

4.4 Phase One: Policy Analysis

4.4.1 Selection of texts

My analysis began with the selection of texts. The documents that I selected for this study included official policies relating to illicit drugs published between 1971, when the drugs issue was first problematised as a policy issue, to 2009. The sample comprised eight documents:

- *Report of the Working Party on Drug Abuse* (Working Party on Drug Abuse 1971)
- *Government Strategy to Prevent Drug Misuse* (DOH 1991)
- *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (Ministerial Task Force 1996)
- *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (Ministerial Task Force 1997)
- *Building on Experience: National Drugs Strategy 2001-2008* (DOTSR 2001)
- *Mid-Term Review of the National Drugs Strategy 2001-2008* (DOCRGA 2005)
- *Report of the Working Group on Rehabilitation* (DOCRGA 2007)
- *National Drugs Strategy (interim) 2009 – 2016* (DOCRGA 2009)

The historical, political and cultural contexts of the selected policies are important considerations in this form of analysis. Therefore, a number of other texts were read as part of my research, such as social policies in other domains, research reports, reports published by agencies across different sectors, parliamentary (Dáil) debates and media material

4.4.2 The key premises of the WPR approach

Discourse analysis is an umbrella term that encompasses at least five broad traditions: Conversation analysis, sociolinguistics, discursive psychology, critical discourse analysis and Foucauldian analysis (Wetherell *et al.* 2001). The WPR is a form of Foucauldian analysis of discourse. In contrast to some other forms of discourse analysis, such as conversation analysis, the WPR approach does not analyse the textual features of language or the content of a text. Instead, the focus of analysis is discourse as knowledge, including the

background knowledges and more specific knowledges associated with the disciplines (Bacchi and Goodwin 2016).

The conventional approach to analysis of policy assumes that it represents governments' best efforts at solving ready-made 'problems' that exist 'out there'. In contrast, the WPR approach understands 'problems' to be produced, or constituted, within policy (Bacchi 2009). The WPR approach challenges the prevailing evidence-based paradigm of 'what works' to solve the 'problem' as an approach to knowledge, practice and policy. Instead, it promotes a 'problem-questioning' paradigm (Bacchi 2009). The word 'problem' in the approach is understood to mean something that needs to change – a recommendation or proposal - explicit or implicit in a policy. One of the goals of the approach is to make the assumptions underpinning the way that the 'problems' are represented within polices visible. 'Problems' can be constructed and represented in different ways in policy, depending on particular understandings of an issue, which enables different ways of governing individuals and groups. In fact, Bacchi asserts that "…we are governed through problematisations rather than through policies" (Bacchi 2009, p. xi).

The WPR approach is interested in understanding the effects of policy discourses; however, it does not seek to measure outcomes. The way that governing takes place has real, lived effects, or political implications, for individuals and groups in terms of how people are evoked to think about themselves and how they are treated (Bacchi and Goodwin 2016). The approach is particularly interested in highlighting potentially harmful effects of problem representations. The emphasis is on uncovering unintended consequences, a task that is often ignored in conventional policy analysis.

The WPR approach is not concerned with deliberate and intentional shaping, misrepresentation or manipulation of 'problems' on behalf of governments. It follows that the focus of analysis is not on the actors that shape policy, nor their intentions, motivations or vested interests. Instead, the main concerns are the "assumptions and presuppositions that *made it possible* to make those 'promises' and to develop those policies" (2009, p. xix, italics in original).

4.4.3 The six questions in the WPR approach

The first step in my analysis included an initial detailed reading of all the policies. Following this I read the policies with the specific purpose of identifying sections within the policies that referred to 'family', 'families' or 'parents' and these were extracted and organised according to year and policy domain, for example prevention, using the QSR NVivo 10 software.

The WPR approach suggests a systematic method of posing six questions to a policy text, outlined in Box 1. Bacchi (2009) adds another step to the analysis, self-problematisation, or the application of the six questions to one's own recommendations and proposals for change. Bacchi (2009) is not prescriptive in how to apply the WPR approach, noting that the questions overlap, and that often an integrated rather than a step-by-step form of analysis is done. In addition, all questions are not always used, depending on the aims and research questions of a particular study. In my analysis, all six questions were considered, with least emphasis on Question Six.

1. What is the 'problem' represented to be in a specific policy?

2. What presuppositions or assumptions underlie this representation of the 'problem'?

3. How has this representation of the 'problem' come about?

4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?

5. What effects are produced by this representation of the 'problem'?

6. How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Box 1: The six questions of the WPR approach (Bacchi 2009, p. 48).

1. What are the 'problem' of families represented to be in Irish drug policy?

The first step identifies the 'problem' and its representation. The starting point is an explicit or implicit policy solution, action, recommendation or proposal in the policy document. From there, the analyst works backwards to uncover what the 'problem' is represented to be. The representation of the 'problem' reflects how the issue is thought about and defined, which may imply different policy solutions. As policy is complex, Bacchi (2009) reminds us that it can contain multiple and different kinds of representations of 'problems', sometimes conflicting and contradictory.

One example from my research is the issue of drug-related intimidation of families, which in the 2009 strategy is represented as two 'problems' of communication. First, it is represented as a 'problem' of low reporting by families to the authorities. Second, it is perceived as a barrier to communication between communities and the police that, in turn, hinders effective law and order efforts. The policy solution in this example is an intervention that aims to improve communication between the police and families.

2. What presuppositions or assumptions underlie the representation of the 'problems'?

This question is underpinned by Foucauldian archaeology, and refers to the taken-for-granted knowledge – the epistemological and ontological assumptions and the normative presuppositions - in the discourses. Therefore, the emphasis is not on the assumptions or beliefs of the authors of the texts (Bacchi 2009). The goal is to identify the conditions that made a problem representation possible. In the case of my research, this referred to assumptions about the nature of family, the nature of drug use, and what or who are responsible for 'problems' and solutions. In this step, one also looks for patterns of problematisations found across contemporary policies, for example, political rationalities such as risk or responsibilisation. Of interest is how certain knowledges gain a 'truth' status through "networks of relations and practices that produce them" (Bacchi and Goodwin 2016, p. 22), or, in other words, the discursive practices that produce what is 'true' (Foucault 1972; Bacchi and Bonham 2014).

To assist with this analysis, Bacchi (2009) suggests identifying how the problem representation is constructed, and to look for binaries, key concepts and people categories. Binaries are polarised concepts or dichotomies. The task is to identify the context in which they occur and their function in shaping the understanding of an issue. For example, in my study young people are more visible in the prevention policy chapter compared to adults. This works to represent the drugs 'problem' as a young person's 'problem', and legitimises policy interventions targeted at young people.

Second, the analyst can examine the key concepts underpinning the problem representations and the meanings that are associated with them. An illustration from my own research is the construction of families as social recovery capital, which is associated with the concept of rehabilitation. Rehabilitation is associated with neoliberal ideas of active citizenship and an economic discourse of work and employment.

Third, people categories are used to construct problem representations, and these are key to understanding governing processes. Examples of people categories from my study are found in the prevention domain of drug policy, which outlines a number of risk factors for drug use. Contained in these risk factors are people categories such as early school leavers, dysfunctional families and families experiencing drug use. These are considered 'high-risk' and, thus, are singled out for interventions in order to attempt to govern their conduct. The goal here is to examine how categories are created (e.g. through measurement techniques such as data collection) and how they function to "give particular meanings to problem representations" (Bacchi 2009, p. 9).

3. How has this representation of the 'problem' come about?

Underpinned by Foucauldian genealogy, discussed in Chapter Three, this question aims to discover how a specific problem representation came to be. This includes analysing the practices that create privileged knowledges and their power effects. Furthermore, analysis includes the mechanisms that allow for certain problem representations to become dominant and take hold, and for alternative ones to be disregarded. One example in my research is the tracing of how affected families, constructed as service users in their own

right, emerged as objects of knowledge and subjects of governance in drug policy (Devaney 2017).

4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?

Question Four considers the limitations of a certain problem representation as it considers the issues and perspectives that have been closed off, left silent or unproblematised. This aspect of the analysis also involves the identification of subjugated knowledges existing at the margins, which challenge dominant discourses (Foucault 2003b; Bacchi and Goodwin 2016). Recognising that "things could have developed quite differently", there is always the possibility that things can change in the future (Bacchi 2009, p. 10). At this point the analyst can begin to imagine alternative problem representations that can open up possibilities for change, if this is the purpose of the analysis. To help with this step, problematisations can be compared with others across time and cultures (Bacchi and Goodwin 2016).

5. What effects are produced by this representation of the problem?

By asking this question, the political implications of the problem representations are revealed. Bacchi (2009) identifies three inter-related effects that should be considered at this stage of the analysis: discursive, subjectification and lived effects.

Discursive effects are defined as "effects which follow from the limits imposed on what can be thought and said" (ibid, p.150). The effects of silencing discourses can be highlighted as certain "options for social interventions are closed off" (ibid, p. 15). Questions Three and Four help to identify the discursive effects.

Subjectification effects consider the social relationships created through discourse and, in turn, how subjects are constituted through these relationships. For example, attributions of responsibility to particular target groups in policy for a particular 'problem' are analysed, and the effects of this practice can be highlighted. The role of professional groups in shaping norms through expert knowledge is also a key consideration.

Foucauldian concepts are useful tools to use when assessing these effects, such as 'dividing practices' and use of the norm. For example, the construction of certain families as 'high-risk' is an example of a 'dividing practice' that separates this group out from the general population. The targeting of certain groups for certain interventions can often have stigmatising effects. Examples of normalisation processes from my study include psychosocial interventions, such as parenting programmes that aim to normalise 'high-risk' families' parenting behaviour.

Lived effects refer to the way that the discursive and subjectification effects translate into people's lives. Bacchi and Bonham suggest that analysis of the lived effects "bridge a symbolic-material division" and, hence, links the analysis of policy discourses with 'material reality' (2016, p. 23)

Bacchi (2009) suggests using a set of questions, found below, to support the analytic process undertaken in Question Five.

- What is likely to change with this representation of the 'problem'?
- What is likely to stay the same?
- Who is likely to benefit from this representation of the 'problem'?
- Who is likely to be harmed by this representation of the 'problem'?
- How does the attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?

Box 2: Additional questions to support the analysis in Question Five (Bacchi 2009, p. 18).

Question five is central to the WPR approach as it makes the unintended consequences of policy visible. In addition, the analysis in this step opens up the space for consideration of alternative problem representations that may result in different effects for groups of people.

6. How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?

This question builds on the genealogical analysis in question three, and aims to examine "the means through which particular problem representations

reach their target audience and achieve legitimacy" (Bacchi 2009, p. 19), such as the particular institutional scaffolding that keeps the representation in place. This step also aids reflection on forms of resistance and challenges to problem representations.

4.5. Phase Two: Field Work

4.5.1 Key premises of the PIA

In traditional qualitative interviewing that adopts a humanist perspective, the subject is seen as a fixed and pre-existing entity that holds 'truths' and 'experiences' that the researcher wishes to access; this is referred to as the "founding subject" by Foucault (1972, p. 227). This assumption poses a "major theoretical challenge" for poststructuralist scholars (Bonham and Bacchi 2017, p. 2). To overcome this challenge, Bacchi and Bonham (2016) have developed an alternative approach to analysing interview data.

In the second phase of my study I undertook qualitative semi-structured interviews with a sample of professionals that hold drug policy making, policy coordination, research, advocacy and service provision roles. The purpose of conducting qualitative interviews was to gather perspectives from professionals with different areas of expertise and knowledge on how families are problematised in how the 'problem' of drug use is understood and addressed. I also aimed to explore how policy discourses relating to families are operationalised and, consequently, how families are governed in relation to drugs and drug use.

I adopted the Poststructuralist Interview Analysis (PIA) approach, an innovative and original methodology underpinned by Foucauldian theory, to analyse the interview data (Bacchi and Bonham 2016; Bonham and Bacchi 2017). Rather than holding a poststructuralist sceptical attitude towards interviews, the authors suggest that interviews can in fact provide "a significant political resource" for researchers as they can have transformative potential (Bonham and Bacchi 2017, p. 3). They refer to the research interview as a site where pervasive knowledge can be challenged, depending on the way that an extract from an interview is analysed and presented by the researcher. Bonham and Bacchi note:

> Interviews are replete with opportunities for transformation but whether and how this transformation proceeds depends on the ensemble of relations that is distributed into other sites (ibid, p. 12).

It is through the dissemination of research findings that "researchers *produce* realities"; this is an important ethical responsibility and political task for researchers according to Bonham and Bacchi (2017, p. 13, italics in original).

The focus of the PIA approach is on the identification and analysis of 'what is said' and the forms of knowledge that makes it possible to say that which is said. The effect of this position is that analysis of interview data involves "de-*person*-alization", where the researcher is not interested in understanding why something was said, such as people's intentions or motives, or who said it (Bacchi and Bonham 2016, p. 115, italics in original). Instead, the purpose is to examine the politics of how it is possible to become a subject of a particular kind. The research interview itself is located within a discursive (knowledge) practice, for example health, psychology or criminal justice. Although the focus is not on 'who' said it, some 'things said' are granted more importance and have a stronger impact depending on their institutional location and their context (Bacchi and Bonham 2016). Here, context refers to the status of the knowledges associated with the institution, for example dominant medical, psychological or law and order discourses.

Similar to the WPR approach, in the PIA approach discourse is understood as knowledge (Bonham and Bacchi 2017). Hence, the knowledges and the practices of knowledge that enable something to be said are critically examined. Knowledge practices and power/knowledge relations, and the "enactment of interview procedures within a *specific discursive practice*", have normative effects (Bonham and Bacchi 2017, p. 7). As a result, certain ideas and subject positions become privileged, and others are silenced.

4.5.2 Application of the PIA

The first step in my analysis included an initial detailed reading of all the transcripts. Following this I used the QSR NVivo software to extract and organise relevant sections of the data from each transcript.[9] The PIA consists

[9] QSR NVivo is a qualitative computer aided data analysis software designed to aid the management of data.

of seven interconnected processes of interrogation applied to an interview transcript, summarised below.

1: Noting "*what* is said"
2: Producing genealogies of "*what* is said"
3: Highlighting key discursive practices
4: Analysing "*what* is said"
5: Interrogating the production of "subjects"
6: Exploring transformative potential
7: Questioning the politics of distribution

Box 3: The seven processes of the PIA methodology (Bacchi and Bonham 2016, p. 115-120, italics in original).

I provide a more detailed explanation of the different processes in Appendix A. Compared to the WPR approach, in the literature the PIA approach is described more briefly, and there are limited examples of its application. As I highlighted in the literature review, I could only retrieve one published study that has applied the PIA approach (Bonham *et al.* 2015; Bonham and Bacchi 2017). I found that the lack of published studies presented both a challenge and an opportunity for the analysis and presentation of the findings. On the one hand, there was no possibility to learn how other researchers had applied the method; on the other hand, the novelty of the approach offered me the opportunity to make the PIA approach 'my own' and ground-breaking as long as I committed to the key premises of the approach.

Guided by my research questions, my analysis comprised four key tasks. I sought to understand 'what is said about families' and whether what is said "reproduces or challenges taken-for-granted" discourses on families (Bonham and Bacchi 2017). I identified the dominant discourses, for example, criminal justice, health or social work knowledge and expertise, that made it possible to say those things. I was also interested in understanding what kind of subjects are produced as a result of the discursive practices, and the effects of this in terms of governing practices and the implications for

those governed. Finally, I sought to examine the transformative potential of the professional discourses.

4.5.3 Selection and recruitment of interviewees

Rapley (2004) suggests that the process of analysis starts with the selection and recruitment of potential interviewees. When certain interviewees are chosen, others are not; consequently, analytic decisions are being made about voices and silences in my research. In this study, I was interested in talking to professionals with different forms of knowledge and expertise as they shape how families are problematised in different ways. The sample included a total of 17 interviewees:

Policy making and coordination roles

- Representative from the Department of Health
- Representative from Tusla, the Child and Family Agency
- Two representatives from Drug and Alcohol Task Forces
- Two representatives from the Health Service Executive

Service Providers

- Statutory adolescent treatment service
- Voluntary adolescent treatment service
- Voluntary adult treatment service, community based
- Voluntary adult treatment service, residential
- Two representatives from voluntary family support services
- Three representatives from An Garda Síochána (police service)

One of the interviewees represented the National Family Support Network, an organisation that advocates and lobbies on behalf of families affected by drug use and that also provides services. Another of the interviewees was a social science researcher from a statutory body, the Health Research Board.

While I aimed for a wide representation of knowledge and expertise, some disciplines are not represented in the sample, such as probation, the court system and youth work. There are practical reasons for their exclusion, primarily limited resources such as time and funding. However, decisions

about what type of expertise and knowledge to access in my research were also taken after preliminary analysis of policy. Because I was interested in how professionals negotiate specific policy recommendations, I targeted certain actors with responsibility for implementing those recommendations. As a result, others were excluded. So, whilst professionals in areas such as the Probation Service work with families, this was not an issue that was problematised in policy (a finding in itself), and therefore not prioritised in my sample.

I recruited all interviewees through email, in which they were provided with a brief summary of my research and the reason for inviting them as potential interviewees (see Appendix B for an example). I asked them to reply to me if they were interested in participating, and, at this stage, I sent them the research information letter and asked them to contact me to ask for more information if they wished (Appendix C). At this point, if they agreed, arrangements were made for times and location of the interviews. It turned out that recruitment was not difficult. All the potential interviewees that I contacted agreed to participate.

I requested permissions from gatekeepers to access four interviewees. In the case of one interviewee, a front-line family support worker, permission to conduct an interview was granted from the line manager. In the case of the police service, the procedure to access individual members is formal. I first sent a letter to the Police Commissioner requesting access to members of the force for the purpose of a research interview. This request was forwarded to the Head of the Data Analysis Unit of An Garda Síochána. I completed the required documentation, and I was subsequently granted permission to interview three specifically named individuals (Appendix D).

4.5.4 The topic guide

The interviewees in my research could be broadly divided into two groups depending on their functions: service provision and policy making and coordination roles. I designed slightly different interview schedules for the two groups and a modified schedule for the interviews with the interviewees from the police service (Appendix E). The topic guides were developed

following consideration of the key research questions, review of the literature and preliminary analysis of policy documents. The interview schedule for the service providers included five sections:

- Introduction: Interviewees were asked to talk about their organisation, the nature of their work and if certain principles or models guided their work.
- Services: Interviewees were asked about services that were provided for families.
- Policy implementation: Interviewees were asked about their views of the policy recommendations relating to families in the 2009 *National Drugs Strategy*. (See Appendix F for a list of the actions that are relevant to families).
- Recommendations for change: Interviewees were asked to provide recommendations for future drug policy developments relating to families.
- Conclusion: Interviewees were asked to add any comments they wished to make.

The questions for the members of the police service followed the same format, but questions were more specific to the topic of drug-related intimidation of families. The schedule for those with policy making and coordination roles followed the same basic format as that for the service providers, however, instead of asking about services provided to families, I asked about the development of and implementation of the policy recommendations relating to families in the 2009 strategy.

4.5.5 The interview procedure

With the exception of three interviewees, the interviews took place at their workplaces. Two interviews took place at a meeting room at a university, and one took place at a meeting room in a hotel. Prior to the interviews, the interviewees were provided with opportunities to ask questions about the research and they were also asked to sign an informed consent form (Appendix G). Permission to record the interview was sought and all interviewees agreed. The interviews lasted between 27 and 69 minutes.

4.5.6 Interview transcription

I transcribed my interviews as soon as feasible after they had been conducted. Interview talk becomes text through transcription of the recorded conversation into a written transcript. Transcription is not a neutral process as it actively constructs a particular version of the interview. Thus, transcription becomes part of the process of analysis as the researcher selects what counts as data. This is observed by Taylor: "A transcript is a construction…[…]…it cannot be a total record of talk…[…]…through what is included and excluded" (2001 p. 34). In my research, language is not assumed to be transparent; hence, it cannot be viewed as simply mirroring back the talk that it is recording. As the focus of analysis in this study is on 'what is said', not on speech acts, the production of highly detailed transcripts may not be "neither practical nor desirable" (Taylor 2001, p.37). Hence, my transcripts did not include notations such as a micro pauses, in and out breaths, slowing down or speeding up of speech, and loudness and pitch of speech – details that are important in other discourse analysis traditions, such as conversational analysis (Wetherell et al. 2001)

4.6 Ethical considerations

In my research, I consider two dimensions of ethics: 'procedural ethics' and 'ethics in practice' (Guillemin and Gilliam 2004). 'Procedural ethics' refers to the broad ethical principles and protocol underpinning this research, and the process of obtaining ethical clearance from the University's Research Ethics Committee. 'Ethics in practice' concerns the on-going day-to-day ethical issues throughout the life of this project.

4.6.1 Procedural Ethics

My research has complied with the University's requirements and has obtained ethical approval from the UL Faculty of Arts, Humanities and Social Sciences Research Ethics Committee, clearance reference number 2013-06-10-FAHSS (Appendix H). As the focus and scope of my research changed during the lifetime of the project, an amended ethical approval application was submitted, which was approved (Appendix I). My code of ethics was underpinned by the Sociological Association of Ireland's (SAI) Ethical Guidelines, which are informed by those of the British Sociological

Association, the American Sociological Association and the Australian Sociological Association (SAI 2014).

4.6.2 Informed Consent

Informed consent entails providing information to the potential participant about

> what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is to be promoted (SAI 2014, p. 6).

It is underpinned by principles of autonomy and self-determination and serves to protect the welfare of research participants. In this project, in addition to provision of information about the topic and purpose of the research, who is undertaking it and funding it, the interviewees were informed about how data would be used and stored, who would have access to data and how findings would be disseminated. They were informed about what their participation would involve and were offered opportunities to ask questions. A research information letter was distributed to potential interviewees before agreeing to take part, and prior to the interview, all interviewees were asked to sign an informed consent form.

4.6.3 Beneficence and Non-maleficence

The basic principles of beneficence (doing good) and non-maleficence (doing no harm) involve "respecting and taking into account their [participants] needs and interests" (Flick 2009, p. 36). Taylor notes that "…respect involves caring for others, honouring them, and treating them with dignity" (2001, p. 37). In addition to the principle of informed consent, it involves other considerations. Although the interviewees in this project are professionals, some with considerable power and expert knowledge, it should not be assumed that this group are not subject to certain vulnerabilities. For example, there is a slight potential for social harm in relation to dissemination of findings as interviewees may not realise the impacts on themselves and others when their words are published (Murphy and Dingwall 2007). While this research analyses professional discourses relating to families, issues such as service philosophy and ethos are central. There is a slight potential that personal and organisational reputation could be impacted. Therefore, protection of the interviewee's personal integrity is essential.

The principle of voluntary participation was used in my study. Interviewees were clearly informed, verbally and in writing, that they could withdraw from the study at any time without any consequences and that they did not have to answer any question they did not want to. Interviewees were free to determine the date, time and place of the interview.

Doing no harm also involves "doing justice to participants in analysing data" (Flick 2009, p. 41). This adds an ethical dimension to analysis of data, and the researcher needs to ensure that the analysis is grounded in data, and as I have referred to earlier, this means being reflexive throughout the process.

4.6.4 Confidentiality

The principle of confidentiality was also in operation to protect interviewees from harm and prevent invasion of their privacy. While this may seem a rational concept, this issue is potentially problematic. Confidentiality is traditionally addressed at four points in the research process: application for the institutional ethics committee approval, data collection, data cleaning and dissemination of findings (Kaiser 2009). During data collection, confidentiality was agreed through the process of informed consent and was discussed and agreed with the interviewees. They decided as to how they wish to be referred to, including the optional use of job title and identification of the agency.

Duke (2002) raises an important consideration relating to confidentiality – when research participants know who at least some of the other participants in the research are through their on-going professional interactions. In a relatively small jurisdiction such as Ireland that has a relatively small pool of professionals and policy makers in the drugs field, potential participants move in the same circles. It is possible that they "communicate with each other, and about you and your research" (Duke 2002, p. 47-48). During data cleaning I removed any identifying details from the transcripts such as names or locations. However, contextual confirmation could remain that could potentially lead to identification of participants, referred to as deductive disclosure (Kaiser 2009). This is potentially an issue in this research as my interviewees are recruited from a relatively small pool where many know, or

know of, each other. It could be possible for professionals to identify others based on 'clues' contained in quotations from transcripts even if identifying details have been removed.

Because of the nature of the procedure to access members of the police service, I had to name the potential interviewees, and therefore their participation was not confidential to police management. This is the condition of accessing police for the purpose of research and the three individuals were aware of this prior to engaging in the interview. However, police management did not have access to raw data, nor do they have ownership of the data.

There is another ethical issue in the data cleaning process in this research. If too much information is deleted from transcripts, the original meaning of the data may be altered or become worthless (Hopf 2004; Kaiser 2009). For example, different services operate based on different models and assumptions about addiction, which makes them potentially identifiable. This information is important as it is a form of knowledge that may shape how families are talked about. Losing some of that information (which could possibly link statements to a particular type of service provision) would compromise the analysis, so I chose not to remove this type of information.

4.7 Conclusions

In this chapter I have outlined the methodological framework that I will use to address the research questions posed in my study, including the ethical considerations in my research. The research questions are concerned with elucidating the relations between knowledge, power, discourse and governing practices in the theoretical space where drug policy, professional practices and families meet. My study adopts a poststructuralist stance, guided by a Foucauldian theoretical framework. The epistemological and ontological assumptions of my research understand knowledge to be produced and realities to be constructed through discourse.

I adopted an iterative approach to my research, where I re-visited the phases throughout the life of this project. Operationally, my research included two phases of data collection and analysis: policy analysis and field work. The phases complemented each other in addressing my research aims and

questions. The first phase used a poststructuralist method of analysis of eight key policy documents, the What's the Problem Represented to Be?' approach (Bacchi 2009). The second phase involved qualitative semi-structured interviews with a sample of 17 professionals. I was guided by a novel poststructuralist approach to analysis of interview data (Bacchi and Bonham 2016).

The concept of self-problematisation underpinning my research understands that research is not a neutral activity. I am a researcher who produces certain version of knowledge and realities through my research. At the same time, I am immersed in contemporary discourses that are dominant and pervasive. The analytic strategies I have used contain a process of self-problematisation, and I apply this to my own proposals in Chapter Ten of this thesis.

Chapter Five:

Policy Context

Chapter Five: Policy Context

5.1 Introduction

The purpose of this chapter is to provide a social policy context relevant to the analysis in the next four chapters. My analyses of policy and interview data are underpinned by the assumption that knowledge is socially produced and historically, culturally and locally contingent. As I am tracing the way that families have been represented as 'problems' in drug policy, these are influenced and shaped by prevailing knowledges and political rationalities. This chapter traces key policy shifts and highlights legacies and discontinuities of certain rationalities in family and drug policy.

Apart from smaller parties on the margins, Irish politics can be characterised as not having the traditional right and left wing ideological divisions in politics. Following independence in 1921, early Irish politics was dominated by nationalism and Catholicism, and, compared to the rest of Europe, the Social Democratic tradition has never taken hold (Considine and Dukelow 2009). The largest political parties, Fianna Fáil and Fine Gael, can be considered centrist; however, Considine and Dukelow (2009) argue that mainstream Irish politics has increasingly shifted towards a more right-wing political orientation since the 1990s.

I start this chapter by examining the social policy landscape in Ireland from the 1960s onwards. Next, I review family policy developments in further detail by tracing how families emerged as a unique domain of social policy, and I examine key shifts in policy priorities such as child protection, family support and parenting support. I follow this by providing an overview of drug policy developments. Next, I discuss the emergence of community-based activism in the 1980s in the absence of effective and timely responses by the state to the drugs issue. In the remainder of this chapter I review key drug policy shifts: the introduction of harm reduction, responsibilisation, a focus on drug-related crime, a turn to risk and, more recently, an emphasis on recovery.

5.2 Catholic social teaching: influence and legacy

While charities had long played an important role in the provision of welfare, the 19th century saw an increasing involvement of the Catholic Church in service provision in areas such as health, education and childcare (Considine and Dukelow 2009). Thus, the Church had a particular concern about the disciplinary control of women and children. Institutionalisation became a preferred model of care, in the form of Magdalen asylum laundries for 'fallen' women such as unmarried mothers, and industrial and reformatory schools for children who were "illegitimate, destitute or delinquent" (McGregor 2014, p. 778; Considine and Dukelow 2017).[10] The legacies of this practice include preferences for institutionalised welfare, a practice that lasted until the 1970s, and later, revelations about institutional abuse in the 1990s and 2000s, which spurred a new political priority of child protection.

The Catholic influence on social policy making continued throughout the early decades of the independent state, characterised by "a values system based on rural, patriarchal family living" as the Church considered itself as an equal to the state (Considine and Dukelow 2009, p. 25). As an institution of moral authority, much of its focus was on the control of women and the family as the "foundation of social order in the newly independent state" (ibid, p. 26). Similarly, the notion of community was used symbolically by the state to help create a national identity and a sense of solidarity, while also serving to mask the idea of society (O'Carroll 2002 cited in McDonnell and O'Donovan 2009, p. 10).

The Catholic principle of subsidiarity shaped the early social policy landscape with emphasis placed on individual, family and community responsibility for provision of social services (Daly and Clavero 2002; Considine and Dukelow 2009). The provision of charity was favoured over welfare provision by the state. Harvey (2012) argues that this approach led to a restriction of state involvement and social policy development coupled with a growth of the

[10] In contrast to the Magdalen homes, the industrial and reformatory schools were funded by the state but run by religious orders. There were different reasons for placing children in these schools: parents being poor, considered unfit or unable to rear children; children being born to unmarried mothers; being an orphan; or, children being convicted for minor offences in court (Considine and Dukelow 2017).

voluntary sector. Thus, Ireland has a long history of community and voluntary services contributing to the welfare of the population and playing a significant role in building a social infrastructure (Considine and Dukelow 2009; Harvey 2012).

The Catholic influence on early social policy aimed to ensure that families were responsible for their own welfare (Daly and Cavero 2002). Fahey (1998, p. 386) refers to "patriarchal familism" as the dominant policy paradigm until the 1960s. The type of family imagined was traditional and patriarchal, where relations were considered private and intervention from the state minimal. Fahey (1998) argues that from the 1960s, this was superseded (but not replaced) by a more individualist and egalitarian approach to family policy that emphasised individual rights over protection of the family as a unit. He provides the introduction of unmarried mothers' benefits in 1973 as an example of the shift in approach. On the other hand, Daly and Calvero (2002) challenge the egalitarian argument. They argue that the provision of benefits to lone mothers was intended as a pro-family measure as women got the benefit only in their capacity as mothers and not as individuals.

The legacy of the influence of the Catholic Church as a social service provider continues today as many AOD services, from prevention to rehabilitation were founded by the Church and, in some cases, are still governed by religious orders or archdioceses. Examples include youth work organisations engaged in drug prevention work such as Crosscare in Dublin and the Irish Bishops Drugs Initiative; residential rehabilitation centres such as the Cuan Mhuire and Aiséirí groups of facilities; and the Merchants Quay Homeless and Drugs Services, one of the first centres in Ireland to provide harm reduction services (Merchants Quay 2013; Aiséirí 2017; Crosscare 2017; Cuan Mhuire 2017; Irish Bishops Drugs Initiative 2017).

5.3 The Irish Constitution

The symbolic importance of the family can be found in the Irish Constitution where the family was "enshrined as the cornerstone of the new Irish nation-state" (Conrad 2004, p. 10). Article 41.1 states:

> The State recognises the Family as the natural primary and fundamental unit group of Society…The State therefore guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State (1937, p. 160-161).

Article 41.1, strongly influenced by Catholic social teaching, further defines the family as "a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law" (1937, p. 162).

Important discursive effects are produced through the Constitution. First, families are given primary responsibility for the care and protection of children. The constitutional guarantee to protect the family gives it important privileges that favoured privacy and minimal intrusion by the state. Consequently, a particular ideal of the traditional Irish family in the 20th century emerged where "family regulated itself by keeping to itself" (Conrad 2004, p. 9). Daly and Clavero (2002) observe that until the 1990s, provision of family services was underdeveloped in Ireland with early provision primarily consisting of institutional 'protective' services for children provided by religious orders for the state. As the family was largely considered a private sphere, family relationships were rarely questioned. However, the sphere became increasingly public in the 1990s, when a more interventionist approach emerged (Brady *et al.* 2004). A range of developments in child protection and welfare policy followed, which I discuss later in this chapter.

A second discursive effect of the Constitution is that families are considered central to a well-functioning society, and any threat to the family unit – such as drug use - is also a seen as a threat to the moral fabric of the nation. I argue that the state's guarantee of protection legitimises practices that govern families, and govern through families, in relation to 'perils' like drug use. Family breakdown and fragmentation are seen as problematic. Hence, interventions that aim to keep families together and functioning well, for example family therapy, relationship counselling and parenting programmes, are prioritised in policy and practices.

A third discursive effect is that the positive character of family and its contribution to society become self-evident. Therefore, the family as an

institution and its connected ideals are not easily critically interrogated. Daly and Clavero (2002, p. 17) note some questions that are implicit in social policy but rarely asked:

> How are relations and responsibilities among family members viewed and treated? Where and when does family responsibility end? What kind of division of labour as regards the welfare of family members is envisaged between the family and the state? These and other questions may be so taken for granted that they are rarely explicitly asked.

Here, my study makes an intervention by troubling taken-for-granted ideas about families in drug policy, such as their imagined roles and responsibilities in addressing societal drug use.

5.4 Governance of the community and voluntary sector

Until the 1990s, the governance relationship between the state and the voluntary sector was based on assumptions of altruism. However, Boyle (2002) notes a shift with the introduction of New Public Management (NPM) in Ireland.[11] Official policies specifying the governance relationship between the state and the community and voluntary sectors emerged relatively late to Ireland, with a flurry of activity taking place between 1997 and 2002 (Harvey 2012). This included an investment in, and formal recognition of, the roles of the voluntary and community sectors in the provision of services. This was accompanied by a new funding and accountability relationship with the sectors in the form of contracting. The formalisation of governance structures reflected wider social policy developments at the time that promoted social partnership, social inclusion and community development in order to address a range of social issues.[12] The voluntary and community sectors were now understood as formal representatives of socially excluded groups (Meade 2012). These developments reflect a Western post-welfarist orientation where responsibility for social issues, such as security and health, are increasingly being transferred from the state to non-statutory sectors and communities, families and individuals (Miller and Rose 2008). Meade (2012) argues that

[11] For further discussion on the introduction of NPM, see section 5.7.1 in this chapter.

[12] Examples include *Partnership 2000 for inclusion, employment and competitiveness*, the *White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary sector*, and the *National Anti-Poverty Strategy* (Government of Ireland 1996; 1997; 2000).

the new formal arrangements shaped the activities of the sectors so that they became aligned more closely with the neoliberal economic agenda of governments. Meade (2012) concludes that this resulted in a depoliticisation of the sectors.

5.5 Economic and social changes

Ireland underwent significant economic, social and cultural changes from the 1960s, and these have been comprehensively documented and discussed by Considine and Dukelow (2009; 2017). Here I highlight the developments that are most relevant to my analysis of drug policy in Chapters Six and Seven.[13]

5.5.1 1960s-1970s

The 1960s and 1970s were characterised by economic growth; rural to urban migration; a modernisation of Irish society; a shift in the prevailing policy of economic protectionism towards one of development; and, an expanding role of the state in social services provision (Considine and Dukelow 2009). New social movements, which addressed issues such as poverty and the status of women in society, emerged. This contributed to a wider questioning of some of the conservative values, strongly influenced by the Catholic church, that had prevailed until then (Considine and Dukelow 2009). Concurrently, there was a growth in community activism, such as women's groups and housing action groups, and the emergence of voluntary agencies that responded to areas of women's needs and issues such as single parenting, rape and domestic violence that had not been addressed by the state (Considine and Dukelow 2009).[14] It was in this policy landscape that illicit drugs were first problematised by government, and the first official drug policy document was published in 1971.

5.5.2 1980s

The economy took a sharp downturn in the 1980s, and this decade was characterised by high interest rates, high inflation, cutbacks in public services,

[13] The official drug policy documents I analyse were published in 1971, 1991, 1996, 1997, 2001, 2005 and 2009. A Governmental report was prepared but never published in 1983, and the most recent strategy was published in 2017 – these are not included in my analysis.

[14] Voluntary agencies included the Well Woman Centre, Women's Aid, the Rape Crisis Centre, and Cherish (ibid).

emigration, unemployment and rising levels of poverty (Considine and Dukelow 2009). There was also political instability, with four different cabinets formed between 1979 and 1982. According to Considine and Dukelow (2009), this decade saw a resurgence of a more conservative Catholic morality against more liberal attitudes towards issues such as sexuality, contraception and divorce. The start of this decade witnessed a sharp increase in injecting heroin use in deprived and marginalised Dublin communities; however, the response by the state in terms of police and health services was delayed and ineffective (Butler 1997; O'Gorman 1998). This led to the emergence of community activism, which I discuss further in 5.7.2.

5.5.3 1990s-2000s

In contrast to the 1980s, the two decades that followed were distinguished by unprecedented economic growth, globalisation and social change in Ireland (Considine and Dukelow 2009). This had implications for social policy as there were now resources available, and issues such as equality, poverty and social exclusion were put on the political agenda. Furthermore, the social partnership consensus model for governing the economy at this time favoured investment in the 'social' (Daly and Clavero 2002). Global neoliberal political rationalities such as activation, managerialism, evidence-based policy making, responsibilisation and risk influence social policy making during this time. These rationalities also shape drug policies published during this time as I discuss in section 5.7.[15]

Mirroring trends across EU states, a focus on activation gained ground in Ireland in the 1990s, with a number of policy developments and measures aiming to 'make work pay' (Considine and Dukelow 2009). The basic assumption underpinning the concept is the idea that employment and work can tackle societal issues such as social exclusion and poverty. Participation in the work force is seen as contributing towards positive self-esteem, stability and, in the case of drug rehabilitation, recovery (DOCRGA 2007). Groups that are considered 'at risk' for social exclusion, but also seen as having employment potential, are targeted for activation processes. One such

[15] Seven official drug policy documents were published between 1991 and 2009.

example is the Community Employment (CE) scheme, which targets those long-term unemployed, members of the Travelling community, those getting disability and illness benefit, refugees, ex-offenders and those engaged in drug rehabilitation (Citizens Information 2017). A dedicated CE scheme with a focus on drug rehabilitation and training was introduced in 2004 (Department of Social Protection 2013).

Around 2008 the economic growth took a sharp downturn and Ireland was the first country in the Eurozone to enter recession, remaining there until 2013 (O'Brien 2008; Molloy 2013). An austerity of 18% of GDP - characterised by increases in taxes, cutbacks in public services, a rise in unemployment and emigration - took place between 2008 and 2014 (Considine and Dukelow 2017). Funding for the community and voluntary sectors was especially affected with cutbacks to family support and drug services; furthermore, competitive tendering replaced grant funding for community projects (Harvey 2014: Considine and Dukelow 2017). Harvey (2016) argues that this funding strategy led to a further depoliticisation of the sectors. In contrast to other areas of social policy, child welfare and family policy continued to evolve during this time. I examine developments in family policy in closer detail below.

5.6 Family policy

5.6.1 Shift towards family as a unique domain of policy

Families have been increasingly visible in social policy across the Western world, especially from the 1990s onwards, with Daly observing that "there are fewer and fewer limits to state engagement with family life" (2013, p. 159). Family policy developments in Ireland in the 20th century have been analysed and comprehensively documented (Fahey 1998; Daly and Clavero 2002). Before the 1990s family policy consisted of a combination of measures that sought to distribute cash benefits (such as child benefit and housing supports) and measures that sought to regulate the family as an institution (such as laws governing marriage). A key development was the second

referendum held on the legalisation of divorce in 1995.[16] The referendum was carried with a narrow margin, with 50.28% voting yes and 49.72% voting no, which is an indication of the deep divisions in opinion on family matters at the time (Considine and Dukelow 2009). The ideology of the traditional nuclear married family was still much alive.

Possibly as a consequence of the referendum result, the family increasingly became a priority for social policy. In 1995 the Commission on the Family was established, which published a report in 1998 entitled *Strengthening Families for Life*. The Commission was asked

> To examine the effects of legislation on families and make recommendations to the Government on proposals which would strengthen the capacity of families to carry out their functions in a changing economic and social environment (Commission of the Family 1998, p. 2).

The key message of the Commission's report was that public policy needed to focus on "preventative and supportive measures to strengthen families in carrying out their functions" (ibid, p. 9). The report set out six principles for future development of family policy (ibid, p. 7-8):

- Recognition that the family unit is a fundamental unit providing stability and well-being in our society.
- The unique and essential family function is that of caring for and nurturing all its members.
- Continuity and stability are major requirements in family relationships.
- An equality of well-being is recognised between individual family members.
- Family membership confers rights, duties and responsibilities.
- A diversity of family forms and relationships should be recognised.

Most of these principles reiterated the dominant ideology of the nuclear married family as stated in the Constitution, while the recognition of equality within the family and of diverse families indicated a new policy direction.

In 1997 the Department of Social Welfare changed its name to the Department of Social, Community and Family Affairs, broadening its remit from social protection. As a result, families were now a distinct responsibility in public administration. The 1990s onwards witnessed an increasing policy

[16] The proposal was rejected in the first referendum held in 1986, with 63.5% voting no and 36.5% voting yes (Irish Political Maps 2017).

focus on areas such as child protection and welfare, family support, children's rights, and parenting. I list the key developments in Appendix J. Here I will discuss the themes with most relevance to my analysis of drug policy: child protection, family support and parenting.

5.6.2 Child protection

A new political and public priority of child protection emerged in the 1990s after a number of cases of familial, clerical and institutional child abuse were highlighted. This called attention to the state's systematic failure to protect children. A key development was the introduction of the Child Care Act (1991), which placed statutory responsibility for promoting child welfare and protecting children with Health Boards.[17] The Act substantially updated the state's approach towards child protection and significant funding was allocated to the creation of new social work posts (Ferguson 2001). The Act emphasised a preventative approach to child welfare over a reactive one; however, a review of practices found that the aspirational focus on child welfare had not been enacted as services continued to operate within a narrow child protection framework (Buckley *et al.* 1997).

Efforts were put into achieving a balance between child protection, family support and prevention towards the end of the 1990s and early 2000s. These included the publication of the *Children First: National Guidelines for the Protection and Welfare of Children* (Department of Health and Children (DOHC) 1999), later revised in 2011 (Department of Children and Youth Affairs (DOCYA) 2011). The guidelines adopted a proactive approach that included child welfare and family support as central to the child protection system, and recommended supportive and preventative interventions where possible. Child protection and welfare services have undergone significant restructuring since 1991, most recently as Tusla was formed in 2014 following the new Child and Family Agency Act (2013).[18]

[17] Regional Health Boards were the statutory provider of health and child care services until 2005 when they were replaced with the HSE.

[18] Tusla is a new word that draws on the Irish words 'tus' (beginning) and 'lá' (day) but conveying a new meaning: "reflecting a shared desire for a new beginning, forging a new identity. A new word, a new way of working" (Tusla 2016a, p.1).

Tusla, the Child and Family Agency, is a new independent authority merging child and family support services previously provided by the HSE Children and Family Services, the Family Support Agency (FSA) and the National Educational Welfare Board. Tusla's primary remit is children rather than all members and generations of families; its website declares that it is "the dedicated State agency responsible for improving wellbeing and outcomes for children" (Tusla 2017, p.1). Furthermore, it claims that the creation of the new agency "represents the most comprehensive reform of child protection, early intervention and family support services ever undertaken in Ireland" and that it will provide an opportunity to "think differently, [and] where appropriate to behave differently" (ibid). While the desire of Tusla to be 'new' and 'different' is clear, its transformative potential remains to be seen.

Critically analysing the setting up of Tusla, McGregor (2014) argues that the creation of a new agency is an attempt to 'purge' past failures and redefine child welfare: "a commitment to be different from before and to leave the dreadful past behind" (p. 776). The author cautions against this simplistic and revisionist view, instead recommending that critical engagement with the past be undertaken. This engagement should not only include learning about the 'dreadful past' but also recognising and learning about previous good practice examples and expertise (McGregor 2014).

5.6.3 Family support

Family support services were underdeveloped in Ireland until the late 1990s; however, following recommendations contained in the Report of the Commission on the Family in 1998, family support became a policy priority. The report stated that public policy needed to focus on "preventative and supportive measures to strengthen families in carrying out their functions" (p. 9). Recommendations included the development of a network of family and community resource centres, and educational interventions such as parenting skills programmes. The political priority of family support was reflected in the rapid expansion of the provision of family resource centres in geographically defined areas of disadvantage at this time – from a budget allocation of € 317,435 in 1994 to € five million in 2001 (Daly and Clavero 2002). The DOH commissioned report *A Guide to what works in family*

support services for vulnerable families (McKeown 2000) paved the way for a Family Support Agency Act (2001) and the creation of the Family Support Agency (FSA) in 2001. The functions of the agency included the provision of a family mediation service; marriage and relationship counselling; family support; information on parenting and family responsibilities; and, funding the Family and Community Services Resource Centre Programme and voluntary bodies for provision of counselling services (Family Support Agency Act 2001). As previously noted, the FSA was subsumed into Tusla in 2014.

5.6.4 Parenting

Gillies (2005) and Daly (2015) argue that while the social policy focus on activation of parents, and the ability to parent in a manner that is socially desirable, is not new, these concerns have intensified in the last 10 – 15 years. Parenting is underpinned by norms of what is considered positive and negative parental behaviour. Currently, it is constructed as a job that requires skills and expertise, and expert knowledge and professional intervention with in order to acquire these; thus, experiential knowledge has been superseded (Gillies, 2008; Daly 2013). Typically, standardised 'evidence-based' parenting programmes are promoted as policy solutions (Daly 2013). These governmental technologies aim to responsibilise and shape the conduct of parents so that they adopt preferred forms and approaches to parenting.

Parenting support interventions are often included under the umbrella of family support, and can be understood as a technology for governing families, parents and children. Parenting support is defined by Daly (2015, p 599) as

> …a set of (service and other) activities oriented to improving how parents approach and execute their role as parents and to increasing parents' child-rearing resources (including information, knowledge, skills and social support) and competencies.

This definition draws on a work discourse, which conceptualises parenting as a job that requires specific knowledge, skills and competencies in order to execute it properly. This prevailing and dominant parenting discourse serves to background other factors that may impact on parenting, such as material and political resources.

This dominant parenting discourse is currently shaping Irish policy. "Supporting parents" is one of six goals of the most recent policy document for children and young people, which states that "Parents will experience improved support in the important task of parenting and feel more confident, informed and able" (DOCYA 2014, xiv). The strong belief in parenting and its influence on life chances is clear:

> *What parents do is more important than who they are*. How children are parented has a larger influence on a child's future than wealth, socio-economic class, education or any other common social factor (DOCYA 2014, p. 27, emphasis in italics added).

This statement is supported by two references, both from the UK. One is an evaluation of the impact of pre-school education and care, funded by Sure Start under the Department for Education and Skills (Sylva *et al.* 2004). The other reference is a UK Government review of early intervention (Allen 2011). The description of this report reads:

> [It] considers how costly and damaging social problems for individuals can be eliminated or reduced. It examines how this could be done by giving children and parents the right type of evidence-based programmes, especially in the children's earliest years (gov.uk 2016, p.1).

Reflecting the discourse in the above extract, the Irish policy further claims that "Effective parenting support can ameliorate some of the more negative impacts of intergenerational poverty" (DOCYA 2014, p. 27). This claim is supported with one reference, an evidence briefing by the UK Economic and Social Research Council (ESRC), *Parenting style influences child development and social mobility* (ESRC 2012).

Clearly, the policy discourse is underpinned by a governmental rationality of responsibilisation. There is an assumption that deficient parenting is contributing to social ills (Edwards and Gillies 2004; Hoffman 2010); furthermore, there is a belief in "the power of parenting to compensate for social disadvantage" (Gillies 2008, p. 112). While the document acknowledges that macro-economic and structural factors can affect a person's ability to parent it is thought that these cause "parental stress" (DOCYA 2014, p.27). Here, the impact of broader factors becomes defined

as an individual psycho-social experience that in turns impacts on parenting behaviour.

Knowledge about parenting has primarily emerged from medical and psychological research, in particular developmental and behavioural psychology and neuroscience (Daly 2013). These forms of knowledge promote a causal link between parental practices and long-term developmental outcomes for children. This knowledge is embedded in the science of prevention, which operates a risk and protective factors framework. Hence, families 'at risk' but also 'potentially at risk' (potentially all families) become targets for parenting support. I return to discuss prevention science in more detail later in 5.7.6.

The bio-psycho-social explanations and behavioural solutions for children's future life chances implicit in the policy have an important discursive effect. The discourse works to shift responsibility for children's future life chances to parents; consequently, the state's responsibility is diminished and an emphasis on structural solutions that address factors such as inequalities of income, class and education are precluded.

5.7 Drug policy

5.7.1 Overview

Ireland is situated in the international drug policy landscape underpinned by the United Nations [UN] drug control conventions and a prohibitionist approach. Ireland enacted drug legislation in 1977 to comply with its obligations as a signatory to the 1961 and 1971 UN Conventions on drugs, and accessed the Conventions in 1980 and 1992 (Butler 2002). All European Union (EU) member states are signatories to the UN conventions. While the EU has published drugs strategies since 2005, drugs are controlled at national level. Apart from a general agreement regarding approaches to drug trafficking and minimum standards for harm reduction, there are variations between EU nations in policy responses (Chatwin 2015). These range from a moralistic and 'zero-tolerance' approach in Sweden, to pragmatic strategies that balance supply and harm reduction approaches in countries such as Ireland, to a decriminalisation approach in Portugal (EMCDDA 2011).

Irish drug policy developments have been comprehensively reviewed (O'Gorman 1998; Butler 2002, 2007; Cullen 2003; Pike 2009; EMCDDA 2013). Table 5.1 outlines the key policy documents. Here I provide a brief chronological overview of developments, followed by a more detailed discussion of key shifts.

Date of publication	**Title**	**Publisher**	**Cabinet Constitution**
1971	*Report of the Working Party on Drug Abuse*	Working Party on Drug Abuse	Fianna Fáil
1991	*Government Strategy to Prevent Drug Misuse*	DOH	Fianna Fáil Progressive Democrats
1996	*First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*	Ministerial Task Force	Fine Gael Labour Party Democratic Left
1997	*Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*	Ministerial Task Force	Fine Gael Labour Party Democratic Left
2001	*Building on Experience: National Drugs Strategy 2001-2008*	DOTSR	Fianna Fáil Progressive Democrats
2005	*Mid-Term Review of the National Drugs Strategy 2001-2008*	DOCRGA	Fianna Fáil Progressive Democrats
2007	*Report of the Working Group on Rehabilitation*	DOCRGA	Fianna Fáil Progressive Democrats

			Green Party
2009	*National Drugs Strategy (interim) 2009 – 2016*	DOCRGA	Fianna Fáil Green Party
2017	*Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*	DOH	Fine Gael Independents

Table 5.1: Key drug policy documents.

1960s-1970s

Illicit drugs first became a concern for government and the health service towards the end of the 1960s. The Commission of Inquiry on Mental Illness (1966) reported a low number of drug users in treatment and recommended a centralised, abstinence-oriented treatment model (EMCDDA 2013).[19] As a result, one specialist clinic under the leadership of a psychiatrist was established in Dublin's City centre in 1969; notably, it was located in a general hospital as psychiatric services were reluctant to address drug addiction (Butler 2002). A Working Party on Drug Abuse was convened in 1968 by the Minister for Health in response to a growing concern about a 'drugs subculture' among students in Dublin, primarily emerging from the media and the police (Butler 1991). Its report quantified the number of people 'abusing' drugs, primarily cannabis and LSD, "…whose names were known to the Gardaí…" as 940 persons (Working Party on Drug Abuse 1971, p. 14).[20] In the report, 'problems' and solutions relating to drug use were individualised, and policy comprised supply reduction measures, targeted education, and abstinence-oriented treatment services.

[19] In March 1963, 16 of 19,829 patients in mental hospitals were treated for drug addiction (Commission of Inquiry on Mental Illness 1966)

[20] The number of known drug users had increased from 350 persons in 1969 (Dean *et al.* 1985).

The Coolmine Therapeutic Community, opened in 1973, was Ireland's first voluntary residential rehabilitation facility. It was an abstinence-based service replicating a strict American model of Therapeutic Communities (Butler 2016).[21] Other residential treatment centres, underpinned by the Minnesota model, emerged in the late 1970s and were provided by the voluntary sector, often under the auspices of Catholic religious orders (Bulter 2011).[22]

1980s

Drug use patterns changed towards the end of the 1970s and early 1980s with a rapid increase in the prevalence of injecting heroin use, primarily in socio-economically disadvantaged areas of Dublin. This was commonly referred to as the opiate 'epidemic' (Dean *et al*. 1985).[23] Mirroring international trends, the prevalence of HIV infections also increased, with 27% of people in drug treatment testing positive for the virus in 1985 (Dean *et al.* 1987). There was a delayed governmental response, possibly as a result of political instability at the time. However, a Special Governmental Task Force of Ministers was assembled in 1983 following the publication of a heroin use prevalence study (Butler 1997). The links between social disadvantage and heroin use were made explicit in its report, which recommended that a geographical approach to taken in directing resources towards high-risk urban areas (Butler 1997; O'Gorman 1998). The report was unpublished (but later leaked); instead, the DOH issued press releases with selected findings that stressed individual responsibility for, and stricter law enforcement responses to, the drug 'problem' (Butler 1991; 1997; O'Gorman 1998).[24] In the absence of a political response and official policy, voluntary services began to respond to the needs of those who injected heroin in a covert manner. Furthermore,

[21] The model views addiction as a personality disorder. Treatment is confrontational and aimed at re-constructing the individual's personality. Coolmine Therapeutic Community is still providing services, although its ideological model of treatment has shifted towards a broader approach in recent years (Butler 2016).

[22] The Minnesota Model is an abstinence-based approach to addiction treatment that uses AA principles such as the 12-steps process (Anderson *et al*. 1999)

[23] An 'epidemic' is a term that evokes moral panic, emotion and alarm. Empirical data from this period suggest that treatment cases for heroin addiction increased from 319 in 1979 to 1,307 in 1982, and were largely confined to inner city Dublin (EMCDDA 2013).

[24] For example, the Drugs Misuse Act was amended in 1984.

community-based anti-drug vigilante movements emerged at this time. I discuss these developments in further detail later in this Chapter.

1990s-2010s

Injecting drug use and HIV/AIDS were subsequently problematised as public health issues, and harm reduction was first referred to in the 1991 strategy and has been official policy since. The 1991 strategy made reference to the contribution of deprivation and environmental factors to drug use, noting factors such as "poor housing and high levels of employment" (DOH 1991, p. 8). However, policy did not include measures that addressed structural factors until 1996, arguably reflecting the new interest in poverty and social exclusion at this time. For the first time measures that targeted disadvantaged communities, including recommendations to improve housing and recreational facilities, were put forward (Ministerial Task Force 1996).

The Irish version of NPM,[25] the *Strategic Management Initiative*, was introduced in 1996, and a managerial discourse shaped drug policy the same year (Department of the Taoiseach 1996). With a new emphasis on drugs as a 'cross-cutting' issue, cross-departmental structures for policy coordination were established (Ministerial Task Force 1996). Managerialism is pervasive in the 2009 strategy, which contains strategic aims and objectives, priorities, objectives, key performance indicators, and an implementation plan with 63 actions and named actors organised under five pillars.[26] The strategy also features the rational organisation of policy solutions into frameworks, such as a three-tier approach to prevention and a four-tier approach to treatment and rehabilitation.

[25] NPM refers to a movement that originated in the UK in the early 1980s, and soon transferred to most OECD countries (Gruening 2001). The term refers to a focus on reforms and management of public sector services, and increasingly non-governmental organisations supported by the state, using strategies borrowed from the private sector in order to seek to improve their quality and efficiency (Hood 2001, Lynch 2014). NPM can also be understood as a governmental rationality, representing the "organisational arm of neoliberalism" (Lynch 2014, p. 1).

[26] One action relates to the inclusion of alcohol, 17 are in the supply reduction pillar, 13 are in the prevention pillar, 17 are in the treatment and rehabilitation pillars, eight are in the research and information pillar, and seven relate to policy coordination.

There has also been an increasing emphasis on evidence-based policy drug making, which reflects the global and pervasive paradigm of evidence-based practice (EBP) and a focus on 'what works' (Ritter and Lancaster 2013a; 2013b; Stevens and Ritter 2013; Lancaster 2014). Davies (2003) observes that EBP has become a strategy for the implementation of managerialism. The presumably rational nature of EBP enables the complex 'problems' of drugs and drug use to become quantifiable and, therefore, manageable and solvable (Miller and Rose 2008). The role of expert knowledge and evidence in the making of drug policy emerged strongly in 2001 when research became a policy pillar and a drug research infra-structure was established. The National Advisory Committee on Drugs (NACD) was established in 2000, its role to conduct, commission and analyse research and advice the government on drug policy (National Advisory Committee on Drugs and Alcohol (NACDA) 2015). It has a membership drawn from statutory, community, voluntary and academic research sectors and relevant governmental departments. A unit of the Health Research Board (HRB), the Alcohol and Drug Research Unit, was also established. It primarily conducts epidemiological research and is the Irish national focal point for the EMCDDA. The biopolitical emphasis on drug use surveillance as evidence was articulated as a strategic policy aim in 2009:

> To ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland (DOCRGA 2009, p. 6).

The 2009 strategy contained a proposal that alcohol be included in a combined national substance misuse strategy. While this did not materialise during the lifetime of the strategy, there were some developments in this direction. The *National Drugs Rehabilitation Framework Document* (Doyle and Ivanovic 2010) included both alcohol and illicit drugs in its remit; the *Steering Group Report On a National Substance Misuse Strategy* was published in 2012; and, the Drug Task Forces were renamed as Drug and Alcohol Task Forces in 2012 (DOH 2012). However, in 2017 a major shift took place as the new strategy includes all substances - illicit drugs, prescription drugs and alcohol - in its remit. The strategy equates alcohol and

illicit drugs, stating that "…alcohol, while legal, is a drug like any other" (DOH 2017, p. 4).

5.7.2 Community-based activism

As I have previously stated, in the absence of a convincing and effective state response to the drugs issue, a grassroots vigilante anti-drug movement was mobilised in the 1980s (O'Gorman 1998; Cullen 2003; Mulcahy and O'Mahony 2005; Butler 2007; Darcy 2008). Heroin use, accompanied by death from overdose, AIDS and suicide, was deeply entrenched in deprived communities, with a fear among families that their children would become addicted (Darcy 2008). There was a lack of statutory health services at the time, apart from one centrally located abstinence-based specialised clinic (Cullen 2003). Families played a central role in these movements. The first wave of activism included the Concerned Parents Against Drugs (CPAD) movement that emerged in inner city Dublin. This movement, originally named Mothers Against Drugs, was started by a women's group in 1983 (Darcy 2008). The CPAD movement used vigilante strategies such as mass meetings, demonstrations, protests outside dealer's homes, surveillance of suspected dealers, information gathering and direct actions such as evictions of dealers and users (Darcy 2008). Bennett (1988, p.4) notes how families of drug users served as key informants in their communities:

> Everything depends on people being concerned as parents and neighbours. And among the most concerned of parents are the parents of heroin addicts… Addict families have provided also some of the best evidence against pushers…The contribution of sisters and brothers, fathers and mothers, must be emphasised first in the consideration of the Concerned Parents information network (p. 4).

Para-military organisations such as Provisional Sinn Féin and the Provisional Irish Republican Army were also involved in the CPAD movement, and this caused significant controversy and criticism (Mulcahy and O'Mahony 2005; Doyle 2014). The state's response was wholly antagonistic, using legal measures including court cases against activists (Bennett 1988; Darcy 2008). Darcy notes that "anti-drugs activists were treated in the eyes of the law as terrorists" (2008, p. 2). O'Gorman (1998) and Cullen (2003) note three factors that limited the movement's transformative potential. First, it had a narrow focus on drug supply, which limited its potential to address other issues such

as provision of relevant health services and community regeneration. Second, its para-military links and aggressive attitudes and conduct led to media and police antagonism. Hence, the CPAD movement was repressed. Third, the relationship between the state and the movement was antagonistic, with no attempts of dialogue.

The second wave of the anti-drug movement took place in the 1990s in the context of increasing injecting heroin use and a continued inadequate response from the statutory agencies. This included the Coalition of Communities Against Drugs that had superseded CPAD. While its activities were also met with negative media and state attention, its activities occurred in a different context.

Some community and voluntary organisations that had been established as a response to the drug issue formed cross-community alliances in the early 1990s. This reflected a more political approach where the alliance shifted towards a focus on the need for policy change as opposed to the drugs supply issue (Cullen 2003). For example, an inner-city network with representation across the community, the statutory, and voluntary sectors had been set up, which submitted a proposal for community-based policy responses (Cullen 2003).[27] Following a public meeting and a march to government buildings in 1995, these alliances across Dublin eventually led to the establishment of the Citywide Drugs Crisis Campaign in 1996. CityWide has since emerged as a leading community sector representative on national drug policy structures, and has been politicising the drugs issue and driving debates on drug-related issues, for example, drug-related intimidation and decriminalisation. Notably, the National Family Support Network was first formed under the auspices of CityWide.

These anti-drugs movements had not been referred to in the 1991 strategy, but were problematised in 1996:

> It must be emphasised that the majority of families and young people in even the most seriously drug-affected areas are not drug misusers. Overwhelmingly, they are seeking better futures for their children and take

[27] Thus, the model for the future Local Drugs Task Forces originated with grassroots community activism.

> legitimate pride in the strengths of their community. This is enhanced by the vast range of voluntary and community effort in these areas. However, it is easy to understand that a community may feel overwhelmed by the scale of the drugs problem and the threat which it poses to its young people. In the absence of a clear and convincing response from the public authorities, parents and others may begin to lose heart or resort to punitive and extra-legal measures which, by leaving the root causes of drug addiction untouched, are ultimately futile (Ministerial Task Force1996, p. 7-8).

In this extract, the government acknowledged that the state had failed to respond adequately to the drugs issue. However, the state's negative attitudes towards the anti-drugs movement are implicit. Furthermore, the policy only commented on the vigilante aspect of the movement while a discourse on its political element and transformative potential was silent.

5.7.3 Responsibilisation

Although community-based responses to the drugs issue had emerged in the 1980s these were not referred to in official drug policy until 1996, when the connections between drug use, social exclusion and poverty were made explicit (Ministerial Task Force 1996). For the first time, a geographical approach with measures that targeted disadvantaged communities, including recommendations to improve housing and recreational facilities. This suggested a broader understanding of the 'problem' of drug use, one that looked beyond the individual for solutions. As I have referred to earlier in this chapter, these developments occurred in the wider context of issues such as poverty and social exclusion being on the political agenda at this time. Furthermore, there were concurrent social policy developments that promoted social partnership, social inclusion and community development in order to address a range of social issues and, a greater investment in and formal recognition of the roles of the voluntary and community sectors.[28]

However, while the measures specifically targeted disadvantaged areas, these communities were co-opted into sharing responsibility for addressing the drugs issue through partnership interventions, such as community policing and the establishment of Local Drugs Task Forces (LDTF). A LDTF is a partnership between statutory, voluntary and community sectors tasked with

[28] See 5.4 and 5.5.3.

developing and implementing local strategies.[29] Hence, since 1996 the community sector has been officially invoked to become involved in the implementation of drug policy and the development and delivery of local solutions (O'Brien and Moran 1998). The envisioned partnership approach can be understood as a technology of responsibilisation, where the responsibility for addressing social issues, such as 'drug problems', is shared with the voluntary and community sectors.

With the arrival of a new Government in 1997, responsibility for drugs policy moved from the Department of the Taoiseach to the Department of Tourism, Sport and Recreation under the Cabinet Committee on Social Inclusion.[30] While this move might indicate that drug policy was no longer seen as a political priority for the new government, it also represented a discursive shift. Just before losing the election in 1997, the government had published a cross-departmental National Anti-Poverty Strategy, where poverty was seen as a major cause for social exclusion:

> As a result of inadequate income and resources, people may be excluded and marginalised from participating in activities which are considered the norm for other people in society (Government of Ireland 1997, p. 3).

With the new government, there was a discursive shift from exclusion to inclusion, evident in the naming of the Cabinet Committee. Social inclusion as a concept works discursively as a 'dividing practice'. It assumes that those 'excluded' strive to become 'included' and that the path to 'inclusion' is ultimately through activation and paid employment (Spandler 2007). It is therefore an individualising governmental technology that targets those 'excluded' (e.g. people using drugs) with the normalising objective of transforming them into 'included' active and responsible citizens. It also works to divert attention from structural factors, such as poverty, as a contributor to drug use. The problematisation of drugs as a social inclusion

[29] One LDTF was set up in Cork and 13 in Dublin.

[30] This Department held responsibility for local development and for the coordination of social inclusion programmes. Government changed from a Fine Gael/Labour/Democratic Left cabinet to a more right wing Fianna Fáil/Progressive Democrats leadership.

issue has continued. For example, in the statutory health sector, current responsibility for drugs falls under the HSE Social Inclusion unit.

The 2001 drugs strategy was published in the context of this new emphasis on social inclusion. For example, in the area of rehabilitation, community reintegration of drug users was promoted with measures such as dedicated CE schemes for 'recovering' drug users, which were introduced in 2004 (Department of Social Protection 2013). The 'taken-for-grantedness' of responsibilisation had taken hold as, when discussing implementation of the policy, the report stated that

> there is, of course, a necessary sharing of responsibility…[…]… The allocation of responsibility across functional categories is made more diffuse and, arguably more effective, by the role in Ireland and elsewhere, of the community and voluntary sectors across the four pillars of the drug strategy (DOTSR 2001, p. 50).

In an acknowledgement that drugs were now a national concern, the strategy recommended that ten Regional Drugs Task Forces [RDTF] be established, geographically including all of Ireland. A year after the publication of the strategy, responsibility for drug policy was moved to yet another government department. The move to the DOCRGA reflects further responsibilisation of the community sector. Policy responsibility stayed in this department until 2011 when, after a change of government, it was moved to back to the DOH. This suggests that drugs and drug use were once again understood as public health 'problems'.

The 2009 strategy was developed in the context of a severe economic downturn and recession in Ireland. In the strategy, the community sector continued to play an important perceived role in policy implementation across policy domains. There was a stronger focus on community safety. Policy solutions included calls for better community engagement through proposed partnership solutions in the form of Local Policing Fora and Joint Policing Committees. Despite the policy emphasis on community, funding priorities did not reflect this during the economic recession. As previously noted, severe cuts in public spending impacted on all areas, but the cuts were not shared equally. Harvey (2012) estimates that with an overall reduction in public

spending of 2.8% between 2008 and 2012, funding for the voluntary and community sectors fell by approximately 35%.

5.7.4 Harm reduction

Abstinence-based treatment was official policy in Ireland until 1991; however, harm reduction services were gradually introduced into Ireland through the voluntary sector in the 1980s.[31] Low-threshold services, supported with funding from the state, were established such as the Ana Liffey Drug Project in 1982 and the Merchants' Quay Project in 1989 (Merchants Quay Ireland 2013; Ana Liffey Drug Project 2016). The statutory sector followed with the introduction of methadone maintenance programmes in 1987 and a needle exchange programme in 1989 (Butler and Mayock 2005). Butler and Mayock (2005) argue that harm reduction was introduced in a covert manner "without debate, announcement or a clearly presented rationale…an Irish solution to an Irish problem" (p. 420-21). The authors suggest that subterfuge is a feature of the Irish policy making process, in particular when sensitive or potentially divisive issues are addressed.

The 1991 strategy made explicit the connections between drug use and HIV/AIDS, and, for the first time, a reference to harm reduction practices was included in official policy (DOH 1991). While this was a shift in policy direction, Butler and Mayock (2005) argue that it did not reflect an ideological shift. Rather, they assert that the rationale was biopolitical - to protect the population from HIV infection and to reduce crime on Dublin city centre streets. The endorsement of harm reduction as the foundation for Irish drug policy has continued in subsequent policy documents. The 1996 policy stated that "Methadone maintenance programmes have a crucial role in stabilising injecting addicts, whose behaviour threatens families and whole communities" (Ministerial Task Force 1996, p. 41). Clearly, here methadone maintenance was understood as a governmental disciplinary technology to

[31] Harm reduction focuses on reducing the harms associated with drug use, not reducing drug use per se. While there is no single philosophy underpinning it, it is often rationalised through a public health discourse with population based objectives such as the reduction of drug-related deaths and infections.

regulate and control ‘dangerous’ individuals in order to protect ‘ordinary’ citizens - in other words, to produce ‘docile bodies’ (Foucault 1979).

The emphasis on harm reduction continued in the 2001 and 2009 strategies, contained in the overall strategic policy objective: “To continue to tackle the harm caused to individuals and society by the misuse of drugs…” (DOCRGA 2009, p. 6). The commitment to harm reduction is also foregrounded as a rationale of the 2017 strategy where it is included in the title (*Reducing Harm, Supporting Recovery)*, vision and strategic goals (DOH 2017).

5.7.5 Drug-related crime

Supply reduction measures have always formed part of Irish drug policy; however, stricter criminal justice responses were introduced in the mid-1990s. Following the first piece of drug legislation, the Dangerous Drugs Act (1934), the Misuse of Drugs Act (1977) was enacted to comply with Ireland’s obligations as a signatory to the 1961 and 1971 UN Conventions on drugs (Butler 2002). The 1977 Act introduced a new criminal justice approach to the management pf drug offenders in Irish courts, with a mandatory requirement for provision of probation reports on the offender’s vocational, educational and social circumstances before sentencing (McNally 2009). The judge could use these reports to order alternatives to imprisonment, for example, probation supervision, drug treatment or participation in education and training (ibid). The Act was amended in 1984 due to the high volume of court cases relating to drug crime linked to the rising levels of heroin use at the time. Notably, while the mandatory requirement was removed, the practice remained popular with the courts (McNally 2009). This suggests that the criminal justice system perceived it to be effective. Butler (2013) suggests that the practice facilitated a problem-solving approach to the management of drug offenders where imprisonment was often the least preferred option. Another effect was the fostering of a collaborative practice between the criminal justice system and drug treatment services, which was managed by the Probation Service (McNally 2009; Butler 2013).

There were other early links between the criminal justice and health service systems. The Probation Service supported and contributed funding to the

Coolmine Therapeutic Community, and its Director joined Coolmine's management committee at the end of the 1970s (McNally 2009; Butler 2015).[32] A number of treatment services, ranging from residential rehabilitation to harm reduction services, were also funded by the probation service (Clarke and Eustace 2016). Another development was the introduction of the pilot Dublin drug court in 2001, where offenders were ordered to undergo intensive and closely monitored treatment and rehabilitation as an alternative to imprisonment (Butler 2013).

The drug court formed part of an intensification of criminal justice responses in the mid-1990s as a concern about the links between drugs, crime and community safety emerged (Farrell and Bunning 1996 cited in O'Gorman 1998, p. 8). Prevalence of heroin use had risen in the early 1990s, with an estimated 13,500 users in Dublin by 1996 (Comiskey 1998). At the same time, recorded drug-related offences doubled from 2,017 in 1990 to 4,021 in 1995 (EMCDDA 2013). The public and political concern about drug use and criminal activity escalated, with a 'moral panic' ensuing following the murder of an investigative journalist, Veronica Guerin, in June 1996 (O'Brien and Moran 1998; Butler 2013). The Government reacted quickly by forming a Ministerial Task Force in July whose report was published in October. Until 1996, responsibility for drug policy had been located with the DOH, but it was now moved to the Department of the Taoiseach, indicating that the drugs issue was a governmental priority. Ireland held the Presidency of the European Union in the same year and committed to tackle drugs misuse and drug trafficking as a priority (O'Brien and Moran 1998). Responding to the 'problem' of drug-related crime, the Government enacted a number of strict legislative responses to address drugs and drug-related crime between 1996 and 1999.[33]

[32] Butler (2015) maintains that a majority of offenders did not opt for treatment at Coolmine due to its confrontational approach to treatment, and preferred imprisonment to treatment.

[33] These include the 1996 Criminal Justice (Drug Trafficking) Act; 1996 Criminal Assets Bureau Act; 1996 Disclosure of certain information for taxation and other purposes Act; 1996; Proceeds of Crime Act; 1999 Criminal Justice Act (amended).

The focus on criminal justice responses has continued. One of the strategic aims in the 2001 strategy was "to reduce the availability of illicit drugs" (DOTSR 2001, p. 4); subsequently, eight pieces of legislation addressing drug trafficking were introduced between 2003 and 2008 (DOCRGA 2009). In 2009, the strategic aim read "to create a safer society through the reduction of the supply and availability of drugs for illicit use" (DOCRGA 2009, p. 6). Securing the population – a safe society - is a fundamental objective of government as people must feel safe in order to participate as active citizens in society (Foucault 2007). The contemporary policy discourse produces knowledge about the assumed links between the supply of drugs and public safety, which works to justify law enforcement policy responses.[34] The most recent legislation, *The Misuse of Drugs (Amendment) Bill 2016*, provides for tighter controls of the illegal trading of prescription medications amongst other drugs. Arguably, this legislation was another visible response by the government to an upsurge of gang-related violence in North Inner City Dublin during 2015-16 (Dáil Debates 2016).

5.7.6 The turn to risk

While the notion of risk featured in Irish drug policy prior to 2009, this year an explicit risk/protective factor discourse underpinned the prevention pillar. Prevention science emerged as a discipline in the US in the 1990s and has gained enduring global support as it seen to produce rational, evidence-based and cost-effective solutions to health and social issues (France and Utting 2005; France *et al.* 2010; Roumeliotis 2015). Prevention science is underpinned by a rationality of risk, which emerged in the 19th century and has permeated all areas of human life and governmental policy (Ewald 1991). The past 40 years has seen a gradual shift from the socialising of risk (the welfare model) towards the individualisation of risk (Rose 2000). Risk factor analysis enables interventions that target specific risks at specific points in the life stages of certain high-risk groups (France *et al.* 2010). Risk is seen in

[34] A discussion about the relationship between drugs and crime is beyond the scope of this chapter; however, explanatory causal models include the psycho-pharmacological, economic-compulsive, systemic and common-cause models. Connolly (2006) suggests that the links are complex rather than causal and that both drug use and crime are related to underlying social factors (Connolly 2006).

terms of probabilities for a future event to take place in a population; by bringing the "future into the present", risk "tries to discipline uncertainty" (Rose 1998, p. 180). Technologies of risk are totalising as they target populations, but have individualising consequences, as each person in the population is assigned a level of risk on a continuum (Rose 1998).

Prevention, therefore, can be thought of as a technology of risk that enables 'governing at a distance' as a network of actors beyond the state are responsible for governing high-risk groups in a population (Miller and Rose 2008). Knowledge created through technologies of governing, including surveillance, enables new disciplinary governing practices that legitimise interventions with individuals and groups considered 'risky' or 'at risk'. Risk discourse has also reconfigured professional practices, which have shifted from a focus on care towards rational administrative techniques such as risk assessment and management (Castel 1991; Rose 1998; France *et al.* 2010; Featherstone *et al.* 2014).

The 2009 strategy incorporated this knowledge stating that "research has identified risk and protective factors…" (DOCRGA 2009, p. 28):[35]

> **Risk factors** are: early school leaving or poor educational attainment; history of unemployment; poverty; poor mental health; family conflict/breakdown; anti-social behaviour; involvement in crime; family history of addiction (including alcohol); ethnicity and marginalisation and drug-taking in social networks.
>
> **Protective factors** are: family factors, educational factors; individual characteristics; personal and social competence (ibid, p.28).

The type of expert knowledge that has shaped this research is rooted in social science, primarily the discipline of psychology. While the source of the research is not stated, it is likely that it refers to a report commissioned by the NADCA, *Drug use prevention, an overview of research* (Morgan 2001), which provided an overview of risk and protective factors and introduced risk factor science into drug prevention policy.

Notably, in the extract above, the risk factors are more specific and numerous than the protective factors, producing a discursive effect that risk factors have

[35] No references are provided.

a stronger evidence base. This creates a rationale for governmental programmes that focus on risk reduction. The use of the binary risk/protective factor framework is an example of a "dividing practice" that produces a normative effect (Foucault 2000, p. 326). Subject groups aligned to the protective factors are understood as the norm. However, groups of people associated with the risk factors are deviating from the norm, and, as such, are turned into legitimate subjects for governing, for example, dysfunctional families and families experiencing addiction.

The proposed strategy for drug prevention is a rational, three-tiered approach based on risk. This practice is another example of a 'dividing practice' that locates people into categories, and works to produce subjects amenable to governing. The first tier targets general population, while the second tier targets those considered most at risk: children of people who use drugs, early school leavers and those involved in anti-social behaviour. The third tier targets people who use drugs.

5.7.7 The (re)turn to 'recovery'

While many European drug policies have increasingly favoured a harm reduction paradigm since the mid-80s, a policy shift has occurred in the UK with a turn towards 'recovery' models (Scottish Government 2008; HM Government 2010). Beyond the UK, the idea of 'recovery' has long been promoted in the US (Betty Ford Institute Consensus Panel 2007; Laudet and Humphries 2013). Recovery is a contested concept and there is no agreement of its meaning (MacGregor 2012; McKeganey 2014; Neale *et al.* 2014). In the UK, it understood as a multi-dimensional concept that refers to 'achievements' in several areas of personal life, such as drug use, criminal behaviour, health, relationships, housing, education and employment (HM Government 2010; Thurgood *et al.* 2014; Neale *et al.* 2016). Consequently, 'recovery' discourse produces a drug using subject that is responsible, rational and active, striving to improve his/her lifestyle in line with societal norms of an economically productive citizen (Lancaster *et al.* 2015).

In Irish drug policy, the term 'rehabilitation' rather than 'recovery' has been preferred until recently. Rehabilitation became an explicit focus for policy in

2005, when the 2001 drugs strategy was reviewed and rehabilitation became a separate policy strand (DOCRGA 2005). Following this, a *Report of the Working Group on Drugs Rehabilitation* was published (DCRGA 2007). The recommendations contained in this report were subsequently endorsed in the 2009 strategy. The notion of rehabilitation in Irish policy discourse is similar to 'recovery', as it is seen to encompass personal development, access to housing, vocational training, education and employment and aims to re-integrate drug users into society (DCRGA 2007).

A 'recovery' discourse has (re-)emerged in recent years, although the philosophies underpinning recovery models differ. A report published by Soilse, an HSE recovery-based drug rehabilitation service, advocated for a re-orientation of drug treatment services with a return to an abstinence-based recovery-based paradigm (Keane *et al.* 2014). This is followed by a HRB Evidence Review, *The role of social and human capital in recovery from drug and alcohol addiction* (Munton *et al.* 2014), underpinned by the concept of 'recovery capital' (Granfield and Cloud 1999; Cloud and Granfield 2008). This report claims that

> addiction recovery has become an increasingly important concept in the design and implementation of substance use treatment and rehabilitation services (Munton *et al.* 2014, p. 11).

Most notably, the term 'recovery' appears in the title and in one of the five strategic goals[36] of the new strategy, *Reducing Harm, Supporting Recovery*, published by the DOH in 2017. However, in the policy, recovery does not equate to abstinence:

> …recovery is often seen as a journey, and rehabilitation as a process, that supports and encourages the individual at each stage along the pathway to recovery. Recovery is a personal matter. A successful outcome or improvement for one person may involve improving their quality of life and overcoming reliance on their primary drug of dependence. For another person, the ultimate goal for their own recovery may be to become drug free (DOH 2017, p. 33).

[36] "Goal 2: Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery" (DOH 2017, p. 33).

Clearly, contemporary Irish drug policy remains pragmatic by the inclusion of both harm reduction and recovery based approaches, where recovery is not conceptualised solely as abstinence, and, as such, avoids conflict and debate.

5.7.8 Decriminalisation

The community sector has led a debate on decriminalisation. Following a conference organised by CityWide in 2013, the debate has gained momentum in Ireland, with increased visibility in media and politics. Another major CityWide conference took place in 2015, where the President of Ireland and the Minister with responsibility for drug policy both endorsed a public health response to drug use (CityWide 2015). In 2015, the Oireachtas Joint Committee on Justice, Defence and Equality published the *Report of the Committee on a Harm Reducing and Rehabilitative approach to possession of small amounts of illegal drugs.*[37] It concluded that there was merit in exploring the Portuguese model of decriminalisation in an Irish context. The newly published strategy contains an action that recommends the establishment of a Working Group, which will examine options to criminalisation for possession of small quantities of drugs for personal use (DOH 2017).

There has been little debate about the fundamental philosophical assumptions underpinning the various policy responses. The new discourse prefers to define drugs as a health issue rather than a criminal justice issue. Notably, the new drugs strategy calls for a "health-led response to drug and alcohol use in Ireland" (DOH 2017, title page). However, the current debate lacks critical analysis of the effects of conceptualising drugs and drug use as a public health issues and the re-definition of the person using drugs from criminal subject to a patient subject, and its political implications.

5.8 Conclusions

This chapter has provided the background policy context for my analysis of drug policy and interview data. In many ways, Ireland is similar to other 'advanced liberal' countries in the Western hemisphere in terms of many of

[37] The Oireachtas refer to the two houses of the Irish Parliament: the Dáil Éireann (lower house) and the Seanad Éireann (upper house). Oireachtas committees act as advisory groups to the houses in a range of areas.

the rationalities that underpin contemporary social policy, such as managerialism, evidence-based practice, risk, responsibilisation, and activation. However, there may also be differences from other countries due to certain historical, cultural and political contexts and legacies such as the influence of Catholic social teaching and the lack of a strong Social Democratic and left-wing political tradition. For example, there is a strong reliance on the voluntary and community sectors for provision of health and social services, although often funded through the state. Furthermore, the Catholic principle of subsidiarity emphasised individual, familial and community responsibility for welfare. Therefore, the post-welfarist governmental technology of responsibilisation is not a 'new' form of governing – it may well be congruent with engrained values and beliefs.

Families have been a key concern for the Irish state since its inception, reflected in the position of 'the family' in the Constitution as the cornerstone of society. A focus on family in Irish social policy intensified towards the end of the 1990s and has increasingly focussed on protection of children and the future potentiality of children, together with an increasing concern about the conduct of parents who are seen as responsible for the future life outcomes of their children. Similar to drug policy, family policy is a contentious field due to its moral connotations. The rhetoric of 'the family' has popular appeal and is often used symbolically, and in an emotive manner, to gain political advantage (Fox Harding 1996). Policies that target families are therefore used to achieve key governmental objectives, such as activation, where the family is viewed as the means to such goals (Fox Harding 1996). From a governmentality studies perspective, Rose observes that "the modern family remains intensely governed, it is linked in so many ways with social, economic and political objectives (1999, p.213).

Contemporary drug policy comprises criminal justice responses, prevention based on a risk factors framework, and a spectrum of treatment responses including harm reduction. Policy in the 1990s made the links between structural factors and drug use explicit; however, the 2000s saw a return towards more individualist models of understanding and responding to drug use. Contemporary policy issues include a focus on drug-related crime, which

intensified in the mid-1990s, while an emphasis on rehabilitation and recovery in policy discourse has increased since the mid-2000s. Community-based partnership responses to the drugs issue, based on geography, have featured in drug policy since the 1990s; however, these were rooted in community activism that resulted from the lack of a statutory response in the 1980s. Hence, these political movements were co-opted into the neoliberal agenda. A feature of Irish drug policy making has been the lack of significant public and political debate, especially in terms of a critical analysis of the underpinning philosophical assumptions underpinning different policy solutions. This has been the case from when harm reduction was introduced in a covert manner in the 1980s, to the more recent 'recovery' discourse, and, to the recent decriminalisation discourse.

Chapter Six:

Governing families through responsibilisation

Chapter Six: Governing families through responsibilisation

6.1 Introduction

Taking Bacchi's premise that "we are governed through problematisations" (2009, p. xiii), in this and the next chapter I seek to answer three interconnected questions: (1) How have families been problematised in contemporary Irish drug policy? (2) What knowledge and expertise have shaped the way that the 'problem' is represented in policy? And (3) What are the effects in terms of governing practices and political implications?

Applying Bacchi's (2009) WPR policy analysis approach, I have analysed the 2009 *National Drugs Strategy* and relevant background materials. This analysis found two dominant forms of governmental rationalities underpinning the way that families are problematised in contemporary drug policy - responsibilisation and risk – both dominant modes of governing in advanced liberal societies (Miller and Rose 2008). In this chapter I discuss how families are governed through responsibilisation, while in Chapter Seven I discuss governing through risk.

In this chapter, I draw attention to three forms of representations of families who have close relatives using drugs as 'problems' in contemporary policy. In all instances responsibilisation as a mode of governance encourages individuals and families to think about themselves as responsible for their current and future lives. The first representation is found as part of the supply reduction strategy of the policy and is framed by a law and order discourse. Families are constituted as victims of crime in the context of drug-related intimidation. Drug-related intimidation is represented as a reporting 'problem' that requires a specific criminal justice intervention to encourage families to report the crime. The way that the 'problem' is represented has been shaped by criminal justice and experiential discourses. While the responsibility for intimidation is placed with the individual family member who owes the debt, families are seen as part of the solution to the 'problem'. I argue that this representation is individualising and shifts responsibility for addressing the 'problem' of intimidation to individuals and families.

The second form of problematisation of families is found in the treatment and rehabilitation strategy. In the context of adolescent drug treatment, families are problematised as dysfunctional, and they are seen as being both part of the 'problem' and solution to adolescent drug use. This problem representation is shaped by psychological knowledge and expertise, and family therapy is promoted as a key intervention.

The third problem representation is also found in the treatment and rehabilitation domain. Here, families are seen as service users in their own right. The 'problem' is represented as a coping issue, and this is shaped by psychological knowledge and expertise. While family members are not blamed for their own difficulties, they are asked to actively work on improving their resilience. This problem representation is nested within a second problem representation of families as a source of social recovery capital in the treatment and rehabilitation process of their close relative. The knowledge and expertise shaping this representation of the 'problem' draw on psychological and sociological theories. I argue that families are understood as service users in their own right in order to improve their own health; however, in accessing services they are also encouraged to develop coping skills so that they, in turn, can better function as social recovery capital for their close relative. In other words, the rationale is biopolitical.

I will now discuss each of the three problem representations in turn. I draw attention to the presuppositions, assumptions and knowledges that make them possible. Throughout the chapter I identify silences to highlight the issues that are not problematised in the policy. The silences call attention to that which is not thinkable, by virtue of the way that 'problems' are represented. Following the WPR approach, I trace how each problem representation 'came to be', focussing on the dominant forms of knowledge and expertise that have shaped them. Finally, I theorise the effects, or political implications, of the problem representations in terms of how families are governed.

6.2 Families as 'victims'

6.2.1 A reporting 'problem'

The issue of drug-related intimidation of families is introduced as a new concern, or object for thought, for drug policy in the 2009 strategy. It is raised as a priority issue in the supply reduction chapter, producing it as a law and order 'problem'. Intimidation is identified as barrier to effective collaboration between the police and the community, which is seen as necessary for effective crime control:

> …community engagement has become more difficult in some areas, due to the increased incidence of intimidation…[…]…there is a need for widespread community engagement to support the conviction of known drug offenders (DOCRGA 2009, p. 21).

An outstanding drug debt is identified as a main reason for intimidation of family members, and it is represented as a 'problem' that is located with the person who uses or deals drugs:

> …a result of drug usage or drug supply whereby the individual is held financially liable for drugs used, or *seized by the authorities*…(ibid, p. 24, emphasis in italics added).

However, this extract also contains a second representation of drug-debt as a drug regulation 'problem' as it is recognised that drug seizures can also lead to drug debts. However, this representation remains unproblematised in the policy, which precludes solutions to the 'problem' that address drug regulation practices.

Families are specifically named as victims of intimidation, producing them as objects of knowledge, and therefore potentially governable subjects:

> The families, friends and associates of drug users…[…]…are increasingly the targets of intimidation and violence…[…]…Apart from the huge impact on the families directly affected, the increased levels of violence have significant negative consequences for the wider communities (ibid).

It is also noted that

> …many of the incidents which may have their origins in acts of intimidation may not be recognised or reported as such. This potentially leads to low levels of reporting and feelings of helplessness among victims and families (ibid).

There is further discussion about the lack of reporting and the difficulty in pursuing prosecutions due to the "nature of the offence" (ibid). It is acknowledged that there is "no easy remedy" to solve the 'problem', but one recommendation is put forward, which becomes an action in the implementation plan:

> The Steering Group recommends that An Garda Síochána, in conjunction with relevant partners, develop an initiative that will allow for communication, either directly between the victims and An Garda Síochána, or via the Family Support Network or other agencies (ibid).

Inherent in this recommendation is the representation of drug-related intimidation of families as a 'problem' of communication, more specifically a lack of reporting. It is assumed that interventions with families will lead to a higher level of reporting of drug-related intimidation. In turn, this will lead to a higher level of conviction of drug criminals, and consequently a reduction in the supply of drugs and overall crime levels. This provides a biopolitical rationale for governmental intervention with families in the name of social order and security.

An underlying assumption is that family members, given help, are able and willing to support law enforcement efforts as rational and responsible citizens (O'Malley and Palmer 1996; Skogan 2008). The implicit link between families and communities makes self-evident the notion that as responsible citizens, families are under obligation to report crimes to make their neighbourhood safer. This is an example of ethopower at work, where the family is governed through the community (Rose 2000).

6.2.2 Knowledge and expertise

My analysis has found that two key forms of knowledge and expertise shape the way that families impacted by drug-debt intimidation are problematised: criminal justice discourses and experiential discourses.

6.2.2.1 New criminal justice discourses

As discussed in Chapter Five, a drug policy shift took place in 1996, with increasing public and political concern about the links between drugs and crime. The early to mid-90s also saw a renewed wave of community-based

anti-drug activities by vigilante groups (Cullen 2003; Mulcahy and O'Mahony 2005; Butler 2007). The 1996 Ministerial Task Force report officially acknowledged that there had been an inadequate state response to the drugs 'problem' in socio-economically disadvantaged communities:

> …the majority of families and young people in even the most seriously drug-affected areas are not drug misusers. Overwhelmingly, they are seeking better futures for their children and take legitimate pride in the strengths of their community…However, it is easy to understand that a community may feel overwhelmed by the scale of the drugs problem and the threat which it poses to its young people. *In the absence of a clear and convincing response from the public authorities, parents and others may begin to lose heart or resort to punitive and extra-legal measures* which, by leaving the root causes of drug addiction untouched, are ultimately futile (1996, p. 7-8, italics added).

In this extract, the vigilante activities that the anti-drugs movement engaged in are understood to be a consequence of the failure of the criminal justice system, but are also clearly not seen as a legitimate alternative. This reflects the prevailing antagonistic attitude of the authorities towards the anti-drugs movement at the time. Non-drug using families are constructed as law abiding families who desire to safeguard the future of their children. Notably, this conceptualisation does not extend to families with close relatives who use drugs, who are invisible in this 1996 policy. As discussed in Chapter Five, some of the parents involved in the anti-drugs movement also included those with children who were using drugs. While the movement articulated that its vigilante activities were primarily directed at those who supplied drugs, those using drugs were also targeted. In late 1996, local activists were implicated in the death of a heroin user in Dublin (Mulcahy and O'Mahony 2005). Due to the nature of the drug market, many users are also dealers (Connolly and Donovan 2014). Hence, it is likely that families who were involved in the drugs trade, or who had close relatives who use drugs, were likely to have been targeted and negatively impacted by anti-drug vigilante activism, but this is not problematised in the policy.

Instead, the Task Force recommends an alternative and legitimate community-based solution - community policing - in order to "build confidence in communities that the drugs problem can be tackled" (1996, p. 46). Community policing emerged in the US in the 1970s and 1980s as an

alternative to professional policing models, often in disadvantaged geographical urban areas (Skogan 2008). Community policing aims to enable dialogue with community representatives as it enlists members of the community in crime prevention and information sharing with the police (Skogan 2008; An Garda Síochána 2014). As such, it is a governmental technology that extends the responsibility (and shares the blame) for addressing crimes, such as the supply of drugs, to communities, families and individuals (O'Malley and Palmer 1996). Together, the police and the community are thought to co-produce safety (Skogan 2008). In the 2001 strategy, the discourse on responsibilisation for supply reduction has clearly taken hold:

> …mechanisms for individuals and communities to actively co-operate with the enforcement agencies must be developed in order to reduce supply radically. Individuals, families, communities and a range of statutory and non-statutory agencies each have a role in curtailing the amount of illicit drugs in circulation (DOTSR 2001, p. 97).[38]

Community policing is underpinned by several assumptions. First, it presupposes a socially cohesive community with an infrastructure conducive to participation (Skogan 2008). Second, it is presumed that cooperation between the police and residents is a rational and unproblematic activity that can negate previous local histories. Community policing works through ethopower as it constructs individuals as responsible and rational citizens who cooperate with the police for the good of their community and society, and because it is morally right (Rose 2000). However, as Mulcahy and O'Mahony (2005, p.2) point out, "relations between police and the public are complex matters", especially in socially marginalised communities. Historically, these areas have been 'over-policed' and 'under-protected', resulting in contentious relations and low levels of public confidence and trust in the police (Mulcahy and O'Mahony 2005; Power and Barnes 2011). For some community

[38] Measures in the An Garda Síochána Act 2005 provided for such approaches, including the establishment of a Joint Policing Committee in each Local Authority, consisting of the police, local members of the Oireachtas, local authority elected members and officials, voluntary and community representatives. It acts as a forum for consultation and discussion, and makes recommendations relating to local policing and crime issues (An Garda Síochána 2017). Local Policing Fora are set up within specific neighbourhoods (Department of Justice and Equality 2017).

residents, the police can often be perceived to be the problem rather than a solution to problems (Skogan 2008). Third, it is assumed that the new roles are unproblematic for the police; however, the idea of community policing can be difficult to operationalise effectively within a strongly hierarchical institution, which has no formal tradition of collaborating or consulting with the community (Mulcahy and O'Mahony 2005). Fourth, despite families being constituted as victims, factors such as fear of reprisal are not assumed to interfere with community engagement with the police. Finally, there is an associated assumption that the police can protect victims against reprisal. These assumptions are not problematised in the drug policy documents. Hence, I argue that the construction of drug-debt intimidation as a reporting 'problem' is shaped by legacies and discourses on community-based responses to crime, such as community policing, and carries similar underpinning assumptions.

The construction of families as victims and the representation of the 'problem' as lack of reporting reflect two broader developments in criminal justice policy and practice in the past thirty years, which are characteristic of neoliberal forms of rule. The first is a focus on the harmful effects of crime rather than the causes, with a particular interest in 'victims' of crime as objects of knowledge and targets for governing (Garland 2001). Garland (2001) argues that this discourse is productive as it has led to the establishment of new relationships between 'victims' and statutory authorities where 'victims' are constructed as consumers in need of expert criminal justice services. These are generally seen as 'positive' and benevolent governmental interventions compared to the traditionally 'negative' practices of punishment that the criminal justice system engages in. However, cautioning against the self-evident nature of this dominant idea, Garland (2001) puts forward an alternative understanding of the focus on victimisation as an extension of the law and order gaze into private lives. Power is still being exercised through the criminal justice system, just in a different form, and existing power relations are therefore reinforced.

The second development is the extension of responsibility for control of crime to non-state actors such as organisations, professionals, communities,

families and individuals (O'Malley & Palmer 1996). Garland (2001) argues that a new criminological discourse of 'everyday life' has shaped these developments where crime is a taken-for-granted idea and the statutory criminal justice system is seen as having limited capacity in addressing it. This reflects the wide network of actors beyond the state engaged in governing individuals and populations 'at a distance' in all areas of life characteristic of governmentality as a form of rule (Foucault 2007; Miller and Rose 2008).

6.2.2.2 Experiential knowledge

The construction of families as 'victims' is also shaped by social scientific knowledge, which produced families impacted by drug-debt intimidation in Ireland as objects of knowledge. In the early 2000s, research on the impacts of drug-related crime highlighted how intimidation and fear of reprisal served as barriers to engagement of community residents with the police (Connolly 2002; 2003; Loughran and McCann 2006). The specific issue of drug-related intimidation of family members was first reported in the public domain by the NFSN at its Service of Commemoration and Hope in 2007, which was attended by senior police officers (O'Leary 2009; Citywide 2013).[39] Following this, the NFSN and the police agreed on a partnership approach to address the issue. The NFSN subsequently produced a report on drug-debt intimidation of families (O'Leary 2009). The study, which surveyed the extent and nature of intimidation of family members, aimed to make lived experiences visible (O'Leary 2009). Although this research is not referenced in the 2009 strategy, it is clear that the Steering Group acted on its recommendations.[40] As I showed in Chapter Two, Irish drug policy appears unique in producing drug-related intimidation of families as a priority policy 'problem'. I argue that the production of knowledge by Irish statutory and voluntary agencies has legitimised drug-related intimidation of families as an evidence-based 'problem' for drug policy to address. It also highlights how

[39] Family support groups organised the first Service of Commemoration and Hope in 2000, which remembers family members who have died as a result of drug use and drug-related causes. It is now an annual event.
[40] See O'Leary (2009), p. 40.

representations of 'problems' are culturally and historically contingent (Bacchi 2009).

Following the publication of the NDS in 2009, the issue of drug-related intimidation of family members has continued to stay high on the agenda. Community organisations such as CityWide have produced knowledge about the issue through conferences (Citywide 2010; 2011; 2013). Scientific knowledge production has continued as further social research on drug-related intimidation has been published (Hourigan 2011; Strategic Response Group 2013; Jennings 2013; Connolly and Buckley 2016; O'Gorman *et al*. 2016). Notably, given the key role of the police, it has not contributed statistical knowledge in the form of recorded offences or successful prosecutions for drug-related intimidation.[41]

A review of the 2009 strategy notes that intimidation is given higher priority as a policy 'problem' in Ireland compared to other jurisdictions, suggesting that this is possibly due to the way that drug markets operate in Ireland (Griffiths *et al.* 2016). Possibly this is due to a high proportion of drug transactions on credit, which makes it easy to build up debts (Connolly and Buckley 2016). It is beyond the scope of my study to analyse the new strategy, which was published in July 2017; however, an initial reading finds that drug-related intimidation has continued as a policy priority 'problem'.

6.2.3 Governing drug-related intimidation

The way that drug-related intimidation is constructed as a 'problem' of reporting enables a police-led intervention that governs families and professionals in specific ways. The *Drug Related Intimidation Reporting Programme*, which was jointly developed by the Garda National Drugs Unit (GNDU) and the NFSN, was piloted and then implemented nationally in 2013 (An Garda Síochána 2017). Through this programme, family members are facilitated to meet with a senior Police officer, a Garda Inspector, who provides information about personal safety and advice about reporting (NFSN

[41] It is possible that some of the crimes recorded under "Attempts/threats to murder, assaults, harassments and related offences" may include drug-related intimidation (CSO 2014).

and GNDU 2013). Appendix K contains a poster that provides information about the programme.

Professionals, such as community workers and family support workers, are understood to play an important mediating role as they are often the first people that family members report intimidation to, and they can refer family members to the programme. To support the implementation of this programme, other governmental technologies have been enacted, such as a *QuADS Responding to Intimidation Policy* template for services and provision of training for service providers (NFSN and GNDU 2013; DOH 2014; Drugs.ie 2014). [42]

The uptake and effectiveness of the programme in terms of reported incidents, prosecutions or convictions for drug-debt intimidation have not been reported in the public domain; however, one study notes that it…

> has been useful for parents to assess risk in paying or not paying the debt. It has also been a useful resource for local community services as they have somewhere to refer families (Connolly and Buckley 2016).

In practice, it appears that the role that the police play is to help families assess the risk of paying or not. Notably, the new strategy calls for the reporting programme to be evaluated separately by the Police and the NFSN in order to "strengthen its effectiveness" (DOH 2017, p. 94).

Several assumptions underpin this technical and rational 'remedy' to the 'problem'. First, the act of reporting is understood as a rational activity for families. The engagement of families, whose close relatives are engaged in criminal activity, with agents of the criminal justice system is seen as unproblematic. The asymmetrical power relations in this context are not questioned or considered. A linked assumption underpinning the intervention is that families believe that the police can protect them. Factors such as lack of trust in the police, previous negative experiences with the police, perceptions about the effectiveness of the police in responding to reporting and fear of reprisal are overlooked in the policy (Mulcahy and O'Mahony

[42] QuADS is an acronym for Quality in Alcohol and Drug Services, which in 2014 published a set of national quality standards for drug and alcohol services in Ireland (HSE and Ana Liffey Drug Project 2014).

2005; Power and Barnes 2011; Connolly and Donovan 2014; Connolly and Buckley 2016).

It is also assumed that professionals such as community workers and family support workers view participation in the programme as part of their brief and that this is unproblematic. It is likely that factors such as previous relationships with the police and fear of reprisal would impact on participation (Skogan 2008). Similarly, the participation of the police themselves in the programme is not problematised. The prohibitionist approach dominating drug policy is likely to shape beliefs and attitudes about drug use and people who use drugs (and by extension their families). The idea of supporting the same families that they may have engaged with in a confrontational manner may not be one that is comfortable or compatible for some police officers. Finally, there is an assumption that the police themselves have the resources to protect victims.

6.2.4 Political implications

In drug policy drug-debt intimidation of family members is constructed as a reporting 'problem'. This representation produces discursive and subjectification effects and closes off alternative ways of representing and governing the 'problem'. The proposed solution is individualising. Responsibility for addressing drug-debt intimidation is shifted on to families and professionals, which reduces the state's responsibility for providing well-resourced and effective policing (Power and Barnes 2011; Connolly and Donovan 2014).

The construction of family members as 'victims' of intimidation overlooks families' own potential resources and agency in addressing the issue. Some families may have political resources in terms of alliances and access to social networks to address intimidation, while others may choose illegal solutions and have access to criminal social networks. Other families may have the financial resources to pay debts.

In the policy, all families are seen as being impacted in the same manner. However, the experiences and effects of drug-debt intimidation of families are mediated by factors such as class and gender. I argue that working-class

families are more likely to experience potentially harmful effects from intimidation than those from the middle-class. Harms related to drugs tend to be "problems of inequality" and are concentrated in the most marginalised and disadvantaged sections of society (Stevens 2011, p. 15). Families who are socially and economically disadvantaged are at risk of further marginalisation and social exclusion, becoming the 'disadvantaged of the disadvantaged' in their community, particularly vulnerable when drug use by a family member is linked with criminality and gang feuding (Hourigan, 2011). Drug-debt intimidation tends to be local and is more likely to take place inside host communities for drug markets, which are those more socio-economically disadvantaged (Connolly and Donovan 2014). It is possible that more well-off families are better equipped to pay drug-related debts, and thus, less likely to be impacted negatively by drug-related intimidation. It is also likely that middle-class families have a different relationship with the police and may be more likely to engage with interventions such as the programme described above. [43] The way that the 'problem' is represented prevents it from being thought of as a class issue or as an inequality of resources issue.

Drug-debt intimidation is also gendered. Women, mothers in particular, are more likely to be the targets for intimidation, while those carrying out intimidation are primarily male (O'Leary 2009; Connolly and Buckley 2016). Gender is silent in the policy, which overlooks thinking about the issue of drug-debt intimidation in terms of gendered power relations and gender inequalities both within families, and between families and those who intimidate.

I maintain that drug-debt intimidation is an unintended consequence of a 'war on drugs' approach to drug policy, the current approach to drug supply control and the adversarial nature of the Irish criminal justice system. A discursive effect of understanding drug-debt intimidation of families as a law and order 'problem' that requires a criminal justice solution is the closing off of other possible responses, such as mediation or restorative justice approaches.

[43] The finding that middle-class families are less negatively impacted by drug-related intimidation emerged in my interview data, see Chapter Eight.

Perhaps most significantly, it precludes thinking about the fundamental prohibitionist ideology of contemporary drug policy and the way that the criminal justice system operates. However, while decriminalisation could possibly reduce some barriers to reporting intimidation, it would not solve the issue. Many people who use drugs are also engaged in the storage, transport and dealing of drugs in order to pay a debt or to pay for their own use and would still be considered to be offenders by the law (Connelly and Donovan 2014). It is beyond the scope of this chapter to analyse the effects of different approaches to regulation of drugs; however, it is possible that the 'problem' of drug-related intimidation could be understood and governed differently.

The extension of responsibility to families as a tactic for the achievement of governmental biopolitical goals is not only found in the supply reduction domain of drug policy, but also in the treatment and rehabilitation strategies. I now discuss how families with close relatives using drugs have been problematised from this perspective.

6.3 Adolescent drug use and families

6.3.1 A 'problem' of family dysfunction

Adolescent drug use has been constituted as a governable 'problem' in the treatment domain since early drug policy; however, the way that families have been represented as 'problems' has shifted. Early policy problematised families as resistant to expert interventions. This shifted in the mid-1990s when adolescent drug use became represented as a 'problem' of family dysfunction, and this persists in contemporary policy.

In early drug policy, families are seen as obstacles to the state's efforts to address drug use:

> …relatives (usually parents) are frequently unco-operative either by refusing to make the necessary application for admission or by seeking the discharge of the patients against medical advice… we feel that given suitable treatment facilities and with a greater understanding of the benefits to be derived therefrom, parents could be more readily persuaded to co-operate in securing admissions… (Working Party on Drug Abuse 1971, p. 42).

Treatment is seen as the sole responsibility of the state and medical/psychiatric expertise and knowledge. This understanding of families

mirrors Foucault's view of the family as "the agency of the abnormalization of individuals" (2006, p. 114), and at the same time "as a source of normalization" (2003, p. 254). Families are called on to exercise its sovereign power to hand the young 'abnormal' person over to the authorities to be 'normalised', a key function of the family in a disciplinary society:

> …the family's role at this point is to reject him in turn as incapable of being fixed to any disciplinary system, and to get rid of him either by consigning him to pathology, or by abandoning him to delinquency (Foucault 2006, p. 82).

There are mutual benefits of this exchange. The state gains a healthy and active future adult with potential to contribute to the economy, while a normalised individual returns to the family: [44]

> …the family is supposed to find again, at the end of the process, an individual who has been disciplined in such a way that he can be effectively subjected to the family's specific schema of sovereignty. Being a good son, a good husband, and so on, is really the outcome offered by all these disciplinary establishments…(2006, p. 116).

The noncompliance of families is seen as problematic for the state; however, a Foucauldian perspective acknowledges the potential for resistance in every relation of power. Noncompliance can therefore be understood as counter-conduct and as an opposition to the "effects of power linked with knowledge, competence, and qualification: struggles against the privileges of knowledge" (Foucault 1982, p. 781). In this case, psychiatric power and expertise are challenged.

However, the problematisation of families as resistant to expert intervention is discontinued in later drug policies. As prevalence of opiate drug use increased in the late 1970s, almost exclusively confined to socio-economically disadvantaged communities in Dublin, families with sons or daughters using drugs are visible in grass roots community-based responses such the formation of peer-led family support groups (O'Gorman 1998; Cullen 2003; CityWide 2016; NFSN 2016). However, families are absent from the 1991 and 1996 policy documents in the context of treatment and

[44] Here Foucault refers to wealthier families in the 19th Century who pay for treatment in private clinics: "…it is necessary to give back a certain benefit to the family proportionate to the profit demanded from it…" (2006, p. 113).

rehabilitation, although they are responsibilised in the context of crime control as discussed earlier in this chapter.

A discursive shift occurs in 1997 with a recommendation for family involvement in addressing young people's drug use, specifically in the form of family therapy (Ministerial Task Force 1997). Now the responsibility for young people's treatment has been extended to families. The focus on the family as a site for intervention in 1997 can be situated within an intensified focus on family in European social policy at this time as discussed in Chapter Five (Daly and Clavero, 2002). This occurs in the context of a broader post-welfarist shift towards individualisation and the shifting of responsibility for social 'problems' from the state to communities, families and individuals (Miller and Rose 2008).

This discourse has taken hold in 2001:

> To ensure that treatment for young people includes family therapy and community integration phases, in order to encourage family involvement which is a crucial component in the treatment of young people (DOTSR 2001, p. 118)

The 2001 NDS calls for the development of a protocol for the treatment of under-18s. The report recommends that "services attempt to involve the client's family in the treatment of child and adolescent drug misusers as a first priority" (DOHC and HSE 2005, p. 58). This clearly signifies the perceived role of the family as contributing to both the 'problem' and the solution of adolescent drug use, a problematisation that continues in the 2009 strategy. Here it is recommended that treatment services for young people be developed, highlighting that "support services for families, including family therapy services, need to be further developed…" (DOCRGA 2009, p. 63).

Implicit in these policy recommendations is a representation of the 'problem' of adolescent drug use as family 'dysfunction' where families are constructed as pathological and in need of specific professional interventions to improve relationships, function and communication.

6.3.2 Knowledge and expertise

The problematisation of families as dysfunctional is shaped by psychological knowledge and professional expertise from a new sub-discipline, family therapy, which was established in Ireland in 1980 (Carr 2013). Family therapy as a governmental technology attempts to normalise the conduct of families. It is a technology of 'confession', a specific technique of pastoral power (Foucault 1982; 2007). Through its production of truth, the 'confession' makes the individual and the family unit a governable subject (Foucault 2007). This process also encourages 'self-work' where the family is encouraged and helped to build capacity as a self-regulating and responsible institution. Furthermore, it prompts the family to voluntary try to transform itself into a family ideal according to the norms generated by expertise and scientific psychological knowledge and the expectations of an advanced liberal society (Rose 1999). Rose suggests that families engage in interventions such as family therapy…

> through family autonomy, through wishes and aspirations, and through the activation of individual guilt, personal anxiety, and private disappointment. And the almost inevitable misalignment between expectation and realization, fantasy and actuality, fuels the search for help and guidance in the difficult task of producing normality, and powers the constant familial demand for the assistance of expertise (1999, p. 132).

In other words, families voluntarily engage in professional interventions because of their desire for normality.

6.3.3 Political implications

There are discursive and subjectification effects of this problem representation. Interventions such as family therapy are underpinned by psychological theories that address individual and family behaviours; consequently, they do not impact on the meso- and macro-level determinants of young people's drug use. They also do not shift asymmetrical power relations between young people, families and professionals; instead they serve to reproduce and maintain professional knowledge and expertise. As a consequence, political and socioeconomic inequalities are reproduced. Thinking about young people's problematic drug use from an inequalities perspective could enable different solutions such as focussing on enhancing

the material, financial, political and social resources for families and young people.

6.4. Families as service users in their own right

6.4.1 A 'problem' of coping

Another discursive policy shift takes place in 2005 in a mid-term review of the 2001 NDS where the concept of drug-related harms to others is introduced. Furthermore, the imagined role of families expands to active involvement in treatment and rehabilitation of their close relative with the recognition of a need for support in this role:

> The Steering Group acknowledges the considerable role that families play in drug prevention through caring for drug misusers and their children, as well as through successful drug treatment and social re-integration of those family members isolated by their drug problem. The Group is also conscious of the great harm experienced by families through drug misuse and notes the strong calls for family support services to feature much more prominently in the Strategy. Accordingly, the Steering Group believes that the provision of services for families of drug misusers should be prioritised, particularly in areas of highest need such as LDTFs (DOCRGA 2005, p.55).

Family support becomes is described as "crucial in delivering the strategic aim of reducing harm to families" (ibid). It is defined broadly as a range of professional expert interventions targeting both children and adult family members who are seen as needing skills, education, counselling and 'development' work:

> Parent education; child development and education; therapeutic interventions; respite for families and drug misusers themselves; home-based programmes; youth work; and community and personal development (ibid).

Accordingly, family support is added as a new action in drug policy. The strategy recommends that the Department of Social and Family Affairs be represented on the National Drugs Strategy Team, and that the Team should "actively encourage" task forces to "prioritise the provision of family support services" (ibid, p. 66).

Family support can be understood as technology for governing socio-economically disadvantaged and 'at risk' families (Daly 2013). Bacchi (2009) suggests that funding priorities draw attention to the most dominant problem representations. Following this new policy action, 61% of drug task force

projects developed a family dimension; €1.7 million from the Dormant Accounts Fund [45] were allocated specifically towards family support projects; and HSE expenditure on family support increased by 80% between 2003 and 2007 (DOCRGA 2009). As already discussed in Chapter Five, family support emerged as a priority social policy concern in the early 2000s, which clearly shaped the discourse in the 2005 mid-term review.

In addition to the new priority of family support, the 2005 review of the 2001 NDS calls for a stronger focus on rehabilitation. A 2007 report by the Working Group on Drug Rehabilitation promotes activation and community reintegration as key factors to ensuring successful rehabilitation. Its report contains clear references to the imagined active and untapped role of families as social recovery capital in the rehabilitation process:

> Families of problem drug users have the potential to be key to the rehabilitative effort. Sometimes they are not adequately involved in the treatment/rehabilitation of family members. As many problem drug users live at home, families should be seen as partners and be centrally involved in the recovery process. Families can also be a valuable resource in terms of childcare (DOCRGA 2007, p. 41).

The 'problem' is here reported as a lack of involvement of families in the treatment and rehabilitation process of the close relative. The welfare generating potential of families is clearly recognised. The report provides five recommendations relevant to families – three referring to affected families as service users in their own right and two referring to the potential role of families in the rehabilitation process. These are adopted in full by the 2009 NSD where one action calls to "Support families trying to cope with substance related problems" (DOCRGA 2009, p. 101).

Explicit in the policy action is the representation of the 'problem' as families having difficulty coping. The suggested interventions include respite, counselling, alternative therapies, mediation, marriage/relationship guidance, information, support and advice. These suggest that the coping 'problems' are represented as mental health and family relationship issues.

[45] The Dormant Accounts Fund, established in 2001, distributes money from unclaimed accounts in credit institutions for specific purposes decided by the government (Pobal 2015).

The 2009 NDS constructs families as service users in their own right; however, I argue that this is nested within the representation of affected families as social recovery capital. This is clearly articulated in the extract below from the section "Role of families in rehabilitation", where the location of the reference to families as service users in their own right is within the context of the rehabilitation of the close relative:

> The active encouragement of family participation is recommended, subject to the agreement of the individual, and the reconciliation of problem drug users with estranged family members should be pursued. Families should be seen as service users in their own right… (DOCRGA 2009, p. 50).

It is an implicit assumption in these problem representations that family participation and reconciliation are important components of the rehabilitation process. This evokes normative assumptions of an 'ideal' family that takes moral responsibility and carries out expected duties and obligations in caring for dependents. These reflect a sociological conceptualisation of the family as theorised by Parsons and Bales, where the institution of the family serves two basic societal purposes: socialising children into prevailing societal norms and values so that they become active and contributing citizens, and providing psychosocial support to adults (1956 in Chambers 2012, p. 12). These function to meet the economic needs of a capitalist society and to maintain social order.

In the context of drug rehabilitation, the family is understood to play a key role in facilitating the transformation of the close relative using drugs to an active and productive citizen, which is the goal of the rehabilitation process. Although Parsons' model of the 'ideal' family has since been discredited in sociological theory (Marsh *et al.* 2009; Chambers 2012), its presuppositions continue to underpin policy discourse. The discourse also reflects the symbolic importance of the institution of the family, with the emphasis on reconciliation denoting a will to safeguard the normative nuclear family ideal. The use of language, such as "active encouragement" and "be pursued" works discursively to make the work of encouraging family participation and reconciliation of families a legitimate part of professionals' roles.

Families are constructed as participants in the rehabilitation process and are therefore allocated shared responsibility for its success with other agents. At the same time, they are seen as needing interventions to build capacity for coping, with the implicit assumption that when coping improves, they are better placed to support the family member who uses drugs. This works to legitimise professional interventions with family members. Through technologies of self (Foucault, 1988), family members are thus facilitated to transform into self-governing subjects who assume responsibility for their own health and that of their families by supporting the close relative to access and progress through treatment. The individual using drugs is thus governed through the family.

After the publication of the 2009 drug strategy, the HSE published a *National Drugs Rehabilitation Framework*, which states:

> The provision of rehabilitation pathways is a shared responsibility of the education, training and employment sectors alongside the health, welfare and housing sector, non-governmental organisations, communities, families and the individual themselves (Doyle and Ivanovic 2010, p. 7).

This statement clearly reflects a post-welfarist ideology to shift responsibility for social issues from the state on to the private, voluntary sector, communities, families and individuals. However, families are absent from the actual framework that outlines the 'integrated care pathway' for the person undergoing rehabilitation. This is highlighted in an external evaluation:

> …the framework had a gap. There was no clear protocol for dealing with and including the family in the treatment of the service user (Barry and Ivers 2013, p. 79).

The evaluation report makes a recommendation that,

> The inclusion of a protocol outlining the various points of inclusion for family members and the limitations of confidentiality and information sharing (as recommended by the National Family Support Network) should be seriously considered by NDRIC. Including the family and agencies representing them appears to be a logical step for NDRIC when attempting to implement a holistic evidence based best practice with the addiction rehabilitation services (Barry and Ivers 2013, p. 87).[46]

[46] NDRIC is the National Drugs Rehabilitation Implementation Committee, which includes a range of stakeholders form the statutory, voluntary and community sectors.

Following the recommendations in the report, the NFSN are a member of NDRIC, and the national protocols were updated to reflect:

> …the inclusion of family for encouragement and support, and also the provision of support to families in their own right (DOH 2014, p 28).

Families have been integrated into national quality standards for drug and alcohol services with the development of a family support template for addiction services by QuADS in partnership with the NFSN (DOH 2014, Drugs.ie 2015). As a result, families are now placed under the professional gaze; the roles of service providers have been reconfigured to also include family support; and, the networks of actors who govern families and through families have expanded.

6.4.2 Knowledge and expertise

Social science, in particular psychological knowledge and expertise, has contributed to shaping the representation of the 'problem', as it has produced families with close relatives who use drugs as an object of knowledge. From the late 1990s, the issue of drug-related impacts on families is an area of research interest. Reported impacts include stress related issues, general ill-health, financial difficulties, isolation, interpersonal conflict, family disharmony and domestic violence (Copello and Orford 2002; Butler and Bauld 2005; Duggan 2007; Orford *et al.* 2010a; Orford *et al.* 2013). This knowledge is produced within a broader context of a research interest in drug and alcohol related harm to others.

Specific to Ireland, in 2007 three reports were published that produce knowledge about impacts on affected families but also about families as a resource. The first is a report commissioned by the NACD that aimed to examine the experiences of families in Dublin seeking support to cope with heroin use (Duggan 2007). This research produced knowledge in relation to how families engage with a family member's heroin use and how they interact with services, proposing a seven-stage model of engagement. It makes 16 recommendations for service provision. The dual recognition of families as social recovery capital and as service users is evident throughout the report as exemplified here:

> The current study also demonstrates the potential role which families can play in dealing effectively with their own problem and in supporting the user into recovery (Duggan 2007, p. 27).

A second report on residential drug treatment calls for family involvement in the rehabilitation process:

> The group were of the opinion that families of drug and alcohol users could be more involved in the overall care plan for recovering users (Corrigan and O'Gorman 2007, p. 52).

The third report is the *Report of the Working Group on Drugs Rehabilitation*, which I have already referred to as containing numerous references to the active role of the family.

As I discussed in the literature review, a UK-based research group has developed a model of families and drug use grounded in health psychology. The stress-strain-coping-support model understands drug use in the family as a long-term stressor that relatives are trying to cope with, and social support is seen as key for effective coping (Orford *et al.* 2010b). Quantitative instruments have been developed that measure impacts, social support and coping (Orford *et al.* 2010c; Toner & Velleman 2014). An intervention based on the model has been developed for use in family support and treatment services (Copello *et al.*, 2010). This approach is known as the 5-Step Method and is designed for family members in their own right. While the stated aim is not about helping close relatives to change, the authors note that this can be a possible outcome of the intervention. The intervention includes the employment of strategies such as active listening, provision of information, and exploring and enhancing coping behaviours and social support with the family member. Practitioners who want to use the intervention need to be accredited. The UK-based group controls the provision of training and access to materials. Practitioners attend training and then submit tapes of recorded sessions with individuals and groups for formal assessment before they can gain accreditation. Appendix L contains a flyer that provides information about the training.

Since 2011, the NFSN has collaborated with the UK-based group to implement training in the 5-Step Method for its affiliated members in Ireland.

Initially, a 'training for trainers' model was adopted, with 12 participants initially selected for training in 2012 (NSFN 2015). Up to the end of 2014, 110 workers and volunteers have been trained in the 5-step method, facilitated through the NFSN (DOH 2015).

This technology enables governing of families and professionals. The conduct of the affected family member is governed through technologies of self as this individual is asked to take responsibility for and regulate their own health, and to improve through self-work (Fouvault 1978). At the same time, the conduct of professionals is governed as they are asked to work with families in defined ways.

6.4.3 Political implications

The problem representations produce a number of effects. Overwhelmingly, the scientific account and the policy discourse promotes the idea that families living with drug use experience only negative impacts, which becomes the normative position. There is no place for alternative accounts of families that do well, possibly as a result of having adequate resources. This reflects broader research concerns in the field drawn from dominant discourses such as medicine, psychology and public health that primarily focus on risks and harms of drug use, while precluding subjugated knowledges that associate of drug use with caring practices, benefits or pleasure (Duff 2008; Moore 2008; Race 2008).

Harms linked to drug use are not evenly distributed as they tend to be concentrated in the most disadvantaged areas of society (Stevens 2011). Impacts on adult family members are mediated by factors such as social class, age, gender, family position, place and culture (Duggan 2007; Orford 2017). However, these mediating factors are absent in policy discourse. My analysis finds that affected adult family members are constituted as 'problems' of conduct (e.g. coping) to be addressed at the level of the individual family member. At the same time, they are assigned shared responsibility for successful outcomes of the drug rehabilitation process of their close relative. The suggested behavioural solutions place responsibility with individuals to improve their coping skills and engage with their close relative. This

precludes alternative representations that address the political, socio-economic and gender inequalities that shape the experiences of affected families and solutions that aim to strengthen the material, social and political resources of affected families.

Understanding affected families as joint agents of recovery designates responsibility for successful outcomes with families without considering the "complex, shifting, nuanced assemblage of beliefs, structure, function and emotion that comprise family and social life" (Barker and Hunt, 2004, p. 352). The interactions and relationships between the person who uses drugs, the family and service providers are produced as unproblematic and rational. This ignores the roles of emotion and pleasure in family life. It also overlooks asymmetrical relationships of power based on gender, generation or family position, or those between service users and professionals. The emphasis on normative expectations of care, support and reconciliation ignores alternative accounts of families, such as families who do not wish to carry out their expected obligations (Pahl and Spencer 2004; Ribbens McCarthy 2012). There is an obvious absence in policy discourse on such alternative accounts of families.

The role of drug treatment professionals has been reconfigured to also include working with families. There is an assumption that this reconfiguration is unproblematic. For example, a discussion of the rights to privacy and confidentiality is absent from the policy, which refers to family involvement "subject to the agreement of the individual" (DOCRGA 2009, p. 50). However, rights to privacy and confidentiality are likely to be key issues for professionals and service users and families (Schanche Selbekk and Sagvaag 2016). Furthermore, professionals' stereotypical beliefs about families being part of the 'problem' of drug use can also limit family involvement (Orr *et al.* 2014). Lastly, there is an assumption that professionals are clear about their role, feel confident in working with families, and that services have the resources to expand from an individualised focus to a family focus, all factors that can act as barriers to family involvement (Lee *et al.* 2012).

Family support work has become increasingly professionalised with the implementation of standardised and accredited programmes, such as the 5-Step Method in peer-led family support practice. Professionalisation can be understood as a strategy for governing conduct (Fournier 1999). The 5-Step Method, rooted in scientific psychological knowledge and promoted as evidence-based, privileges expert scientific knowledge over experiential knowledge. Knowledge based on expertise by experience has been the cornerstone of the bottom-up organised and community-based peer-led family support groups in Ireland since the 1990s. The possible effect of professionalisation is a dilution of such forms of knowledge and expertise and a de-politicisation of the activities of the support groups.

Alternatively, families can be viewed within a paradigm that places less emphasis on self-governing and responsibility, and more on building the political and material resources that families possess. Within this paradigm, there can be opportunities for families to understand, question and challenge their economic, political and social realities, and the normative and dominant discourses that shape their lives.

6.5 Conclusion

In this chapter I have drawn attention to how responsibilisation is used as a tactic in drug policy across the criminal justice and the health domains to govern families with close relatives who use drugs and, by extension, to govern the family member who uses drugs through the family. I have identified that in contemporary policy, families are constructed as jointly responsible with authorities to address crime and to encourage family members who use drugs to enter treatment and support them through the process. In addition families are responsibilised to work on themselves to achieve a better functioning family system, and to build better coping skills to deal with drug use in the family.

The criminal justice policy discourse has constructed drug-debt intimidation of families as a governable ‘problem’. Affected families are targeted for an intervention that aims to improve communication with the police but ultimately its goal is the reporting of crime, prosecution and conviction of

offenders involved in the drug trade. The reluctance to produce evidence of this suggests that this is a failed policy.

The analysis of the health domain of drug policy in this article has identified a dual but discursively linked representation of the 'problem' of affected adult family members as service users in their own right and as a source of social recovery capital in the last decade. A third representation of families as dysfunctional and pathological in the context of adolescent drug use has continued since its introduction in the mid-1990s.

Implicit in these conceptualisations are assumptions about the 'ideal' family and active citizenship characteristic of forms of rule in an advanced liberal neoliberal society. Rose (1999, p. 213) notes that "the modern private family remains intensively governed, it is linked in so many ways with social, economic and political objectives". Following the logic of Foucault (2007) and Rose (1999), I argue that the family is more persistent in drug policy discourse because it is seen as an effective governmental site for achieving biopolitical goals such as security and social order, a healthier population and activation of excluded members of society.

Policies that mainly targeted individuals who use drugs for interventions have now widened to also include affected families. As a result, the roles of a wide network of professionals are reconfigured to include affected families in their remit. The family becomes a nexus of power relations, where power is exerted on, through or by the family. The subjectification effects are individualising and responsibilising. There is a general absence of discourse on factors beyond individual conduct that impact on experiences and impacts of drug use in the family, such as class, gender, stigma, marginalisation, and access to material and political resources. Consequently, contemporary policy referring to affected families is likely to reproduce existing asymmetrical power relations within families, and between affected families, the state and its network of actors.

Chapter Seven:

Governing families through risk

Chapter Seven: Governing families through risk

7.1 Introduction

In Chapter Six I argue that families experiencing drug use by a close relative are primarily governed through responsibilisation. In this chapter, I focus on the governmental rationality of risk, which I argue underpins the representations of the 'problem' of parental drug use. I start this chapter by identifying how the concept of risk is underpinning the prevention domain of the 2009 policy. I trace how it came to be a dominant discourse, and I discuss how the use of the technology of risk in the policy is productive as it constructs people categories through 'dividing practices'. The people categories, in turn, create 'high-risk' target groups, which are subject to governing through professional interventions. In the 2009 policy, there are three distinct representations of the 'problem' of parental drug use: family dysfunction, parenting and child welfare. The representations are underpinned by different assumptions and presuppositions about the 'problem', and therefore enable different forms of governing families. However, what they have in common is the biopolitical concern about the future potentiality of children.

I discuss each of these problem representations in turn. As in the previous chapter, I draw attention to the presuppositions, assumptions and knowledges that make them possible. I also identify silences to point out the issues that are not problematised in the policy. In the chapter I also trace how each problem representation 'came to be', highlighting the key knowledges and practices that have shaped the contemporary problem representations. Finally, I theorise the effects, or political implications, of the problem representations in terms of how families are governed.

7.2 Representations of the 'problem' of parental drug use

In Chapter Five I discussed how a discourse on risk dominates the prevention domain of the 2009 strategy, which is underpinned by a risk/protective factors framework. The primary subject understood to be at risk is the young person, with some groups of young people singled out to be at higher risk. The proposed approach to drug prevention is a three-tiered approach. The second

tier targets those considered most at risk: "early school leavers, young offenders, children of drug and/or alcohol dependent parents and disadvantaged communities" (DOCRGA 2009, p. 39).[47] In terms of families, the three-tier prevention strategy is a 'dividing practice' that produces parental drug use as a 'problem' that needs governing, and by extension, construct parents who use drugs and their children as governable subjects.

The policy states that "research has identified risk and protective factors" and outlines them as follows:[48]

> **Risk factors** are: early school leaving or poor educational attainment; history of unemployment; poverty; poor mental health; *family conflict/breakdown*; anti-social behaviour; involvement in crime; *family history of addiction* (including alcohol); ethnicity and marginalisation and drug-taking in social networks.
>
> **Protective factors** are: *family factors*, educational factors; individual characteristics; personal and social competence (ibid, p.28, bold in original, emphasis in italics added).

The reference to 'research' in policy is powerful as science is a dominant discourse used by governments to legitimise certain ways of governing subjects and populations (Bacchi 2009). It is productive as it uses science to constitute subjects, in this instance enabling a number of categories of people, such as 'dysfunctional' families and parents who are 'addicted' and their children to become objects of knowledge and targets for policy (Foucault 2000). It is likely that the 'research' that the 2009 strategy talks about is a report commissioned by the NADC, which introduced prevention science into Irish drug prevention (Morgan 2001). This report provides an overview of risk and protective factors, highlighting the family as both a risk and protective factor.

Risk factor analysis enables interventions that target specific risks at specific points in the life stages of certain high-risk groups (France *et al.* 2010). These groups are understood as needing expert intervention to manage risks, while the rest of the population are seen (and governed) as active and responsible

[47] The first tier targets the general population, while the third tier targets people who use drugs.
[48] No research sources are cited in the text.

citizens that can self-regulate and self-manage risks (Bacchi 2009). Hence, in the context of the 2009 strategy, the binary risk/protective framework produces dysfunctional families and families with parental drug use as high-risk groups in need of expert interventions.

The policy proposes three broad prevention strategies aimed at families in Action 29:

> - supports for families experiencing difficulties due to drug/alcohol use;
> - parenting skills; and
> - targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation (DOCRGA 2009, p. 100, bullets in original).

While these policy solutions share the biopolitical objective of securing healthy and active future citizens, they represent three different ways of representing the 'problem' of parental drug use. I will now address each one in turn.

7.2.1 A 'problem' of family dysfunction

The first recommended measure is "Supports for families experiencing difficulties due to drug/alcohol use", and here, the 'problem' is represented as 'family difficulties'. To further identify what type of 'problems' that 'family difficulties' are represented to be, the main body of the prevention chapter provides insight:

> …the considerable negative impact that problem drug and alcohol use has on families is well known. The effects include deteriorating relationships and making the family dysfunctional, psychological and social problems, increased stress, depression and behavioural disorders, and financial difficulties – all of which can contribute to family breakdown and negative impacts on adults and, *particularly on children* in families. The latter are likely to be at *high risk* due to the prevalence of drug/alcohol misuse with their families, peers and communities and are *at risk of becoming problem drug users in later life*…[…]…actions to support the families of drug users should be developed as part of the new NDS (ibid, p. 38, emphasis in italics added).

These are family dysfunction, mental health, social and financial 'problems'. Two key assumptions about causation are implicit in this extract. First, drug use is understood as the primary cause for family dysfunction and other 'problems' listed above. There is a silence about other factors that can

contribute to these family, mental health and financial 'problems' experienced by families living with drug use. The focus on the behaviour in isolation without a consideration of its social, material and political context is individualising; consequently, it precludes collective responsibility for, and solutions to, the 'problems' that families living with drug use experience.

Second, although impacts on adults are referred to in the above extract, the focus in this representation of the 'problem' is the 'risky' child as a future citizen. Thus, a causative link between parental drug use, family difficulties and potential future drug use is established. This produces an understanding of addiction as the intergenerational transmission of risk mediated through family factors (e.g. Thornberry *et al.* 2006; Pears *et al.* 2007). This understanding draws on dominant biomedical and psychological discourses on the contribution of genetic and psychosocial pathways in determining human behaviour such as drug use; however, Thombs (2006) points out that research does agree on the relative contribution of nature and nurture.

The knowledge claims made in the above extract about the links between parental drug use and the stated consequences are not referenced. The effect of this is that the causal explanation is produced as a taken-for-granted fact. However, in tracing of how this problematisation 'came to be', I identify some key influences. Previous drug policies had not problematised parental drug use. The first reference to the 'risky' family in drug policy is in the 2005 midterm review report of the 2001 strategy, which, in the context of early school leaving, states:

> …there is a need to expand the engagement of Home School Community Liaison with families, particularly those dealing with drug misuse (DOCRGA 2005, p. 26).

Causal links are assumed between parental drug use and early school leaving, and between early school leaving and future drug use. This recommendation becomes a new policy action and, consequently, the education sector is enrolled in governing the 'risky' family at a distance.

As discussed in the previous chapter, family support as a specific policy intervention does not feature in Irish drug policy until 2005 when the midterm

review of the 2001 strategy recommends adding family support as a new policy action. However, in the midterm review family support primarily concerns supporting adult family members in their perceived role as a resource for drug treatment and rehabilitation as discussed in Chapter Six and does not refer specifically to parental drug use.

It is likely that the policy recommendation that relates to "supports for families experiencing difficulties due to drug/alcohol use" in the prevention chapter is shaped by knowledge about family support produced in a report commissioned by the National Advisory Committee on Drugs. *The Role of Family Support Services in Drug Prevention* recommends that existing family support services expand their remit to include drug prevention by "strengthening families to act as a buffer to drug problems" (Watters and Byrne 2004, p. 13). This report is underpinned by a causal understanding of the links between drug use and families as one where "family dysfunction can contribute to drug problems, as well as drug use resulting in family problems" (ibid, p. 12). Thus, dysfunctional families and/or families where drug use occurs are seen as sources of risk. Consequently, a widening network of professional expertise and practices, in the form of family support services, are called on to govern these 'risky' families.

The dominant knowledge shaping this way of thinking about families and drug prevention is drawn from the dominant psychological discourses on prevention and reduction of juvenile delinquency originating in the US. These assume that the family has the primary responsibility for moral guidance and behavioural management of children (e.g. Kumpfer and Alvarado 1998). When families are not able to fulfil this societal expectation, governmental intervention is legitimised to shape the family towards one that is socially desirable. Parenting practices are seen as especially important in reducing delinquent behaviour. While societal and community level factors such as deprivation and lack of opportunities are recognised in this model as contributing to social ills, it is the high-risk family that is targeted for change, not the root causes. A specific governmental technology based on these theories and targeting high-risk families, the *Strengthening Families Programme*, has taken hold in Ireland. I will analyse this programme towards

this end of the chapter as an example of how attempts are made to shape the conduct of high-risk and 'dysfunctional' families.

The report on family support and drug prevention published in 2004 builds on a flurry of family policy developments from the late 1990s, which I have outlined in Chapter Five. In the context of rapid economic and social change in Ireland, the period between the 1996 and 2001 saw a number of developments relating to family policy. These include the *Strengthen Families for Life* report (Commission on the Family 1998), the establishment of a Department of Social, Community and Family Affairs in 1997, a government commissioned report on family support (McKeown 2001), the Family Support Act in 2001 and the establishment of the Family Support Agency in 2002.

Prior to 1998, family support interventions typically targeted vulnerable children, but following the report of the Commission on the Family, parenting emerged as an area of concern for services (Watters and Byrne 2004). This is clear in the report by McKeown (2001) where the scope of family support was widened to include therapeutic interventions, parent education, child development and education, home-based parent and family support.

7.2.2 A 'problem' of deficient parenting

The second proposed policy recommendation – parenting skills - represents the 'problem' as deficient parenting. Parenting is not discussed explicitly in the policy, but it is implicit in the risk/protective factors framework underpinning the prevention chapter where "family factors" are listed as a protective factor. It is assumed that 'good' parenting can prevent drug use, while 'bad' parenting can contribute to drug use later in life. This reflects a broader, dominant idea that deficient parenting is responsible for contributing to social ills (Edwards and Gillies 2004; Hoffman 2010) and a belief in "the power of parenting to compensate for social disadvantage" (Gillies 2008, p. 112).

Parenting was first problematised in the 1996 drug policy:

> As a priority, a range of Departments and their supporting agencies develop programmes aimed specifically at addressing the deficit in parenting skills,

> which has become apparent in modern society and which exacerbates the problem of substance misuse and anti-social behaviour in general (Ministerial Task Force 1996, p. 18).

The text talks about a decline of the quality of parenting in "modern society", which arguably reflects a political assumption about a 'crisis' of the modern family. As referred to in Chapter Five, following the weakening influence of the Catholic Church on the state – family relationship, Ireland saw significant social change relating to families from the 1980s onwards. This included reduced fertility rates, increased rates of non-marital births, legalisation of contraception, enactment of divorce legislation and increased diversity in family composition (Canavan 2011).

A causal explanation is produced in the 1996 policy, linking deficient parenting and family dysfunction to adolescent drug and alcohol use and anti-social behaviour. These 'problems' are typically associated with socio-economic disadvantage; hence, implicit in this discourse is the selective targeting of socio-economically disadvantaged families for interventions.

The idea of parental deficiency continues in the 2001 strategy. However, while the tone is more positive and benign, the strategy is explicit that parents in high-risk families are targets for interventions:

> …initiatives aimed at equipping parents of at risk children with the skills to assist their children to resist drug use or make informed choices about their health, personal lives and social development (DOTRS 2001, p.116).

The turn to parenting as a policy solution for drug prevention from the mid-1990s in Ireland can be located in the wider social policy context as discussed in Chapter Five. From the 1990s, the state is increasingly concerned with parental competencies in raising children in socially desirable ways (Daly 2013). In contemporary societies, parenting is constructed as a job that requires skills and expertise, and expert professional interventions are needed for parents to acquire these (Gillies 2008; Daly 2013). The provision of standardised parenting skills programmes, common in Ireland, endorses certain normative approaches to parenting. This adds a moral dimension to parenting, which is classed: parents 'ought to' engage with their children in

ways that often align with middle-class values (Daly 2013). Parental conduct outside this norm is assumed to need disciplinary correction (Foucault 1979).

Medical and psychological discourses, in particular the sub–disciplines of developmental psychology, behavioural psychology and neuroscience, have shaped the way that parenting is problematised (Daly 2013). There are causal assumptions about the links between what parents do and developmental outcomes for their children and clear distinctions are drawn between positive and negative parental behaviours. Parenting skills training, thus, aims to modify behaviour. Through these discourses, parents are constituted as governable subjects. In the instance, in drug prevention a selectivitist approach is adopted as high-risk parents are targeted for interventions - families deemed to be 'dysfunctional' and families with parental drug use. Towards the end of this chapter I discuss a specific governmental technology that targets high-risk families, the *Strengthening Families Programme*, as an example of how governing takes place.

7.2.3 A 'problem' of child welfare

The third proposal under Action 29 in the 2009 NDS calls for

> Targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation (DOCRGA 2009, p. 100).

Here, the governmental objective is to prevent future drug use. This policy proposal represents the 'problem' of parental drug use as child welfare, and constitutes children in families where parents use drugs as governable subjects. There are two dimensions to the 'problem'. The first is contained in the metaphor of 'breaking the cycle', a term used to refer to the family as a site where social disadvantage and unhealthy traits such as addiction are thought to be transmitted through generations (Gillies 2008). This statement is not supported by reference to research evidence in the policy, but works to make the intergenerational links between parental drug use and future drug use of children a self-evident 'truth'.

The second problematisation, referring to 'safeguarding', is one of child abuse and neglect, shaped by a child protection discourse with an assumed causative link between parental drug use and child abuse. Together, and in

sequence, the two dimensions establish a rationale for vulnerable families to be targeted with professional intervention in the name of children's wellbeing and securing the next generation (Gillies 2008).

Prior to the 2009 NDS, a child protection discourse did not feature in Irish drug policy. It was first referred to in the 2007 *Report of the Working Group on Drugs Rehabilitation*, which identifies "Children of drug using parents" as a specific risk group, and refers to potential developmental harms:

> While the impact of the drug use of parents on their children, in terms of personal, social and educational development, has not been studied in any comprehensive way, it is accepted that such children constitute a particular risk group (DOCRGA 2007, p. 18).

The report acknowledges the lack of research evidence base for the causal links between parental drug use and children's outcomes, yet it asserts that children of parents who use drugs are a high-risk group. This produces a discursive effect in that the causal link is understood as a taken-for-granted fact. The report's recommendations relating to the 'risky' family include the provision of parenting programmes, and it also recommends that "research is required to ascertain the number of children with drug misusing parents" (DOCRGA 2007, p. 42). This recommendation legitimises new technologies of surveillance as children of drug users and their parents become objects of measurement and knowledge and made amenable to governing.

The absence of a child protection discourse in the 2007 report is surprising; instead, it is clear from the report's recommendation that parental drug use is represented as a parenting 'problem'. Similarly, except for one reference to 'safeguarding', a child protection discourse is not dominant in the 2009 drug policy. This is surprising as child protection had emerged as a family policy priority from the end of the 1990s, as discussed in Chapter Five.

As discussed in the previous chapter, the concept of harm to others has been subject to international empirical research and policy developments in the previous 10-20 years, including a body of empirical research that has examined the negative impacts of parental drug use on children (see e.g. Barnard and McKeganey 2004; Barnard 2007; Velleman and Templeton 2007). The term 'hidden harms' is specifically used to refer to harms to

children and defined as "an aspect of the harm caused by drug use that until now has remained largely hidden" (Advisory Council on the Misuse of Drugs 2003, p. 7). 'Hidden Harm' has featured high on the UK policy agenda from the early 2000s (Advisory Council on the Misuse of Drugs 2003, 2007; Scottish Executive 2003; Public Health Agency/Health and Social Care Board 2009). For example, the contemporary Scottish drug strategy talks about child welfare as a core concern for services that engage with people who use drugs (Scottish Government 2008). Notably, this discourse had not transferred and been used to shape the Irish 2009 policy.

However, there have been some developments since the strategy was published. An Irish version of the 'Hidden Harm' agenda has started to take shape with the establishment of a *National Hidden Harm Project* in 2013 (DOH 2014; 2015). It is a partnership project between the HSE and Tusla. The aim of this project is to "…bridge the gulf between substance misuse and childcare systems nationally; and to ultimately improve outcomes for children" (DOH 2014, p. 18). The HSE refers to 'hidden harm' as "the experience of children living with, and affected by, problem parental drug and alcohol use" (HSE 2014, p. 1), with two features:

> …that children are often not known to services; [and] that they suffer harm in a number of ways through physical and emotional neglect, including exposure to harm and poor parenting (ibid).

It is assumed that an unknown number of children exist 'out there' who need identification and intervention by services. It is also assumed that there is a causal link between drug use, poor parenting, neglect and harms. This assumption is however qualified:

> Not all parents who use substances experience difficulties with parenting capacity. Equally not all children exposed to parental substance use are affected adversely either in the short or longer term (ibid).

The document does not expand on this statement; however, a discursive effect is produced. The use of the word "not all" places a focus on the negative, which works to produce a 'truth' that most parents experience difficulties and that most children are negatively impacted.

Currently, the project is developing a strategic statement of intent and a practice guide (DOH 2015), and an information leaflet for practitioners listed as teachers, GPs, youth workers, sports coaches, child care services and family support services was published in 2015 (North South Hidden Harm Group 2015). However, progress is slow as the strategic statement drafted in 2015 is still at draft stage (HSE 2017).

The 'hidden harm' concept has extended to other social policy areas, as it appears in *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020* (DOCYA 2014). Discourse relating to risk and drug use appears in the context of priorities for achieving the desired outcome of "full potential in learning and development" (ibid, p.5):

> Strengthening parental understanding of the importance of the ante-natal period is vital and the consequences of alcohol, drugs, smoking and poor diet in pregnancy.
>
> The importance of measures that tackle the conditions of poverty, substance abuse and parental stress, which may give rise to detrimental experiences for some children in their early years…(ibid, p. 65).

Implicit in the first extract is the assumption that parents have deficits in knowledge about 'proper' antenatal lifestyle behaviours, which needs correction, but also makes them responsible for the future life outcomes of their children. The second extract lists three factors that are seen to impact negatively on young children, the first a macro level determinant, the second a behaviour, and the third a psychological subjective experience. The language used is vague ("measures", "conditions", "may", "detrimental", "some"), and there is no indication of their relative importance, cognisance of how they might relate to each other or how they might impact on young children. However, causative links are made between substance 'abuse' and poor early childhood outcomes, which justify governmental interventions that target parents who use drugs.

In the context of the outcome "safe and protected from harm" (ibid, p. 5), the Government commits to:

> Adopt an effective interagency approach in relation to cases of child protection and welfare, establishing information and coordinating protocols (including 'Hidden Harm' protocols) between agencies serving children and young people and adult focused addiction, domestic violence and mental health services. (ibid, p. 83).

This 'priority' emphasises interagency work. Rose (1998, p. 186) notes that risk as a style of thought demands team working "to answer the administrative question: what is to be done and how can we decide", which has led to new technologies of "recording, monitoring, evaluating". This is clearly a feature of Tusla's new protocol, the *Meitheal Toolkit*, for working with vulnerable families who do not require social work interventions, (Tusla 2015).[49] The effect is a widening network of actors that are given responsibility for governing risky families through surveillance and communication. It also works to govern professionals as it regulates practices in the interest of accountability (Rose 1998). It assumes that interagency work is a rational and unproblematic activity, and it ignores factors that impact on interagency work: historical relationships between agencies, competing principles and values, competing resourcing agendas, competing policy domains and politics at national and local levels (France and Utting 2005).

The 'hidden harm' developments have occurred in the context of the political priority of child protection and child welfare in the last decade, with a number of resultant policy developments and restructuring of services. Arguably, these are a response to numerous inquiries into child protection failings in institutions and in private homes in Ireland, one being the *Roscommon Child Care Case Report*, which investigated a case of child abuse and neglect in a family and found that both parents' alcohol and drug dependency was a contributory factor to their ability to parent (Roscommon Child Care Inquiry Team 2010) The following year, the revised *Children First: National Guidance for the Protection and Welfare of Children* was published, stating, "research tells us that children whose parents misuse drugs or alcohol are more at risk of neglect or maltreatment" (DOCYA 2011, p. 2). Notably, there is no reference to research evidence in the policy.

[49] Meitheal is further explained in Chapter Nine.

Garratt *et al.* refer to "a type of reactionary politics" where crisis points in child protection in one context creates a 'moral panic', which impacts on all related social policy and practice contexts (2013, p. 616). In effect, a "general politics of truth" is produced (Foucault 1984, p. 73), as the dominant discourses of risk, child protection and child welfare have now entered the field of drugs policy and practice.

7.3 A governmental technology: *The Strengthening Families Programme*

Annual progress reports on the 2009 drug policy have been published by the DOH, and these provide insight into how proposed policy solutions are implemented, and, in turn, how subjects are governed. I will examine a specific intervention, the *Strengthening Families Programme* (SFP), which is referred to as a key outcome under Action 29 (DOH 2014). The SFP was introduced into Ireland in 2005 by its founder and in Ireland it targets high risk families with children in the age group 6-12 and 12-16.

The SFP was developed by an American psychologist, Dr. Kumpfer, in the mid-80s through US governmental funding. It is grounded in prevention science and aims to influence family risk and protective factors seen to be associated with delinquency, such as anti-social behaviour or drug use. The programme draws on psychological discourses, in particular, family systems and cognitive behavioural theories, and it aims to improve family relationships, parenting skills, and youth's social and life skills (Iowa State University 2017). The duration of the programme is 14 weeks: the first part of each weekly session involves skills training delivered separately to children and parents, and the second half involves 'family skills' training with the whole family. Incentives are provided for attendance, such as a family meal. Leaflets advertising the SFP are found in Appendix M.

It is a resource-intensive intervention as five trained professionals are required: two group leaders for the parents, two for the children and a site coordinator. Those delivering the programme have to undergo specific training. The SFP is a commercial enterprise: it controls training and evaluation, and it provides the course materials. The programme is ranked

third in a compilation of the 'most effective' evidence based family skills programmes (United Nations Office on Drugs and Crime (UNODC) 2009).

The underlying assumption of the programme is that an inoculation of skills will alter problematic conduct such as 'bad' parenting and drug use, and enable young people and families to become more responsible and govern their lives in a more optimal manner (Gillies 2008; Roumeliotis 2015). It is presumed that experts equipped with special knowledge are needed to enable this process. Under the 'gaze' of these professionals, families are 'governed at a distance' (Miller and Rose 2008), as their conduct is monitored and shaped (Foucault 1979).

There is significant investment in programmes such as SFP by the state, and it is funded by different statutory bodies such as the HSE, Le Cheile and Drug and Alcohol Taskforces.[50] 'One size fits all' programmes, such as the SFP, have global appeal as they are marketed as commodities based on claims of scientific evidence of effectiveness. As such, they fit neatly into advanced liberal forms of rule where the 'evidence-based' paradigm is the privileged way of knowing and doing. Such programmes are in demand by policy makers who seek simplified scientific solutions for complex social issues (France *et al.* 2010).

While these types of programmes can contribute to positive changes for individuals and families, they focus on risks that are individualised. Furthermore, the focus on behaviour in these programmes in closes off the option of thinking about drug prevention at macro-level, with solutions that address the structural determinants of drug use. Finally, as the roles of scientific knowledge and expertise are central to these programmes, they do not shift asymmetrical power relations between families and professionals. Knowledge about parenting by experience is marginalised, and parenting practices that lie outside middle-class norms are not seen as legitimate. This

[50] Le Cheile is part of the probation service. It is a mentoring service for young people engaged in probation and their families.

suggests that an unintended consequence of such programmes is a reproduction of political and socioeconomic inequalities.

7.4 Political implications

Problem representations inevitably produce effects, often unintended (Bacchi 2009), and the construction of the family as 'risky' produces both discursive and subjectification effects. A 'zero risk' label is not possible in a risk factor framework as each person is allocated a 'level of risk' (Rose 1998); consequently, all parents who use drugs, regardless of type of drug or quantity used, are seen as potentially risky. This can have stigmatising effects for an already marginalised group, as services working with these parents can only think and talk about, and act on them as 'risky' (Chandler *et al.* 2013; Chandler and Whittaker 2014). The normative assumption that people who use drugs are 'irresponsible' parents can shape drug users' own perceptions of themselves. It can also impact on professional attitudes towards them, which can result in parents being reluctant to access services as they are worried about losing their children (Klee 1998; Rhodes *et al.* 2010; Radcliffe 2011; Lloyd 2013).

The representation of the 'problem' of young people's (potential) drug use as intergenerational transmission of attributes blame to parents, which has stigmatising effects (Gillies 2008). Furthermore, this understanding of pathways to addiction oversimplifies the issue, and it ignores the wider structural and political factors that contribute to addiction.

The construction of parents as 'risky' overlooks their own agency and active work that parents do to provide care and protect their children from harms of drug use (Klee 1998; Rhodes *et al.* 2010), and it precludes a construction of drug using parents as 'responsible'. Discursively, this closes off solutions that include recognising, enhancing and supporting parents' harm reduction work, what Rhodes *et al.* refer to as "damage limitation interventions" (2010, p. 1496). It also works to silence alternative scientific accounts of parental substance use, for example those that see parents as actively protecting children from harm when they have the resources to do so (Klee 1998; Rhodes *et al.* 2010).

The framing of discourse in terms of children's outcomes, and child protection and welfare legitimises surveillance of family life and targeted professional interventions, which can be intrusive or even unnecessary from the perspective of the parent (Chandler and Whittaker 2014). The prioritising of children's needs can take precedence over those of the parents, whose needs might not be adequately met. If children are placed in care, parents tend to do worse in terms of drug treatment and life outcomes (NTASM 2012; Comiskey *et al.* 2016).

In cases of family breakdown, parental drug use can be seen as the primary cause instead of other contributory factors such as poverty, homelessness or mental health issues (Woods 2000). This can lead to excessive admission of children into care, especially around the time of birth (Zhou and Chilvers 2010; McGivern and McDonnell 2015), and low levels of family reunification (McGivern and McDonnell 2015). People who use drugs, especially pregnant women, are more likely to experience stigma when they encounter the health and social care system (Radcliffe 2011; Lloyd 2013). Consequently, fear of children being admitted into care can act as a real barrier for parents to accessing services.

The problematisation of children as 'at risk', and later as 'risky', produces subjectification effects that are potentially both stigmatising and pathologising. Younger children are seen in terms of potential developmental deficits, while older children are seen as potential drug users. Consequently, they are seen in terms of their potentiality with less emphasis placed on their daily lives. It is therefore difficult to construct these children as active agents who successfully negotiate their lives (Bancroft and Wilson 2007). As a result, resources may be primarily directed towards interventions that aim to fix the deficits rather than those that aim to enhance strengths. Furthermore, resources may be directed towards surveillance technologies and interventions prioritising the early years of children born to known drug using parents. As a result, other groups of children may be overlooked, such as older children whose parents have difficulties as a result of drug use, or children whose parents are not engaged with treatment services. The framing of drug use and addiction as intergenerational has implications for 'risky' children. It

works to produce a sense of inevitability of children being destined to become drug users without intervention. If they do experience drug use, the presumption that their drug use is a direct result of parental drug use rather than other factors limits the options for potential interventions.

Carr (2011 in Martin and Aston 2014, p. 350) argues that power relations shape and dominate drug treatment settings. The added dimension of child protection is likely to further impact on these relations, especially for mothers, as professionals have additional authority to exert power on the conduct of families (Foucault 2000). As a result, asymmetrical relations of power between professionals and parents in child care and drug treatment services are likely to be reproduced.

7.5 Conclusion

This chapter has examined how the governmental technology of risk is used to govern families where parents use drugs. The subject of the 'risky' family emerged towards the end of the 1990s and early 2000s in the context of increasing political priorities of family support, parenting and child welfare. The policy is primarily concerned about the potentiality of children and the biopolitical objective is to prevent future drug use and secure a healthier population. The policy constitutes three distinct representations of the 'problem': family dysfunction, parenting deficits and child welfare. All families where there is drug use, regardless of type and patterns of use are constructed as high-risk families, regardless of their own agency and active work to protect their children from any potential harm. This legitimizes the use of disciplinary power in the form of surveillance of family life and targeted professional interventions that may be unnecessary and unwanted.

Families are represented as 'problems' of behaviour to be addressed at the level of the individual or at the level of the family unit. This diverts attention from a broader understanding of the 'problem' of parental drug use and how factors such as housing, unemployment and social isolation shape children's outcomes.

Finally, there are silences in the contemporary policy around different factors that potentially impact on the experience of parental drug use and family well-

being such as gender, stigma, societal and professional attitudes, and access to material and political resources. There are silences in the policy around the complexities involved in addressing parental drug use. The potential tensions between different approaches such as family support versus child protection, between rehabilitation/recovery models and child protection, and between meeting the needs of the child versus the adult, are left unproblematic. The dominance of medical, psychological and child protection discourses shaping the way that the 'problems' are represented in policy precludes other forms of knowledge from shaping ways of thinking and talking about parental drug use, such as experiential knowledge and expertise – the perspective of the parents who use drugs and their children. The dominant representations of parental drug use are likely to reinforce societal and professional attitudes towards and stereotypes about parental drug use, and hence, reinforce existing socio-economic and political inequalities for families experiencing drug use.

Chapter Eight:

Professional discourses and ‘responsible’ families

Chapter Eight: Professional discourses and 'responsible' families

8.1 Introduction

In this and the next chapter I present the findings from my analysis of data from interviews with 17 professionals. The objectives of my study include exploring the operation of policy discourses relating to families as they are interpreted and negotiated by professionals in the drug field; understanding how governing takes place; and, examining the political implications of the identified problem representations. In the interviews, I asked the interviewees about their understanding of the perceived role of the family in addressing drug use, how they work with families, and how policy actions relating to families are implemented.[51] [52]

Guided by Bacchi and Bonham (2016), I have applied a poststructuralist strategy to analyse interview transcripts. The focus of the analysis is on "*what* someone says" about families rather than 'what *someone* says'" (Bonham and Bacchi 2017, p. 4, italics in original). Of interest are also the forms of knowledge/discourses that make it possible to say those particular things. That which is said can reproduce or challenge self-evident ideas about families, drugs and drug use. I am interested in the degree to which professional discourses challenge or reproduce policy discourses. Hence, according to Bonham and Bacchi (2017, p. 3), interviews can also provide a "political resource" when the analysis attends to "possibilities for 'objects' and 'subjects' to be formed otherwise" (ibid, p. 7). In other words, interviews have transformative potential. I interpret this to mean that possibilities for challenging dominant and pervasive discourses about families, drugs and drug use might exist in the interview data.

My analysis of professional discourses identified two key themes which reflect modes of governance: responsibilisation and risk. In this chapter I discuss responsibilisation of affected families, while in Chapter Nine I discuss how parental drug use and adolescents are governed through a technology of

[51] Appendix F contains the relevant actions.
[52] Appendix E contains the topic guides.

risk. Throughout both chapters I provide extracts from the interview transcripts to illustrate my analysis. In some extracts, I italicise some statements to emphasise that which is said.

I start this chapter by providing a brief introduction to the interviewees. Following this I engage with three themes: governing drug-related intimidation, governing affected families as a source of social recovery capital and governing affected families as service users in their own right. The technologies used to govern families are different but they work on the premise of eliciting personal responsibility for addressing crime, for drug treatment and rehabilitation outcomes and for one's own health.

8.2 The interviewees

Although '*who* says what' is not my focus of analysis, I examine how specific forms of professional knowledge and expertise shape discourses and practices. However, since my ontological and epistemological assumptions understand interviewees to be embedded in dominant and disciplinary discourses, it is important to locate what is being said to professional roles and disciplinary affiliations.

I conducted a total of 17 interviews. Six interviewees held policy making and coordination roles in the statutory sector including one in the Department of Health (DOH) and one in Tusla, the Child and Family Agency; two in the Health Service Executive (HSE); and two in Drug and Alcohol Task Forces (DATF). One interviewee was a social scientist affiliated with the Health Research Board (HRB). One interviewee represented an advocacy organisation for families affected by drug use, the National Family Support Network (NFSN).

Nine interviewees held service provision roles whose remit included working with families to different degrees. Four worked in drug treatment services - three of those in the voluntary sector and one in the HSE. Two held family support roles, both in the voluntary sector. Finally, three interviewees were members of the police service, An Garda Síochána (AGS). Interviewees are represented by pseudonyms. Table 8.1 provides this information in some further detail:

Pseudonym	**Department/ Agency**	**Sector**	**Role**	**Remit/ Type of service**
Catherine	DOH	Statutory	Policy making; policy oversight	National remit
John	Tusla	Statutory	Policy making; policy oversight	National remit
Sarah	HSE	Statutory	Policy coordination	National remit
Clodagh	HSE	Statutory	Policy coordination	National remit
Gary	DATF 1	Statutory	Policy coordination	Regional/ local remit
Michael	DATF 2	Statutory	Policy coordination	Regional/ local remit
Paul	HRB	Statutory	Research	Research
Sharon	NFSN	Voluntary	Advocacy/ Service provision	National remit Family support
Carol	HSE	Statutory	Service provision	Adolescent treatment
Seamus		Voluntary	Service provision	Adolescent treatment

Brian		Voluntary	Service provision	Adult residential treatment
Geraldine		Voluntary Community	Service provision	Adult community based treatment
Aoife		Voluntary	Service provision	Family support
Lorraine		Voluntary	Service provision	Family support
Ciaran	AGS	Statutory	Service provision	Policing
Fiona	AGS	Statutory	Service provision	Policing
Eoin	AGS	Statutory	Service provision	Policing

Table 8.1: List of interviewees

8.3 Governing families through responsibilisation

8.3.1 Governing drug-related intimidation

The issue of drug-related intimidation (DRI) was raised in most interviews when I asked about how Action Three of the 2009 drug strategy was being implemented.[53] Most interviewees talked about having knowledge and experience of the issue of DRI and the reporting programme, and most talked about DRI of families as being commonplace. For example, Lorraine, manager of a community-based family support project, explains:

> Intimidation is always an issue for us. On all different levels, even child to parent intimidation. To the very extreme where we have participants giving over their money every week to people outside the bank or post office. So

[53] Action Three is found in the supply reduction domain of the 2009 strategy and refers to the development of a response to drug-related intimidation.

> it's always an issue and we can't give any advice on it, we can only listen to it.

Carol, who works directly with young people and families in an HSE adolescent treatment service, provides insights into the issue:

> **Eva: Now, looking at some of the policy actions… […]…Now, I suppose one was about responding better to intimidation in communities, do you want to talk about that?**
>
> Yeah, we do have a big problem with that. We'd find, right from, we'll say demands for €50, there'd be some parents coming in with panic about demands for smaller amounts. But there'd be a good percentage that would be coming in with demands for the high hundreds and thousands, €450, €300 and €750, and we've had some, there've been demands for thousands. The biggest amount, and it was recent, was about €28,000 that was owed, and that family is in a position of saying they're not paying it….[…]…I'd have four people that I'm actively working with at the moment that are very concerned about the threats that are being made…

Carol also offers some possible explanations for how drug debt accumulates:

> And it seems to be unique to Ireland and it's mainly in relation to weed. And like…see very easy for a young person heavily smoking weed to be spending €350 per week…that's a lot of money. I think there's several aspects of the drug selling in Ireland that lead to this. That they will all get their bags of weed on lay, so they don't have to have cash up front. So there used to be the idea I think, among the adult population generally, that evil drug users were enticing young people by giving them free drugs, but it's not free. It's just a way for people selling drugs that you don't have to have cash up front. It's like the old thing of going into the shop and getting your groceries on a book. And they're getting their weed on a book, and then it'll go so far, and then they'll say they need the money, and then they'll say there's pressure on the young person, and pressure at home, and pressure on families.

This experiential knowledge about the nature of the Irish drug market as a factor in DRI concurs with Connolly and Buckley's (2016) discussion on how the credit-based drug trade creates drug debt, which, in turn, is a major cause of DRI.

I also asked about the interviewees' experiences of the DRI reporting programme, which is the intervention that has been developed to respond to DRI. The findings suggest that the reporting programme is a failure in terms of achieving its intended outcomes. It is thought that there is a low level of engagement with the reporting programme, that official complaints by those impacted by DRI are few, and that prosecution for DRI is very rare.

What is said in the interviews reveals the complexities of attempting to govern DRI. The interview data reveal several challenges to addressing DRI through a reporting programme, the most obvious ones linked to the prohibitionist approach to drug control and the way the criminal justice system operates. Factors such as class, gender and place also mediate the process. Other challenges relate to legacies of relationships between police and individuals, families and professionals in disadvantaged communities.

First, the prohibitionist approach to drug control produces DRI as an unintended consequence. Two of three key performance indicators in the supply reduction pillar of the 2009 strategy relate to quantified increases in volume of drug seized and number of supply detection cases. This is how success of drug policy and the effectiveness of the AGS are judged. However, this is contradicted in the interview by Eoin, a member of the police service (AGS):

> I don't just say that because it's the party political broadcast, but our *number one priority is the public health issue* you know, and, you know, arresting and prosecuting people for offences is actually, it's down the list of priorities. *Prevention is the number one issue* and that's the way we look at it as well. It's not about statistics for An Garda Síochána either in relation to drugs. It would be great some year to be able to say we have had very little seizures of heroin and cocaine this year.

What is said in this extract is shaped by a contemporary criminal justice discourse that places emphasis on prevention and a concern about victims (Garland 2001); furthermore, what is said reproduces official police discourses. For example, the *Crime Prevention & Reduction Strategy – Putting Prevention First* states: "An Garda Siochana [sic] is committed to making crime prevention a top priority" (AGS 2017, p. 3). A discourse of public health is invoked to make this point. There is a clear contradiction here between the professional criminal justice discourse and the policy criminal justice discourse.

While drug seizures are deemed a success for the police and often get media attention, seizures have unintended lived effects for those active in the drug market and their families. When drugs are seized, the unpaid debt remains. If an individual is convicted, the drug debt remains and is often shifted to the

family. This is acknowledged by Eoin, who states: "maybe in some circumstances because of drugs seizures that the police have made are the reason for…[the intimidation]"

The interview with Paul (social scientist) clearly highlights this paradox:

> …and the other thing about the drugs trade and about that sort of law enforcement response is that that debt is still there, so the debt has to be paid by someone. So that will now go to his family. So, while the Guards are judged in terms of having seized drugs, that's how their effectiveness is determined in the national drugs strategy, that successful seizure will very probably lead to greater levels of violence as a consequence of the debt that is outstanding.

The passing on of the drug debt from dealers to their families, with the possibility of associated violence, is an unintended consequence of current drug policy.

Another negative consequence is involvement in criminal activity by the person owing the debt and the family in order to pay off the debt. This issue was raised in the interview with Paul (social scientist):

> the credit unions realised that people were taking out loans to pay drug debts and they stopped giving out loans, so people basically had no sources of income, so what that did then was that people then would start holding drugs, or people would start trying to, you know, holding goods, guns, holding drugs, couriering drugs, you know to pay off debts etcetera. Allowing their houses to be used to mix drugs or to sell drugs. So people, families get increasingly, sort of, brought into the web of the illicit drug market, generally from a position of complete innocence they get embroiled in this…in this trade. So I think that is something that is…and that has increased, and *it's also hidden, it's not on the radar* really.

This unintended consequence of drug policy is contained in what is said in these extracts. Paul talks about this consequence as being "hidden" and not on the "radar". These are subjugated knowledges that do not feature in dominant public and political discourse on drugs and crime.

Second, the accusatorial nature of the criminal justice system acts as a barrier to reporting DRI, as discussed by Paul (social scientist):

> If people don't report to the Gardaí, there is very little the Guards can do, and people won't, and the Guards will be the first to acknowledge it, you know, that people are too fearful. And even if they do report to the Gardaí, or if they report informally, *the Gardaí want a prosecution*, you know, that's

> what their role is essentially. And nobody wants to take part in a prosecution. A prosecution won't take place without a witness.

Notably, in this extract what is said about the role of the police, to prosecute, contradicts what Eoin (AGS) had previously stated about prevention being the priority.

The court system as a barrier to reporting DRI is also raised as an issue in the interview with Ciaran (AGS):

> If you make a statement that, a complaint, accusing a person of coming to your house and threatening you, we then go on and arrest the alleged culprit, drug dealer, drug supplier, we bring them in, what's the first thing, we retain them for questioning, and then we have to tell them who has made a complaint.
>
> They may well get bail. And if they don't get bail their cronies will be sitting in court watching, you have to bring the person, if you want to put them in custody you will have to bring your complainant to court to get in the box, the witness box to tell the judge, he is just after threatening me, and the house was burnt down,
>
> …and they are entitled to have a solicitor asking questions. How many people want to do that? *I have had no complaints yet. So for me it is 0 % of the 100% people that I have seen*.

The fear of reprisal stops people from making an official complaint. In the above extract, the failure of the DRI reporting programme to achieve its intended outcome is acknowledged by the police.

Third, using and dealing drugs classified under the Misuse of Drugs Act is a criminal offence. If family members talk to the police about DRI, they draw attention to drug use and possibly other criminal activities, such as drug dealing and trafficking, in the family. Thus, the drug law in itself acts as a barrier to reporting crime as families may think that by reporting DRI they, or their close relative, will be prosecuted for a drug-related crime. This barrier is acknowledged in the interview data from both the police service and treatment services:

> I am very conscious that us as a police force, for obvious reasons, a lot of people probably would have been reluctant to discuss these issues with ourselves, because people would assume if someone owes a drug debt, well then that indicates that someone has been involved in criminality, perceived criminality, the police are only going down, you know, a certain role, and want to extract information on that front (Eoin, AGS).

> there's such a huge amount of fear and anxiety around it, especially for parents. There's the fear also that they report the intimidation to the guards you know and no matter how much I would say to them 'you know the guards won't press charges with you', they don't see it in that way (Aoife, family support worker).

There is a perception amongst the public that the policing role is about crime detection and arrest, with an assumption that the police will use this information in law enforcement. The supportive role of the police presumed in the reporting programme cannot compete with the perceived traditional perception of the police role held by the public, especially amongst those who may have had a problematic previous relationship with the police.

Fourth, the legacy of relationships serves as another barrier to engagement in the programme. The community as whole, or individual families, may have had a previous relationship with the police that has not been positive. This was raised in one of the interviews with the police:

> …sometimes the families which you are dealing with may not have had a very good relationship with the police, may not be trusting of the police, may themselves, you know, have been involved, like you could have first generation, second generation families who were involved in crime…[…]…a lot of these situations, and I have experienced it myself, where there is intimidation and drug debts, we may have searched that house six weeks earlier which is a very confrontational situation. There is no such thing as a nice search when somebody arrives, when the police arrive at your door, particularly a drugs search, it's confrontational from beginning to end (Eoin, AGS).

In the extract below, references are made to historical relationships between socioeconomically deprived communities and the police service, which mediate whether families will engage with the police:

> …Blackrock or an affluent part of Dublin, those people will tend to have no problem, they will come in to the police, they will seek advice, you know…[…]… in the areas where most of this intimidation is going on, the relationship with the police for a lot of families and that, has always been, it's confrontational, it has been difficult… (Eoin AGS)

As I have discussed in Chapter Five, these problematic relationships date back to the 1980s and 1990s, when community activism emerged in the absence of a political response to the drugs issue (O'Gorman 1998; Cullen 2003; Mulcahy and O'Mahony 2005; Butler 2007; Darcy 2008). At the time, there was an antagonistic response by the state to the community movements

(Bennett 1988; Mulcahy and O'Mahony 2005; Darcy 2008). The legacy of these events has resulted in contentious relations and low levels of public confidence and trust in the police (Mulcahy and O'Mahony 2005; Power and Barnes 2011). These legacies continue to shape contemporary relationships between families and police.

Fifth, in the interview data fear of reprisal was talked about as a significant barrier to reporting DRI, as exemplified in these extracts from different interviews:

> there was a great deal of alienation from the Guards, in a lot of the working-class communities, always has been, but people were very reluctant to cooperate, not so much because of you know their antipathy towards the Gardaí, but fear was an element, fear of reprisal from those involved in the drugs trade (Paul, social scientist).

> As far as I suppose the family members I would work with, there's a huge amount of fear about intimidation. So they're not really open to coming forward. There's a huge fear…[…]… Even to get them to talk to us about it in the [NAME] service they're very closed… (Aoife, family support worker).

> I think that there's a group of people that it was hoped to help that will never go to the guards that will never … that they will be afraid because of the threats that are being made towards them (Carol, HSE adolescent treatment service).

Strong asymmetrical power relations operate in the areas where drug markets are located, where those on the receiving end of intimidation often have few political resources to act.

In addition, the stigma of being a 'grass' in Ireland is raised as an issue that also acts as a barrier to reporting:

> It's the stigma of being an informant, and it's an issue that is totally engrained in Irish society, full stop. It's not just in these communities, there is that issue of being an informant, about being a grass (Eoin, AGS).

Sixth, the police see the role of other professionals as very important in supporting them in their work as they view professional networks as a means to address the trust issue:

> I would think it's through the Family Support Network, it's through the social worker network, I think they are the people that need to push it more so than the police. Because, you know, me going out into a community and going, I want…listen we are here, talk to us. It's almost like I am trying to just grab intelligence, you know, off people. Whereas if the trust is there and

> the people who they will talk to, and they will talk to the social workers, they will talk to the local community workers, they'll, you know, give them the information, it's them that need to encourage. And probably in a lot of those areas there may not be a great like or trust of the police either amongst some of those professional people that would be dealing with that, which is an issue (Eoin, AGS).

This discourse reflects a contemporary criminal justice discourse characteristic of neoliberal rule, where it is acknowledged that the state alone cannot address crime and that responsibility for crime control is extended to non-state actors (O'Malley and Palmer 1996; Garland 2001). At the same time, however, the complexity of engaging with other professionals is also acknowledged in the extract above - there may be a legacy of negative relationships between the police and professionals working in deprived communities.

This legacy is raised as an issue by an interviewee working in a family support service:

> The initial … I suppose our initial findings of it was that there was uncertainty within the Garda stations. When we were…went about it. So we weren't getting positive feedback about it. But recently there's been a new inspector…I've spoken to him, he's just trying to find his feet and he's willing to come out and talk to our participants. So anything like that is positive. *Anything that breaks down barriers. So we'd welcome him, cautiously.* But we're definitely here to get involved with him and give him a go (Lorraine, family support worker).

Seventh, another feature of the nature of the Irish drug market impacts on the reluctance to report. Drug markets tend to be local and tend to exist in socio-economically disadvantaged communities. Those who intimidate and are intimidated often know each other, or live close to each other:

> a lot of these people intimidating are just small fry, the same as, I had a juvenile, well I think he was about 18 or 19, and he was being intimidated for 50 euros, sure the crowd intimidating him they were his former thieving friends he was out at night doing, breaking into cars and stealing cars with three months earlier, with the two boyos that were threatening him (Ciaran, AGS).

Here it is pointed out that those who intimidate and their victims move within the same social networks, and that power relations can shift depending on the context of the relationships.

Geographical location and class mediate the impacts of drug-related crime. Paul (social scientist) explains how people in different geographical communities experience different impacts:

> So, for example, if somebody is shot, say in West Dublin, people in West Dublin probably know the person who was shot, they probably know the person who shot him, they probably are related to them in some way, or related to somebody, so they are much more, you know, close to the actual reality, so the fear associated with the shooting is much more real, and that's a reality that is only…it is very specific to the communities what they refer to as the host communities of illicit drug markets.
>
> Now, for many other people in broader society, or middle-class society etcetera, drug-related crime, they would see it in terms of drug users robbing things, you know, so they would look at the economic-inquisitive issue, primarily, because they are not impacted by the violent element. They see it in the newspapers, you know, the latest gangland figure, but that does not have an immediate impact on them…the way it would have in other communities.

The way that emphasis is put on place, class and legacy in the interviews when talking about DRI indicates that the potential success of an intervention such as the reporting programme is contingent on local and historical contexts.

A discussion on gender in relation to DRI is absent in the policy; however, the interview data highlight the gendered nature of DRI. This extract from my interview with Ciaran (AGS) exemplifies this:

> But I think in terms of families, it's the violence impacting on all family members, and particularly on mothers…
>
> **Eva: Yeah, Megan O'Leary's research showed that…**
>
> It showed that and that, you know, the impact on families, because often a mother will try and manage a debt in a household. Often, you know, for example in the North Inner City you…data has shown…you got 50% of families, are single parent families so you have a lot of mothers trying to deal with kids…their kids getting into debt, or if they have a...if they are married or they have a partner, sometimes they would try to keep that so that he doesn't get heavy, or respond aggressively (Paul social scientist).
>
> Well, they are the strongest…nearly in my experience in troubled communities, in tough communities the main movers are always the women. The men are gone, or they are in prison, or they are not around, or they are dead (Ciaran, AGS).

The interview data brings to the fore the way that DRI disproportionally impacts on women and in particular, those living in disadvantaged

communities, and this finding concurs with previous research on impacts of DRI on families (O'Leary 2009; Connolly and Buckley 2016).

I asked the interviewees about their views on the success of the reporting programme that has been developed to address intimidation. Generally, the interviewees see it as a positive intervention, while being realistic about what it can achieve – the provision of information and advice to families. This is reflected in what Paul (social scientist) says about the programme:

> What that scheme does, it provides support for, you know, generally you are talking about a mother, primarily, who is caught up in a situation and doesn't have a clue of what to do about it, but has no interest in either going to the Gardaí, and certainly no interest in pursuing a prosecution against the individual. So, it's very limited, you know, it's a very important initiative, and it does provide people with support, and it provides people who are…drug workers, or project workers with some way of responding (Paul, social scientist)

As noted earlier in this chapter, Ciaran (AGS) had observed the failure of the programme in terms of achieving its intended outcome of official complaints.

I asked the members of the police service what they do when families make contact but do not want to make an official complaint. Sometimes, alternative and informal ways of addressing the issue are used by the police. This includes: patrolling in a manner that would not look out of place during vulnerable times; covert surveillance of those who intimidate in order to catch them for another, unrelated crime; and, following up on outstanding warrants. Eoin and Ciaran (AGS) elaborate:

> If they engage with us, you know, we know who the people are then within the community that are causing the problem, so we know these people need to be targeted, you know, from a wider…not specifically for this threat, but there are people who can become under our interest who can be targeted covertly with eventually, hopefully, you know, catching them for 'a' crime which would result in them being taken out of the equation (Eoin, AGS).

> If I do know who they are, there could be a warrant. In that situation [referring to a case he had talked about earlier], there was a warrant for one of the people, he was another juvenile who was threatening and I rang the Guard up and I said to him 'when you get him, put him in custody', I didn't tell him why, so I said if you get him in, ring me and let me know, you know, people might have money warrants or penal warrants they might not have paid a fine. So this fellow…go out and arrest him on a penal warrant, he might have 45 days and a lot of them in prison. And then as an Inspector, I can ring the Irish Prison Service and tell them I want you to keep that fella in as long as you can (Ciaran, AGS).

The mediating role of service providers is talked about in some of the interviews. A lot of work happens informally, as Seamus (adolescent treatment service, voluntary sector) explains:

> We do phone the guards and we ask for their understanding in this situation and they're really good like that. They'll say, 'well do you know what, I could drop around the house'. We have in a couple of situations said, 'look this guy is under threat can you do this, he doesn't want to contact' … and they'll say 'we can just throw an eye over'. Which is really helpful if it's that severe…

The interview data suggests that the police adopt alternative practices to help those help those who are intimidated. However, as an unintended consequence of drug policy, DRI is extremely challenging to govern.

The legal system is problematised in only one of the interviews:

> I don't see any simple answers and I probably know more about the issue than most people, or I have certainly focussed, you know, in terms of research, focussed on it, so it's a very very challenging area because the criminal justice system, at least as it is currently constituted doesn't seem to have an answer to it. And, you know, it may call for other approaches, there are different approaches that can be…you know, how do you…how do you intervene in that relationship, between a dealer who is involved in the illegal trade and a vulnerable family. And, you know, it's…to go in there and mediate, or to try to find some solution, politically, that would be challenging, because you would now be seen to be legitimating illegal behaviour. But these people need support, you know, they need assistance. And I think it really does question…*it of course questions the whole nature of the legal system when it comes to the drug issue* (Paul social scientist)

In this extract, what is said is that which cannot be said by others. In other words, the social scientific position of the interviewee enables the critique and problematisation of the current criminal justice approach to the drugs issue as a root cause of DRI. While other interviewees talk about the legal system as a barrier to reporting DRI, they do not problematise the fundamental prohibitionist nature of drug policy. The prevailing and dominant prohibitionist discourse and stance towards drugs precludes a serious public and political debate about alternative approaches to regulation of drugs.

Governmental programmes such as the reporting programme are therefore likely to fail. Such programmes individualise and responsibilise family members and do not take account of the legal, juridical, cultural, social and

political contexts in which DRI takes place. My analysis has identified that in practice, there is vast experiential knowledge of these complexities.

Transformative potential

The professional discourses do not reproduce policy discourses about DRI of families. Because of the experiential knowledge that is produced through the interviews, about DRI as an issue and about the complexities associated with governing the issue, there is transformative potential in the data. Fundamental issues, such as the nature of the legal system and the court system in relation to drugs, are problematised. This suggests that there are opportunities to challenge the current dominant discourses on regulation of drugs. Bonham and Bacchi (2017) state that the transformative potential identified in interview data is closely linked to the distribution of research findings. This implies that I as the researcher have an ethical responsibility to reflect on the dissemination of my research as it in itself produces political implications. I discuss this in further detail in Chapter Ten.

8.3.2 Governing affected families as social recovery capital

The dominant policy discourse on families as a resource in treatment – as the potential "key to the rehabilitation effort" (DOCRGA 2007, p. 50) - is not seen as a taken-for-granted idea in some of the interviews. For example, Clodagh, (Policy coordination, HSE) when talking about the *National Rehabilitation Framework*,[54] observes: "Families can, *in some cases*, have a place in a person's recovery". This reflects an understanding of families as diverse, and it implies that family involvement is not a self-evident idea.

Some informants emphasise the ethical challenges of family involvement. When asked about her views on the implementation of family-related policy actions, Catherine (DOH) talks about some of the complexities associated with engaging family members:

> …it was always a slight reluctance to involve families because they were worried about confidentiality, or if the individual would sort of, wouldn't want their family to be involved or indeed if the family wouldn't want to be involved either, and so it was, it's a sensitive one…

[54] The *National Rehabilitation Framework* is a guide document for drug treatment services (Doyle and Ivanovic 2010).

When talking about family involvement, Geraldine (community based drug project) makes it clear that the proposed social recovery role of families does not always play out as imagined:

> In reality, the lads coming into our methadone are either…most of them are older and they are not going to have their families…[…]…more times than not, they are adults in their own right and they do not want anybody else involved.

Geraldine continues:

> It's a formalised system, and I just don't think it would be manageable. It just wouldn't be attended. You know, how would you get them to buy into it.

Instead, several times during the interview, Geraldine speaks about the need for "practical everyday support" for families. This quote exemplifies what this might entail:

> One of the children is really ill and both of the parents are in crisis because the child is in hospital…they are not interested in doing the tick-box model. They are interested in how they're going to get supports for the rest of the kids while they are in the hospital…[…]…even medical things like the methadone for the drug user, how is that going to be sorted out if they are not going to be able to get back to the clinic.

In these extracts, the self-evident nature of families as a source of social recovery capital, which is assumed in policy discourse, is challenged. These are alternative understandings of families that differ from the imagined normative, functionalist 'ideal' family type that is contained in policy discourses. Instead, these are examples of families that may not want to be involved, individuals who do not wish to have their families involved, and families trying to cope with the practical challenges of daily lives in difficult circumstances as a priority.

Issues such as rights to privacy and negotiation of confidentiality are brought up in the interview with Clodagh (Policy coordination, HSE), again in the context of a discussion of the *National Rehabilitation Framework*:

> And then asking the question, would you like anybody here with you at any stage. So…and then obviously getting the consent of that person about what can and can't be shared…getting that delicate balance as well around the confidentiality…[…]…Which is a delicate balance throughout, not just for the family involved…

Eva: And it's a process as well…an issue the whole time…?

> Exactly, yeah, the checking back, and it's, you know, and can be, you know, making it available to withdraw consent at any time, you know really checking in that that is being followed through.

What is said in these interviews is a discourse on autonomy and rights to privacy and confidentiality by acknowledging the autonomy of individuals to determine the course of their rehabilitation, and also of family members to choose not to get involved. Responding to my description of confidentiality as a process, Clodagh highlights the complexities for professionals of operating simple official discourses in practice. In practice, family involvement needs to be negotiated continuously with the service user. The literature on family involvement in drug and alcohol treatment is limited; however, studies suggest that practitioners' perceptions about rights, involvement and confidentiality can act as barriers to family involvement (Lee *et al.* 2012, Schanche Selbekk and Sagvaag 2016). Hence, client confidentiality can serve as a strategy by professionals to not engage in the desired conduct (family engagement) as imagined in policy discourses.

In relation to confidentiality, individuals are understood as rational and active citizens having rights as they are provided with opportunities to choose whether to involve their family and decide how much information is shared with family members. The negotiation of confidentiality can be understood as an element of active service user involvement. While service user involvement owes it origins to social movement demands, for example, in the areas of disability and mental health, it is also incorporated into NPM. Underpinned by the political rationality of neoliberalism, the notion of active service user involvement is a feature of contemporary service provision as citizens are imagined as consumers of health and social care services rather than passive recipients (Considine and Dukelow 2009).

In contrast to these accounts, in a voluntary residential treatment setting,[55] family involvement is compulsory. Here individuals entering treatment give up their rights to privacy in exchange for receiving help:

[55] This centre uses a 'Minnesota Model' philosophy, based on AA principles (Anderson *et al*. 1999).

> You cannot be in treatment unless your family engages from the get go…[…]…that person would need to come every [weekday] which is a family day in treatment. So the family is seen as a key piece that needs to be engaged with and worked with. I'd say probably more so to help the drug user or drinker or gambler (Brian, manager of a voluntary residential rehabilitation facility).

I asked Brian what happened on the family day:

> Wednesday mornings it's a general…lectures, education, material that's provided to the families. Then there's an individual piece or a three-way piece with the counsellor. Then in the afternoon there is more of a group…it's just for family members…and that's really about getting them to identify with each other and support each other.

In this discourse, family involvement is self-evident. This discourse draws on a conceptualisation of addiction as a disease and an understanding of families as contributing to both the 'problem' of and solution to addiction. Underpinned by psychological knowledge and expertise, specific therapeutic technologies of governing such as counselling and mutual help are used to shape the family member into a certain subject. This family member subject aims to understand and transform both relations to self and to the family member undergoing treatment.

Transformative potential

The interview data contains accounts of families that deviate from the normative 'ideal' account of family that is contained in drug policy discourses. This highlights transformative potential for widening the narrow and normative conceptualisation of families that dominates drug policy and practices.

8.3.3 Governing affected families as service users in their own right

Most interviewees refer to families affected by drug use as service users in their own right and therefore as governable subjects. However, my analysis has identified that there are nuances in the construction of their subject positions, with some seen as more legitimate than others by authorities. Attempts at governing subjects perceived as less legitimate have encountered resistance.

Michael works with a DATF in an area consisting of mainly disadvantaged communities. Heroin use became a serious concern in this area in the early

1990s. Services for affected families, primarily in the form of bottom-up organised peer-led family support groups, have been in operation since the 1990s, even before the DATF was established. In the quote below, Michael speaks about the families that currently engage with the groups:

> A lot of the families have become *addicted* to family support, and they find it difficult to *move beyond it*. And we have some rather ludicrous situations with some of the families, where their drug using 'child', who maybe started using drugs when he was eighteen, and is now thirty-five, and hasn't used drugs for ten years. And they are still attending family support. Now they still…some of them have come to identify with the group…there is a lot of *institutionalisation*…and because of that these groups are not always as open to newcomers as they should be…[…]… a big challenge for the families as well, to accept, for the original families, to accept that they *need to let go* now.

The metaphors of 'addiction' and 'institutionalisation' reflect a medical discourse that produces family members as pathological subjects. The reference to 'letting go' implies a desire for family members to become autonomous, self-regulating subjects. They are perceived as no longer being in need of the service that is funded by the state, and any potential benefits that these families may draw from engaging with the service are not recognised, or seen as valid. Instead, their continuing involvement is seen as a failure of the intervention as it has created a culture of dependency and an 'in-group'.

Sharon (NFSN) explains how such grassroots peer-led support groups originated in the early 1990s:

> I spoke to a few like-minded people, and we met up, and we decided that we would try and get together and set up a helpline for families. And accidentally, I would say, we set up what is now known as a peer-led family support group…[…]…We were also very involved in what was known then as the Street Campaign, where communities had got together and said, like, enough is enough, there's open dealing on our streets, we need to look at the whole drugs issue and not just from a supply…from a drug dealing perspective. What came out of the Street campaign, I suppose, was that a lot of the dealers were user-dealers, so they needed treatment, they needed help.[56]

What is captured in this extract is the shift in purpose of the anti-drug movement in the 1990s from just addressing drug supply through vigilante

[56] The Street Campaign eventually led to the formation of CityWide in 1996 as discussed in Chapter Five.

activities to a more diverse understanding of how the drugs issue should be addressed. As a result, the movement got more organised across Dublin and adopted a more political approach (Cullen 2003). Thus, the peer-led family support groups that are talked about in the interviews with Michael (DATF, above) and Geraldine (manager of a voluntary community-based drug project, below) have their roots in community activism and community development.

In contrast to Michael's account, Geraldine (manager of a voluntary community-based drug project) offers different insights into the benefits that such families gain from peer-led support:

> You might have three of four kids that are now in their 30s or 40s, and some of them may have committed suicide, some of them may be actively using, and outside in the community or in their own lives, they may not have anybody or anyone they speak to and this is a safe space to just come up and we give them their tea…[…]…and that's very quiet work…[…]…but it's very real work. And for some of the…longer term parents that are coming, some of them are living in quite horrific circumstances…[…]...they may have been marched on, they may have been…their families might still be very active and they may not feel that they can talk or they're even part of the community. Really for those it's about just having a place…they don't have to explain…

The legacy of the anti-drugs movement is also raised in this interview. The families who may have engaged in drug-dealing, but who also had sons or daughters that were using heroin, had been targets of the vigilante activities. As a result, they are still excluded from their community. Geraldine draws on concepts of social exclusion and marginalisation, echoing Hourigan's description of families experiencing drug use, especially if connected to crime, as the "disadvantaged of the disadvantaged" (2011, p. 128). Social support for these families is seen as vital. At the same time, it is implied that peer-led family support as an intervention is not always recognised by others as a vital service.

Experiential knowledge is central to the purpose and activities of the peer-led support groups:

> What we realised was that by coming together we were supporting each other, and we were all getting better in ourselves. We were learning a lot more because we were all at different stages and it was just amazing what was happening, and it was happening just naturally. None of us had training, none of us had a clue how do you facilitate a group. We knew by coming

> together, having a cup of tea, having an informal chat was helping us (Sharon, NFSN).

This discourse of experience is not an easy fit with contemporary dominant managerial discourses that valorise evidence, accountability, measurable outcomes, expertise and professionalism. This tension emerges in the interview with Michael (DATF).

Peer-led family support is not seen as legitimate by the DATF, as it is not perceived to be a 'professional' service:

> …it's a suspicion about it because it is not run by professionals, and in general people would prefer to give money to services to run things, in a so called professional way than to give it to families to run themselves (Michael, DATF).

Peer-run respite weekends are not seen as legitimate activities to be funded by the state:

> On paper sometimes people have looked at it and said, well, there is a bunch of families, and they are going away to a hotel for a weekend and, you know, there may even be alcohol consumed at the weekend, I mean is this really something the Task Force should be paying for (Michael, DATF).

Moral assumptions about what respite weekends ought to look like underpin this representation of affected families, which precludes a discourse on pleasure. This reflects broader dominant harms and risk discourses on drugs and alcohol, from which pleasure is typically excluded (Duff 2008; Moore 2008; Race 2008).

The interview data contains competing discourses about what counts as legitimate knowledge. Practices such as peer-led family support groups and peer-run respite are shaped by experiential knowledge. This is subordinate to the pervasive managerial discourse that governs drug policy making and professional practices, emphasising accountability and evidence-based practice. Michael (DATF) talks about negotiating this tension:

> …we have to make sure we don't throw out the baby with the bath water, but we still have to balance the fact that if we are going to fund this, that we have to be able to stand over the quality of what is it that is being delivered…[…]…We want to maintain the family support in [LOCATION], and particularly because we have a high profile, we have a long record. And because it's important, you know.

The idiom of the 'baby and the bath water' in the quote suggests that even though the family support service does not fit with contemporary managerialism, the service is valued. The concern is about accounting for the aspects that are controlled by the service users, yet there is an acknowledgement that this element is what provides buy-in from the community.

In contrast, in another DATF, where the interviewee Gary works, affected families are constructed as legitimate service users. This area consists of a mix of urban and rural, and middle-class and working-class communities, and impacts of drug use were not seen until the early 2000s. Family support services were developed in the latter half of the 2000s, and while some services were developed from the grassroots and some include peer-led support, they are provided using a professional-led model.

Programmes such as family respite and peer-led family support are not seen as problematic in this area, and they have not met with resistance from the Task Force as in the other location:

> …one of our more successful projects would be the likes of the family respite service, which provides what it says, which is respite to families which are experiencing very chaotic…I suppose…experiencing chaotic lives at home because of their loved one's misuse (Gary, DATF).

The respite service referred to in the interview is a professional-led service where individual families can visit a facility for a day, over-night or a weekend.[57] Here, affected families are constructed as deserving service users in their own right as they are experiencing current 'chaotic' situations at home. The pleasure of a break away is sanctioned. In addition to providing therapeutic services, such as complementary and alternative therapies, the service also aims to develop personal and family skills. It is also seen as a support to drug rehabilitation through its aim to reconcile families:

> And from a rehabilitative perspective, I think the respite could fall under that too, because there is a very strong rehabilitative piece to it, and it's about, I suppose fixing broken pieces that have been developed over the years in families that have suffered the chaos, yeah, so it's about rebuilding, and building self-esteem, building the confidence to kind of not only develop

[57] This is in contrast to the peer-led respite activities in the other DATF area.

> their own skills, but then develop skills to get their family functioning again, so it's that rehabilitative side in the respite piece as well…(Gary, DATF).

This discourse concurs with the dominant policy discourse on affected families as service users in their own right in the context of being seen as social recovery capital. This desired role of families is actively fostered through capacity building of the individual family member during the respite.

The different ways that affected families are represented as 'problems' in the two Task Force areas illustrate the Foucauldian notion that dominant discourses are contingent on local and historical contexts. The different problem representations also result in different forms of governing families. When affected families are constituted as less deserving and 'dependent', the governmental objective is to attempt to regulate activities, control the families and legitimise the interventions. Throughout the interview with Michael the terms "we" or "us" (for the Task Force) are used in contrast to "they" or "them" (for the families). This binary implies a hierarchy in the power relationship. The power relations between the Task Force and the families are complex and contain tensions that highlight the complexities of governing at a distance.

Different technologies of governing are employed to attempt to make the family support service more legitimate and to shape the families into more governable subjects. First, the Task Force allocates a proportion of the family support budget towards what is seen to be a more 'legitimate' intervention, the Strengthening Families Programme, which is seen as being evidence based and having measurable outcomes - a better fit with the requirement for accountability:

> So it is helpful for us for a start to use two-fifths of the budget for something that is completely evidence based. You know, so first of all we can say, well park all that, that's totally measurable (Michael, DATF).

Second, in order to make respite weekends legitimate, a capacity building element in the form of therapeutic activities designed to address coping is added:

> They go away on respite weekends a couple of times a year. And we try to build in a therapeutic kind of element to that, now it could be something like mindfulness training, stress management…(Michael, DATF).

The inclusion of interventions shaped by scientific psychological knowledge and middle-class norms serves to justify the spending of the state's resources on respite weekends. It also attempts to shape family members into self-governing subjects, where 'technologies of self' are employed as subjects are asked to work on themselves to enhance their inner resources for coping (Foucault 1978; Rose 1999).

Third, there is an attempt to professionalise the peer-led family support service through the encouragement of peer support workers to become accredited in therapeutic approaches such as the 5-step method.[58] This has met with resistance:

> There is a lot of resistance. People say that they don't want…they have often said that they don't want the service to become too professionalised…they want it to retain its kind of informality, because that's what makes it special, and unique and different. Like, for instance, they reserve the right to give people a hug, you know, a professional sitting in an office is never going to give you a hug…(Michael, DATF).

The reference to the 'right to give hug' in this quote reveals a tension between different forms of knowledge. On the one hand, there is the dominant discourse on evidence-based practice associated with the professionalisation of community development; on the other hand, there is the less dominant discourse on experiential knowledge as the basis for expertise, and in alternative practices for providing community support. In negotiating this tension, Michael (DATF) acknowledges the difference between the felt needs defined by lay people and normative needs defined by professionals. The 'hug' symbolises the emotional connection aligned to experiential knowledge, whereas professionalism demands emotional distance.

Michael (DATF) attributes the resistance to professionalisation to the low levels of education of the peer support workers:

> There is also very low levels of educational attainment among a lot of the families and people who provide and deliver a lot of the support. And so

[58] The 5-step method is a programme designed to enhance affected family members' coping skills (see Chapter Six).

> they are deeply suspicious and fearful of having to submit themselves to any kind of exam or assessment or anything like that…

The NFSN is providing the 5-Step Method training for workers. The interview with Sharon (NFSN) provides insights into the rationale of introducing the model of intervention into Ireland:

> *I know when I meet with a family member, what I am doing works. But I can't prove that.* I can't prove that…[…]… I can see it. But a lot of it is emotion…how do you measure emotional development, how do you evaluate that?...[…]…what it [the 5-Step Method] did do was put structure on the work and there was a questionnaire…

The new practices are shaped by a discourse of managerialism, which values accountability and the ability to measure 'what works'. Later in the interview, Sharon (NFSN) reaffirms this:

> I think 5-Step is…is…I suppose for the want of a better word…is going to professionalise family support. And we can now say that what we do works…

In contrast, in the other Task Force area, where family support services are already more professionalised, the governmental strategy of professionalisation of family support work has not met with resistance:

> [Referring to the 5-step method]…Quite intensive in terms of accreditation and training, but again, what I have been fed back is the simplistic approach and how they can put a bit of structure in what can be very difficult challenging work (Gary, DATF).

Instead, here the introduction of a rational and prescriptive model is seen as helping to simplify work that can be messy, emotional and complex.

A fourth governmental technology is surveillance. Surveillance is a productive form of disciplinary power that works to individualise and control subjects (Foucault 1979). The Task Force wants to introduce a tracking system into the peer-led family support service, which has met with resistance:

> …we are looking at a system, for instance, of unique personal identifiers, so that although we don't want people's names and addresses, we want to know if the same person is coming every week, we want to know if the same person is going to two or three groups, you know, this kind of thing, we want to know if that person is going on the respite weekends but is not bothering to attend the weekly groups…you know, we want to be able to have some

> picture of what's going on. And that's been treated with huge suspicion, people just say, oh well you just want to track and trace everybody and you want to know their details and whatever…(Michael, DATF).

The purpose of such techniques is to make people knowable, countable and monitorable so that governing can take place (Miller and Rose 2008). The focus on control systems demonstrates the influence of a managerial discourse on the practices of the Task Force as it seeks to measure and produce knowledge about the family support services it is funding. This quote also reveals hidden power relations in the assumption that the system is being 'abused' by some families.

These examples of counter-conduct illustrate three points about the nature of power relations. First, relations of power are not unidirectional and there is always a potential for resistance (Foucault 2000; 2007). Second, as illustrated in the example on attempted professionalisation, these are "oppositions to the effects of power linked with knowledge, competence, and qualification – struggles against the privileges of knowledge" (Foucault 2000, p.330). Third, in the example on surveillance, these are "struggles against the "government of individualisation"" (Foucault 2000, p. 330). Foucault maintains that ultimately, counter-conduct is about resistance "against the submission of subjectivity" (Foucault 2000, p. 332).

Transformative potential

The professional discourses reproduce policy discourses to a large degree in terms of a dual understanding of families as service users in their own right, and, at the same time, as a resource in drug treatment. However, the instances of counter-conduct I have found in the data, as family members in peer-led family support practices resist attempts to govern their conduct, provide a space for transformative potential. These instances of resistance are about competing domains of knowledge and expertise. This creates an opportunity for wider reflection on the forms of knowledge and expertise that shape contemporary drug policy and practices.

8.4 Conclusions

In this chapter discuss the findings of my analysis of interview data that relate to responsibilisation of affected families – families that live with drug use. I discuss three issues: drug-related intimidation, family involvement in treatment, and families as service users in their own right. What they have in common is that the technologies employed to attempt to shape conduct of families elicit responsibilisation in terms of tackling crime and successful drug treatment and rehabilitation outcomes. Technologies of self are also utilised to induce family members to transform into self-regulating subjects who assume responsibility for their own health and that of their families. The professional discourses shed light onto the complexities of governing 'at a distance'. The professional discourses also show that rational governmental programmes as imagined in policy "never work out as planned" (Foucault 1991b, p. 80)

In relation to DRI of families, the professional discourses, drawing on experiential forms of knowledge, reveal the complexities of attempting to govern such a challenging issue. The intervention that has been designed to encourage families to report intimidation to the police is seen to have failed to achieve its intended outcome. I argue that the rational solution in the form of a reporting programme is individualising and shifts the responsibility for addressing the crime onto the victim. The intervention does not take account of the legal, juridical, cultural, social and political contexts in which DRI of families takes place. Miller and Rose observe that "the solutions for one [governmental] programme tend to be the problems for another" (2008, p. 35). In other words, drug prohibition as a policy solution to the drugs issue produces the unintended outcome of DRI of families. However, there is transformative potential in the interview data for challenging the fundamental nature of drug policy and how the legal system operates.

There is a dominant discourse in drug policy on the benefits of family involvement in drug treatment and rehabilitation, and family involvement is seen as an unproblematic and rational process. However, this taken-for-granted idea is problematised in some of the interviews, where a discourse on ethics highlights issues such as rights to autonomy, confidentiality and

privacy as important factors. In contrast to the policy discourse on families, which understands families as normative, functionalist and 'ideal' types, the interviews construct alternative accounts of families that deviate from the 'ideal' in terms of normative expectations of care and support obligations. This highlights transformative potential for challenging the narrow and normative conceptualisation of families that dominates policy.

Drug policy discourse constructs affected families as service users in their own right; however, this is nested in a problem representation of families as a source of social recovery capital. This dual and nested representation of the 'problem' of families is reproduced in professional discourses. However, the professional discourses suggest that the simple policy proposal of 'supporting families in their own right' is complex in practice and contingent on cultural and historical contexts. One example apparent in the interview data is the practice of peer-led family support, in which there are competing discourses about what counts as legitimate knowledge. There is a significant tension between the pervasive and dominant discourse on evidence-based practice associated with the professionalisation of community development on the one hand, and the less dominant discourse on expert knowledge as the basis for expertise and for providing community support. The instances of counter-conduct and attempts to govern practices that are seen as less legitimate draw attention to the Foucauldian idea of resistance in power relations as refusal to become a certain subject (Foucault 2000). In this way, transformative potential can produce an opportunity to reflect on the forms of knowledge and expertise associated with advanced liberal rule that shape contemporary drug policy and practices.

Chapter Nine:

Professional discourses and ‘risky’ families

Chapter Nine: Professional discourses and 'risky' families

9.1 Introduction

In this chapter I discuss the findings in relation to 'risky' families under two key themes: governing parental drug use and governing families with 'risky' young people. My analysis identified three dominant discourses that shape how parental drug use is governed: family support, child protection and psychological. Here I discuss each in turn and point out areas of tension in the interview data. Following this, I discuss the second key theme of the 'risky' young person. A prevention science discourse shapes the governing practices of how families with 'risky' young persons.

The technologies for governing 'risky' families and 'risky' young people are different. However, the shared primary concern is children's future potentiality in terms of health and life chances. Here, biopower is at work with the governmental objective of producing healthy future citizens.

9.2 Governing parental drug use

My interview questions centred on the policy actions related to families contained in the 2009 drug strategy. While I did not specifically ask a question about parental drug use, the issue was raised in only three interviews. The issue was not raised in any of the interviews with interviewees who held a service provision role. In the interviews where parental drug use was talked about, it is understood as 'risky' to children, but considered harmful once a 'threshold' of conduct has been breached, where the ability to parent according to acceptable social norms is seen as deficient. The 'threshold' refers to child abuse. Under the theme of governing parental drug use, I identify three discourses: family support, child protection and psychological. My analysis identified that the professional discourses on risk largely reproduce policy and official discourses and that the transformative potential in the data is limited as a result.

9.2.1 A family support discourse

For families that have not crossed the 'threshold' of child abuse, the main concern is not drug use *per se*, but the ability to parent responsibly and function 'effectively'. John (Tusla) notes:

> …maybe families need a certain level of support and they can function reasonably well and probably to a level which is *acceptable* so that they are able to carry on and parent their children, and you know pay their bills and get on with their lives in the community…

Here, a process of normalisation is at work through the combination of disciplinary power and biopower (Foucault 1978; 1979). Families are seen to need a supportive intervention to facilitate them to become responsible and participating citizens that contribute to their community and society according to prevailing societal norms.

John refers to the *Meitheal* model of practice. This is a model of assessment and intervention being implemented by Tusla to govern the conduct of families where child abuse is not a primary concern, but where some form of support is seen as necessary. According to John (Tusla), the programme is:

> …for families who have a level of need which falls *below the threshold* of child abuse, so doesn't specifically require a social work element to this, but for families who have a range of needs around parenting, general family functioning, and for whom perhaps a coordinated response from a range of agencies might be required…[…]…a community based, coordinated response to individual families…

The solution is located in the community, rather than with the state, and provided through a network of agents:

> We are most effective in our role when we are close to local communities and linked in with local services and resources (John, Tusla).

Meitheal is a national practice model that is intended for use by all agencies who work with children, young people and their families. As a governmental technology *Meitheal* engages a network of local actors in governing the 'risky' family at a distance, where the community acts as a buffer zone between 'risky' families and the state (Rose 2000). In this interview extract, 'community' is understood as the range of services and agencies that are located in a geographical community, not as collective of the people living in the geographical community.

9.2.2 A child protection discourse

Families that are not able to carry out their expected functions, even with supportive interventions, are differentiated in the interview data. They are seen as having attributes that make them deficient in their ability to parent effectively:

> …there are some families who, for a range of reasons, don't and can't function as effectively as others. It could be addiction issues, you know it could be mental health issues, it could be, you know domestic violence issues, you know it could be income issues, there's a whole range of issues which will impact negatively on families around their ability to function effectively. And particularly, I mean the most important function of the family is to rear children and to rear them effectively…(John, Tusla).

In this interview extract, three issues are raised that are increasingly talked about as the 'toxic trio' in social work and child protection discourses: the interaction of the 'problems' of mental health, drug and alcohol use, and domestic violence (Institute of Public Care 2015). The compound effect is thought to be 'toxic' in terms of increasing the risk of harm to children.

The main concerns are the risk for child abuse in the form of emotional neglect and the need for safeguarding of children:

> …the whole dynamic of life for addicts is complex and it is important when you are in that situation to understand the point at which a *threshold has been reached and children are no longer safe*. Because very often parents with addiction issues, they are not going to abuse their children, they are not going to beat them, they tend to be very quiet, relaxed…the problem is they are too relaxed, the problem is, you know, they are not available, they are not meeting the developmental needs of their children…(John, Tusla).

This discourse is shaped by social work knowledge and expertise. The metaphor of the 'threshold' is used as the trigger for an intervention. This implies that a critical level of unacceptable parental conduct, which here is assumed to be related specifically to drug use, has been reached. This, in turn, triggers an intervention. When parental conduct has exceeded the 'threshold' of neglect, the technologies of disciplinary power switch from being supportive and normalising to punitive as the state and its governing agents assume parental responsibility. The assessment of risk is a process that is understood as requiring expert knowledge:

> …in our statutory child care role we need to understand at what point it's no longer possible to maintain a family…and despite everything that can be

> done it's not working for the children…[…]…*specialist knowledge and specialist skills* are required to understand, you know, at what point it's no longer acceptable or no longer tenable to continue trying…the children have needs and perhaps their needs are best met with other carers…(John).

This extract highlights the disciplinary power that is linked to expert social work knowledge – the power to make decisions about families that result in significant lived effects for all family members. However, the extract highlights that the prioritised concern is children's needs, not those of the parents. In this interview, the need for more expertise and social work intervention both within the statutory child protection system and drug treatment services is expressed:

> …there is probably a need for *more specialist and more specialist* element of services to be introduced, both within Tusla and within some of those organisations so there is a capacity to intervene in a safe guarding role for children and parents, I think that's a gap…(John, Tusla).

This articulated need for more social work professional expertise and intervention with families where there is a parental drug use reflects the increasing focus on child protection discourses in Irish social policy in the last decade. It suggests a desire for a more interventionist state in this area as well as a desire for social work knowledge and expertise to be integrated into drug treatment practices.

While the primary concern in John's interview data is clearly the safeguarding of children, a somewhat different way of thinking about families is put forward in Catherine's (DOH) interview. In this extract, the tension between the desire to support the whole family to stay intact and the desire to protect and safeguard children is recognised:

> …there is a wish to identify who these kids are and help them…on the other hand there is a wish to keep families together, and give people support and strengthen their families and help them, you know, work out their issues and actually, you know, have proper family structures, proper family lives.

Here, contradictory subject positions are produced, which enable different governmental programmes to take effect: one more punitive and one more supportive in nature. I did not probe further in this interview about the reference to 'proper' families; however, the context suggests that normalising supportive interventions that aim to enable families to conduct themselves

according to societal normative ideals are recommended. This also suggests the value that is placed on nuclear, intact families.

There are implications of these discourses in terms of the lived effects for families. Studies indicate that parents who do not have custody of their children do less well in terms of drug treatment outcomes and life outcomes compared to those who live with their children (NTASM 2012; Comiskey *et al.* 2016).

9.2.3 A psychological discourse

A parallel discourse is taking place in the interviews with Catherine and John when they are talking about parental drug use. This discourse is shaped by psychological knowledge and is centred on child development and children's future life chances. In the earlier quote from the interview with John, it is clear that emotional neglect, as a form of child abuse and as a consequence of parental conduct, is the 'threshold'. The use of terms such as "too relaxed", "quiet" and "not available" pictures these parents as passive; they are not seen to comply with the social norm of the active and engaged parent that actively intervenes with their children in order to optimise their development and future life chances (Gillies 2008).

This discourse is echoed in the interview with Catherine (DOH):

> …you are seeing children not necessarily being, you know, harmed physically, but neglected as a result of this...it's probably *self-evident* that neglect in fact is *far far worse than, and far far more damaging*, than random, maybe random violence…

A little later in the interview, Catherine continues:

> …if parents don't have the skills to actually, you know…care for very, very young children there are *catastrophic consequences down the road*. Those children will have all kinds of problems and even if they are born with, you know, alcohol foetal syndrome, they may recover from it, but it's going to take a long time to recover where they are actually neglected…

What is said in these extracts reproduces official Tusla discourse about neglect as a form of child abuse being…

> …the most harmful. Not only does neglect generally last throughout a childhood, it also has long-term consequences into adult life. Children are more likely to die from chronic neglect than from one instance of physical

> abuse. It is well established that severe neglect in infancy has a serious negative impact on brain development (Tusla 2016b, p.1).

In the two extracts from the interview with Catherine (DOH), psychological discourse about neglect is reproduced, which understands neglect as having severe long-term impacts on development and, therefore, being more harmful than physical abuse, and understanding neglect early in life as particularly harmful (Hildyard and Wolfe 2002).

9.2.4 Competing policy domains

John and Catherine represent different disciplines and institutional discourses – child protection and health (encompassing treatment and rehabilitation) respectively. These two discourses shape what is said in the different interviews. A tension between the desire to meet the needs of children and the desire to meet the needs of adult drug users in a family is highlighted in the interview data. Because of its statutory child safeguarding role, Tusla prioritises children's needs over those of the adults:

> …there can be differences, you know, let me put it this way, differences in emphasis…from a social inclusion[59] perspective…probably is more about supporting parents and adults to, you know, to engage with their issues to, you know, to have more fulfilling lives etcetera etcetera within their addiction, whereas a Tulsa perspective is about safeguarding and protecting children […] there are probably two different…there shouldn't be two different perspectives, the best interest of the children should inform everybody's practice but there can be a different perspective on that, let's put it that way (John, Tusla).

The tension between the competing discourses is acknowledged in this extract; however, the child protection discourse is foregrounded. On the other hand, in the interview with Catherine (DOH), the perspective is shaped by a discourse on rehabilitation and recovery:

> …part of that rehabilitation of the drug user is very much linked to them repairing their relationships with their families and getting their children back living with them so it's a sort of…it's a kind of a holistic issue, it's about helping the person at the centre who has the addiction problem and supporting them through their recovery, but in doing so recognising that there are different needs that they will have and making sure that those issues around their children, their child care needs, their aspiration, which in many

[59] The reference to "social inclusion" in the interview excerpt is to the HSE National Office of Social Inclusion, the unit of the HSE with responsibility for treatment and rehabilitation of substance misuse. The Unit is also a partner in the *National Hidden Harm Project*, along with Tusla and other HSE units.

> cases to get them back, to keep their children with them or get back with them, that that's addressed as well.

The discourse in this interview reflects drug policy discourse wherein family relationships and family reconciliation are seen as part of a holistic therapeutic strategy.

The different discourses on child protection and rehabilitation in these extracts reflect the different and competing policy domains and practice orientations of the DOH and Tusla. Responsibility for oversight, coordination and implementation of drug policy resides with the DOH, and drug rehabilitation is coordinated by the HSE. While both Catherine and John referred briefly to the *National Hidden Harm Project*, where both the HSE and Tusla are partners, to date, Tusla has not participated in the drug policy making and oversight process to a large degree. It is not a formal member on the Oversight Forum of Drugs,[60] nor is it represented on the National Drug Rehabilitation Implementation Committee. In the interview with Catherine, the limited engagement of Tusla in drug policy making is raised as an issue and it is perceived that the drugs issue is not central to the remit of the agency:

> I would like to see the Family Support Agency,[61] which does provide money to the Family Support Network, being more engaged in the drugs issue because of their name, you know, I mean it's all about family support, but they sometimes see the drugs issue as a marginal, a marginal issue…

The limited engagement by Tusla with drugs issues is also acknowledged in the interview with John:

> I do think from our perspective, it's a niche, it's a small area but I do believe it's important…[…]…the National Drugs Strategy I think would be enhanced if the safeguarding of children was plugged into it a little bit more.

While the need for more engagement is articulated in this interview, it is limited to a discourse on child protection. The issue of impacts of drug use on adults in the family was not raised in the interview.

The dominant discourse of whole family support in the DOH interview data on the one hand, and the dominant discourse of child protection in the Tusla

[60] The Department of Children and Youth Affairs is represented on the OFD; however, Tusla is an independent state agency.
[61] The Family Support Agency was the predecessor of Tusla.

interview on the other hand, reflect the competing principles and values, competing resourcing agendas, competing policy domains and politics at national and local levels (France and Utting 2005). These are significant challenges to interagency work, such as the 'Hidden Harm' collaborative project and the implementation of the National Drug Rehabilitation Protocols.

Transformative potential

I am surprised that parental drug use is only talked about at depth in two of the interviews. This might reflect the discourses in the 2009 drugs strategy, where 'hidden harm' was not referred to. The lack of talk about parental drug use in this set of interviews indicates that it is not a dominant issue for most of the interviewees, and the agencies and services they represent.

When parental drug use is talked about, what is said reproduces discourses in family and drug policies. As I note in Chapter Seven, these discourses have potentially stigmatising effects for families, which may act as a barrier for families to access services (Klee 1998; Rhodes *et al*. 2010; Radcliffe 2011; Lloyd 2013). Furthermore, the desire for a more interventionist state may result in interventions that can be perceived as intrusive or unnecessary by parents (Chandler and Whittaker 2014).

There is an absence of the alternative discourses on parental drug use in these interviews, such as parents engaging in active work to protect children from harm when they have the resources to do so (Klee 1998; Rhodes *et al*. 2010). There is also a silence in the data on how parental drug use, and children's future outcomes, are impacted on and shaped by wider socioeconomic factors. Hence, I identify limited potential for the challenge of dominant and pervasive discourses on parental drug use in this set of interview data.

9.3 Governing families with 'risky' young people

My analysis of interview data identifies a second discourse where families are governed through a technology of risk. The primary concern in this discourse is also the young person's future potentiality, especially in terms of future drug use. Here, biopower is at work with an economic rationale for

intervention, and with the objective of producing healthy future citizens. This is illustrated in this extract from my interview with Michael (DATF):

> …the people that we are dealing with are the kids who will be in the methadone clinics or they will be abusing tablets or whatever in a few years' time if nobody intervenes now…*they've got all of the risk factors* you know and, you know, it's just so *cost effective* to intervene with people when they are 12 or 13 rather than waiting until they're 23…(Michael, DATF 2).

What is being said is shaped by a prevention science discourse. Families are seen to have one or more risk factors that enhance the chances of poor life outcomes for the young person. The perceived risk factors pertaining to families can be excised from the interview data. The extract below, from the interview with Michael (DATF), illustrates this. Here he speaks about participants on the *Strengthening Families Programme* (SFP)*:*

> …where the family are having difficulties with its communication, difficulties…just conflict resolution…[…]…some of them are very dysfunctional families. We have an awful lot of single parent families, and we have a lot of large families, we have immigrant families. A lot of families with a lot of other issues going on. Many have drug and alcohol abuse within the families, some have domestic violence in the family. We have had all sorts of issues on that programme.

Through "dividing practices" (Foucault 2000, p. 326) this discourse excises certain subject positions (single parents, large families, immigrant families) as problematic. These are family types that fall outside the normative ideal of the middle-class nuclear family type. The reference to communication and conflict in the quote implies an assumption, underpinned by psychological knowledge, that dysfunctional family relations are associated with these forms of families and linked to young people's problematic conduct.

When I asked about how Action 29[62] of the 2009 strategy is being implemented, most interviewees talked about the SFP. It is an intervention that is widely used across Ireland, often funded by Drug and Alcohol Task Forces or the Probation Service. As a governmental technology, the SFP targets families and children aged 12-16 considered to be at high risk of future drug use, as previously discussed in Chapter Seven. The SFP defines the 'problem' of teenagers' (potential) drug use as a 'problem' of family

[62] Action 29 is contained in the prevention domain of the strategy.

functioning. The solution is also located with families as the programme aims to enhance parenting skills, family skills and teenagers' personal skills in a range of areas. The governmental objectives are to shape this family into one that functions effectively, and to break the intergenerational cycle associated with social ills. Hence, the programme works as a technology of disciplinary power that attempts to normalise families to conduct themselves according to social norms (Foucault 1979). It also nudges families towards taking responsibility to self-govern to improve conduct and to seek to achieve certain standards according to societal norms (Dean 2010).

The SFP is seen as a positive and effective programme in these interviews. It is understood as having a high retention rate and as being of benefit to the participating families. This is exemplified in this extract below from the interview with Gary (DATF):

> Some of the bigger agencies like probation recently fed back some information to us on how beneficial the programme has been to some of the individuals they are working with, and the support that it has given to their families, that has actually been fed back…
>
> **Eva: So you would view that programme as a success?**
>
> I: Big success, and I suppose one of the benefits of it from a family perspective is that they are number one working with other families, two, they are working with their young people together, so it's the young people and their parents…

The high retention rate is noted as an indicator of success in the interview data, exemplified here by what Carol (HSE adolescent treatment service) says, "The thing that's outstanding for me is the retention rates…the retention rates were huge". This indicates a managerial rationality in understanding 'what works' and what constitutes success.

Transformative potential

In the main, the professional discourses reproduce the dominant policy discourses rooted in prevention science and psychological knowledge on families and risk. My interview data contains no counter-discourses to challenge this pervasive way of thinking about families where there is a concern about future drug use. Hence, the transformative potential in my set of interview data for challenging such discourses is low.

9.4 Conclusions

In this chapter I discuss the findings of my analysis of interview data that relate to governing of 'risky' subjects. Here the shared concern is risk in terms of children's future potentiality as healthy and productive citizens. The first concern is parental drug use and there are three discourses present in the data: family support, child protection and psychological. A family support discourse is used when there is no suspicion of child abuse. Technologies of disciplinary power are employed to govern this 'risky' family in the form of surveillance and supportive interventions that aim to normalise family conduct.

When there is a suspicion risk of child abuse the form of power exerted on the family shifts from discipline to sovereignty as the state and its agents assume parental responsibility. The professional discourses on child abuse are shaped by psychological knowledge and these produce causative links between parental drug use, emotional neglect, child development and children's future life chances. There are areas of tension in the data between including the desire to meet the needs of children first and foremost, underpinned by a child protection discourse, and the desire to meet the needs of the children but also the parents. The latter desire is underpinned by a holistic therapeutic discourse of rehabilitation, which considers an intact family important for successful recovery. These tensions pose challenges for the collaborative interagency work that is proposed in drug and family policies

The 'risky' adolescent is seen as being at risk for future drug use and family factors, mainly in terms of functioning, are seen as contributing to that risk. The discipline of prevention science informs the professional discourses. As a result, high-risk families are targeted for governmental technologies that aim to shape family conduct towards normative expectations in order to reduce risk and break the presumed intergenerational cycle associated with social ills such as drug use. These expert-led interventions are individualising. There is no counter-discourse in the set of interviews I analysed, and the transformative potential for challenging the pervasive dominant discourse of prevention science is low.

Chapter Ten:

Conclusions

Chapter Ten: Conclusions

10.1 Introduction

My research is conducted as a sociological response to families' increasing visibility in the AOD policy, practice and research fields. This increased visibility has largely been a taken-for-granted development: there is little critical analysis in the literature of its underpinning presuppositions and assumptions. This form of examination is important because the presuppositions and assumptions that underpin how policy proposes to address 'problems' shape how groups of people, such as families, are governed in relation to drugs and drug use. In turn, the way that people are governed has political implications in terms of power relations and real lived effects.

My thesis is a theoretical study, underpinned by a Foucauldian framework, which examines how families are thought and talked about in Irish drug policy and practices, and how families are being governed as a result. My overarching research question asks how families are problematised in Irish drug policy. The objectives of the study include: exploring the operation of policy discourses relating to families as they are interpreted and negotiated by professionals in the drug field; understanding how governing takes place; and, examining the political implications of the specific ways that families are problematised.

I start this chapter by presenting the key findings. Following this, the original empirical, theoretical and methodological contributions of my study are discussed. I then consider the limitations of my study. Next, I propose directions for future research, and I conclude this chapter with a personal reflection on my study.

10.2 Key findings

My overarching research question asked how families are represented as 'problems' in Irish drug policy and how governing takes place as a result. The analysis of drug policy identified two key modes of governing: responsibilisation and risk. Here I discuss governing through responsibilisation under two themes: drug-related intimidation and affected

families. These reflect the policy domains where the problem representations are located, supply reduction and treatment/rehabilitation, respectively. Next, I discuss governing through risk under the theme 'risky' families, where the problem representations are located in the prevention domain.

Under these three themes, I juxtapose the findings of my analysis of interview data. I discuss the extent to which policy discourses are reproduced or challenged in the professional discourses. I draw attention to the complexities of governing 'at a distance'. Finally, I identify the transformative potential contained in the interviews, which can indicate possibilities for challenging pervasive and dominant discourses of families, drugs and drug use.

10.2.1 Drug-debt intimidation of families

Drug-debt intimidation of family members is an issue that is problematised as a drug policy and research priority in Ireland since the latter half of the 2000s. It is likely that it is an issue in other jurisdictions; however, it is not articulated as a drug policy priority in other national policies. In the Irish 2009 drug strategy, drug-debt intimidation of families is represented as a communication 'problem': the issue to be addressed is that families are not reporting intimidation to the police. An alternative representation of the 'problem' of intimidation as a consequence of drug control laws and policing practices is present in the policy document, but is not a dominant discourse.

How the 'problem' is represented legitimises a particular 'positive' criminal justice intervention with families to encourage reporting. Thus, family members are constructed as victims and, at the same time, as rational and responsible actors. Families are governed through a strategy of responsibilisation as they are given shared responsibility for addressing intimidation with statutory authorities. As professionals are understood to play an important mediating role in this intervention, their remit has been reconfigured to also address intimidation. As a result, the network governing families at a distance has widened.

This particular problematisation is shaped by neoliberal criminal justice discourses and experiential discourses. Policy is silent on factors that mediate the experience of intimidation such as gender, class, place, fear of reprisal and

legacies of relationships between communities and the police. I argue that such governmental programmes are likely to fail as they are individualising and responsibilising in their effects and do not take the legal, juridical, social and political contexts in which intimidations takes place into consideration. The simplistic and rational solution to the 'problem' is not likely to reduce the potentially harmful effects that intimidation can have on families; therefore, addressing this issue in an alternative way is imperative.

The analysis of interview data highlights transformative potential as 'what was said' in the interviews was that which was not said in drug policy. The interview data contain discourses that problematise the contemporary system of drug control and the adversarial nature of the court system. Furthermore, in the interviews, mediating factors such as class, gender, place and previous experiences with the police are talked about.

I conclude that drug-related intimidation of families is an unintended consequence of a prohibitionist approach to drug control. The way that the 'problem' is represented in policy precludes an alternative construction of the issue as one that is constituted through drug laws and policy and, thus, precludes solutions that address and challenge the fundamental nature of drug policy and the legal system.

The new drug strategy makes multiple references to drug-related intimidation. The issue continues to be high on the list of policy priorities as it is listed as one of only six terms of reference for the Standing Subcommittee, which will drive the implementation of the strategy (DOH 2017). However, it is problematised in a different way as it is talked about in the context of community safety rather than as an issue for families. [63] A collaborative inter-agency response is advocated to respond to the issue and the action plan contains the recommendation that the reporting programme be evaluated to improve its effectiveness.

[63] Drug-related intimidation is discussed under Goal Four, which states: Support participation of individuals, families and communities (DOH 2017, p. 63).

10.2.2 Affected family members

Since the mid-2000s, families affected by a close relative's drug use are constructed as service users in their own right, with the 'problem' represented as difficulties with coping. This has legitimised specific professional interventions with affected families that aim to improve coping skills. I argue that the conceptualisation of affected families as service users in their own right is nested within another representation of the 'problem' where families have become part of the solution and understood as a key resource in treatment and rehabilitation of their close relative. In other words, if families are helped to cope better, they are in a better position to support the family member who is undergoing drug treatment and rehabilitation.

These problem representations have largely been shaped by psychological discourses that privilege expert professional interventions over those based on experiential knowledge of drug use and its effects on families. Knowledge based on experience has been the cornerstone of grassroots community-based and peer-led family support in Ireland and the increasing professionalisation of such services can lead to a dilution of this more marginalised form of knowledge and a de-politicisation of such activities.

As a result, affected families are increasingly placed under the professional gaze and governed at a distance as the roles of a wide network of professionals are reconfigured to include affected families in their remit. I argue that implicit in these conceptualisations are normative assumptions about 'ideal' nuclear families and active neoliberal citizenship. The family has become more persistent in drug policy discourse as it is seen as an institution where governing of individuals can take place and for achieving biopolitical governmental goals such as a health and activation of excluded members of society.

Affected family members are thus governed through responsibilisation. They are elicited to become self-regulating subjects that work to improve their resilience and coping. At the same time, they are prompted to support their close relative to access and progress through treatment and rehabilitation, sharing the responsibility for successful outcomes with other actors. There

are silences in drug policy discourse about factors that impact on and mediate experiences of drug use in the family – class, gender, family position, stigma, marginalisation and access to material and political resources. I argue that the behavioural focus of the policy solutions individualise complex and multi-factorial issues such as the impacts of drug use of families. Consequently, contemporary drug policy discourses are likely to reproduce existing inequalities and reinforce asymmetrical relations of power within families, and between families, the state and other actors involved in governing the conduct of families.

The professional discourses reproduce policy discourse of family involvement; however, they also draw attention to some of the complexities of this practice. A discourse on autonomy, both in relation to the service user and the family, draw attention to the fact that sometimes there is reluctance on both sides to become involved. Confidentiality and privacy are key issues to be managed by professionals and service users. This discourse challenges the self-evident idea of the involved family and understands families as diverse.

There is a tension about what counts as legitimate knowledge in relation to supporting affected family members as service users in their own right. This tension is between practices shaped by experiential knowledge (such as peer-run support groups and respite) and those shaped by 'evidence-based' knowledge and expertise (such as professionalisation of peer-led family support services). This tension highlights the complexities of governing at a distance. However, the instances of resistance contained in the interview data also create opportunities for reflection on the forms of knowledge and expertise that currently shape policy and practices and consideration of alternative ways of problematising affected families.

10.2.3 'Risky' families

The construction of parental drug use in policy as 'risky' is shaped by child protection and prevention discourses. The main concern is the future potentiality of children in terms of their development and future drug use. These discourses emerged at the end of the 1990s in the contexts of increasing

political priorities of family support, parenting and child welfare. However, the first reference to safeguarding of children in drug policy is in 2009.

The 'problem' of parental drug use is problematised in three different but interlinked ways: as family dysfunction, as parenting deficits and as child welfare. All families where drug use takes place are constructed as high-risk, neglecting factors such as parents' agency and active work in protecting children from harm. In addition, all forms of parental drug use, regardless of drug of choice or frequency of use, are seen as risky, and all children are seen as being at risk. The way that the 'problem' of parental drug use is represented in policy therefore legitimises a range of state and professional interventions such as surveillance, supportive interventions aimed at 'strengthening families', parenting programmes and punitive measures in cases of suspected child abuse.

While, in the main, the professional discourses reproduce the wider dominant discourses on parental drug use as produced in drug policy, one area of tension emerged in the interview data. This was the tension between, on the one hand, the priority of child protection, shaped by the discourse of social work, and, on the other hand, the priority of drug rehabilitation, shaped by a therapeutic discourse. The former is black and white about prioritising the meeting of children's needs, which is not surprising given its statutory responsibility. The latter offers a more holistic therapeutic perspective that also takes the needs of the parents into account. This highlights the competing priorities and agendas of different domains of social policy and suggests that collaboration in practice areas such as the *National Drug Rehabilitation Protocols* and the *National Hidden Harm Project* may pose challenging.

Apart from this tension being apparent in the interview data, I find little transformative potential in my data that could suggest alternatives to the dominant and pervasive ways of thinking about parental drug use.

I argue that the governmental technologies that are employed are individualising as they aim to change behaviour of individuals and families. This focus on behaviour diverts attention from a broader structural understanding of the 'problem' of parental drug use and how factors such as

housing, unemployment or social isolation may shape children's outcomes. Furthermore, the way that policy and professional practices problematise parental drug use can produce stigmatising effects for both parents and children, often already part of groups in the population that are marginalised. The dominance of medical, psychological and child protection discourses shaping the way that the 'problems' are represented in policy and practices has precluded other forms of knowledge, such as the experiential knowledge of the parents who use drugs and their children, from shaping ways of thinking and talking about parental drug use. The dominant representations of parental drug use are likely to reinforce societal and professional attitudes towards and stereotypes about parental drug use and, hence, reinforce existing socio-economic and political inequalities for families experiencing drug use.

10.3 Contribution

My work makes an original and significant contribution to knowledge. It does so theoretically in terms of examining the governing of families in the context of drug policy and professional practices; empirically through drawing attention to unintended consequences of drug policy; and, methodologically by applying novel poststructuralist approaches to the analysis of policy and interview data.

10.3.1 The theoretical value of the research

In Chapters Three I set out the theoretical framework that underpins the research. Using Foucauldian ideas of power/knowledge, problematisation and governmentality as my central concepts I have also drawn on the work of scholars who have developed Foucault's theories on problematisation and governmentality, in particular Rose, Miller, Dean and Bacchi. This framework has enabled me to analyse how power and knowledge have shaped the way that families have been problematised in drug policy and to theorise how governing of families takes place as a result.

In my view, the most powerful aspect of this framework is its potential to challenge taken-for-granted ideas relating to families in drug policy and practices, and it is here that my study makes an important contribution. In challenging these, critical debate and possible transformation can be created

– these can result in alternative discourses about families being articulated that may result in alternative forms of governing.

10.3.2 The empirical value of the research

In Chapter Two I examine two discrete bodies of literature – representations of families in the AOD literature and studies of governmentality literature in the AOD field. My review identifies gaps in these two bodies of work.

While there is a vast body of work on the family and drug use, especially in the drug prevention domain, there is a distinct lack of theoretically informed critiques. Families are usually understood as taken-for-granted, fixed entities, underpinned by normative assumptions. My study makes an original contribution to this body of research as it uses critical social theory to 'trouble' self-evident ideas about families and their roles in contributing to and addressing the drugs issue as problematised in drug policy. In doing so, I address Barker and Hunt's (2004) criticism of the AOD field being conceptually stagnant with respect to understanding families.

In examining drug policy research, I have located less than a handful of papers that take families as their distinct focus of analysis. My study makes two contributions to drug policy research. First, the analysis of professional discourses in my study has enabled me to provide insights into the extent to which policy proposals relating to the governing of families are operationalised as imagined in drug policy.

Second, the originality in my study lies in its focus on the political implications of how families are problematised in drug policy, which enables the analysis of unintended consequences of drug policy for families. This is usually not addressed in traditional forms of policy analysis that instead tend to focus on measurable outcomes that are predefined by policy objectives and key performance indicators. This is particularly salient as the new Irish drug strategy, where families feature prominently, has recently been published. The findings and the analysis can be used by policy makers, researchers, professionals and families to reflect on the proposed policy recommendations that relate to families from a perspective of problematisations and political implications.

The literature that uses a Foucauldian theoretical framework, with governmentality as its central concept has critiqued health promotion and harm reduction policies and practices. More recently, the body of work that understand realities as constituted and enacted through drug policy and practices has analysed drug policy, legal texts and professional discourses for how 'problems' such as drugs, addiction, drug and alcohol use are produced. Here, my study makes an original contribution to this research literature with its novel focus on the 'problem' of families and the governing of families in the context of drug policy and professional practices.

10.3.3 The originality of the methodological approach

In Chapter Four I outline the methodological approach that I have used in my study. I adopt a poststructuralist methodological strategy that is strongly rooted in Foucauldian theory to address my research question and objectives. This strategy involves the analysis of policy discourses and expert discourses – understanding the term discourse as knowledge. I use aspects of Bacchi's (2009) 'What's the Problem Represented to Be' (WPR) approach to analyse policy. The key premise of this approach understands 'problems' such as parental drug use, and subjects such as families to be constituted through policy. Problem representations shape the possible policy solutions that are available. Hence, governing takes place through problem representations in policy.

I complement this set of data with transcripts of 17 interviews conducted with a range of professionals in the drug field comprising policy makers and professionals. The interview data provides expert discourses for analysis, which enables me to analyse how dominant policy discourses on families are negotiated and operationalised. I use Bacchi and Bonham's (2016) novel Poststructuralist Interview Analysis (PIA) approach to analyse the interview transcripts. The focus in analysis is on *what* is said rather than *who* says what and what makes it possible to say that which is said. Both the WPR and the PIA analytical approaches are concerned with the political implications of the way that issues and subjects are problematised, in particular the unintended consequences of policy proposals and governing practices. Understanding the political implications of how families are problematised in policy and

practices is one of my research objectives; hence, my chosen analytical strategy is particularly suited to address this objective.

My study makes a methodological contribution to the research literature by building on the emerging body of work in the AOD literature that has used the WPR approach to analysis of policy. Here my study adds a new perspective by using families as a focal point for analysis. Furthermore, as the PIA method is recently disseminated, this study will make an original contribution to the application of the PIA in poststructuralist studies.

10.4 Limitations

In this study I analyse all areas of contemporary drug policy - across supply reduction, prevention, treatment and rehabilitation - for how families are represented as 'problems'. My analysis has produced a vast amount of findings, especially as I traced the genealogy for each representation of the 'problem'. Hence, some details have been excluded in the presentation of this thesis for pragmatic reasons.

The sample I selected for my interviews included professionals from different areas of expertise and different disciplines including policy making, research, advocacy, family support, counselling, drug treatment and policing. These were purposively chosen as I wanted to examine how expert and professional knowledge and practices shaped how governing of families took place. There are limitations associated with my sampling strategy. The interviewees were selected because of their areas of professional expertise, i.e. being named as actors in the 2009 strategy and responsible for specific actions that included families. Hence, other areas of knowledge and expertise that engage with families in the drug field were not included in the sample, such as medical, probation and court areas of service provision.

10.5 Future directions

To build on the findings of my study, further research may be conducted. Firstly, in my study I ask how families have been problematised across different areas of drug policy including supply reduction, prevention, treatment and rehabilitation. As a result, my thesis provides an overview of how families are represented as 'problems' in drug policy. In future research,

each of these areas could be addressed in further depth. The problematisations that carry potentially harmful effects for families should receive priority. I suggest two such areas: drug-related intimidation of families and parental drug use.

Second, future research could include families affected by drug use as research participants and as lay experts. The addition of experiential discourses would provide further insight into how families are governed and the lived effects of those governing practices.

Third, a cross-cultural comparative study of how families are represented in drug policy would provide further insights into similarities and differences across jurisdictions, and further highlight cultural and historical contingencies of problematisations. In addition, as Bacchi and Bonham (2016) suggest, cross-cultural comparisons can open up ways of thinking about a 'problem' in different ways. This can have transformative potential as alternative ways of representing the 'problem' can be imagined.

Finally, my study is limited to a critical examination of drug policy. A similar comparative study into how families are problematised in alcohol policy would provide further insights into whether and how alcohol and drugs are thought of as 'problems', and the role that families are thought to play in contributing to the causes of and the solutions to the 'problems'. In the early part of my thesis I discussed how the concepts of harm to others (for example families) from substance use, and in particular alcohol, has got increased attention in the AOD research and policy fields. With some exceptions (Devaney 2017, Bacchi 2015), this development has undergone little critical examination as regards its presuppositions and assumptions. With an increasing number of jurisdictions, including Ireland, now adopting policies that combine alcohol and drugs as objects for governance this form of critical research is topical.

10.6 Personal reflection

My research is a study of policy using a poststructuralist perspective. In other words, I do not make recommendations for policy and practice to change in specific ways in order to somehow improve things. However, my study still

makes certain proposals when I invite researchers, policy makers, and professionals to reflect on my research findings in terms of the assumptions that underpin the way that families are problematised and the political implications that follow. I am suggesting that there could be alternative ways of representing the 'problem' that may result in different forms of governing families, which, in turn, produce different effects. I am also making specific recommendations for areas for further research that I believe warrant further examination.

Inherent in Bacchi's (2009) and Bacchi and Bonham's (2016) approaches to analysis of policy and interview data is a process of self-problematisation, which involves questioning the assumptions underpinning my own proposals and their possible effects. I believe it is important to make assumptions and presuppositions visible. Throughout my research I have become increasingly sceptical of pervasive ways of thinking that are underpinned by neoliberal rationalities. These are presented as self-evident ideas in policy and professional discourses about families, drugs and drug use. I wish to challenge these rationalities that underpin contemporary governmental strategies, such as individualisation, responsibilisation and risk, and I wish to highlight the effects of such forms of rule. Thus, my world view comprises certain values that favour ideas such as social justice, social equity, and collective responsibility for social issues.

The way that my research is disseminated may have political implications. Bacchi recommends that researchers should ask themselves "what realities do my methods create and with what effects for which creatures and places" (2012, p. 7). To date I have distributed my research findings to academic audiences through papers at several conferences and though one published article. I intend to distribute the findings to those who participated in my research as interviewees and to other actors in the field with the goal of creating an opportunity for challenging and possibly transforming problem representations and governing practices.

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Appendices A-L

The Seven Processes of Poststructuralist Interview Analysis

Process 1: Noting "what is said"

> "What "things said" have been noted? On what grounds have they been noted?" (Bacchi and Bonham 2016, p. 116)

The focus of analysis is not the speaker or his or her intentions; instead, the starting point is the examination of "*precisely* "*what* is said" – the "things" said" (Bacchi and Bonham 2016, p. 115). The things said are often taken-for-granted or self-evident; however, these have normative implications for subjects. The analyst can look for

> moments of excision and attribution…[…]…points in the interview where particular ways of thinking, feeling, characterizing and doing are differentiated from the mass of existence" (Bonham et al. 2015, p. 189).

The analyst is here looking for how certain attributes are placed with subjects. Examples of subjects in my study could include parents who use drugs or families with a close relative who uses drugs. Another moment to examine in the interview data is instances of quantification, or measurement, such as use of words such as 'more', 'less', 'many', 'few' etc. (Bonham et al. 2015). Finally, moments in the data where the interviewees speak of themselves as a particular kind of subject, referred to as self-formation by Bonham et al (2015), are noted.

Although the focus is not in 'who' said it, some 'things said' are granted more importance and have a stronger impact depending on their institutional location and their context (Bacchi and Bonham 2016). Here, context refers to the status of the knowledges associated with the institution, for example dominant medical or psychiatric discourses.

Process 2: Producing genealogies of "what is said"

> What meanings need to be in place for particular "things said" to be intelligible?
>
> Where and how has a specific "thing said" come to be accepted as "truth"?
>
> (Bacchi and Bonham 2016, p. 117).

At this stage in analysis, the focus is on the conditions that made 'what is said' possible and legitimate to say, and Bacchi and Bonham (2016) suggest adopting a genealogical approach. In particular, attention should be paid to the interconnected practices that produce a particular truth.

Process 3: Highlighting key discursive practices

> Which discursive practices are relevant to the "things said" that are the focus on analysis?
>
> Which subject positions are made available within these discursive practices?
>
> (Bacchi and Bonham 2016, p. 118).

The third process consists of identification of the discursive practices that relate to the interview topic and how they work to produce the 'things said' in the interview. These have normative effects and as a result, certain ideas and subject positions become privileged.

Process 4: Analysing "what is said"

> Which norms do the "things said" invoke?
>
> Which "subjects" are produced?
>
> Which "objects" do they create?
>
> Which "places" are produced as legitimate?
>
> (Bacchi and Bonham 2016, p. 118)

During this process the 'things said' are examined in terms of their normalising effects and also the subject positions that they produce.

Process 5: Interrogating the production of "subjects"

> "What" does the individual relate to the self?
>
> What ways of moving, thinking, characterizing and feeling has the interviewee excised and related to the self?
>
> In which discursive practices have these attributes been, and continue to be, formed?
>
> (Bacchi and Bonham 2016, p. 119).

Drawing on Foucault's concept of problematisation (1986), interview data is examined for how people problematise themselves as certain subjects and what they do according to certain norms.

Process 6: Exploring transformative potential

> Does a particular interviewee comment appear unusual, inappropriate or out of context?
>
> Does a particular comment offer an alternative to a taken-for-granted "reality"?
>
> (Bacchi and Bonham 2016, p. 119)

Understanding the subject as always in formation, the purpose here is to "explore mutations in subject positions" and to provide opportunities to disrupt dominant discourses (Bacchi and Bonham 2016, p. 119).

Process 7: Questioning the politics of distribution

> Do particular interviewer comments ("things said") challenge or reinforce pervasive ways of thinking?
>
> Do the questions asked (either in a survey or in a semi-structured interview) function to reinforce or challenge pervasive ways of thinking?
>
> Are the sites for distributing research results constrained in ways that reinforce pervasive ways of thinking?
>
> (Bacchi and Bonham 2016, p. 120)

The PIA approach encourages researchers to reflect on the 'things they say' and their use of power as they make decisions about selection, reporting and dissemination of interview material. This builds reflexivity into the analysis of interview data.

Copy of email invitation to participate in study

From: Eva.Devaney
Sent: 06 March 2015 10:01
To: [redacted]
Subject: Invitation to participate in an interview

Dear [redacted]

I am writing to you in my capacity as a PhD researcher at the Department of Sociology at the University of Limerick. In my research I aim to trace how 'family' has been understood, how drug policy relating to family has developed, and how policy recommendations relating to family operate in practice.

Accessing the perspectives of [redacted] is vital to this research as it holds vital experience and expertise, and plays a key role in implementing the current National Drugs Strategy. Based on your experience and your position, I have identified you as an individual whom I believe would make an important contribution to this research, and I would like to invite you to participate in this study.

An interview would take place at a date, time and location of your choice. I anticipate it will take approximately one hour, and I am scheduling interviews between March 16th and April 17th.

I have attached a research information sheet for your information. My mobile number is (086) 8105969 if you wish to contact me.

Thank you for taking the time to consider participating, and I am looking forward to hearing back from you!

Kind regards,
Eva

Eva Devaney
Government of Ireland Scholar
FG 165 -1
Department of Sociology
Faculty of Arts, Humanities and Social Sciences
University of Limerick
Castletroy, Co. Limerick
Ireland

IRISH RESEARCH COUNCIL
COMHAIRLE TAIGHDE na hÉIREANN

FACULTY OF ARTS, HUMANITIES AND SOCIAL SCIENCES

RESEARCH ETHICS COMMITTEE

INFORMATION LETTER

Research Study: Governing the family: State discourses and professional practices in the making of Irish drug policy, 1971 – 2016

Dear

I am writing to you in my capacity as a PhD researcher at the Department of Sociology at the University of Limerick. In my research I aim to trace how 'family' has been understood, how drug policy relating to family has developed, and how policy recommendations relating to family operate in practice. This study will add to the limited body of research about family in the context of drug policy in Ireland, and make recommendations for policy and practice in the field.

As part of this research project I seek to interview individuals with specific expertise and experience in service provision and policy development in the areas of drug supply reduction, prevention, treatment and rehabilitation. Accessing the perspectives of XXXXX is vital to this research as it holds vital experience and expertise, and plays a key role in implementing the current National Drugs Strategy.

Based on your experience and your position, I have identified you as an individual whom I believe would make an important contribution to this research, and I would like to invite you to participate in this study. You, however, retain the right to decline to participate in this research. The research will be conducted in a confidential manner and as such I will neither identify those who chose to participate, nor those who declined to do so.

If you feel that the perspectives of XXXXX can make an important contribution to this research, but you are not available to participate yourself, you may wish to nominate another individual and give your permission for me to approach that individual. All potential participants retain the right to decline to participate, to decline answering questions and to withdraw from the study at any time. The research will be conducted in a confidential manner and as such I will neither identify those who chose to participate, nor those who declined to do so.

The broad topics I would like to discuss with you include the nature of your work, in particular in relation to implementation of the *National Drugs Strategy (interim) 2009-2016* recommendations and actions relevant to families. Other topics might arise as our conversation develops.

Throughout the interview, you retain the right to refuse to answer any question that may be asked of you. You can withdraw your participation in this study at any time

during the life of this project simply by contacting me by e-mail stating that you wish to do so. In this case any data relating to your participation will be deleted.

If you are willing to take part in an interview, I will meet with you for approximately one hour at a date, time and location that is convenient to you. The interview will be audio recorded and confidentially transcribed from the recording by me. You retain the right to opt out of audio recording, and in this case I will take written notes during our conversation. If you wish, I can provide you with a copy of the interview transcript. After transcription, the audio recording will be deleted. All transcriptions will be stored in a secure location at the University of Limerick and will be destroyed after a period of seven years following the completion of the study. Only the researcher and her supervisors will have access to any data collected as part of this study.

Your name, and any information that might identify you, will be excluded from the interview transcripts, thesis or any other outputs of the research. Any contributions will be attributed to your generic position and sector (for example, 'family support worker, voluntary sector'), rather than you as an individual.

Should you have any questions about this research you can contact me, Eva Devaney at eva.devaney@ul.ie or my supervisors Dr. Orla McDonnell: orla.mcdonnell@ul.ie (061- 204298); and Dr. Amanda Haynes: amanda.haynes@ul.ie (061-202445) without any implication of commitment to participate.

I have attached a short biography with this letter for your information.

This research study is partly funded by the Irish Research Council.

This research study has received Ethics approval from the Arts, Humanities and Social Sciences Research Ethics committee (approval number 2013_06_10_FAHSS). If you have any concerns about this study and wish to contact someone independent, you may contact:

Chairperson, Arts Humanities and Social Sciences Research Ethics Committee
AHSS Faculty Office
University of Limerick
Tel: +353 61 202286
Email: FAHSSEthics@ul.ie

Thank you for taking the time to consider participating in this research.

Yours sincerely,

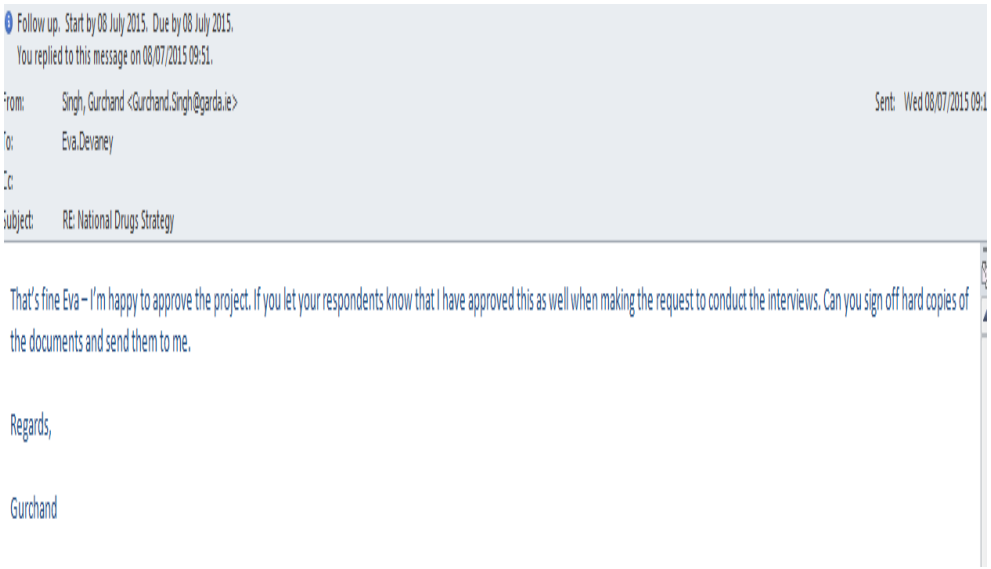
Eva Devaney, Department of Sociology, University of Limerick, Limerick

(086) 8105969 eva.devaney@ul.ie

Biographical Profile

Eva Devaney is currently a full-time PhD researcher at the University of Limerick, Department of Sociology, and a holder of an Irish Research Council Government of Ireland Post-graduate Scholarship. She received an M.A. in Health Promotion and Health Education at the University of Limerick in 2003. She is on study leave from her positions as Joint Course Director of the Diploma in Drug and Alcohol Studies at the University of Limerick and as Acting Health Promotion Co-coordinator at Mary Immaculate College. For the past ten years she has acted as an independent research and evaluation consultant, working with a variety of statutory and voluntary organisations. Her current research areas of interest include the areas of family studies, drug policy, drug prevention and professional education in the area of substance use.

Copy of email granting permission to interview members of An Garda Síochána



Follow up. Start by 08 July 2015. Due by 08 July 2015.
You replied to this message on 08/07/2015 09:51.

From: Singh, Gurchand <Gurchand.Singh@garda.ie> Sent: Wed 08/07/2015 09:1

To: Eva.Devaney

Cc:

Subject: RE: National Drugs Strategy

That's fine Eva – I'm happy to approve the project. If you let your respondents know that I have approved this as well when making the request to conduct the interviews. Can you sign off hard copies of the documents and send them to me.

Regards,

Gurchand

Interview Schedule AGS

A: Introduction

1. Can you tell me about your previous experience and your current role within the AGS?
2. Can you tell me about the work of the XXXX?
3.

B: Drugs- related intimidation & families

4. Could you tell me about your experiences of drugs-related intimidation (DRI) of families?
5. How do families respond to DRI?
6. How does the AGS respond to DRI?

C: The Drugs-related Intimidation Reporting Programme

7. What are your experiences of the Drugs-related Intimidation Reporting Programme?
8. How successful do you think the Programme has been?
9. What are some challenges to its implementation?

D: Future policy developments

10. In relation to future policy developments that relate to DRI and families, what do you think the next National Drugs Strategy should address?

E: Conclusion

11. Is there anything else you would like to add?

Interview Schedule A

A: Introduction

1. Could you tell me a little bit about the nature of your work?
2. Is there a particular model or theory that guides your work?
3. Coming from this model, how do you see the role of the family in addressing drug misuse in supply reduction/prevention/treatment/rehabilitation?

B: Development of the 2009 NDS

4. Could you tell me about the role of your (Dept./agency/organisation) in the development of the NDS?
5. What do you think led to the development of the actions that are specific to families in the 2009 NDS (Actions 5, 29, 41)?
6. In your view, what kinds of families does the NDS refer to?
7. Do you think that the role of family in national drugs policy has changed over time? How?

C: Implementation of the 2009 NDS

8. Could you tell me a little bit about the role of your (Dept./agency/organisation) in the implementation of the NDS, specifically Actions 5, 29, 41?
9. In your view, what are the key issues relating to the implementation of the specific actions?

D: Future policy developments

10. In relation to future policy developments that relate to family, what do you think the 2017 NDS will or should address?

E: Conclusion

11. Is there anything else you would like to add?
12. Is there anyone else that you think it would be important for me to interview?

Interview Schedule Task Force

A: Introduction

1. Could you tell me a little bit about the role and the nature of the work of the Task Force?
2. Are there particular principles or models that guide your work?

B: Services for families

3. What would you define as family support in the context of addressing substance misuse?
4. What kinds of services are provided for families in this Task Force area?
5. Are there any services for families that have been particularly successful?
6. Are there any types of services for families that have worked less well?
7. In your experience, how have services for families changed over time?

C: Implementation of the 2009 NDS

8. Could you tell me a little bit about the role of your Task Force in implementing the 2009 NDS, in particular the actions that relate to families (5, 29, 41)?
9. In your view, what are the key issues relating to the implementation of those specific actions?

D: Future policy developments

10. In relation to future policy developments that relate to family, what do you think the 2017 NDS should address?

E: Conclusion

11. Is there anything else you would like to add?
12. Is there anyone else that you think it would be important for me to interview?

Interview Schedule NFSN

A: Introduction

1. Could you tell me a little bit about the history of the NFSN?
2. What is the nature of your work today?
3. Has the nature of your work changed since the FSN was formed?
4. Are there particular principles or models that guide your work?
5. What do you see as the role of the family in addressing drug misuse?

B: Services for families

6. How would you define family support?
7. What kinds of services or programmes are provided for families experiencing drug use?
8. Are there any types of services for families that have been particularly successful?
9. Are there any types of services for families that have worked less well?
10. Are there certain types of services that are more likely to be funded?
11. In your experience, how have services for families changed over time?

C: The 2009 NDS

12. What was your role in the development of the 2009 NDS, in particular the actions that relate to families (5, 29, 41)?
13. What is your role in implementing the 2009 NDS, in particular the actions that relate to families (5, 29, 41)?
14. In your view, what are the key issues relating to the implementation of those specific actions?

D: Future policy developments

15. In relation to future policy developments that relate to family, what do you think the 2017 NDS should address?

E: Conclusion

16. Is there anything else you would like to add?
17. Is there anyone else that you think it would be important for me to talk to

Interview Schedule B

A: Introduction

1. Could you tell me a little bit about your organisation and the kinds of services you provide for families?
2. Is there a particular model or theory that guides the way you deliver your services?
3. Coming from this model, what do you see as the role of the family in addressing drug misuse?

B: Services provided to families

4. How do families find out about your services?
5. Could you tell me a little bit about the types of families that use your services?
6. How do you assess the needs of the families that you provide services to?
7. Are the services that you provide to families evaluated?
8. In your experience, are there particular types of services for families that are more likely to be funded?

C: The 2009 National Drugs Strategy

9. What do you think about the 2009 NDS, in particular, the recommendations that relate to families?
10. What do you think led to the development of these actions?
11. How successful do you think these recommendations have been?
12. Do you think that the role of family in national drugs policy has changed over time?

D: Future policy developments

13. In relation to future policy developments that relate to family, what do you think the next NDS should address?

E: Conclusion

14. Is there anything else you would like to add?
15. Is there anyone else that you think it would be important for me to interview?

Relevant Actions in the 2009 National Drug Strategy

No	Pillar	Action	Actors
5	SR	Develop a framework to provide an appropriate response to the issue of drug-related intimidation in the community.	An Garda Síochána (lead); FSN; D/JELR
29	P	Develop a series of prevention measures that focus on the family under the following programme headings: • Supports for families experiencing difficulties due to drug/alcohol use; • Parenting skills; and • Targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation.	HSE and D/ES (joint leads); OMCYA; D/SFA; DTFs and Service Providers
41	TR	Support families trying to cope with substance-related problems, in line with the recommendations of the Report of the Working Group on Drugs and Rehabilitation.	HSE (lead); FSA; Depts. and Agencies; FSN; DTFs; C&V Sectors

- D/EHLG: Dept. of Environment, Heritage & Local Government (Currently known as the Dept. of Environment, Community and Local Government)
- D/JELR: Dept. of Justice, Equality & Law Reform (Currently known as the Dept. of Justice and Equality)
- DTF: Drugs Task Force
- FSN: Family Support Network
- OMCYA: Office of the Minister for Children and Youth Affairs
- D/SFA: Dept. of Social & Family Affairs (Currently known as the Dept. of Social Protection)
- FSA: Family Support Agency (currently known as Tusla, The Child and Family Agency)
- C&V: Community & Voluntary

- SR: Supply Reduction
- P: Prevention
- TR: Treatment/Rehabilitation

FACULTY OF ARTS, HUMANITIES AND SOCIAL SCIENCES

RESEARCH ETHICS COMMITTEE

CONSENT FORM

Consent Section:

I, the undersigned, declare that I am willing to take part in research for the project entitled **Governing the family: State discourses and professional practices in the making of Irish drug policy, 1971 – 2016.**

- I declare that I have been fully briefed on the nature of this study and my role in it and have been given the opportunity to ask questions before agreeing to participate.
- The nature of my participation has been explained to me and I have full knowledge of how the information collected will be used.
- I am also aware that my participation in this study may be recorded (audio) and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am entitled to copies of all recordings made and am fully informed as to what will happen to these recordings once the study is completed.
- I fully understand that there is no obligation on me to participate in this study.
- I fully understand that I am free to withdraw my participation at any time without having to explain or give a reason.
- I am also entitled to full confidentiality in terms of my participation and personal details.

_____

_____

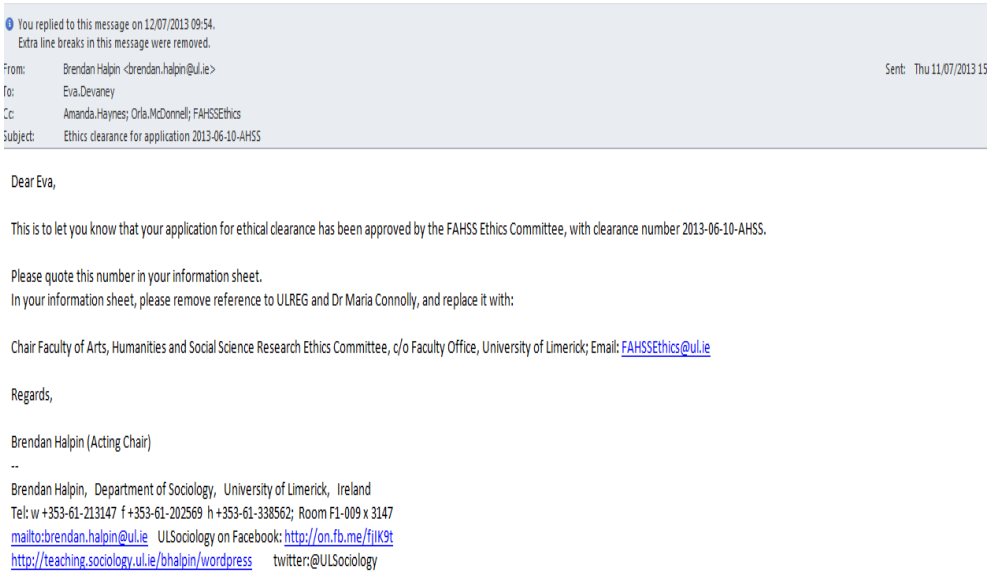
Signature of participant Date

_____

_____

Signature of researcher Date

Copy of email granting original ethical approval from ULREC



You replied to this message on 12/07/2013 09:54.
Extra line breaks in this message were removed.

From: Brendan Halpin <brendan.halpin@ul.ie> Sent: Thu 11/07/2013 15
To: Eva.Devaney
Cc: Amanda.Haynes; Orla.McDonnell; FAHSSEthics
Subject: Ethics clearance for application 2013-06-10-AHSS

Dear Eva,

This is to let you know that your application for ethical clearance has been approved by the FAHSS Ethics Committee, with clearance number 2013-06-10-AHSS.

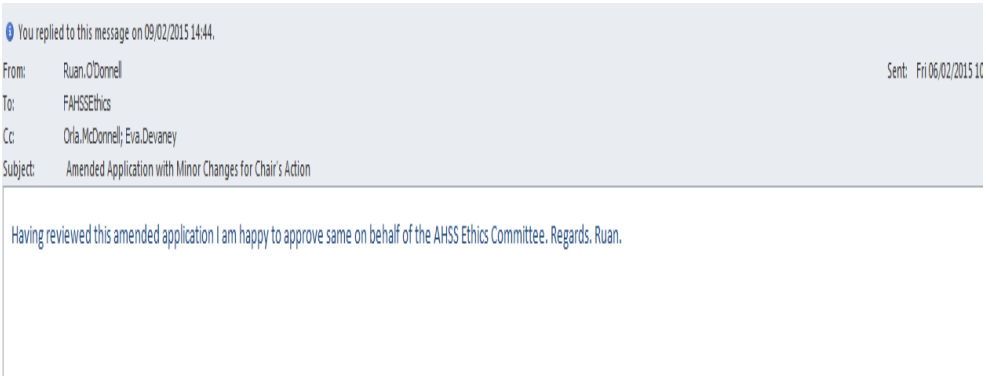
Please quote this number in your information sheet.
In your information sheet, please remove reference to ULREG and Dr Maria Connolly, and replace it with:

Chair Faculty of Arts, Humanities and Social Science Research Ethics Committee, c/o Faculty Office, University of Limerick; Email: FAHSSEthics@ul.ie

Regards,

Brendan Halpin (Acting Chair)
--
Brendan Halpin, Department of Sociology, University of Limerick, Ireland
Tel: w +353-61-213147 f +353-61-202569 h +353-61-338562; Room F1-009 x 3147
mailto:brendan.halpin@ul.ie ULSociology on Facebook: http://on.fb.me/fjIK9t
http://teaching.sociology.ul.ie/bhalpin/wordpress twitter:@ULSociology

Copy of email granting amended ethical approval from ULREC



You replied to this message on 09/02/2015 14:44.

From: Ruan.O'Donnell Sent: Fri 06/02/2015 1

To: FAHSSEthics

Cc: Orla.McDonnell; Eva.Devaney

Subject: Amended Application with Minor Changes for Chair's Action

Having reviewed this amended application I am happy to approve same on behalf of the AHSS Ethics Committee. Regards. Ruan.

Selected Publications, Policy & Structures Developments Relating to Family Support and Child Protection/Welfare 1970-2016[64]

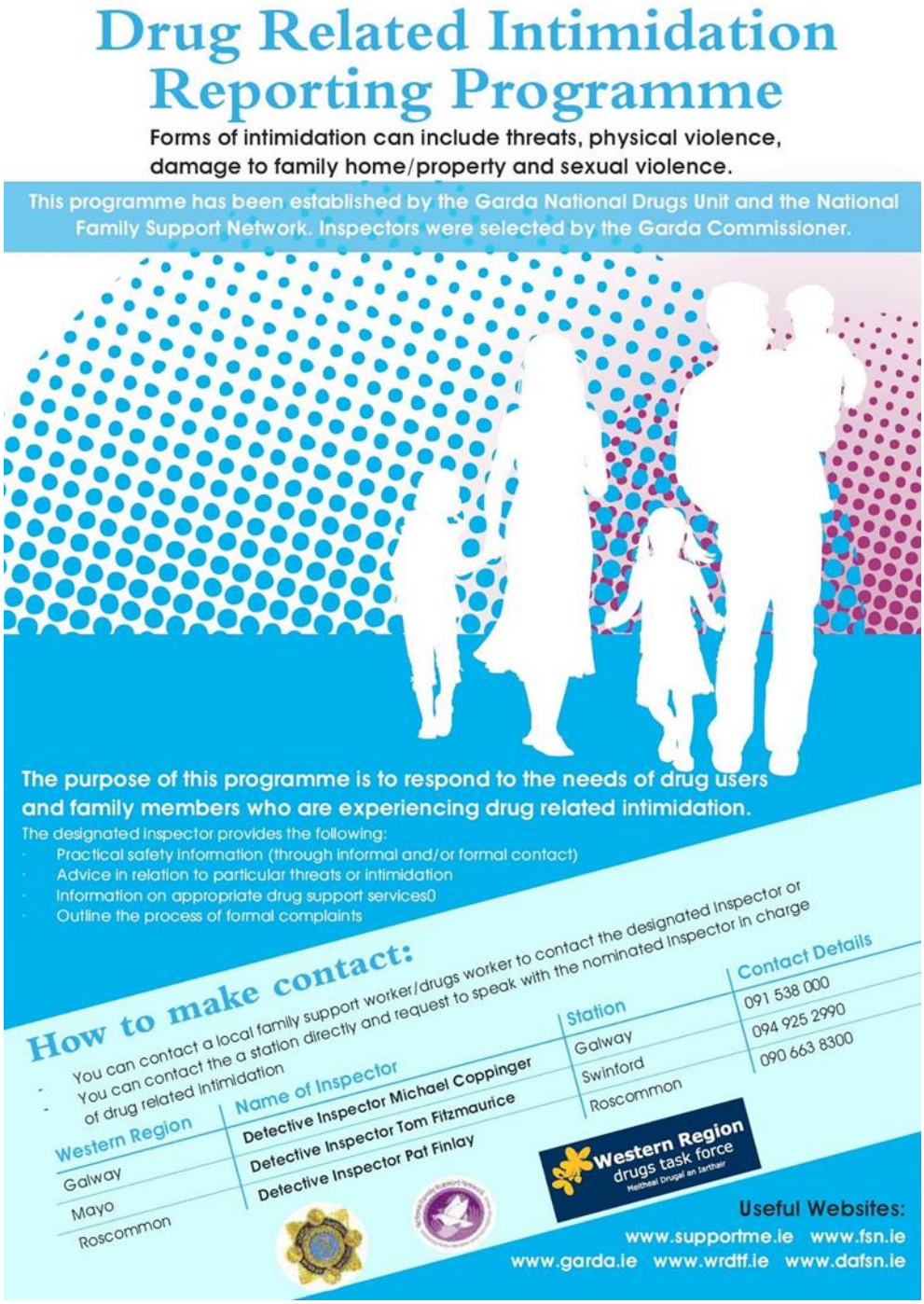
Year	Name	Notes
1970	Health Act 1970	Health Boards allocated responsibility for child care services
1971		**Drug Policy published**
1974	Minister for Health assigned primary responsibility for child protection & welfare	
1975	Establishment of a Task Force on Child Care Services	
1980	Report of the Task Force on Child Care Services	
1987	Child Abuse Guidelines	
1991	Childcare Act (fully enacted in 1996)	Statutory role of the State to protect children and promote child welfare
1991		**Drug Policy published**
1992	Irish Government ratified the UN Conventions of the Rights of the Child	
1994	Minister of State with responsibility for child care services	
1995	Establishment of the Commission of the Family	
1996		**Drug Policy published**
1997	Family Affairs Unit within the Dept. of Social and Family Affairs	
1997	Putting Children First: Promoting and protecting the rights of children	Department of Health
1997		**Drug Policy published**
1998	Final Report of the Commission of the Family	Empowerment/prevention as key approaches
1998	Springboard Programme Children First Guidelines	15 support projects, families at risk, child protection
1999	Children First: National Guidelines for the Protection and Welfare of Children	Inclusion of welfare – centrality of family support in the child protection system. Supportive and preventative interventions made possible.
1999	National Development Plan contained several commitments to development of family related services	
2000	A Guide to What Works in Family Support Services for vulnerable families	McKeown, K. / DoHC
2000	National Children's Strategy	DoHC

[64] These do not include developments relating to institutional and community based child abuse by religious

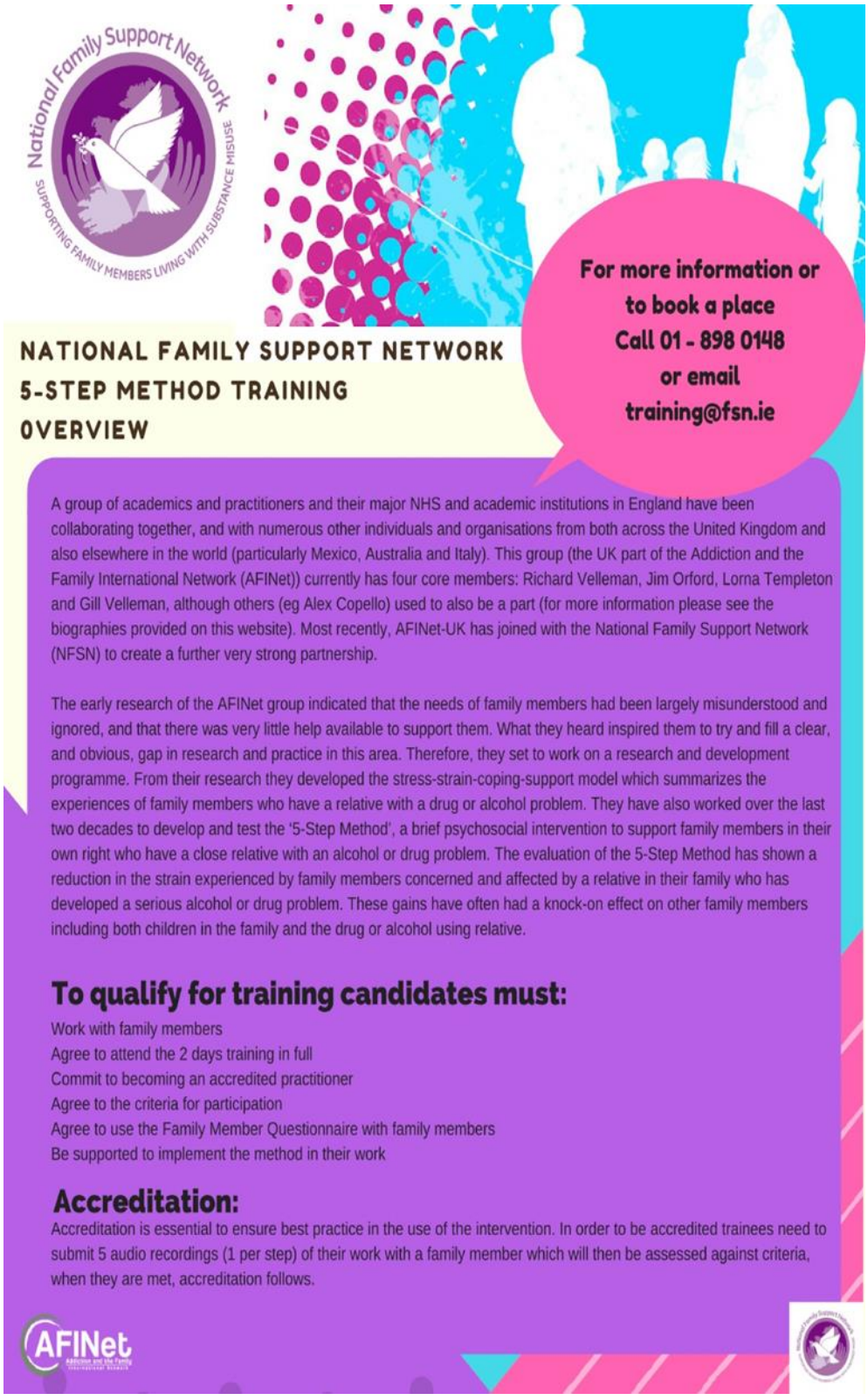
2001	National Children's Office	Staffed by Dept. of Education, DoHC, DoSW, DoJ
2001	Family Support Act (2001)	
2001		**Drug Policy published**
2002	National Family Support Agency under the Dept. of Social and Family Affairs	
2004	National Ombudsman for Children	
2005	The Role of Family Support Services in Drug Prevention	NACD
2005	Significant restructuring of child protection and welfare services as HSE replaced health boards	
2005	Office of the Minister for Children (OMC)	Rep. at Cabinet as Jr. Min.
2005		**Review of 2001 Drug Policy published**
2006	Special Rapporteur for child protection	
2006	Review of Adequacy of Children and Family Services (HSE)	Preference for early intervention and family support rather than investigation-driven approach
2007		**Report of Working Group on Drugs Rehabilitation published**
2009	OMC renamed Office of the Minister for Children and Youth Affairs (OMCYA)	
2009	Report of the Commission to Inquire into Child Abuse	Ryan Report
2009		**Drug Policy Published**
2010	National Director for Children and Family Services HSE	The first standalone child protection and welfare services directorate
2011	Children First: National Guidance for the Protection and Welfare of Children (revised)	Dept. of Children and Youth Affairs
2012	The Report of the Independent Child Death Reviews	This group was set up in 2010 by the Minister for Children and Youth Affairs. Its terms of references included the examination of the causes of deaths of children in care, after care and those known to child protection services, occurring between 01/01/2000 – 30/04/2010
2013	Child and Family Agency Act	
2013	An examination of recommendations from inquiries into events in families and their interactions with state	Buckley & O'Nolan/DoCYA & IRC

	services, and their impact on policy and practice	
2014	TUSLA – The Child and Family Agency	Brought together the HSE Children and Family Services, Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender based violence
2014	Better Outcomes, Brighter Futures: the National Policy Framework for Children and Young People 2014-2020	Department of Children and Youth Affairs

Poster providing information about the Drug Related Intimidation Reporting Programme



Poster providing information about the 5-Step Method training



Leaflet providing information about the Strengthening Families Programme