How research impacts on health policy in Ireland: A case study of alcohol and drug policy

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Authors' Declaration

I certify that, except where acknowledged all work of this thesis were undertaken by myself. I have not obtained a degree in this University or elsewhere based on this work.

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Abbreviations and Acronyms

AA	Alcoholic Anonymous
INCA	Irish National Council on Alcoholism
ABFI	Alcohol Beverage Association of Ireland
ACF	Advocacy Coalition Framework
AHA	Alcohol Health Alliance
AIDS	Acquired immune deficiency syndrome
ARHA	Alcohol related hospital admissions
ASTCG	Arts, Sports, Tourism Community, Rural and Gaeltacht Affairs
BAC	Blood Alcohol Level
CAHS	Canadian Academy of Health Sciences
CPA	Combat Poverty Agency
DALYS	Disability-Adjusted Life Years
DIGI	Drinks Industry of Ireland
DOH	Department of Health
DOHC	Department of Health and Children
EBM	Evidence based medicine
EBP	Evidence based policy
EMCDDA	European Monitoring Council on Drugs and Drug Addiction
ESRI	Economic and social research institute
EU	European Union
H1N1	Pandemic Influenza A (Swine Flu)
HBSC	Health Behaviour of School Aged Children
HEA	Higher Education Authority
HIPE	Hospital Inpatient Enquiry
HIV	Human immunodeficiency virus
HPV	Human Papilloma Virus
HRB	Health Research Board
HSE	Health Service Executive
HTA	Health Technology Assessment
ICT	Information and Communication Technology

IPA	Interpretative Phenomenological Analysis
IRCHSS	Irish Research Council for the Humanities and Social Sciences
IVDU	Intravenous Drug Users
LDTF	Local Drug Task Force
LSD	Lysergic acid diethylamide
LSE	London School of Economics
MDMA	methylenedioxy-n-methylamphetamine
MEAS	Mature Enjoyment of Alcohol in Society
MKWH	Making Knowledge Work for Health
MRC	Medical Research Council
NACD	National Advisory Council on Drugs
NACDA	National Advisory Council on Drugs and Alcohol
NDS	National Drugs Strategy
NDST	National Drug Strategy Team
NESC	National Economic and Social Council
NESF	National Economic and Social Forum
NGO	Non-Governmental Organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPM	New Public Management
NSMS	National Substance Misuse Strategy
OECD	Oragnization for Economic Cooperation and Development
OMCYA	Office of the Minister for Children and Youth Affairs
PEPFAR	Presidents Emergency Plan for AIDS Relief
PRTLI	Programme for research in third level institutions
RCT	Randomised Control Trials
SFI	Science Foundation Ireland
SIAMPI	Social Impact Assessment Methods for research and funding instruments through the study of Productive interactions
SMI	Strategic Management Initiative
STFA	Strategic Task Force on Alcohol
UK	United Kingdom
UN	United Nations

VAT	Value Added Tax
VHI	Voluntary Health Insurance
WHO	World Health Organisation
WTO	World Trade Organisation

Abstract

The goal of public health and health promotion practitioners is to increase the health of populations through evidence informed health policy. Comparable to evidence-based medicine, public health advocates argue health policies based on scientific knowledge are ultimately better than those based on moral or ideological beliefs. Increasingly too in research proposals and in institutional research assessment exercises, academic researchers are being asked to provide evidence of the wider impacts of their work, outside of their field of academic pursuits. This study explored the utilisation of academic research by policymakers in the development of alcohol and drug policy in Ireland. In addition, it tested the practicality of using the Research Impact Framework (Kuruvilla et al., 2006) in examining how academic researchers think through the impact of their work.

A triangulation of methods was employed in this retrospective case study. Semi-structured interviews were conducted with key informants from the policymaking community, and with academic researchers from the fields of alcohol and drug research. This was complemented by the analysis of publically available policy documents on drugs and alcohol.

The findings demonstrated that research evidence is only one type of knowledge used in public health policymaking. In the policy documents, it was most frequently used to identify the extent of an issue in society and to justify policy development in a specific area. In developing policy solutions its use was more haphazard and subject to the economic and political environment in which the policy was being developed. In these contextual situations for research to influence policy outcomes it needed to be acceptable to policymakers, acceptable to the public and cost effective to implement. This thesis found that researchers seeking to increase their influence on policy are required to increase their understanding of the policymaking process. Research evidence, framed and packaged in a way that was conscious of the contextual policy environment in which it would arrive was more likely to have an impact. The Research Impact Framework (Kuruvilla et al., 2006) was found to be an appropriate and efficient tool in helping academics to identify the impacts of their work.

Chapter One: Introduction

"Show us not the aim without the way.
For ends and means on earth are so entangled
That changing one, you change the other too;
Each different path brings other ends in view"

Arthur Koestler in Darkness at Noon, (1940)

1.1 Overview

Numerous debates and a multitude of treatise have been published on the benefits of evidence-based health policy over the previous two decades. What has emerged from the many writings on this topic is that policymaking is a complex endeavour with a multitude of factors impacting on and competing for the attention of policymakers. Policymakers require a policymaking process that is strong and robust in developing policy solutions to address many of society's ills. The use of research evidence in this process, it is argued, is the way to achieve more effective and transparent policy-decisions (Ruane, 2012). Originally, it was believed that the success of evidence-–based clinical medicine could be replicated in evidence-based health policy (Sackett, Rosenberg, Gray et al., 1996). This would entail the judicial use of evidence for public health decisions (Cookson, 2005; Bowen and Zwi, 2005; Milio, 2005). As Klein states:

> Just as no one would argue that clinicians should practice medicine without regard to evidence, so it would seem an incontestable, self-evident proposition that policymakers should base their decisions on evidence ... (Klein, 2000; p.65).

However, a more in-depth exploration of evidence-based policymaking reveals a concept that is full of complexities and contradictions (Klein, 2000). Emerging from the research literature, two arguments are advanced for the failure of policymakers to respond to proven health and public policy interventions based on scientific knowledge (Greenhalgh and Russell, 2009; Lee, 2003). First, scientific evidence is not readily accessible to policymakers, and second, the evidence is ignored for political or ideological motives (Greenhalgh and Russell, 2009; Hawkins and Parkhurst, 2016). Consequently, this study explores the use of research evidence in alcohol and drug policy in the Republic of Ireland. This introductory chapter provides an overview of the main concepts of the study and how these concepts interlink. It gives a brief

introduction to the policy areas that are employed as a vehicle to explore the relationship between public health policy and research evidence in the Republic of Ireland. Next, it outlines the overall aim of the thesis and the research questions that are addressed in this study. Finally, it provides an outline of the overall thesis structure.

1.2 Defining policy

The word policy comes from the Latin word *politia,* polity meaning organised society, civil Government. The Oxford English Dictionary defines 'policy' as 'a course of action adopted by a government, business or individual'. There are many diverse views on what policy is, for example, it can embody the aspirations of a Government to the outcomes and activities of public organisations (Lin and Gibson, 2003). Individuals located outside of the policy system frequently view policymaking as an event rather than a process (Lomas, 2000a). Lomas suggests that this view 'fails to do justice to the ethereal nature of that diffuse, haphazard, and somewhat volatile process called decision making' (p.140). Building on Lomas's argument of misconception, Colebatch (1998) considers individuals on the outside assume that it is a rational, hierarchical process conducted with authority and employing expert knowledge in the planning and implementing of solutions to many of society's problems. Policymaking involves making decisions with debate and discourse both around the method used for solving the policy problem and defining exactly what the policy will address? Political pragmatism, economic restraint and the requirements of an organisation all impact on how policy is developed, often to a greater degree than the scientific evidence involved. It is within this context of the political process that the use of scientific evidence is often misunderstood (Lin and Gibson, 2003).

1.3 Defining the evidence

If policy is viewed as an art form, evidence is a science (Lin and Gibson, 2003: Stone, 1997). Gray, (1997) defines evidence as knowledge derived from research. Lomas suggests it is more than this, he concludes that 'evidence concerns facts (actual or asserted) intended for use in support of a conclusion' (Lomas, Culyer, McCutcheon,

et al., 2005; p.1). Evidence is associated with the scientific outputs of research-focused institutions, for example universities, research institutes, think tanks and Non-Governmental Organisations (Hawkins and Parkhurst, 2016). Policymaking is about developing policy solutions to confront real world problems. In Health Promotion building and improving the quality of the evidence base to address and improve population health is fundamental to ensuring the utilisation of evidence in creating healthy public policy. The current gaps in our understanding of the processes involved in this utilisation provide the rationale for this thesis.

In developing policy many of the solutions proposed and agreed upon will have been shaped and defined by the contextual nature of the problem. The concerns and objectives of policymakers and researchers are fundamentally different. Policymakers want to know 'what works' in each set of circumstances, for example under time and financial constraints (Oliver, Innvaer, Lorenc, et al., 2014). Whereas in the production of scientific evidence the researcher takes the lead in deciding how the problem will be defined and investigated. As such, policymakers and researchers operate in two very different worlds (Lomas, 2007; Lavis, Robertson, Woodside, et al., 2003; Ouimet, Landry, Ziam et al., 2009). Consequently, a whole industry has developed around how to transfer the research evidence from research scientists to policymakers (Dobbins, Robeson, Ciliska, et al., 2009; Jackson-Bowers, Kalucy, McIntyre et al., 2006).

1.4 Knowledge Translation

Effective knowledge translation for Health Promotion and population health is concerned with transferring the outputs of scientific research into policy and practice (Contandriopoulos, Lemire, Denis et al., 2010; Graham, Logan, Harrison et al., 2006; Lavis et al., 2003). Knowledge transfer was the term originally used to describe the practice of researchers pushing messages derived from the research evidence to policymakers and practitioners (Lavis et al., 2003). The term more frequently used now is 'knowledge exchange' as it acknowledges that communication is a two-way process requiring genuine interaction between researchers and policy decision-makers. Many strategies and frameworks have been devised to illustrate the knowledge exchange process and improve the transfer of scientific knowledge

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(Graham et al., 2006; Lavis et al., 2003). These will be explored further in Chapter Three, together with the barriers and facilitators to the use of research evidence in policymaking.

1.5 Situating the research in the Irish context

This section introduces the two policies areas selected to explore the impact of research evidence on policymaking in Ireland; alcohol and drug policy. The overconsumption of alcohol and misuse of illicit drugs in society have long been the concern of public health, both nationally and internationally (Butler, 2009; Hope, 2006; Hope and Butler, 2010; Lim, Hellard, Hocking, et al., 2010; Room, Babor, Rehm, 2005; Strang, Babor, Caulkins, et al., 2012). Both policy areas have seen an escalation in use over the latter half of the last century and the beginning of the Millennium (Edwards, Anderson, Babor, et al., 1994; King, 2004; WHO, 2018). This increase in consumption has occurred concurrently with a greater awareness and understanding of how environmental, political and economic factors influences our health (Marmot, 2001; Marmot & Wilkinson, 2005). The Ottawa Charter (WHO, 1986) for Health Promotion identified many of the key strategies and action areas that could be employed to address these public health concerns. Nonetheless, many of the policies developed to address these issues have fallen short of the full aspirations of Health Promotion (Butler, Hope, Tonen et al., Duke and Thomson, 2014; Room, 2002).

1.5.1 Alcohol
Together with the increase in alcohol consumption, there has been a corresponding increase in alcohol-related morbidity and mortality (Lim et al., 2012; Nutt, King, Phillips, et al., 2010; Rhem, Mathers, Popova, et al., 2009). Over 60 different medical conditions have been causally related to the volumes and patterns of alcohol consumption in the population (NICE, 2010; Rehm, Room, Graham, et al., 2003; Rehm, et al., 2009). Deaths in young men, from intentional and unintentional injuries with alcohol a factor accounted for one in four of all deaths in Europe, between the ages of 15 and 29 years (Rehm et al., 2003). Alcohol contributed to

one in three deaths in young women in the same age group from poisonings, drowning and homicide (Rehm et al., 2003).

In Ireland between the years 2000 to 2010, the increase in consumption of alcohol beverages paralleled with an increase in alcohol-related problems related to the individual and to society (Hope and Butler, 2010; Mongan, Hope and Nelson, 2009; OECD, 2014; WHO, 2014). This has led to numerous reports and recommendations (Department of Health, DOHC, 2002; 2004; 2012). Overwhelmingly the research evidence supports an integrated national alcohol policy with a public health approach. This includes introducing minimum unit pricing, restricting access to alcoholic beverages and controlling the promotion of alcohol. This will be explored further in Chapter Two.

1.5.2 Illicit Drugs

The use of illicit drugs in society were prohibited internationally for over a century as it was considered they were an addiction risk to populations (Degenhardt and Hall, 2012; Kumah-Abiwu, 2014 Musto,1991). There are many challenges to collecting data on illegal drugs use in society as it is a criminalised, stigmatised behaviour in most countries (Degenhardt and Hall, 2012). In 2004, the WHO estimated the Global Disability-Adjusted Life Years (DALY) attributable to amphetamine, cocaine, or opioid use accounted for 0.9% of global DALYs (WHO, 2004: Ferrari, Norman, Freedman et al., 2014). Wide variations in the statistics between countries were reported (WHO, 2004: Ferrari, et al., 2014). The health-related problems of drug misuse are not only due to the absorption of the drug, but to how they are administered. Drugs like amphetamines and heroin administered intravenously can cause severe damage to veins. Similarly, the sharing of needles can result in infections of hepatitis, AIDS and HIV. Illicit drug use is more prevalent in high income countries, with cannabis being the most frequently reported drug consumed (Degenhardt and Hall, 2012). The Republic of Ireland, a high-income country too has had issues with illegal drug use among its population (Belerose, Carew Lyons et al., 2009; Butler, 1996; Delaney Wilson, 2007; King, 2004; Mayock and Moran, 2001; O' Kelly, Bury, Cullen, et al., 1988; O' Gorman, 1998).

At the beginning of the 20th century all drugs were legal but controlled (King, 2004). By the close of the century trade in illicit drugs had become a billion-dollar industry matching that of the oil or arms industry (Dixon, 1998; Davenport-Hines, 2001). Multiple strategies have been employed by Governments to tackle the use of illicit drugs in society. Public health focuses on harm reduction, treatment and rehabilitation services for those with drug related health problems. The justice and criminal system is concerned with supply reduction by implementing legal and technical measures to restrict drug trafficking and production. The education system implements school-based prevention programmes to stop young people from being initiated into drug use (Strang, Babor, Caulkins, et al., 2012; Lancaster, Duke, Ritter, 2015). This topic is looked at in more detail in Chapter Two.

1.6 The current study

This thesis aims to identify the extent to which academic research influenced policy development in alcohol and drug misuse in ROI Ireland[1] between the years 2001 and 2012. This research employed a retrospective case study with documentary analyses and semi-structured interviews. The case study is a particularly appropriate method when it is difficult to separate the phenomenon under investigation from the surrounding context (Yin, 2014). It permits the researcher to study the case from several different perspectives and allows for the use of several different data collection methods.

To achieve the aims of this research study, the thesis objectives are as follows:

- To explore the context in which research evidence was successful in making an impact on alcohol and drug policy in Ireland
- To examine pathways, linkages and exchange models that best describe how research impacts in this area of policy
- To investigate how best the barriers can be overcome and facilitators enhanced in the utilisation of research evidence in policymaking

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[1] From here on Ireland refers to the Republic of Ireland in this research

- To test the Research Impact Framework (Kuruvilla, Mays, Pleasant, Walt, 2006) in exploring how academic researchers think through the impact of their work.

Research impact is defined here as, 'the contribution of research activities to achieve desired societal outcomes' (Banzi, Moja, Pistotti, et al., 2011; p.1). The societal value of health services and medical research has become progressively important to funders, policy makers, universities and other higher institutes of education (Ovseiko, Oancea, and Buchan, 2012; Wilson, Petticrew, Calnan, et al., 2010; Warren and Garthwaite, 2015). This is particularly relevant in the present climate of economic austerity and increased competition for funding. Consequently, researchers are expected to identify the impact of their work outputs in grant proposals, project reports and research assessment exercises (Kuruvilla, et al., 2006). This thesis explores researchers' awareness of the broader impacts of their work, outside of their academic endeavours to include impacts on health policy, health service impacts and societal impacts.

This thesis contributes to knowledge in this field by identifying the strategies utilised by academics to increase the uptake of scientific evidence by policymakers. It discovers where and how research evidence is used in the policy documents. It investigates the other types of knowledge cited in Government policy documents and the legitimacy of the use of this knowledge. The views and opinions of policymakers and researchers are obtained through in-depth semi-structured interviews to identify the different influences in this area of policymaking in Ireland. How the research evidence is used in developing policy is also explored with the policy-decision-makers. Furthermore, researchers' views on the wider impacts of their work beyond their specialised academic fields are explored.

1.7 Structure of thesis

This thesis adds to the growing body of knowledge on the complexity of policymaking and the multitude of factors that influence policy at national and international level. This opening chapter has provided an overview of the topic. The rationale for researching the academic influence of policy formulation at the

national level was outlined. The remaining chapters explore each theme defined in more depth. Chapter Two provides the background and context for this study by describing the mechanisms and procedures used in the policymaking process. It explores the historical development of alcohol and drugs policy both nationally and internationally. Chapter Three reviews the extant literature on evidence-based policymaking and situates this research in the wider academic debate regarding evidence-based health policymaking. Chapter Four presents the rationale for the methodological approach chosen. It details the procedures employed in the collection of data. This is followed by a discussion on the ethical considerations that underpinned the research and the positionality of the author. Chapter Five presents the findings of the in-depth analysis of the government policy documents in Ireland from 2001-2012. This is supplemented by the findings from the interviews with key informants from the Irish civil service on how public health policy is formulated. Chapter Six presents the empirical results of the qualitative interviews with participant researchers. Chapter Eight concludes with a summary of the empirical findings from this study and reflects on the research questions in light of these findings. It identifies further areas for research and makes several recommendations for policymakers and academic researchers seeking to increase the influence of research evidence to inform policy decision-making.

Chapter 2: Background and Context

2.1 Introduction

It has been argued that the emergence and popularity of the concept of evidence-based policymaking in the late 1990s stemmed from the merging two phenomena: the establishment of new public management in the civil service and the emergence of the concept of evidence-based policymaking (Head, 2008). Information that provided evidence of policy effectiveness and programme evaluations was consistent with the ideals of efficiency and effectiveness of new public management (NPM) (Christensen and Laegreid, 2011). To put the current study in context, this chapter describes the structures of public administration in Ireland and its role in the policymaking process. This is followed by an overview historical development of policy in the two areas that are the focus of this study, alcohol and illicit drugs. The chapter concludes with a reflection on the key topics introduced.

2.2 The function and role of the Irish civil service in policymaking

The ability of a country to develop and implement policy varies over time and across policy domains (Hardiman and MacCarthaigh, 2010). Painter and Pierre (2005) suggest that a country's capacity to action is influenced by the administrative and policy roles of the state, which are in turn influenced by the political actors. These three areas are inter-dependent (Christensen, Lægreid, Roness, et al., 2007). Organisational theorists contend that public policy and decision-making cannot be understood without first understanding the relationship between the political and bureaucratic function of government (Christensen et al., 2007). The role and function of the civil service is 'to assist members of the government in making policy and to carry out policy decisions' (Irish Civil Service, 2008, p.14). The present structure and organisational practice of the civil service in the Republic of Ireland has its origins in the year 1922, when the state was founded (MacCarthaigh, 2012). Notwithstanding attempts to move away from the British Whitehall System under the 1924 *Ministers and Secretaries Act*, (www.irishstatutebook.ie) many of the central rules of Whitehall

are still present in the Irish administration. For example, mid-level and senior-level roles in the administration are apolitical and generalist in nature, with permanency of tenure for personnel. Staff are recruited on merit through open competition (Hardiman and MacCarthaigh, 2010).

Four distinct periods in the evolution of the Irish public administrative system are documented (MacCarthaigh, 2012). Each period can be classified according to its political priorities and dominant administrative principles. These include the 'emergence' period from the years 1924 to 1949, which was characterised by a focus on the strengthening of the centralisation of power under 11 government departments. Under the 1937 constitution, the Westminster/Whitehall style of government[2] was reinforced, and the number of ministerial positions was expanded to 15. In the 'development' phase from 1949 to 1969 a bureaucracy with the ability to develop policy evolved. This era too witnessed major changes in economic policy. Ireland moved from an inward looking self-sufficient nation to an outward focus on international markets in preparation for joining the European Economic Community (EEC) (Geary, 2010). Senior civil servants were at the forefront in developing the new economic strategy for the country. Many were subsequently appointed to boards of commercial state companies by succeeding governments. This was considered necessary at that time, as Ireland was perceived as lacking a significant entrepreneurial or industrial class (MacCarthaigh, 2012). However, McCarthaigh, (2012) gives no evidence for this assertion.

Throughout the 'modernisation' period 1970s to 1989 government departments began to take responsibility for specific policy areas, for example the Department of the Environment was established in 1977. The size and complexity of the administrative

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[2] The modern civil service in Britain originated in 1850 from recommendations in a report published at that time (The Organisation of the Permanent Civil Service, Northcote and Trevelyan, 1853). It replaced the old patronage system, where ministers had used the power of the 'Crown' to exert power and patronage over the apparatus of government. The new system, under the newly created Civil Service Commission (CSC), meant that recruitment into the service was by competitive merit. Two classes of civil servant were introduced, higher and lower, each with their own separate examination. A pension scheme was introduced for civil servants if they could prove they had a certificate of establishment and that they were expected to resign their position if they wanted to stand for government. It was also confirmed that the ministers would be answerable to parliament and the public for the work of their departments, thus ensuring the anonymity of the civil servants in going about their work as advisors to ministers.

system grew, with regular movement of policy portfolios between departments to logically group policy areas together (MacCarthaigh, 2012). The role of civil servants in the development of policy had increased from the 1950s onwards. Nonetheless, what emerged in this period was a greater use of external consultants and research commissioned from the private sector (MacCarthaigh, 2012). This practice was indicative of a perceived lack of competence among civil servants in developing policy (Hardiman and MacCarthaigh, 2010). The government practice of recruiting external advisors had been in place since the 1960s (Chubb, 1992). This custom of recruiting special advisors became more systematic in this time-period and is still in place today (Connaughton, 2010. The role of special advisors involves working closely with civil servants, in representing the views and opinions of the Ministers in their respective departments (MacCarthaigh, 2012). In 1984, the Top-Level Appointments Commission was established. This allowed governments, for the first time, to select personnel from a shortlist of candidates for senior civil service posts. Throughout the 1980s in accordance with international trends, there were many calls for reform of the service, as it was viewed as overly conservative and rigid in its structure and practices (MacCarthaigh, 2012).

The 'complexity phase' from 1989-2010 witnessed many complex manoeuvres and distributions of portfolios across government departments. This was primarily due to successive coalition governments competing for responsibility over key policy areas. Only four government departments did not change their name during this phase (i.e. the Departments of the Taoiseach, Finance, Defence and Foreign Affairs), as under the terms of the Irish constitution, they are prohibited (Hardiman et al., 2011). Factors that led to the increase in the intricacy and complexity of policymaking were the larger number of non-state actors involved in the process, together with increased government responsibility through regulation (MacCarthaigh, 2012). New reforms of the public service were introduced through the Strategic Management Initiative (SMI) launched in 1994 (MacCarthaigh, 2012). Its aim was to apply management-style practices of financial accountability and reporting, human resources and customer services to the public services available. Similar reforms were conducted in Whitehall in the UK during the 1980s (Aucoin, 2011). The reforms achieved in the UK never materialised in Ireland, as the initiative coming from the civil service, never received full political support. The objectives of the reforms were for increased political

control, transparency and accountability over the direction and performance of state organisations. In Ireland, the reverse occurred, and political control deteriorated (MacCarthaigh, 2012). However, examining the roles and responsibility of departments and senior civil servants alone does not give a complete picture of the policymaking landscape.

2.2.2 Policymaking structures

In 2014, the Civil Service had approximately 35,000 people employed in clerical and administrative, senior- managerial, professional and technical posts (Irish Civil Service, 2014). There are two categories of employment: General Service or Professional and Technical. Examples of categories of employment under General Service are clerical officer, executive officer and assistant principal. There are 15 grades in all, ranging from store person to secretary general. Individuals with expertise in agricultural science, pharmacy, engineering and accountancy are employed under the category Professional and Technical. There is a code of standards and behaviour that all employees of the Irish Civil Service must adhere to under Section 10 (3) of the Standards in Public Office Act 2001. Civil servants must not engage in any activities that could be interpreted as a conflict of interest, for example, working in a private practice in their professional capacity while being employed as a full-time civil servant. They must also refrain from using their civil service position to influence a decision concerning himself or herself or any other person (Irish Civil Service, 2008). While in the employment of the civil service, no individual can become a member of the Oireachtas (Irish Parliament) or of the European Parliament. Grades in the civil service above clerical officer level, up to the most senior level (i.e. secretary general), are debarred from participating in any type of political activity, including commenting publicly on political topics or joining a political party (Irish Civil Service, 2008).

Table 2.1: Change in government departments between 2014 and 2016

Departments 2014	2016
Taoiseach	Taoiseach and Minister of Defence
Finance	
Agriculture, Fisheries and Food	
Arts, Sports and Tourism	
Communications, Energy and Natural Resources	
Community, Rural and Gaeltacht Affairs	
Defence	New - Department Public Expenditure and Reform 2016
Education and Science	(Education and Skills, 2016)
Enterprise, Trade and Employment	
Environment, Heritage and Local Government	Housing, Planning and local Government 2016
Foreign Affairs	(Foreign Affairs and Trade
Health and Children	
Justice Equality and Law Reform	(Justice and Equality, 2016)
Social and Family Affairs	
Transport	

Members of the Irish Government[3] are called 'Ministers'.[4] Individual Ministers have singular responsibility for the management of the different departments of state. However, they meet and act as a collective authority (Irish Civil Service, 2008). This means that individual Ministers must publicly support all decisions made via the cabinet even if they do not privately agree with them. Table 2.1 lists a recent example of the different government Departments. Under the 2016 Government the Departments that were amalgamated or underwent a change of name between 1014 and 2016 are highlighted in blue.

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[3] The constitution embodies in legislation the structure of the Irish Government. The central structures are the legislature, which is made up of the president of Ireland, Dáil Éireann and Seanad Eireann. The executive/government comprises the Department of State, Dáil Éireann, the Taoiseach (prime minister), the Tánaiste (deputy prime minister), the minister for finance and the judiciary, which governs justice through the court system. The government is supported in its role by the attorney general, which acts as legal advisor to the government and the comptroller, and the auditor general, who, in the best interests of the state, oversees issues regarding monies to the government and audits government accounts (Irish Civil Service, 2008). Ireland is a democracy and members of the government can be voted in every five years.

[4] The Irish Government must be composed of at least seven, and not more than 15, ministers.

After each General Election, the government can amalgamate departments or change the names and responsibilities of existing departments (e.g., the Department of Public Expenditure and Reform, 2016). Figure 2.1 presents the structure of a government department.

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                        ┌──────────────────┐
                        │     Minster      │
                        │ Policy direction │
                        └──────────────────┘
                                 │
  ┌──────────────────┐           │
  │ Minster of State │           │
  │ Certain policy   │───────┐   │   ┌──────────────────┐
  │ areas within     │       │   │   │ Secretary general│
  └──────────────────┘       │   └───│Administrative head│
                             │       └──────────────────┘
  ┌──────────────────┐       │
  │Assistant secretary│      │
  │     general      │       │
  │Top manager –     │───────┤
  │certain policy    │       │   ┌──────────────────┐
  │areas             │       │   │ Principal Officer│
  └──────────────────┘       │───│Managing a main   │
                             │    │structural unit   │
  ┌──────────────────┐       │    └──────────────────┘
  │Assistant Principal│      │
  │Assists in managing│──────┤
  │main structural    │      │
  │unit              │       │
  └──────────────────┘       │
          ┌──────────┬───────┼───────┬──────────┐
    ┌─────────┐┌─────────┐┌───────┐┌──────────┐┌──────────┐
    │ Advisors││Inspectors││Experts││Specialists││Other     │
    │         ││         ││       ││          ││grades    │
    └─────────┘└─────────┘└───────┘└──────────┘└──────────┘
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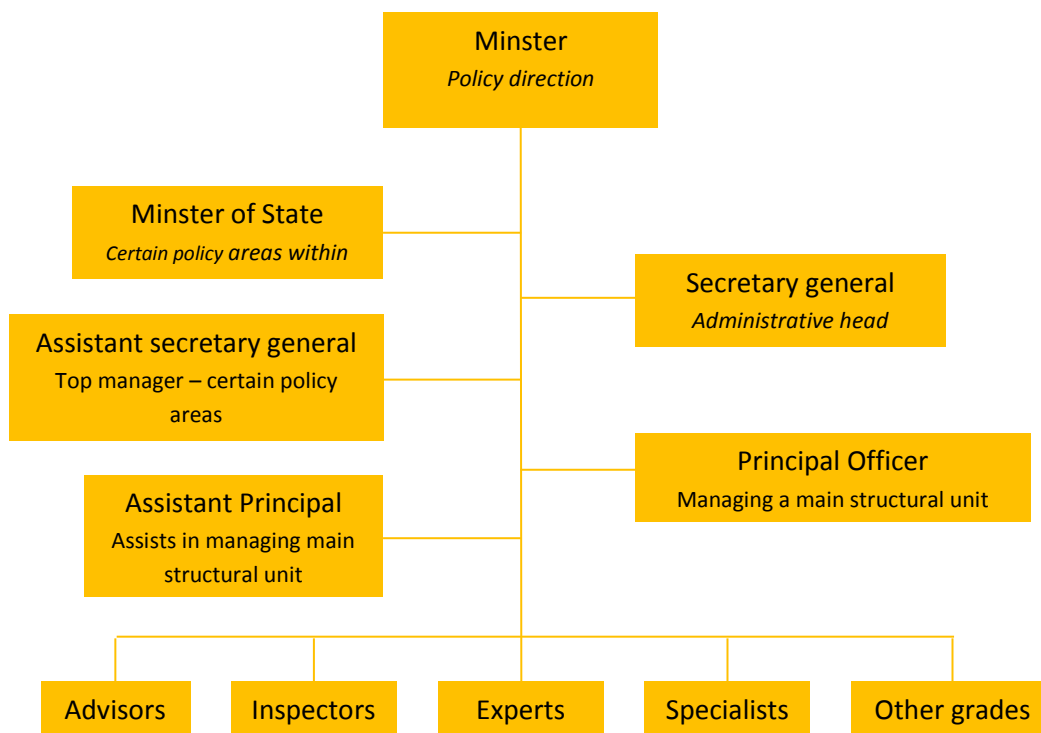
Figure 2.1: Structure of a government department

2.2.3 State agencies

In addition to the increase in the numbers of civil service employees and attempts to reform the service, there was a corresponding increase in the number of department bodies and non-departmental bodies. These public bodies with varying levels of public authority are commonly known as agencies. State agencies were not an invention of the Irish state. They were used by Whitehall prior to Ireland gaining independence from the UK, (Orloff and Skocpol, 1984) and are used by most developed governments (Pollitt, Bathgate, Caulfield, et al., 2001; OECD, 2008). Several terms have been used to describe these organisations, including 'state-sponsored bodies' and 'semi-states'. FitzGerald (1963) defines state-sponsored bodies as:

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'autonomous public bodies other than universities and university colleges, which are neither temporary in character nor purely advisory in their function, most of whose staff are not civil servants, and to whose board or council the government or Ministers in the government appoint directors, council members, etc'. (p. 5)

State agencies in Ireland increased from 50 to 112 between the years 1924 and 1958, and 350 agencies were performing public functions at the national level by 2008 (Hardiman and MacCarthaigh, 2010). Agencies are established to undertake a variety of tasks in different policy domains and are most frequently created by a Ministry to perform a function (Hardiman and MacCarthaigh, 2010). Several reasons are given for the increase in agencies in the Irish state; for example, the European Union's (EU) demand for independent regulation to facilitate stakeholder involvement and to assist with prioritising new policy areas (Hardiman and MacCarthaigh, 2010). The state's ability to develop and implement policy is achieved through the apparatus of public administration, special advisors and a vast array of state agencies. Through this process, policy is influenced by information and knowledge coming from various sources.

The Irish Government post-independence established several state agencies explicitly to provide evidenced-based research to inform public policy. The Economic Research Institute (ESRI) was established in June 1960. Its function was to provide expert research to policymakers on the Irish economy, independent of government or political interference (Murray, 2009). An influential figure in the setting up the institute was T.J. Whitaker (the then Secretary in the Department of Finance). The Irish Universities did not possess the level of expertise or resources to undertake this research at that time. The first director was the R.C. Geary and he emphasised the independence of the institution and its researchers (ESRI, 2017). The Social Research Institute established in 1963, later amalgamated with the Economic Research Institute to form the Economic and Social Research Institute (ESRI) consequently expanding the scope of research possible.

During the 1970s and 1980s the Institute developed a large body of research in a diverse range of topics from industrial policy, public finances to unemployment, sociology and social psychology. The austere recession in the 1980s led to severe cutbacks in funding. Alternative funding opportunities were sought through commissioned research and fund-raising. Today grant-in-aid from the government accounts for one third of its total expenditure (ESRI, 2017).

The ESRI outline several measures they have implemented to ensure their continual independence and objectivity in conducting research on issues of national importance. This is to uphold quality in technical standards and academic publications while working within budgets (ESRI, 2017). Contracts are accepted only on condition the findings of the study are permitted to be published, and no unfavourable results are suppressed. The Institute has developed multi-annual programmes of research that has allowed researchers to commit to a specific area of work over the medium term so that large databases and large-scale models could be developed as long-term resources. This also helped the Institute to develop collaborative relationships with major decision makers in government departments, state agencies, and the private sector, yet retaining their independence to continue their impartiality in researching and publishing their findings. With the expansion of the Survey Unit in the 1990s the hospital in-patient enquiry (HIPE) unit and the national prenatal reporting system (NPRS) were established. They are funded on long-term contracts with the Department of Health and Children.

Over the last twenty years the capacity of the ESRI to collect, process and analyse large data sets has expanded enormously. There is greater competition as University departments; consultancy firms with the relevant technical expertise and research institutions tender for the same research contracts. These tendering submissions are subject to rigorous evaluation frequently involving international experts. The ESRI has responded by collaborating with third level colleges and with leading firms of consultants in submitting bids for large tenders. An example of their collaborative work is the 'Growing Up in Ireland Study', funded by government and carried out by the ESRI and Trinity College Dublin (Williams, Greene, Doyle et al., 2011)

In the 1980s the Medical Research Council and the Medico-Social Research Board were combined to create the Health Service Research Board (HRB). It conducts research in the fields of medicine, epidemiology and health services research. From its initial foundation and up until the late 1990s it worked under limited funding from the Irish Government (Nason, Janta, Hastings et al., 2008; p.2). It funded research through project grants, postdoctoral fellowships and provided a minor number of bursaries for students. At that time, they were the only committed funders of health research and the Irish Government had no health research strategy.

In 1997, the Irish Government agreed a three-year funding partnership in collaboration with the Wellcome Trust Foundation. The Foundation made 3 million pounds available for biomedical and health related research with a corresponding 3 million pounds from the Irish Government (HRB 2008). Over the next decade, the HRB's total budget increased from 5 million to approximately 50 million euro in 2007 (Nason et al., 2008). In recent years, its annual budget is more than €45 million and it has responsibility for managing a research investment portfolio of €200 million (hrb.ie). It has responsibility for the maintenance of health information systems that are an important source of information for government policy; for example, The National Drug Treatment Reporting System, The National Drug-Related Death Index, The National Psychiatric In-Patient Reporting System, The National Intellectual Disability Database, and The National Physical and Sensory Disability Database. The HRB provides synthesis and reviews of research evidence on topical issues and problems relevant to health policy in the Evidence Generation Unit since 2011 (www.hrb.ie).

Research in Universities
The programme for research in third level institutions (PRTLI) was established in 1997 with funding from the Higher Education Authority (HEA). This was the first committed resource for supporting Irish Universities and Institutions of Technology to carry out research. Prior to the establishment of the PRTLI, these institutions were primarily funded for their teaching. By establishing this programme, it was unequivocally acknowledged that Institutions of Higher Education had a role in both teaching and research (Nason, et al., 2008). Biomedical and health related-research have been consistently successful in attracting funding from this source (ibid). The

Irish Government demonstrated its commitment to supporting research for economic and social development and the building of an effective and high quality health system in publishing its strategy for health research *Making Knowledge Work for Health* (MKWH) (DOHC, 2001). In the health strategy document *Quality and fairness: A Health System for you* (DOHC, 2001) the Government again increased their commitment for supporting "science for health" and to the setting up of a research and development function within the health system. Under the National Development Plan 2000 -2006 the PRTLI was expanded and Science Foundation Ireland (SFI) was established. Two funding agencies were founded, the Irish Council for Science, Engineering and Technology and the Irish Research Council supported by the Department of Education and Science (p.3). The SFI originally to set up to fund research in biotechnology and ICT and to encourage research teams from overseas to come and work in Ireland, has grown to become one of the biggest funders of research in Ireland (Nason, et al., 2008). Figure 2.2 represents the total investment by the Irish Government in research and development in 2014 – Euro 724 million was invested in total not just in health research.

Other agencies that conduct research that contributes to the development of public health policy are the Health Service Executive (HSE), established in 2005. The HSE is responsible for the delivery of health and social care services. It evaluates and publishes information about the delivery and performance of Ireland's health and social care services, for example in assessing quality and standards in addiction services in Ireland (HSE, 2008).

This section has described the policymaking structures of the Irish State. It discussed how these structures have evolved and expanded over time to include a wider range of actors and organisations in the policy decision-making process. The next two sections now describe how policy has evolved in the policy areas of alcohol and drugs in Ireland to embody a Public Health and a Health Promotion approach.

2.3 Alcohol and illicit drug use in society

The global health burden of alcohol and drugs in society is well-documented (Degenhardt and Hall, 2012; Room et al., 2005). Nonetheless, humans for medicinal and ritual purposes have used alcohol and drugs since ancient times. They were used in births and marriage ceremonies and celebrating seasonal festivities such as those
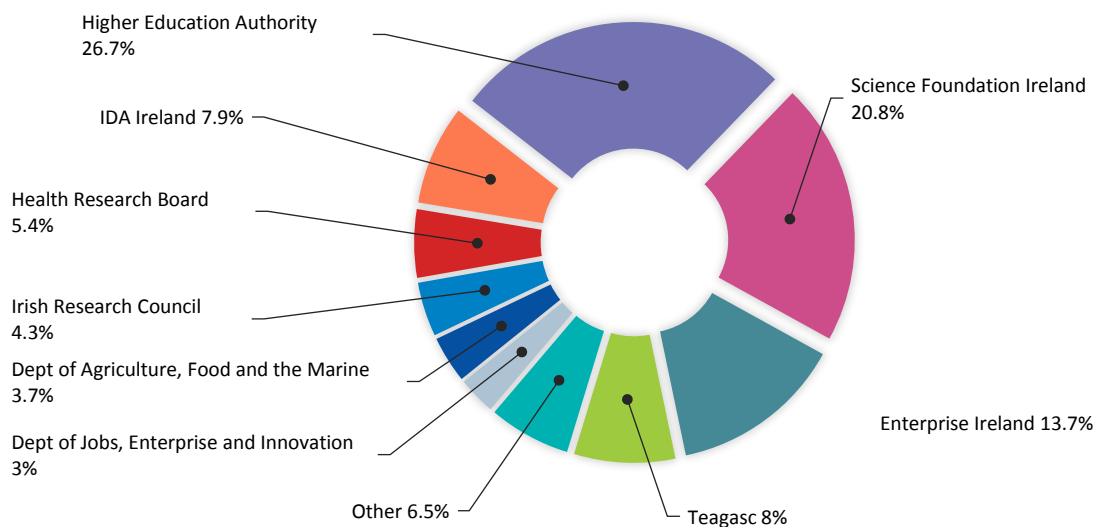
Figure 2.2: Irish government investments in research and development -2014 (source: Ferguson, 2014)

associated with harvest time (Westermyer, 2005; Davenport-Hines, 2003: Butler, 2002). Reports have been found in the early writings of the Egyptians, Chinese and Palestinians, of humans engaging in the use of alcohol, opium and other psychoactive substances (McCoy, 1996; Westermyer, 2005; Davenport-Hines, 2003). In Homer's *Odyssey*, there are descriptions of Helen comforting those who were bereaved due to the Trojan War in the 12th Century BC. Davenport- Hines (2003) suggests this was most likely a mixture of 'a solution of opium and alcohol';

> 'Into the bowl in which wine was mixed, she slipped a drug that had the power of robbing grief and anger of their sting and banishing all painful memories' (Davenport-Hines, 2003; p.8-9).

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Early societies were very aware too of the many health and social problems caused to communities and to individuals by the overconsumption of alcohol and drugs. Thus, social and cultural norms have evolved around their usage. For example, all major religions in the world advocate some level of abstinence from alcoholic beverages (Thurn, 1978; Room et al., 2005; Westermyer, 2005). In the following section, how illicit drug policy has evolved to become the international prohibition policy we have today is explored.

2.3.2 Historical context of drug use

Heroin is derived from *Papaver somniferum*, the opium poppy plant. It contains the alkaloid morphine. It has medicinal and pain-relieving properties. It originated in the Mediterranean region. However, most production today takes place in Southwest Asia, with Afghanistan and Burma being the largest producers (King, 2004). European explorers brought crude opium to Europe and to North America in the late 18th and 19th century (Musto, 1991). Its beneficial effects for relieving pain were very quickly realised, and it was used extensively to treat many common ailments. The danger of using opium over long periods was recognised as far back as 1818 (Musto, 1991). By the 19th century, addiction problems were affecting both the middle and working classes. At that time, addiction was viewed as a 'self-inflicted disease' or an 'intemperate habit' (Berridge, 1978; p.456).

In the 19th Century major advances in organic chemistry coupled with the expansion of the pharmaceutical industry increased the use of opium and later cocaine (Musto, 1991). Morphine was extracted from the opium poppy plant in 1804, and in 1874 diacetylmorphine was synthesised from morphine. The invention of the hypodermic syringe greatly aided the appeal of opium, and later morphine to the medical profession (Musto, 1991). The Bayer pharmaceutical company subsequently renamed morphine 'heroin' and, in 1898, marketed a cough mixture containing this substance called Heroin Cough Syrup (Musto, 1991).

The coca plant was first brought to Europe between the 15th and 18th Centuries by the Spanish conquerors and scientists. In Spain, it was used in the treatment of stomach disorders, skin ulcerations, headaches and muscular pains (Petersen, 1977). It was not

until the second half of the 19th Century that its use became widespread (Petersen, 1977). This was due to the extraction by the German scientist Albert Nieiuann of the alkaloid cocaine from the coca plant. The medical profession quickly embraced the use of this new drug for its analgesic and anaesthetic properties. It was also advocated for use in morphine addiction (Goldstein, DesLauriers and Burda, 2009; Small, 2016). Cocaine was marketed and sold commercially in its pure form for sniffing and injecting, and as an ingredient in other products (Goldstein et al., 2009).

A growing disquiet concerning the misuse of drugs began to emerge in the United Kingdom and the United States towards the end of the 1800s. Opium dens and the smoking of opium were banned in San Francisco in the mid-1870s. This is regarded as the first drug law (Redford and Powell, 2016). In the late 1800s and the beginning of the 1900s not unlike today, increasing concerns emerged among the population regarding the safety and source of food, its ingredients and the environment. These concerns included the ingredients in patent medicines such as Coca-Cola, Bayers Heroin and their addictive qualities (Musto, 1991). In response to pressure from public movements the Pure Food and Drug Act was introduced 1906 (Redford and Powell, 2016). This required the accurate labelling of all patent remedies sold in the United States (Musto, 1991; Goldstein et al., 2009). Prior to the enactment of the Act, pharmaceutical companies had already discovered less dangerous alternatives to opium and cocaine. Bayer introduced aspirin in 1899 for pain relief (Musto, 1991).

Over the next number of years, there was a gradual move towards the international prohibition of narcotics. Several factors precipitated this development. In the US, the expanding temperance movement saw many similarities between alcohol addiction and addiction to narcotics. The temperance moment proselytized for the individual to abstain from alcohol consumption, as it lessened their ability to regulate and control their own behaviour (Levine, 1992). Addiction to opium and morphine were comparable in that they interfered with the individual's ability to self-discipline and self-master (Nadelmann, 1990; Redford and Powell, 2014; Musto; 1991). Concern was also emerging among the authorities regarding the use of opium in migrant Asian communities. For example, California had the highest density of Chinese nationals where smoking opium was prevalent (Musto, 1991; Kumah-Abiwu, 2014). America wanted to ensure the perpetuation of their commercial interests with China. It had

supported China in banning the opium trade that Britain had initiated between India and China[5] in the late 1700s. The Chinese Emperor opposed the importation of opium as an increasing number of the population had become addicted to the smoking of opium (Musto, 1991; Westermyer, 2005). Concerns in the United States also grew over opium problems in the Far East. America had taken control of the Philippine Islands in the 1890s after the Spanish-American war. American missionary[6] groups working in those countries became concerned of the widespread use of narcotics among the indigenous populations (Buxton, 2006; Redford and Powell, 2016). They campaigned to restrict the import and sale of opium in the Philippines for medical purposes only (Andreas and Nadelmann, 2006; Buxton, 2006).

In the United Kingdom, the Society for the Suppression of the Opium Trade founded in 1884 campaigned successfully for an end to Britain's involvement with the Indian opium trade with China (Berridge 1978). Like the US, opium use became associated with seamen from China who lived in the East End of London, a minority group whom differed in their customs and habits to the local population. Berridge (1978) suggests the association of drug use with a marginalised group in society encouraged the view that opium use was an 'aberrant and dishonourable habit', that required official regulation (p.460).

The meeting in Shanghai in 1909 of the International Opium Commission was the first collaborative effort to globally control the use of narcotics. Subsequent meetings culminated in the signing of the treaties in The Hague convention in 2012 (Kumah-Abiwu, 2014; Musto 1991). Each country that signed up to the treaty was responsible for developing laws and legislation to control the narcotics trade and to ensure it was used for medical purposes only (Musto, 1991). In the US, the Harrison Act passed in 1914 (Redford and Powell, 1916) regulated for strict controls over the import and distribution of opium and coca and their derivatives to patients. The Harrison Act imposed a tax on all persons who imported, produced, manufactured, dealt in, sold and

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[5] British authorities had supported the cultivation of an opium crop in the Bengal province of India in the late 1700s, in order to trade with China for their silks, spices and tea. This resulted in two opium wars being waged between the British and the Chinese from 1839 to 1842 and again from 1856 to 1858 (Bowman 111, 1995; Berridge, 1984).
[6] Bishop Charles Brent was the leader of the American Episcopal Church of the Philippines and campaigned with other missionary groups for the prohibition of narcotics. He later went on to play a lead role on the global stage in the prohibition of narcotics (Buxton, 2008; Musto, 1991).

distributed these products. The patient was the only individual in the chain that paid no tax. The indefinite prescribing by physicians for patients with addiction was allowed under the act. This was later revoked with the argument that prescribing for indefinite maintenance was not the legal practice of medical practitioners (Redford and Powell, 1916; Musto, 1991). Goldstein et al., (2009) contends rather that this being a prohibitive practice it was enforced because internal revenue received no tax from the transaction with the patient.

In the UK, due to increased concerns for the health and welfare of working-class populations and children, opium was included in the list of poisons under the 1868 Pharmacy Act. It was restricted for sale through pharmacy outlets (Berridge, 1978). Over the remaining decades, the control of narcotic substances increased. Cocaine, morphine and its derivatives were restricted under the new Pharmacy Act of 1906 (Berridge, 1984: 1978). However, control and regulation of narcotic substances still relied on the professional expertise of the pharmacist or doctor and not on state regulation (Berridge, 1984). During the war years, more rigorous regulations were enacted (1914-1918). This was the result of media reports on the war effort being undermined, owing to the smuggling of opium and cocaine for use by soldiers on leave in London. The Army Council, on May the 11th 1916 enacted an order, '*forbidding the sale or supply of cocaine and other drugs (a wide range which included codeine, heroin, Indian hemp and morphine) to any member of the forces unless ordered by a doctor on a prescription marked 'not to be repeated*' (Berridge, 1984; p.20). These restrictions eventually led to the 1920 Dangerous drug Act which extended the wartime measures to include morphine and medicinal opium (Berridge, 1984). The medical and pharmaceutical professions objected to the Home Office's excessive regulation of their professional practice. It was believed the understanding of addiction as a disease that had emerged over the previous decades was under attack (Parssinen and Kerner, 1980; Levine, 1978). General practitioners objected to the interference of government policy into the private area of the doctor/patient relationship. Many doctors regularly prescribed doses of opiates to patients who were addicted. However, the Home Office were determined to stop this practice. They viewed addiction a short-term problem that could be eliminated (Berridge, 1984).

After prolonged and combative negotiations between the Home Office and the Ministry for Health, the Rolleston Committee was established in 1924 (Berridge, 1984). The Home Office wanted the medical profession to support a punitive and corrective approach to the problem of addiction in society. Doctors viewed it as a disease that needed medical attention. The latter approach represented a more humanitarian attitude to drug addiction than the American penal model. However, Berridge (1984) suggests this had more to do with addicts being overly represented in the middle classes. She writes the medical profession had no problem supporting a more repressive system in the 1960s, when the numbers of addicts were greater, and were predominantly from the lower socio-economic groups and subcultures in society (Berridge, 1984).

It is argued that drug use in the UK was never on the scale of their American counterparts, who had a much larger working-class population addicted to drugs (Berridge, 1984). This is disputed by Courtwright (1982), who writes the 'majority of addicts were from either the middle or the upper class', in that they could afford to pay for medical services (p. 56). Other arguments advanced to explain the difference in approaches to the misuse of drugs was the medical profession in the United States was weaker than the UK (Berridge, 1984). Under the Rolleston Act of 1926, all doctors could prescribe opioids to treat addiction (Berridge, 1984). In both the US and the UK, the use of opiates and cocaine declined over the following decades. Opiate misuse was found predominantly among subgroups at the margins of society. It was used to a lesser extent used by health professionals and the middle classes (Musto, 1991; Goldstein et al., 2009). Cannabis was brought to America by Mexican immigrants in the 1920 but was not used widely until the 1960s. Predominantly its use was associated with Mexican immigrants and white and black jazz musicians in the 1930s (Musto, 1991).

From the 1960s onwards, the incidence of narcotic use increased internationally (King, 2004). Many countries witnessed an expansion in drug consumption in society. There was also an increase in the different types of psychoactive agents available. For example, LSD (lysergic acid diethylamide), peyote and 'magic mushrooms' (psilocybin) became popular among the 'hipsters' and anti-Vietnam activists in California (van Amsterdam, Opperhuizen, van den Brink, 2011: Wesson, 2011). As in

the earlier part of the 20th century, drugs became associated with different classes and cultures in society (King, 2004). Marijuana was the recreational drug of choice for many middle and upper class college youths of the 1960s (Harrison and Pottieger, 1996). Amphetamines were linked to the youth culture of that period and the punk era of the 1970s. Ecstasy, which emerged in the 1980s was associated with the rap culture in the United States and the dance clubs of Northern England (King, 2004). The popular youth dance and music culture of the 1990s was associated with the drugs ecstasy, cocaine, amphetamines, ketamine, GHB (gamma hydroxybutyrate), also known as liquid ecstasy, and amyl nitrate, more frequently known as 'poppers' (Measham and Moore, 2009; Mills, 2004).

In Ireland, studies conducted on the use of illicit drugs over the last two decades have found that drug use over the past year had increased. The highest increase was reported in the use of cannabis and ecstasy among the 16-34-year age group (Bates, 2017). Like Europe the demand for the treatment of cannabis misuse has increased. This was particularly notable among the younger population (EMCDDA, 2015; Montanari, Guarita, Mounteney, Simon, 2017). The use of new psychoactive substances too (NPS) was found to be higher among young people in Ireland than in other EU countries. In addition, young people reported that it was easy to obtain substances including cannabis and ecstasy in comparison to findings from other EU countries. Data on polydrug use revealed that alcohol was the most commonly reported drug used with other substances (Bates, 2017). It was also found that the prevalence of opiate use in Ireland between 2006 and 2014 had either decreased or stabilised (Hay, Jaddoa, Oyston, et al., 2017). The number of drug related deaths in Ireland between 2005 and 2014 were higher than the European average. This has resulted in an increase in demand for better services for the drug using communities, with more comprehensive harm reducing policies for instance drug treatment rooms (Bates, 2017).

2.3.2 International responses to drug use

Following The Hague Convention in 2012 the US played a leading role in shaping policy direction on the global narcotics regime throughout the 20th century (Buxton, 2008). It used its considerable hegemonic power through its key tools of policy

influence to push for a worldwide prohibition of narcotics (see Kumah-Abiwu, 2014 and Bewley-Taylor, 1999 for more information on this topic). However, there have been many disparities in this policy direction. The Netherlands for example in the 1970s decriminalised the use of soft drugs like cannabis (Kumah-Abiwu, 2014). Other countries have followed suit with similar liberal drug policies (e.g., Switzerland, France, Portugal, Canada and Austrailia) (Hall and Fischer, 2010: Edwards and Galla, 2014). The more liberal attitudes to drug use throughout the EU transpired due to the growing recognition that the EU policy known as 'tough on drugs' was not working (Edwards and Galla, 2014; p. 942). EU drug policy changed from focusing on a reduction in the supply side of drugs to focusing on demand reduction. The catalyst for the move to demand reduction strategies was the spread of HIV/AIDS among injecting drug users in Europe (Edwards and Galla, 2014). The European model of drug policy was described as a 'balanced approach' in that it involves a mix of demand – and harm reduction policies (Edwards and Galla, 2014; p.943). These policies were devised to protect public health and the human rights of the individual. Simultaneously it encouraged international collaboration in devising strategies and incentives in the field of law enforcement. The approach taken to illicit drug use in the US, the Russian Federation and China is argued would not be accepted in most European societies, owing to the level of judicial and social interference required. This would not in be keeping with European culture (Ibid).

By the 1960s, policy differences between the American and the British approaches had narrowed. In the US, the provision of methadone maintenance to drug misusers was established. In Britain, the 'clinic' system was created, with specially licensed doctors working in the new clinics allowed to prescribe heroin and cocaine. Prior to the setting up of the clinics under the Rolleston Commission in 1926, all medical practitioners were permitted to prescribe heroin and cocaine indefinitely. This was to ensure individuals who had a dependency would become socially stable and would be kept out of the criminal drug supply network (Berridge, 1984; Butler, 1991). In the US under the Harrison Act of 1914, the criminal justice system was predominantly responsible for illegal drug use in society (Butler, 1991; 2009). The prevailing ethos in the United States concerning illegal drug use was that it is a deviant behaviour involving criminal activity, posing a serious threat to society (Butler, 1991). This punitive approach to drug misusers was relaxed in the 1970s. This was predominantly

due to the work of two doctors Dole and Nyswander (1967), who defined heroin addiction as an objective, identifiable 'metabolic disease' (Bourgois, 2000). In subsequent decades, the number of methadone treatment clinics increased and expanded across the United States (ibid).

2.3.3 Policy responses to drugs in Ireland

In Ireland, public awareness of illicit drug misuse only came to the fore in the late 1960s and early 1970s (Butler, 2009; 1991). Studies conducted at that time reported the misuse of amphetamines, cannabis and LSD (Walsh, 1966; Masterson, 1970; Niven, Wilson-Davis, O'Rourke, et al., 1971), with amphetamines and barbiturates being the most popular (Dean, Bradshaw, Lavelle, et al., 1985). According to *The Report of a Working Party on Drug Abuse* 1971, established by the minister for health in 1969, there were 350 drug users in the Dublin area (DOH, 1971). However, by 1970 that had increased to 940 persons. Cannabis and LSD were the drugs most frequently used (Dean et al., 1985). During this era, Ireland's first major treatment centres for drug users emerged. Jervis Street Hospital opened in 1969 catering for clients on an outpatient basis only. The Central Mental Hospital in Dundrum established a small rehabilitation unit in the early 1970s. The Eastern Health Board managed the unit and clients were referred to it via the prison system (Butler, 1991). In Butler's (1991) review of the practices pursued at that time, he found that 'there was little evidence that mainstream health services had any great interest in drug problems' (p. 4). Drug misuse then was considered an issue only for a niche group in society (Glynn, Curtin, Clarke and O' Muireartaigh, 1973). It would have been unreasonable therefore, to expect the health services to dedicate limited recourses to these services. In contrast alcohol addiction at that time was a much greater problem in Irish society, affecting many more individuals (Walsh, 1987).

Due to this lacuna in the Health Services voluntary organisations developed to service the needs of individuals with drug addiction. The Coolmine Therapeutic Community was established in 1973 providing a 'concept-based programme' for rehabilitation. This type of programme was popular in America and included the experience of former addicts in the delivery of programmes. The core philosophy of these courses was that the addicts/drug users had a flaw or a weakness in their personality. The

individual was required to challenge and overcome this weakness to achieve full recovery (Comberton, 1982).

Early responses to drug treatment in Ireland resembled the British system, in that the responsibility for drug addiction services was under the remit of the health services (Butler, 1991). A working party on drug abuse was established in 1969 to investigate the incidence of illicit drugs use. It was tasked with making recommendations to the Minister on what actions to take to discourage young people from becoming involved in drugs. This included conducting publicity campaigns, implementing educational programmes and proposing treatment services to rehabilitate individuals who were already addicted. The focus of the policy measures was on reducing the supply of illicit drugs in society and ensuring that the drug misuser would be rehabilitated and become abstinent (Butler, 1991).

Critiques of their first report suggested that the term 'drug abuse' was not defined and that controlling the supply of illicit drugs was the sole focus of the policy measures (Report of the Working Party on Drug Abuse, 1971). In addition, it was asserted that the authors of the report did not look to other countries for best practice (Butler, 1991). It could be argued that it would have been too early to have evidence of what were the most effective policies in other countries. Both the United States and the United Kingdom had only recently moved their policy responses on drug misuse from their previous positions (Bourgois, 2000; Berridge, 1984; King, 2004). Recommendations from the report resulted in the establishment of the Health Education Bureau in 1974. Drug Education was to become an important part of the school curriculum. It was taught in combination with health, religious and civic education (Butler, 1991). The delivery of drug services become specialised as part of the newly developed mental health services (Report of the Working Party on Drug Abuse, 1971).

Researchers have described the government's response to drug misuse in society in the late 1970s and early 1980s as lethargic (King, 2004). In Dáil[7] debates, the then Health Minister John O'Connell is cited as stating that cannabis was 'no more dangerous than a glass of beer' (Butler, 2002, p.128). The leader of the opposition

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[7] The Dáil is the Irish name given to the House of Representatives in the Irish Government. A member of the House of Representatives is called a Teachta Dála (TD).

party Charles Haughey during debates on the Misuse of Drugs Bill 1977 discussed the need to discriminate between 'hard' and 'soft' drugs (p.128). Concerns regarding the bill's impact on an individual's civil liberties were also raised. King (2004) suggests this relaxed attitude to the drug problem resulted in the Irish government being ill-equipped for the opiate epidemic that erupted in the Dublin City in the mid 1980s. In this decade, a 'needle culture' emerged among the Dublin drug scene together with an increase in organised commercial drug 'pushing' (Butler, 1991; p.5).

In 1983, the Special Government Task Force on Drug Abuse was established. It introduced the *Misuse of Drugs Act 1984*, which legislated for higher fines and harsher sentences for drug offences. The report suggested that the high incidence of drug misuse in Dublin's inner city was largely explained by;

> the poverty and powerlessness of a small number of working class neighbourhoods (Report of the Special Governmental Task Force on Drug Abuse, 1983).

Recommendations from the report suggested the establishment of a Youth and Community Development Forum to coordinate and deliver services to combat youth unemployment levels. Proposals were made to address the problem of educational attainment in early school leavers and to establish social and recreational amenities in the areas of greatest deprivation (Report of the Special Governmental Task Force on Drug Abuse, 1983). However, the Irish Government ignored these recommendations. In a subsequent press release the Department of Health reported that drug problems were a feature of all sections of society. It suggested that experimenting with drugs was a choice that individuals could make before they become addicted. The belief among policymakers prevailed that drug misuse was an individual problem rather than a societal or environmental failure (King, 2004).

This lack of a government response to the increasing drug problem in Inner City Dublin prompted families in working-class communities to become organised. Community groups were established, for example the Concerned Parents Against Drugs (CPAD) movement and the Ballymun Youth Action Project (YAP 1983; Seery, 1999). The CAPD very quickly fell in to disrepute because of its vigilante activities

(O'Gorman, 1998). Reports in the media of the intimidation of drug misusers and dealers, and the shooting of a CAPD activist brought the group to the attention of the authorities. The movement was quickly disbanded (Cullen, 1990). The government's policy response was to introduce more stringent legislation that restricted the supply of drugs and improve services through the health services for drug misusers (O'Gorman, 1998; Butler 1991). The goal of the health service treatment measures persisted that the drug addict/misuser should become drug free. Studies in subsequent years demonstrated a decline in several of the indicators of drug misuse, for example treatment figures, seizures and prosecutions (Dean, O'Hare, O'Connor, et al., 1987). The government believing that the drugs issue was now contained and confined to inner city Dublin moved their focus away from the drug problem (O'Gorman, 1998: Cullen, 1990).

It is argued that this left the government singularly unprepared for the emergence of the HIV and AIDS[8] crises from the mid-1980s (King, 2003). Others have claimed that the drugs problem in Ireland had never been a priority issue on the Irish political agenda (Butler, 1991). However, when one considers the broader political and economic context of the 1980s, Ireland was experiencing one of the deepest recessions in its history. Therefore, it is understandable if the governments priorities were elsewhere (Ahearne, Kyd and Wynne, 2006; Doherty, 2011; Nolan, 2017).

A Public Health doctor James Walsh in the Department of Health, is credited with introducing most of the positive work in drug treatment practices that were initiated in the 1980s (Nolan, 2017; Butler, 1991). In 1987, a methadone maintenance programme commenced at Jervis Street Hospital to cater for opiate-dependent clients. In 1989, an AIDS Resource Centre opened at Baggot Street Hospital. It provided a needle exchange programme for drug users. Furthermore, it provided the venue for outreach workers to access clients associated with problematic drug use (Seery, 1999; Nolan, 2017). This move towards a harm reduction approach in the misuse of drugs was considered quite radical at the time. It was predominantly due to a fear of the spread

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[8] The acquired immune deficiency syndrome (AIDS) is a medical condition first diagnosed in the 1980s. It is caused by the human immunodeficiency virus. The known methods of spread was the transfer of bodily fluids from an infected person to a non-infected person, such as semen, blood, and mother – to - child contact, through the placenta, breast milk, birth canal (Morison, 2001).

of HIV from the intravenous drug-using (IVDU) population to the wider public (Butler, 1991). Butler (1991) argues that the changes in service delivery occurred slowly and were marked by disagreements and inconsistencies. What is not acknowledged in Butler's paper was the very conservative nature of Irish culture to sex and sexuality in the 1980s (Nolan and Larkin, 2016). Politicians, by nature are conservative, and are reluctant to introduce radical changes in policy if they believe the public, on whom they rely on for votes, are not accepting of these changes. Consequently, they were contented for agencies influenced by international liberal ideas to take the lead in this area (Nolan and Larkin, 2016). In 1991 under the Government Strategy to Prevent Drug Misuse (Dept. of Health, 1991) the new harm reduction strategies were formally authorised (O'Gorman, 1998; Seery, 1999)

A second wave of a heroin crises emerged on the Dublin drug landscape in the 1990s (O'Gorman, 1998). This coincided with the arrival of an ecstasy and a rave culture on the Dublin youth scene, which appeared to permeate all socio-economic groups and the urban and rural divide. In the 1990s too public concerns over the rising rates of drug-related crime intensified (O'Donnell, 1999; Mayock and Moran, 2000). Media reporting of the increase in drug related crime and specifically the murder of the crime reporter Veronica Guerin[9] helped to put the drug problem high on the government political agenda (Memery and Kerrins, 2000). Policy responses moved away from the spread of HIV to focusing on other issues around drug misuse, crime, community safety and wellbeing. There was an increase in the provision of services for drug treatment, predominantly methadone treatment and detoxification programmes (O'Higgins, 1996; O'Higgins and Duff, 1997). It was acknowledged that broader environmental factors impacted on the demand for drugs, as evidenced in the report (Dept. Of the Taoiseach, 1996). Several studies over the previous decade had consistently indicated a link between poverty, social exclusion and illicit drug use (O'Kelly, Bury, Cullen and Dean, 1988; McKeown, Fitzgerald and Deegan, 1993; O'Higgins and O'Brien, 1995). Drug-related diseases, for instance AIDS and hepatitis were common in these communities. The Chairman on the Task Force, Minister of

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[9] Veronica Guerin was an investigative journalist in Dublin in the 1990s who reported on violent drug crime and the lifestyle wealthy Drug Lords operating in the city at that time for a major Sunday newspaper. Veronica was shot dead in her car while she waited at traffic lights on the 26th June 1996. She was the victim of a professional hit (Adamczyk, 2014).

State, Mr. Pat Rabbitte reported that life in these estates for many had become 'nasty, brutish and short' (Department of the Taoiseach, 1996; p. 5).

Following on from the recommendations in the report (Dept. of the Taoiseach, 1996), for the first time, a coordinated interdepartmental structure was developed to formulate drug policy (Butler and Mayock, 2005). This was in accordance with new developments in the civil service. The recent strategic management initiative (SMI), planned to increase efficiency by coordinating policy responses to 'cross-cutting' issues across government departments (Byrne et al., 1995). The structures included a Cabinet Committee on Social Inclusion. This was chaired by the Taoiseach (Prime Minister) and was made up of ministers from the Departments of Health, Education, Environment and Justice. A minister of state was appointed with responsibility for drug issues (Dept. of Tourism, Sport and Recreation, 1996). An inter-departmental team was created consisting of high-level representatives from the key departments with a role to play in addressing the use of illicit drugs in society. It was responsible for the overall coordination and implementation of the strategy. Figure 2.3 provides a graphical representation of the key structures and its reporting mechanisms.

Taoiseach

Cabinet Drugs Committee

chaired by the Taoiseach and comprising the Ministers for Health, the Environment, Education and Justice and the Minister of State to the Government

Interdepartmental Group

Departments represented on the IDG: Tourism, Sport & Recreation (Chair); Taoiseach; Finance; Education &Science; Enterprise, Trade & Employment; Environment & Local Government; Health & Children; Justice, Equality & Law Reform.

Responsible for the overall implementation of the drug strategy and policy

National Drug Strategy Team

Representatives from the Department of Health and Children, Department of the Taoiseach, Environment & Local Government, Garda National Drugs Unit, Social, Community and Family Affairs, Department of Education & Science, Justice, Equality & Law Reform, Voluntary Representative, Community Representative, ERHA

Eleven Local Area Drug Tasks Forces

locally-based – inter-agency, with representatives from Health Board, the Gardaí, the Probation and Welfare Service, the relevant Local Authority, the local Youth Service and voluntary drugs agencies, together with community representatives and a chairperson proposed by the local Partnership Board and a co-ordinator provided by the relevant Health Board.

Figure 2.3: Key structures of the National Drug Strategy 2001-2008

The National Drug Strategy Team (NDST), made up of representatives from government departments, state agencies and members of the community and voluntary sector, had responsibility for the ongoing implementation of the strategy. Local Areas Drug Tasks Forces (LDTFs) were established in the 11 areas of highest priority to coordinate and implement community initiatives to tackle drug use. Regional task forces were later established to identify and respond to emerging drug issues in their regions (Dept. of Tourism, Sport and Recreation, 1996). Four pillars underpinned Ireland's first comprehensive National Drug Strategy 2001-2008: supply reduction, prevention (education and awareness), treatment and research (Dept. of Tourism, Sport and Recreation, 1996). For many the research pillar of the NDS (2001-2008) represented the 'new public management initiative' taking place in the civil service (Butler and Mayock, 2005). It was anticipated that scientific research henceforth, and not personal values, views or opinions would now underpin the development of policy.

The National Advisory Committee on Drugs (NACD) was established in July 2000. Its remit was to advise the government on problematic drug use in Ireland in relation to prevalence, prevention, consequences and treatment. The advice was founded on the analysis and interpretation of research findings and information available to it from commissioned studies (www.nacda.ie). It was initially established under the patronage of the Department of Tourism, Sport and Recreation. In 2011, it moved to the Department of Health where the committee now reports to the Minister of State at the Department of Health. Since its establishment, it has built up a national and international reputation in the production of high-quality research and reports relating to drugs. Its work is focused on 'compiling a comprehensive inventory of research, information and data sets relating to early warning and emerging trends, prevalence, prevention, treatment/rehabilitation, and consequences of drug misuse in Ireland' (www.nacda.ie). In 2013, the minister of state in the Department of Health reconstructed the National Advisory Committee on Drugs to incorporate alcohol into its remit. It is now known as the National Advisory Committee on Drugs and Alcohol (NACDA). The Drug Misuse Research Division of the Health Research Board is the point of contact for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (NDS 2001-2008).

This section explored the historical context of the misuse of drugs in society. The factors that led to the international prohibition of specific drugs at the meeting of The Hague Convention in 2012 were recounted. It briefly described how the emphasis on supply-side approaches to drug misuse in society of the United States resulted in a punitive system of drug control. This was contrasted with the more humanitarian approach of the demand and harm reduction methods of EU policy. It traced the development of a drug culture in Ireland from the 1960s onwards. The policy responses of the government over the decades were outlined, culminating in the establishment of the National Drug Advisory Council on Drugs in the year 2000. The following section gives a brief history of the evolution of alcohol policy.

2.4 Alcohol use – historical context

Historical records show that alcoholic beverages have always been a part of human culture, used in ceremonial and ritual traditions (Room et al., 2002). Over time,

societies implemented policies and established social norms to reduce the detrimental effect of the misuse of alcohol on populations (Room, Babor and Rehm, 2005). Frequently, religious organisations were at the forefront of this movement. Hinduism was the first to demand abstinence from alcohol from its followers, and later, Buddhism advised abstaining from alcohol as a way of lessening our desires for earthly objects and achieving contentment in this life (Westermeyer, 2005). Nonetheless, in nearly all modern societies, the production and sale of alcoholic beverages is viewed as an important part of the economy, providing jobs in the production, retail and tourism sectors (Room and Jernigan, 2000). The remainder of this chapter will review government policies internationally and nationally to control the over-consumption of alcohol in society.

2.4.1 Policy responses in the United States

Up until the 17th and 18th centuries, American settlers did not view alcohol misuse as a major problem (Levine, 1984). It was used by all classes of society as a medicine, a tonic or a relaxant by both men and women, and it was frequently given to children (Levine, 1984). Puritan ministers commonly referred to it as 'the Good Creature of God' (Levine, 1984; p.110). However, by 1835 changes in ideas and beliefs on alcohol consumption began to arise. A prominent American physician Dr. Benjamin Rush, is credited with this change in attitudes and beliefs (Levine, 1978). In a pamphlet published in 1884, he reasoned that distilled beverages were addictive and poisonous to the body. Rush (1884) claimed that alcohol destroyed the moral character of the person with regular drinking leading to addiction and indiscipline (Levine, 1978). The solution to this problem was total abstinence by the drinker. Following Rush's lead, many well-known physicians in the US advocated total abstinence from alcohol and joined temperance organisations (Levine, 1978).

Over the next 40 years, temperance societies sprung up across the United States (Levine, 1978; Westermeyer, 2005). At first these societies were mainly associated with the wealthy elite, concerned about the drinking behaviours of the working classes. Later the temperance society grew to be a mass movement that included the middle classes, with many teachers, shopkeepers, lawyers, judges and women joining the associations. The temperance societies were sympathetic to persons addicted to

alcohol, and many programmes were developed to help such people abstain (Levine, 1978). The temperance movement viewed alcohol as 'dangerous and destructive precisely because it destroyed drinkers' ability to regulate their own behaviour' (Levine, 1993; p.10). The views of supporters of the movement believed that alcohol was an addictive drug, very like the views of heroin today. In the mid to late 1800s the misuse of alcohol was considered the cause of many ills in society, like crime, poverty and family breakdown. Beliefs and opinions began to take hold among the wealthy industrialist class regarding the abolition of alcohol in society, as a way of ensuring an obedient and industrious working class (Timberlake, 1963).

Gradually, across the US owing to the influence and zeal of temperance organisations (the Anti-Saloon League for example, was supported by Protestant Church money and influential wealthy men, such as John D. Rockefeller), many states began to pass prohibition laws (Timberlake, 1963). This culminated in the national prohibition of alcohol across all states in 1919 (Levine, 1984). Outright prohibition was unsuccessful primarily due to the difficulty in policing borders to prevent illegal importation and smuggling. While the overall levels of alcohol consumption fell during this period, the consumption of distilled liquor increased. This was a consequence of the number of domestic whiskey stills across the country providing an adequate supply of alcohol for illegal trading (Levine, 1984). In 1926, the Association Against the Prohibition Amendment (AAPA) was founded to lead the campaign for repeal. It was argued that the levels of smuggling and illegal trade that were being conducted were undermining the rule of law in society. Levine (1984) reports a lesser-known fact about the AAPA: that it was headed and financed by Pierre Du Pont (Dupont Chemicals), John Raskob (the head of General Motors) and other very wealthy and influential men. In terms of economic self-interest, they believed that if taxes from alcohol were restored, their own personal and business taxes would be reduced (Levine, 1984).

Following the repeal of prohibition in 1933 each state had responsibility for regulating the sale and distribution of alcohol, referred to as 'alcohol control' policy (Levine 1984). In an influential book written by close advisors of John D. Rockefeller Jr. in 1933, it was argued that the 'law was not the appropriate mechanism for handling many of the personal and social problems thought to result from drinking' (Fosdick and Scott, 1933; Levine, 1984; p. 116). It suggested these concerns would be better

addressed by medical, educational and religious organisations (Levine, 1984). It has been found that when severely restrictive and punitive policies on alcohol or drugs are implemented, consumption decreases in the short term. However, in the longer-term Room (1992) suggests this can often give rise to a counterculture of drug misuse. For example, there was an increase in alcohol consumption among college students during the 1920s and 1930s. A similar increase in the smoking of marijuana and LSD was witnessed among students during the 1960s and 1970s (Room, 1992).

Towards the end of the 20th century, a more measured socio-cultural approach to limiting or reducing the consumption of alcohol was adopted by American society (Hanson, 1995). This approach was derived from contemporary societies around the world that consumed similar amounts of alcohol but did not suffer the associated problems of misuse; for example, the Italians, the Jews and Greek communities (Hanson, 1995). The conventions that underpinned this approach related to a focus on the misuse of alcohol rather than viewing the product itself as the source of the problem. A distinction was made between alcohol use and abuse. It was suggested that through education individuals could be encouraged to drink responsibly or to abstain. In addition, in circumstances where individuals chose to drink alcohol, there would be social norms around what was acceptable behaviour for the drinker (Hanson, 1995).

2.4.2 Policy responses in Europe

In Europe alcohol control policies were in existence for many centuries. The Gin Act legislated in the UK in 1751 introduced a range of measures to reduce the high levels of consumption in society. These included excise duties on the wholesale of spirits, licensing fees and limiting the type of outlets that could sell spirits (Warner, Her, Gmel, et al., 2001). The temperance movement was imported from the United States, to countries Finland, Sweden, Norway and Britain in the 19th century. According to Levine (1993) the most remarkable fact of the countries in which the temperance movement flourished was that they were predominantly Protestant societies. Another unique feature of these countries was their preferred alcohol beverage – distilled liquor for instance vodka, gin, rum and whiskey (Levine, 1993). The wine-producing countries of Italy and France consumed more alcohol than Norway and Sweden, and the people of these countries suffered more physical ill effects (e.g., liver cirrhosis).

However, it was the Protestant drinkers who talked more about the addictive nature of alcohol. Other countries in Europe that also had substantive temperance movements were Denmark, the Netherlands, Switzerland and Germany (Levine, 1993).

There was a distinct absence of temperance activity in the wine-producing countries of southern Europe, in Spain, Portugal, Greece, Romania, France and Italy (Levine, 1993). In these countries, alcohol was rarely viewed in a negative light and was regarded as a food, frequently used in symbolic ways in religious or cultural ceremonies (Lolli et al., 1958; Sadoun et al., 1965). Conversely, Northern European countries that had state-imposed alcohol control measures, rules and laws governing the physical availability of alcohol and high taxes on alcohol products, found that the informal cultural norms and customs in their countries pushed the consumption of alcohol up rather than down (Osterberg and Karlsson, 2002; p.18). Likewise, strict alcohol control policies have been a necessary part of public policy in many East European countries (Moskalewicz and Simpura, 2000). What has emerged from the variance between temperance and non-temperance countries is that alcohol movements are accepted as legitimate, influential organisations in these countries. They contribute to the debate at government level on alcohol policy (Levine, 1993). This discrepancy in attitudes and social norms to drinking alcohol in the different member states of the EU has given rise to different legal and official regulated alcohol actions being implemented (Osterberg and Karlsson, 2002). In Southern and some Central European countries, informal rules or customs have resulted in many people in these countries either abstaining totally or restricting alcohol drinking to certain occasions. Consequently reducing the need for more legal and formal alcohol measures to be implemented (Osterberg and Karlsson, 2002; Ahlström-Laakso, 1976; Gefou-Madianou, 1992).

Bruun, (1975) defined alcohol control policies as 'the legal, economic and physical factors, which bear on the availability of alcohol to the individual'. Edward, Anderson, Babor, et al., (1994) use the term 'alcohol policy' rather than 'alcohol control policy', and they consider it 'a public health response to the burden inflicted by alcohol to society' (p.19). These definitions have been criticised, as they do not affect informal social controls or the activities of the private alcohol industry; for example, in the advertising and marketing of alcoholic beverages (Osterberg and Karlsson, 2002). The

alcohol industry has consistently opposed strict regulations in this area, arguing that it is a self-regulating and responsible industry, adhering to voluntary codes of practice (Savel, et al., 2014). All modern nations and states deal with alcohol matters (Room, 1999). There are several interests around alcohol that concern the state. These include fiscal and economic development interests, the need to maintain the safety and public order of the population and ensuring the reproductive health of the population (Mäkelä and Viikari, 1977). There are wide variations in the approaches nation states adopt to tackling these issues (ibid). As a result, many of the concerns around alcohol policy are split between different government departments. For example, in a study carried out in the UK on alcohol policies (Bruun, 1982), 16 government departments were responsible for alcohol related concerns. These included the production, sale and distribution of alcohol products, in addition to responding to the social and physical harm resulting from the misuse of alcohol in society.

To understand the current social and political context of alcohol in the EU, one must go back to the founding of the European Community in 1951. The six countries that came together to establish the EU were either beer-producing or wine-producing countries (Österberg and Karlsson, 2002). The raw materials of wine and beer are agricultural crops, which are ordinary goods and commercial products. Those agricultural products were subsidised by the EU through its common agricultural policy (CAP). The aim of EU policy in relation to wine production was to ensure the viability of small wine farms in member states and to ensure that a reasonably priced product was available to the consumer. This involved increasing and regulating the production of grapes within the EC countries and encouraging a greater demand for wine within the EC. The policy also supported wine exports to secure a stable income for the farming sector (Kortteinen, 1990).

In 1973, the countries of Ireland, Denmark and the United Kingdom joined the EU. These respective countries were 'beer-preferring countries' (Österberg and Karlsson (2002). Ireland and the United Kingdom also had a history of producing distilled spirits. What was noteworthy about these new entrants to the EU was they had very high excise duty on alcohol products. They also had a sophisticated range of alcohol control measures in place for controlling the sale and consumption of alcoholic beverages (Ibid). The countries that joined the EU in the 1980s (Greece in 1981,

Portugal and Spain in 1986) had a tradition of producing and consuming wine with few control measures or taxes on the sale and distribution of alcoholic beverages. However, in 1995, when Austria, Finland and Sweden joined the EU, measures implemented by governments to regulate and control the misuse of alcohol and protect the health of their populations became undermined by external developments (Osterberg and Karlsson, 2002). Finland and Sweden had a long history of producing and consuming distilled spirits. They had the most regulated control measures in alcohol policy of any of the other EU states. The state controls the supply and sale of alcohol beverages, with very high excise duties. During its negotiations on membership in the early 1990s, they attached a declaration to the agreement indicating that 'their alcohol policies were based on important health and social policy considerations' (the Agreement of Oporto of May 1992). Nevertheless, after joining the EU, Sweden and Finland, under articles to the Treaty of Rome, were forced to give up their monopolies on the import, export and wholesale of alcoholic products (Österberg and Karlsson, 2002).

International trade agreements in a global market have progressively influenced local and national alcohol policies (Barbor, Caetano, Casswell, et al., 2003; 2010). In 2000, the World Trade Organisation had registered 127 trade agreements, most of them referring to trade in alcohol products (Barbor, et al., 2010). These have resulted in countries that had policies which targeted the whole population, coming under pressure to abandon state monopolies, reduce taxes and extend opening hours. The net result of these trade agreements was that alcohol was reduced to being an ordinary commodity and as such was subject to the same regulatory and control measures as other common products. In the EU, there has been a move towards the equalisation of excise duty on alcoholic beverages and other alcohol policies (Barbor, et al., 2010). While policies around alcohol consumption have been going through adjustments, there was a notable increase in the concern around the harm that the overconsumption of alcohol can cause to the individual and to society. Governments responded to these fears by implementing stricter controls on drinking and driving. In addition, governments have implemented public health campaigns and educational awareness programmes to highlight the detrimental effects of the over-consumption of alcohol (Barbor et al., 2003: 2010).

2.4.3 Ireland

Ireland's consumption of alcohol has steadily increased since the 1950s. Between 1989 and 1999, when most other countries in Europe were showing a decrease in alcohol consumption, Ireland's consumption rate increased by 41% (see Figure 2.4) (DOHC, 2002).

The organisation for economic Co-operation and Development (OECD, 2011) Health Data Report showed that alcohol increased from 4.9 litres per capita consumption in 1960 to 11.3 litres in 2009. It peaked in 2001 at 14.3 litres. These figures, Hope and Butler (2010) suggest, confirmed what had been a cultural stereotype; that Ireland was a nation of heavy drinkers. To put the present-day alcohol policies in Ireland in perspective, this section will explore the development of alcohol control policies from the founding of the state in 1922 up to the first decade of the 21st century.
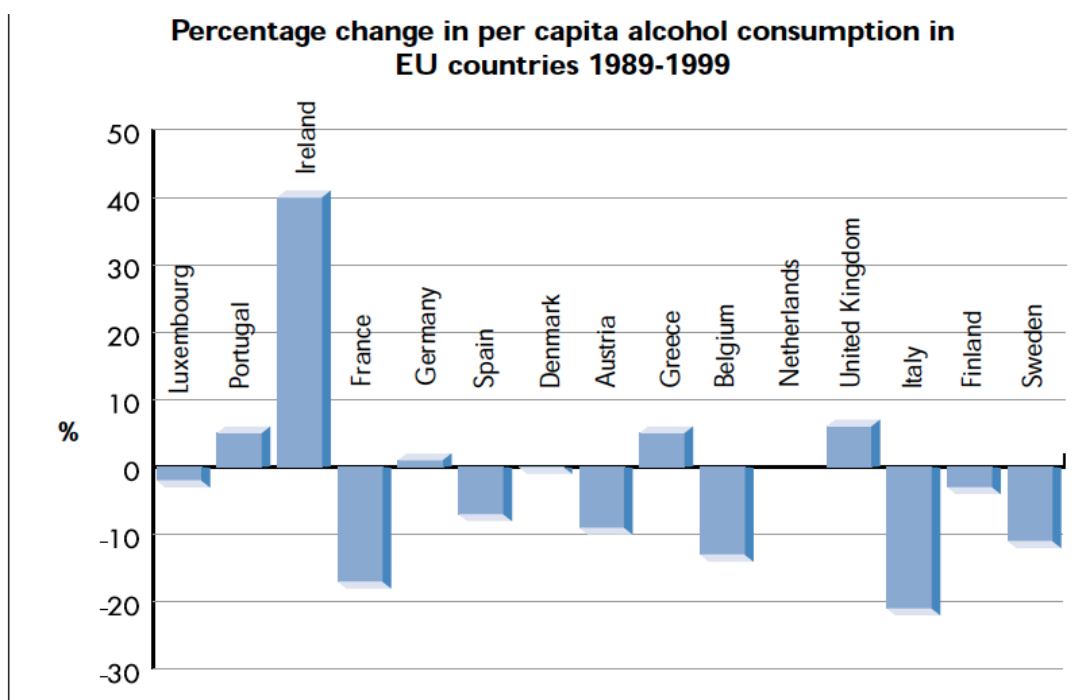
Figure 2.4: Change in alcohol consumption in EU countries. Source: Revenue Commissioners and Central Statistics Office; others World Drinks Trend

Ireland's 'curious and pervasive relationship with alcohol' was written about many historians and researchers (Ferriter, 2003; p.1). Ferriter cites Hadfield and McVeigh (1994: 55), who reported how in the early 17th century, a British visitor to Ireland at that time, Freynes Moryson, wrote of 'the mixture of over-indulgence and crudity

which seemed to be associated with Irish drinking habits, practices which seemed to traverse class and gender boundaries' (p.1). In the mid-1800s, social scientists from Statistical and Social Inquiry Society of Ireland (SSISI) were concerned with alcohol-related problems in the Irish population. The function of the society was to provide the government of the day with independent information on alcohol consumption in society. The impact of this information on the political establishment was considered insignificant, as the Church-based temperance groups had considerably more influence on the population and policy at that time (Butler, 2002). A temperance campaign founded in the 1840s by Capuchin priest Fr. Theobald Mathew attracted many members during the priest's lifetime, but the movement did not survive after his death (Levine, 1993). Levine suggests the temperance movement never thrived in Ireland, as most of the population never viewed alcohol as fundamentally evil (Levine, 1992). In contrast to the Protestant view of alcohol, the Catholic Church viewed alcohol as a divine gift from which the individual could willingly abstain (Ferriter, 1999). The Irish Pioneer Total Abstinence Association was established 1898. Its aim was to unite 'all Catholics in a warfare against the drinking habits of society', particularly focusing on the young and encouraging those already addicted to become abstinent (Malcolm, 1982; p.12). Butler and Jordan (2007) contend that the Pioneer Total Abstinence Association had no ideological position on whether alcoholism was a disease. Rather it emphasised that people had a choice regarding whether they wished to drink or abstain. They encouraged the view that through spiritual guidance and help, they could make the decision to abstain if this was their wish (Butler and Jordan, 2007). The Pioneer Total Abstinence Association remained influential in Irish society up until the latter half of the 20th century, when its influence started to decrease (Fagan and Butler, 2011).

The 1925 Intoxicating Liquor Commission was the first governmental committee to review alcohol issues in Ireland after the establishment of the free state in 1922. It decisively rejected the idea that alcohol misuse was a disease and that the medical profession should treat it thus. The commission considered the pervasiveness of alcohol misuse in society to be directly related to the ease of access to alcoholic beverages. Its recommendations were to retain the licensing and control measures already in place, in as far as they were accepted by the electorate (Butler, 2002).

In the United States, following the repeal of the Prohibition Act 1933, several physicians and natural scientists came together to form the Research Council on Problems of Alcohol (Schneider, 1978). Its aim was to find the causes of alcoholism. Schneider (1978) suggests that three developments occurred in the decade after prohibition that helped to promote the disease concept of alcoholism; the establishment of the Yale Centre for Alcohol Studies in 1939, the self-help group Alchohol Anonymous and the claim by non-psychiatric doctors that 'alcohol is a disease' (p.365). Ideas of alcoholism as a treatable disease were promoted through the establishment in 1944 of the National Council on Alcoholism (Schneider, 1978). These ides diffused internationally and had a significant influence on Irish policymakers (Butler, 2002). The WHO recognised the disease concept[10] of alcoholism when it was established in 1946. It acknowledged that the aetiology of alcoholism was not fully understood. However, it suggested could be explained as a deficit in the genetic nature or character of the person, and that there was no relationship between the levels of alcohol consumed in society and the pervasiveness of alcohol problems (WHO, 1946).

The disease concept of alcoholism was accepted in Ireland under the 1945 Mental Treatment Act. It permitted for the voluntary and involuntary admission to hospital of individuals addicted to alcohol (Walsh, 1987). Butler (2002) observes that the inclusion of individuals suffering from alcohol and drug addiction under this act was greatly influenced by the Irish Medical Association. Alcohol addiction accounted for the most frequent admissions to psychiatric hospitals up until the 1970s (Walsh, 1987). Walsh (1987) attributes this practice to the prevailing belief in society of alcoholism as a specific disease and the idea that hospitals were there to cure diseases.

2.4.4 The reduction of alcohol control measures
From the foundation of the state up until the 1940s, Ireland's licensing laws were very restrictive and highly regulated. Over the coming decades, these laws and regulations came to be perceived as old fashioned and as unnecessarily controlling (Butler, 2002).

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[10]The WHO acceptance of alcoholism as a disease can be traced back to the Yale Centre of Alcohol Studies and E.M. Jellinek. Jellinek had previously been a director at the Yale Centre of Alcohol Studies. From 1950 to 1955 he worked as a consultant to the WHO (Bruun, Pan, and Rexed, 1975).

On recommendations from the Commission of Inquiry in 1957 (comprised of the licensed trade, trade unions, Bord Fáilte, the Pioneer Total Abstinence Association and Dáil Eireann), the *Intoxicating Liquor Act 1960* allowed for the extension of opening hours on Sundays and weekdays. There was no opposition from public health to these measures. However, concerns were raised by the Catholic Church hierarchy on the consequences of excessive alcohol consumption on criminal behaviour in society and injury on the road. The Minister for Justice at the time responded to these concerns quoting the WHO reports, indicating that there was no significant relationship between the levels of alcohol consumed in society and the incidence of alcoholism in the population (Butler, 2002).

From 1960 to 1979 alcohol consumption in Ireland increased by 100% (Walsh, 1987; McCoy, 1992). Walsh's (1987) subjective opinion on this period suggests that it was due to Ireland having more disposable income because of increasing economic prosperity and more women and young people drinking. The level of alcoholism in society was also increasing, as evidenced by the growing number of treatment centres opening to treat this illness (Walsh, 1987; Butler, 2002). A new professional role emerged around this time, the 'alcoholism counsellor'. In Ireland, this professional role arose from social workers and psychiatric nurses, and was trained by the Irish National Council on Alcoholism (Walsh, 1987; Butler, 2002).

The Irish National Council on Alcoholism (INCA) was established in 1966. Like its sister organisation in the United States, its function was to increase the level of awareness among the public of the disease concept of alcoholism. Additionally, it advocated for the establishment of more treatment services and research in this area. The council was mostly made up of psychiatrists working in the private sector and Alcohol Anonymous members (AA) (Butler, 2002). Two factors helped to prolong the acceptance in Ireland of the disease concept of alcoholism. The first was the *Report of the Commission of Inquiry on Mental Illness* in 1966, which recognised the WHO definition of alcoholism as a disease, and recommended specialised inpatient and community treatment centres. The second was the establishment of the Voluntary Health Insurance organisation. This was a non-profit organisation established by the state, to offer private insurance cover to those who were not entitled to the means-tested public health service (Butler, 2002). Private health insurance allowed alcohol-

dependent individuals to avail of treatment in the private hospitals. In a report on admissions to psychiatric hospitals in 1979, it found that alcoholism accounted for 40% of all private hospital admissions (O'Hare and Walsh, 1980).

By the 1970s, new research was published that questioned the disease concept of alcoholism (Christie and Bruun, 1969; Cahalan and Room, 1974). Studies that compared the treatment regimens of conventional alcohol programmes with advice-giving sessions found no significant differences in the rehabilitation rates of the two groups (Orford and Edwards, 1977; Vaillant, 1983). Alcohol dependency and alcohol-related diseases have remained on the WHO International Classification of Diseases (WHO, 2018). However, its approaches to tackling alcohol misuse began to move away from the disease concept of alcoholism towards a public health approach (Butler, 2002). One of the most significant studies that contributed to the development of the public health approach was the *Alcohol Control Policies in Public Health Perspective* (Bruun, Edwards, Lumio, et al., 1975). The study found that the combined levels of alcohol consumption in society were a good forecaster of the incidence and prevalence of alcohol-associated problems in a population (Bruun et al., 1975). The control of alcohol beverages through several fiscal and regulatory measures to reduce consumption was recommended (Bruun, Edwards, Lumio, et al., 1975).

2.4.5 A public health approach to alcohol misuse in Ireland

Irish researchers that had worked on the international study on alcohol consumption, (Single, Morgan, Lint, 1981) helped to bring to Ireland these new ideas of alcohol control measures in tackling alcohol problems in society. One of the researchers Dr. Dermot Walsh was involved in developing the national mental health plan (Department of Health, 1984). In tackling alcohol problems in society, Walsh emphasised that preventative measures rather than expanding treatment services should take precedence. He advocated using regulatory and control measures for example, 'raising alcohol taxes, restrictions on advertising, on retail availability and strict enforcement of existing legislation on drunk-driving and underage drinking' (Butler, 2009, p.347). In the mid-1980s, in line with practices in the United States, private health insurance companies (for example, in Ireland the VHI) reduced their cover for in-patient alcohol and drug treatments (Walsh, 1987). Among this group,

alcoholism was responsible for lengthy in-patient stays and high rates of readmission (Butler, 2002). Despite these developments, the Irish government was slow to embrace a public health perspective on alcohol policy. The levels of alcohol consumed in Irish society continued to increase until its peak in 2001 (Hope, 2006). Figure 2.5 demonstrates how as Ireland's economic prosperity increased and alcohol control policies relaxed, our consumption increased exponentially.

Ireland 1960-2009 – Per capita consumption of alcohol
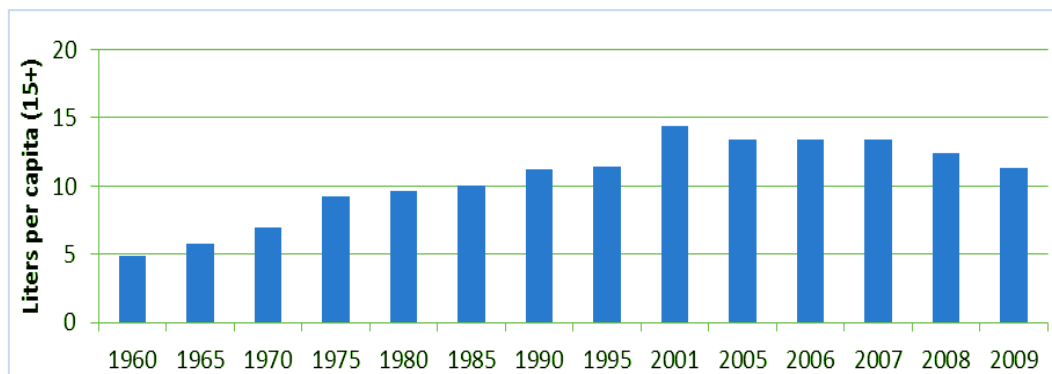
Figure 2.5: Ireland – alcohol consumption 1960-2009, OECD (2011) **Health Data**

http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH LVNG

2.4.6 A Health Promotion National Alcohol Policy

Discussions and proposals for a national alcohol policy incorporating a public health approach began to emerge in the late 1980s and early 1990s. This approach towards alcohol policy by the Irish Government coincided with a new direction emerging in public health, that of health promotion (Kelleher, 1992). The origins of health promotion are complex. Its emergence can be linked to several events and key initiatives in the 1970s and 1980s that helped to transform the thinking around public health (Keleher and Murphy, 2004). The *Lalonde Report* in 1974, published by the Canadian Ministry for Health, argued that:

'The health care system […] is only one of the ways of maintaining and improving the health [of a population] […] For the environmental and behavioural threats to health, the organised health care system can do little more than serve as a catchment net for the victims' (Lalonde, 1974: p.5).

The WHO (1977) strategy Health for All by the Year 2000 considered the broader determinants of health and how it was defined. This strategy served as the impetus for wide-ranging developments in health, creating an environment that was favourable to the dissemination of ideas on health promotion. In 1986, in Ottawa, Canada, the first of a series of conferences on health promotion globally was organised. One of the most enduring and influential documents in health promotion was created; the Ottawa Charter for Health Promotion (WHO, 1986). This document lays down the guiding principles and identifies the five key action areas of health promotion:

- Building health public policy
- Creating supportive environments
- Strengthening communities
- Developing personal skill
- Reorienting health services (Naidoo and Wills, 2009; Keleher and Murphy, 2004)

The principles of health promotion were in alignment with a public health perspective on alcohol policy. Consequently, the newly established Advisory Council on Health Promotion and the Health Promotion Unit were tasked with developing a National Alcohol Policy (Butler, 2009). As discussed in Section 1.2, the setting up of the Strategic Management Initiative (SMI) in 1994 in the civil service would have greatly assisted in the development of a public health approach to alcohol policies (Boyle,1999). This initiative required collaboration between government departments for cross-cutting issues like alcohol policy (Boyle, 1999). A further development that was occurring across Western democracies in the 1990s was the campaign to have health policy based on research evidence (Oliver and McDaid, 2002: Milio, 2005: Lavis, Oxman, Moynihan, et al., 2008). The belief was that policymaking would be based on a balanced, transparent and the most prudent use of research evidence (Cookson, 2005). These factors occurring simultaneously should have provided the perfect environment for the development of a national alcohol policy in accordance with the public health perspective.

However, the National Alcohol Policy when it was published in 1996 did not fully embrace the public health perspective. It did incorporate some health promotion principles in developing personal skills in young people and the importance of different settings in influencing attitudes and increasing awareness of alcohol addiction (DOH, 1996). Research was referenced in the policy document to justify why certain groups in society needed to be targeted, for example adolescents and problem drinkers (Morgan and Grube, 1994: Murray 1996; Nic Gabhainn and Kelleher, 1995). The importance of the alcohol industry to Ireland's economy was also highlighted (Scott, 1994: ESRI, 1992). Butler (2002) suggests that where it failed to fully commit to a public health approach was in its recommendations. No collaborative initiatives with government agencies or government departments responsible for alcohol issues were advanced. The disease concept of alcoholism was still dominant, and the political supports for a more wide-ranging public health approach were absent. A report in the *Irish Times*, 20 September 1996, regarding the launch of the policy, signified the reluctance of the then Minister for Health to implement a highly regulated or restrictive alcohol policy (Butler, 2009).

The disease concept of alcoholism and how these ideas were perpetuated for many decades, help us to understand how ideas and norms can create realities. They become embedded in the culture and structure of States (Krook and True, 2010). Later these ideas and norms when found not to be working for most of the population can be very difficult to reverse. To overcome this Hartmann and Millea (1996) argue that all democratic societies need to ensure that governments have in place a system by which viewpoints and ideas that oppose the dominant ideological perspective can be heard and explored.

This section described how alcohol policy has evolved internationally and nationally over the last century. It traced the move from prohibition to a disease concept of alcoholism, and eventually to a public health approach. The transformations in policy have emerged due to changing ideas and beliefs in society on the overconsumption of alcohol, based on scientific research.

2.5 Reflections

At the foundation of the Irish state the policymaking structures comprised a central administration system known as the civil service and elected public representatives. As in most western democracies, the states policymaking structures have evolved and expanded over time (Hardiman and MacCarthaigh, 2010; Craft and Howlett, 2012). They now include not only the bureaucratic and technical experts of the civil service, but also special advisors, think tanks, research institutes and agencies responsible for the delivery of government services and regulatory oversight. This no doubt has added to the complexity and difficulty in the policy decision-making process.

International drug control policies emerged at the end of the 1800s and the beginning of the 20th century out of a growing concern of the misuse of drugs like cocaine, opiates and later marijuana among the lower working classes. The misuse of these drugs among the middle classes was frequently viewed as a disease of addiction, rightfully treated by the medical profession. However, among the poorer sections of society drug misuse was viewed as anti-social conduct leading to violent and disreputable behaviour. Over the century policies in this area have evolved according to the changing views and beliefs on the misuse of drugs in society. Nonetheless the development of illicit drug policy has remained chiefly the reserve of the justice and public health departments of a countries administration.

Alcohol policy in Ireland progressed from a highly regulated area in the early part of the 20th century to viewing alcoholism as a disease in line with international norms. The disease concept of alcohol addiction was accepted because of the belief that the problem was in the individual, unrelated to overconsumption. Ensuing from the disease concept, alcohol control policy measures were relaxed, resulting in over consumption and an increase in the prevalence and incidence of alcohol addiction and alcohol-related problems in society. By the end of the 20th century, there was a move back towards increasing alcohol control measures in society, incorporating a public health approach based on research evidence. Nevertheless, Ireland has been slower than other nations to fully adopt this approach.

This chapter has provided a background for the starting point of this thesis, 'How did research evidence impact on alcohol and drug policy in Ireland between 2001 and 2012?' The policymaking apparatus of the Irish State was examined and the evolution of drug and alcohol policy both internationally and nationally was explored. The next chapter will review the academic literature in the field of health, specifically regarding the relationship between evidence and health policy.

Chapter 3: A review of the literature and theoretical frameworks

3.1 Introduction

The previous chapter established the background and context of this study. This chapter now builds on these findings and reviews the literature in health policy, policymaking, and the use of research evidence in this process. The key concepts of public health and health promotion are defined. Next the characteristics of power and its relationship with policymaking are explored. This is followed by a review of the most popular theories of the policymaking process. How knowledge influences health policy development is assessed and an overview of the models and frameworks that have been developed to measure the impact of research evidence is presented. Strategies to increase the uptake of research by policymakers are outlined. The different types of exchange mechanisms employed by researchers are explored. Finally, a critical review of the empirical literature published in this field of scientific enquiry in Ireland is presented. This is to situate the current study within the body of research already conducted on how research evidence impacts on health policy in Ireland.

3.2 Literature search

A comprehensive review of the literature was conducted via manual and electronic resources. Databases searched included Web of Knowledge, Scopus, Embase, CINAHL, Cochrane Database of Systematic Reviews, PsychInfo, Medline and the Social Science Citation Index. Manual searches of the university library and print resources of books and journals were conducted. Due to the complex nature of the phenomenon under review and the heterogeneity of the studies conducted, it was difficult to develop a search strategy, as other researchers in this area have already found (Greenhalgh and Peacock, 2005; Banzi et al., 2011; Contandropolous et al., 2010). Two searches of the literature were undertaken. The first search identified

documents that made a core contribution to the understanding, either conceptually or empirically, of evidence-based policymaking. The second search strategy identified original research papers assessing the impact of scientific knowledge on public health policy. The following combinations of key words were employed: 'research and health policy', 'research utilisation', 'research impact', 'evidence based health policy', 'knowledge transfer', 'knowledge exchange' and 'knowledge broker'. The terms addressed the objectives of the literature review. Other resources searched included the Department of Health website (i.e. National and International), as well as Google Scholar. The review was limited to papers published between 1990 and 2017. These dates were chosen due to the influence of the evidence-based medicine movement and the call for public administrations and politicians to become more accountable for their policy decisions from the 1990s onwards. Consequently, many academics began to take an increasing interest in this field, with the volume of studies published increasing exponentially (Sackett et al., 1996; Gray, 1997; Murray and Frenk, 2000; Blunkett, 2000; Nason, et al., 2008). However, papers were included outside of these dates if considered relevant to the study. Foreign-language papers were excluded from the review.

3.3 Health promotion and the new public health

As alluded to in the previous chapter the concept of health promotion first emerged in the public health consciousness in the mid-1970s. Significant events like the Lalonde Report (1974), the Alma Alta Conference (WHO 1978) and the WHO global strategy Health for All by the Year 2000 (WHO, 1991) are viewed as setting the foundation for the health promotion approach in public health that followed (Naidoo and Wills, 2009; Catford, 2006). Health Promotion charted an innovative direction in public health by identifying how the wider social determinants of health impacted on the health of a population. This is robustly illustrated in the Dahlgren and Whitehead model of the Social Determinants of Health (1991). The move towards an ecological model of health, from a biomedical model, necessitated a multi-sectoral approach towards health policy in society. It required from governments a commitment to address public health concerns in all areas of policy. This included the sectors education, agriculture and transport – to support and improve the health of populations

(Catford, 2006). In 1946, the World Health Organisation (WHO) defined health as follows:

> Health is a state of complete physical, mental and social-wellbeing and not merely the absence of disease or infirmity (WHO, 1946, 2017, p. 1).

This holistic view of health acknowledged the importance of mental and social wellbeing to the overall health of individuals. Criticisms of this definition reveal that this statement can only ever be aspirational, as complete physical, mental and social health is impossible to achieve all the time (Jadad and O'Grady, 2008). Its relevance today has also been contested on the basis that many individuals with chronic diseases (e.g. coronary heart disease, CVD and diabetes) can adapt and manage disabilities. Chiefly because of modern advancements and developments in technology and medicine, individuals can now hope to live a fully functioning and fulfilling life (Huber, Knottnerus et al., 2011). The WHO (1984) later expanded its definition of health to include;

> The extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and on the other hand, to change or cope with the environment […] A resource for life, not an object of living; it is a positive concept emphasising social and personal resources, as well as physical capabilities (WHO, 1984).

This later definition recognises the broader determinants of health and how they impact on the health of individuals as they travel through the life course. It is the definition that underpinned the Ottawa Charter, which emerged from the first Health Promotion Conference held in Ottawa, Canada, in 1986 (WHO, 1986). The Ottawa Charter identified three approaches for advancing health at the local, regional and national levels, through advocacy, mediation and enablement (Kickbusch, 2003). Health promoters are encouraged to serve as advocates for health on behalf of populations to ensure that physical, cultural, political and economic environments are favourable to health. Health promotion too involves enabling people to achieve their optimum health potential through access to education, resources and life skills. Mediation refers to the profits of negotiating between different sectors of society and different interest groups to ensure that the best health outcomes are achievable for all

the population. As with traditional public health, it acknowledges that to promote health, the preconditions of health must be available, for instance good housing, income and peace (Ibid). The key action areas defined in the Ottawa Charter for Health Promotion are listed under section 2.2.9 in Chapter Two.

Fundamental to health promotion is the acknowledgement that health cannot be delivered exclusively by the health sector. It requires coordination and cooperation across all sectors; for example, the government, public and private organisations and the community (Naidoo and Wills, 2009; Kickbusch, 2003). Several studies and reports on the broader determinants of health have consistently demonstrated the link between poverty and ill health the Black Report, 1980 (Smith, Bartley, Blane, 1990), the Acheson Report, HM Government 1998 (Gordon, 1999); the Marmot Review (Marmot, Allen, Goldblatt et al., 2010). Health promotion, sometimes referred to as 'new public health', sought to address the broader socio-economic and environmental factors that influence the health of populations and impact on individual lifestyle choices (Naidoo and Wills, 2009).

3.3.1 What is public health?

Public health is a broad concept. Fundamental to its purpose is the health of populations, their absence from disease and individual lifespans (Berridge, 2016). Throughout history it has been informed by social policy, as well as medical science (Naidoo and Wills, 2009). In Edwin Chadwick's 1842 report for the Poor Law Commissioners of Great Britain, it was argued that it was outside of the control of the poor to change their own living circumstances. The local government was deemed the appropriate authority responsible for the sanitary conditions of the urban poor (Naidoo and Wills, 2009). Today, public health not only refers to health promotion and wellbeing in the population, but it also has a role in identifying future threats or trends in a population's health (Berridge, 2016). Its focus is on healthy as well as sick people (Ibid). A professor of public health, Charles Winslow of Yale University, defined public health in 1920 as:

> the science and the art of preventing disease, prolonging life, and promoting
> physical health and efficiency through organised community efforts for the

sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health (Winslow, 1920: p. 30).

The role of governments and societies working together in prolonging and promoting the health of populations is emphasised in this definition (Graham, 2010). It continues to have significance today; for example, in the 1980s, the chief medical officer (CMO) of England, Sir Donald Acheson, defined health policy as:

'The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' (Acheson, 1988).

In 2004, the UK Government's review of public health policy and practice expanded on Acheson's definition of public health to include the voluntary and private sectors;

'The science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals '(Wanless, 2004).

Graham (2010) suggests that the definition of public health has essentially not changed over the decades. Berridge (2016) argues that how public health is defined has altered and that the revisions made reflect the changing political ideologies of the different time periods. In the 1980s Achesons' definition of public health was mindful of the outbreak of HIV/AIDS and its consequences for the whole population, in that it required a comprehensive public health response (Ibid). The later definition of public health in the (Wanless Report, 2004), represented a shift in focus towards the individual being responsible for his/her own health, through informed choices and a greater role for private and voluntary institutions (Berridge, 2016). Reflecting on the changing definitions over the decades, public health has always been influenced by changes in the political, cultural, economic and physical environment (Ibid).

In Ireland, the evolution of public health and the healthcare system over the 20th century has been greatly influenced by Britain. Following the establishment of the Free State in 1921, many public health initiatives were introduced. In the 1930s, modern water and sewage schemes were established to improve the health of the population (Barrington, 1987). County medical officers were appointed to all counties and were given responsibility for rolling out government public health initiatives. For example, the provision of free milk to children and pregnant mothers from deprived backgrounds. The medical officers were also responsible for the medical examinations of school-going children (Ibid). Nonetheless, it has been argued that public health in Ireland has never received the same attention it has in Britain or in Europe, where public health is considered important enough to influence many public policy initiatives (Burke, 2009). The smoking ban that was introduced in 2002 by the then Health Minister Micheal Martin was considered an anomaly. It is regarded as a good example of how a single policy change can protect the health of individuals and lead to population behavioural change (Ibid). Following its successful implementation, the smoking rate among the Irish population has continued to decrease (Fong Hyland, Borland, Hammond, et al., 2006: Buggy, 2017). Other successful areas in Ireland where policies have been implemented to protect the health of the population are in the use of seatbelt laws and drunk - driving legislation (Hope, 2014; Downey and Donnelly, 2018).

Public health in Ireland is concerned with three specific domains: protecting the health of the whole population, health service development and health improvement (www.rcpi.ie/faculties/faculty-of-public-health-medicine/). This thesis is concerned with two of the three domains – protecting the health of the population and health improvement. These fields of public health are directly related to the role of the health promotion practitioner, and require a multi-sectoral response from government in developing evidence-based health policies.

3.3.2 Public policy

The term 'policy' is widely used and yet Exworthy (2008) argues it can be difficult to define. More commonly understood, policy is viewed as decisions made by those responsible for an area such as health, education and the environment (Ibid). It can

include decisions made by people in central or local government and in private or public organisations to achieve a specific goal (Buse, Mays and Walt, 2012; Hanney, et al., 2003). Public policy refers to decisions made or actions taken by governments or government agencies to achieve societal goals (Cochran and Malone, 2010). Milio (2001) defines policy as;

> A guide to action to change what would otherwise occur, a decision about amounts and allocations of resources: the overall amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers. Policy sets priorities and guides resource allocation (Milio, 2001; p. 622).

Milio's (2001) definition represents the final policy statement that governments put down in a policy document (Exworthy, 2008). A criticism of this definition is that it ignores Dye's (2001) definition of public policy, in that policy can also be thought of in terms of non-decision-making (Birkland, 2014). Dye (2001) suggests that a government decision not to address certain societal issues similarly represents policy. Other definitions do acknowledge that policy is very much what governments decide to do or *not* to do. Easton (1971) defines policy as the 'Authoritative allocation of values'. Greenhalgh and Russell (2006) suggest this explains how governments define and pursue the right course of action 'in a particular context, at a particular time, for a particular group of people and with a particular allocation of resources' (p. 35). It is worth considering the role of research evidence in this process. Weible et al., (2012) define the policy process as 'the study of change and development of policy and the related actors, events, and contexts' (p. 3). Schlager (2007) suggests that the word 'process' implies a progressive and continuous 'unfolding of actions, events, and decisions that may culminate in an authoritative decision, which, at least temporarily binds all within the jurisdiction of the governing body' (p. 293).

In analysing the terms 'policy' and 'policymaking', there are two distinct areas of study in the scholarly literature. The first is analysing *for* policy, and thus assisting actors in the policymaking process. In its traditional sense this comprises identifying alternative policy choices and their potential impacts. Thenceforth deciding what the most desirable alternative is in terms of monetary and societal efficiency and

preferences (Carlson, 2011; Boardman, Greenberg, Vining and Weimer, 2006). The second is the analysis *of* policy to understand how the different factors influence and impact on policy decisions (Hill, 2013; Hogwood and Gunn, 1984). This study originates from the second area of scholarship in that it seeks to understand the policy process and how research evidence is used in this context.

3.4 Theories of policymaking

Numerous models and theories have been developed to understand the policy process and how public policy decisions are made (Sabatier, 2007; Cairney, 2013; Hill, 2013). Earlier theoretical models of policymaking were underpinned by the philosophical concepts of 'comprehensive rationality' and 'policy cycles' (Simon, 1957; Cairney, 2012; p. 5-6). Comprehensive rationality assumes that there is a linear relationship whereby problems are identified and policymakers make choices based on a range of alternative solutions (Edelman, 1988, Simon, 1957). This occurs in several stages, or sequences. A problem is acknowledged and competes for the attention of policymakers on the policy agenda. Alternative solutions to the problem are appraised, decided upon, implemented and evaluated. This theory gave rise to the popular 'stages heuristic' model (Lasswell, 1956; Brewer and deLeon, 1983).

However, individuals are not always able to make comprehensive rational choices in decision-making due to varied circumstances (Simon, 1957). The term 'bounded rationality' is used to describe situations where individuals or organisations are subject to cognitive limitations in making choices (Ibid). Viewing policymaking from a bounded rationality perspective, policymakers are understood to make choices based on limited and incomplete information. This process is often referred to as 'muddling through' a convoluted series of stages for policymakers to achieve their goal (Lindblom, 1959; p. 79-88). This 'incrementalist model', Lindblom (1979) suggests more accurately describes the policy process, whereby 'decision accretion' can exist and several small steps are taken to develop policy (p. 517). It allows for more debate and discourse among interested groups on policy options. Policymakers can learn from their experience and adapt policy in accordance with unintended outcomes (Lindbolm, 1959; Hanney et al., 2003). A criticism of this model is that it can lead to 'path

dependency' (Greener, 2002; Cairney, 2012; p. 107). Policymakers may feel constrained by previous policy decisions and find it difficult to diverge from a certain policy direction.

The early models of the policy process continue to inform and influence many of the current theories on policy analysis (Cairney, 2012). The models and theories are not uniquely distinct, but rather have many overlapping characteristics. Where this could be viewed as a weakness in policy analysis, Weible, et al., (2012) view it as a strength. It allows scholars of the policy process to view policymaking from multiple perspectives. Moreover, it is argued that no single framework could capture this multifaceted and complex process (Weible et al., 2012). A discussion on policymaking would not be complete without first understanding the political nature of this endeavour and the exercise of power within the process (Buse, et al., 2012). A brief discussion of the key theories of power will be conducted before presenting an overview of the most popular models and theories of policymaking.

3.4.1 Power and public policy

Power definitions are highly contested (Dowding, 2012). Power is viewed as an attribute of individuals, organisations, special interest groups or political parties (Simon, 1953, Dahl 1957; Weber 1978, Dowding, 1991, Morriss, 2002). It can also be enshrined in systems or structures; for example, in holding official office which can be legal or political (Foucault, 1980; Wolf, 1990; Clegg, 1989). Dahl (1957) understands power in the political process as existing where an individual or group can exercise power over decision-makers, to shape the policy outcome in accordance with his/her/its own preferences. Critics of this understanding of power argue that the power of certain groups or individuals in society to keep specific issues off the political agenda is not acknowledged. Therefore, ensuring non-decision-making in issues, that would conflict with their own interests (Bachrach and Baratz, 1962; Lukes, 1974). One example of this is the power of the alcohol industry in positioning itself in many countries as a partner of senior policymakers in the development of policies to address the misuse of alcohol in society (Hope, 2006; Hastings, 2012).

Lukes (1974) adds another dimension to power outside of its role in decision-making or non-decision-making, that of 'thought control' (Buse, Mays and Walt p. 23.). Power here is exercised in the art of persuasion and using convincing arguments to shape people's ideas, preferences and wants, even if they are in direct competition with one's own interests (Lukes, 1974). Nye (2004) uses the term 'soft power' to refer to how some political actors can exercise influence to shape other people's values and beliefs. For example, soft power is exercised through the control of information and the mass media (Luke, 1974). Many policy studies have explored how power is exerted in the policy process and the power relations between actors (Lewis, 2006; Sotarauta, 2009; Lee and Goodman, 2002). Individuals who have power in the process to influence outcomes will vary according to content and context. In health policy, those who wield power are considered from several theoretical perspectives (Buse, Mays and Walt, 2012).

Pluralist understanding of power believes that power in a democratic system is distributed throughout society and exercised through the electoral system. No one group has absolute power, all groups compete, cooperating and bargaining for their own vested interests, with the state the final arbitrator in developing policy that is in the best interests of society (Dahl, 1961). This theory has been criticised for portraying the state as an impartial entity. It does not acknowledge the role of informal or unofficial influences on policy decision-making in the process (Bachrach and Baratz, 1962; Buse, May and Walt, 2012).

In elitist theory, power is viewed as residing in the hands of the privileged minority. For example, individuals and organisations rich in resources like material wealth, technical expertise and professional positions, which are frequently a reflection of class and politics (Lewis, 2006; Statham, 2006; Buse, Mays and Walt, 2012). Their values and interests are reflected in the policies that are developed. Critics of this theory argue it is not relevant in societies where equal opportunities exist. However, studies attest to the growing influence of elites on policymaking (Chong and Druckman, 2007).

Like the pluralist's theory, public choice theorists view society as being comprised of groups seeking to maximise their own self-interested goals. Groups include all

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political actors such as taxpayers, the voting public, special interest groups, parties, bureaucracies and government (Buse et al., 2012; Dye, 2002). The state is not viewed as a neutral entity, but rather strives to exercise power over policymaking to achieve the best interests of civil servants and elected public representatives (Buse et al., 2012). Dye (2002) suggests that public choice theory helps to explain why there is often ambiguity concerning policy alternatives between political parties in election campaigns. Political parties are interested in winning elections, not in advancing clear policy ideas. They are interested in formulating policies that will attract the most votes to help them win elections (Dye, 2002).

Though an appreciation of power and how it is used is fundamental to the understanding of the policy process, it is not the focus of this thesis. This study explores the utilisation of evidence in policymaking. Jewell and Bero (2008) have discovered that actors in the process too can use 'research evidence' as a powerful tool. By understanding the use of evidence and the factors that facilitate its uptake in the policy process, recommendations can be made for public health and health promotion researchers and practitioners.

Ostrom (2007) makes a clear distinction between the conceptions of theories, models and frameworks that are devised to explain the policy process. Frameworks for example, help to organise inquiry by identifying the relationship between variables and categorising them into specific groups. They do not provide explanations of themselves, and are unable to predict the outcomes or the behaviour of a phenomenon. Theories make assumptions about the different elements of a framework by illuminating processes, identifying a phenomenon and predicting outcomes. Models are developed to test theories; they do this by making precise predictions about a set of variables and the given characteristics of a phenomenon. They work together in an interactive way, as theories can be modified and revised through repeated testing. Knowledge is generated and accumulated from the broader conception of the framework, through the generation of theories to the specifics of the model (Schlager, 2007). Many scholars of political science do not always distinguish between models and theories, and the words are regularly used interchangeably (Schlager, 2007).

Models and theories assist in the understanding of real life phenomena. They help to order and simplify reality, and to identify the important aspects of the public policymaking process (Dye, 2002). This complex area of study has numerous influences, making it difficult for any one theory to describe and explain the process comprehensively (Sabatier, 2007; Cairney, 2012). The specific theories reviewed here seek to explain different aspects of this complex endeavour and offer a range of perspectives on the intricate world of policymaking. It is critically important for researchers who wish to influence the policy process to develop an understanding of these theories. Equipped with this knowledge, researchers, public health officials and health promotion practitioners can then identify and exploit opportunities for increasing the influence of research evidence in policymaking at specific junctures in the process.

3.4.2 Stages heuristic

The 'stages heuristic' model (Lasswell, 1956; Brewer and deLeon, 1983) up until the 1980s was the most influential of the frameworks devised for understanding the policy process. This model divides the policy process into several distinct stages – agenda setting, policy formulation and legitimation, implementation and evaluation. Agenda setting refers to the stage of the policy process when several societal issues compete for the attention of the policymakers. The formulation stage involves the design and enacting of policies by legislatures and other decision-making bodies. Governments implement the policies in the implementation stage, and in the evaluation stage, the impact of the policy programme is assessed (Walt et al., 2008).

Academic writers critical of this model contend that policymaking does not always occur in a cyclical manner. In addition, policymakers are occasionally limited in their access to information that would allow them to comprehensively consider all alternative solutions (Sabatier, 2007; Cairney, 2012). Nonetheless, it is valued for facilitating exploratory research in the different phases, most notably agenda setting (Cobb, Ross and Ross, 1976; Kingdon, 1984) and the implementation of policy (Pressman and Wildavsky, 1973; Hjern and Hull, 1982). It has also been acknowledged for providing a simple framework that captures the public policy

process and facilitates scholars in terms of locating their work within a wider framework (Walt et al., 2008).

3.4.3 Kingdons's Multiple Streams Model

Kingdon's (1984) Multiple Streams Model describes how the policy process functions under conditions of 'ambiguity'. It is based on the hypothesis that vagueness and opacity surround many policy situations and that this allows those involved in the process to pursue self-interest and 'to infuse meaning into a partially comprehensible world' (Zahariadis, 2014, p. 25). Kingdon's model seeks to explain the role of certain actors in this process, particularly that of policy entrepreneurs and their influence on setting the political agenda. At any one time, there are many issues competing for the attention of government and policymakers. Only a limited number of these issues will make it onto the policy agenda. Agenda setting is concerned with prioritising specific issues over others to obtain a policy response (Cairney, 2012; Buse, Mays and Walt, 2012).

Kingdon (1984) identifies three factors, or 'streams', that need to occur simultaneously for a policy to be moved on to the policy agenda. The *problem* stream describes policy issues that need to be addressed by government policy; for example, escalating health care costs, drug misuse or homelessness. The *policy* stream describes a mixture of ideas and solutions, and it is referred to by Kingdon (1984) as a 'primeval soup' generated by specialist networks in policy communities (e.g., health or educational policy) waiting to be attached to a problem. The *politics* stream is concerned with 'the national mood', 'changes in the elected administration' and 'pressure groups' in society (Zahariadis, 2014, p.33-34). A change of government often places certain issues at the top of the policy agenda; in the US for example, healthcare went to the top of the policy agenda when President Barack Obama was elected (Zahariadis, 2014).

Changes in the national mood can make some things possible that were previously impossible. The introduction of the smoking ban in workplaces in Ireland in 2004 is a good example of this phenomenon. It was found that public support was achieved through a sustained and deliberate public health campaign. It was one of the factors

that contributed to the successful implementation of the policy (Currie and Clancy, 2011). It is assumed that each stream acts independently, and at a specific stage in the policy cycle, the three streams are expected to combine and what is termed a 'policy window' will open (Zahariadis, 2014; p. 34). At this juncture, policy entrepreneurs have an opportunity to influence the policy process and outcomes. Policy entrepreneurs are defined as individuals or corporate actors with commercial or political influence whose aim is to link the three streams to facilitate innovative policy change (Minstrom, 1997). When all three streams merge, the likelihood of a specific policy being adopted by policymakers increases. Zahariadis (2007) suggests that successful entrepreneurs are determined and skilful at connecting their policy solutions to policy problems and finding politicians who are receptive to their ideas. Individuals with access to power have the most influence; for example, in the UK, during the reign of the Thatcher administration, the Smith Institute had significant access to and influence over government policy, as their philosophies were aligned (Zahariadis, 2007). This model has been applied successfully in many international studies (Guldbrandsson and Fossum, 2009; Exworthy, Blane and Marmot, 2003).

3.4.4 Policy networks and the Advocacy Coalition Framework

Policymaking rarely occurs in isolation. It usually occurs because groups working together want to advance their own specific interests or ideas. These groups or networks are comprised of stakeholders from inside and outside the policy process. Frequently they are in possession of expert skills or knowledge that allows them to contribute to policymaking in a specific policy area (Exworthy, 2008). Policy communities can be defined as 'policy networks' or 'issue networks'. The difference between the two groups is apparent in how close they are to the policy process. Policy networks are made up of civil servants, politicians and technical experts who have a stable working relationship over a long period of time. In the US 'iron triangles' is the term used to describe small, close-knit, long-term relationships between stakeholders in the policy process, typically including politicians, senior civil servants and powerful interest groups (Cairney, 2012; p. 178; Overman and Don, 1986). Trust and co-operation among individuals are not necessarily a requirement to be a member of the network. Rather a mutual understanding of the policy area and the importance of

power and influence within networks is what unites members (Considine et al., 2009; Lewis, 2006).

In contrast, 'issue networks' are loosely formed communities that come together to discuss and negotiate on a policy subject. There may be variable levels of commitment among members, and barriers to entry are low (Heclo, 1978). The policy issue under consideration is what holds the network together, rather than personal interests (Nutley et al., 2007). Examples of policy areas most associated with issue networks are tobacco control, nuclear power and climate change (Baumgartner and Jones, 1993). Conversely, interpersonal ties are the binds that hold social networks together. It is this theory that is used as a basis for network analysis. Network analysis seeks to understand the relationships and communication patterns between influential actors within policy networks (Lewis, 2006; Considine et al., 2009). The theory has traditionally been associated with organisational culture to understand the diffusion of ideas and knowledge in organisations (Cross and Parker, 2004). Social capital refers to 'the resources embedded in social networks accessed and used by actors for actions' (Lin, 2001; p. 25). This understanding of social networks helps us to understand how key actors in networks can shape and apply influence owing to their recognised roles and reputations within organisations. Their own personal attributes for example, levels of expertise and skill, are what connect them with others who have important resources (Lewis, 2006). Different types of networks are discussed in this thesis, as they may increase our understanding of how linkages between researchers and those who seek to influence policy may contribute to the use of evidence in the policy process.

The Advocacy Coalition Framework grew out of the studies on policy networks and the limitations of the stages heuristic model in explaining the policy process (Sabatier and Jenkins-Smith, 1999). The key assumption underpinning this framework is that many different types of actors operate in policy networks at different levels of government. These include government officials, civil servants, the media, interest groups and experts with technical and scientific knowledge. They share common beliefs and values on societal issues and possible solutions to address policy problems. This model is based on the principle that the individual is rational and relies on experience and beliefs as a guide to decision-making (Simon, 1985). Beliefs are identified as the causal factor affecting how actors behave in the political process.

The Advocacy Coalition Framework (ACF) comprises a three-tiered model of a belief system. *Deep core beliefs* are at the top of the model, and they are considered the most stable; they are primarily normative (for example, liberal and conservative beliefs) (Weible, Sabatier and McQueen, 2009; p. 122). *Policy core beliefs* occupy the middle ground in the hierarchical system of beliefs, and they represent how actors think about the role of governments and elected officials, welfare and the public. *Policy core beliefs* help actors with establishing coalitions and organising activities among members. They are more amenable to change compared to *deep core beliefs* as they are fashioned on the findings of new evidence and experiences. Secondary beliefs are narrower in scope and represent views on a specific policy programme, on rules and the application of budgets. Secondary beliefs are the most responsive to change over time (Weible, Sabatier and McQueen, 2009, p. 122).

The ACF is promoted as a way of understanding the complex world of policymaking. Devolving decision-making responsibility to officials within government who are less senior but who have more technical expertise and knowledge is one way in which governments deal with the immense array of policy decisions that they must deal with every day (Sabatier and Jenkins Smith, 1999). Sabatier and Weible (2014) suggest that policy coalitions have strong beliefs and are motivated to transfer their beliefs into actual policy before rival coalitions can do the same. Beliefs are the 'glue' that binds members together within advocacy coalitions. How successful advocacy coalitions are in influencing and guiding policy in their preferred direction is contingent on the resources that are available to them e.g., wealth, expert knowledge, number of allies and legal influence (Sabatier, 1993). The ACF success is also conditional on the garnering of support from the public by disseminating information on the costs and benefits of alternative policies (Sabatier and Weible, 2014). Critics of the ACF argue that it does not explain the conditions under which major policy change occurs (Olsson, 2009; Cairney, 1997; Peters, 1998). Other criticisms have focused on the makeup of coalitions and how they develop. This framework does not explain how internal conflicts are resolved, the relative influence of individuals within the coalitions or their relationship with external policy actors (Olsson, 2009; Cairney, 1997). Despite the framework's shortcomings, it has been used across several diverse geographical areas and can be used with other policy process theories and frameworks (Weible et al., 2014).

3.4.5 Punctuated Equilibrium

Punctuated Equilibrium Theory (PET) seeks to explain how in some policy areas there is little change in policy direction over several years. A stasis or stability in specific policy fields can be observed over long periods, while in others rapid shifts in direction are witnessed (Baumgartner and Jones, 1993). This theory builds on the work in the literature on policy networks and bounded rationality.

Individuals and organisations make decisions under time and resource constraints, and with imperfect information (Cairney, 2012; Jones, 1994, 2003; Simon, 1986). Therefore, policymakers are unable to focus on all areas of policymaking simultaneously. Confronted with many policy concerns every day, governments manage their portfolios by devolving responsibility to several policy subsystems. A single policy interest can dominate the subsystem, or there may be competition for the pressing issues that need political solutions (May, Sapotichne, Workman, 2006; Weible et al., 2012; Worsham, 1998). These subsystems or communities are usually made up of a small number of actors, government officials, interested members, consultants and technical experts who have significant experience in a policy area. This monopoly of policy experience, for example, in public health or education by a small number of actors can result in long periods of equilibrium in policy development (Cairney, 2012; Baumgartner and Jones, 1993). However, policy communities can be subject to shocks over time from the wider political process. External influences like economic and environmental factors, along with new findings in research, can punctuate the equilibrium by attracting attention from the media and the wider public. This increased attention that a policy area receives can result in rapid policy change over a short period of time.

The reframing of old policy problems in new ways can similarly result in challenging or punctuating policy monopolies. The issues that receive attention on the political agenda frequently depend on the ability of the champions of those policy problems to present their issues as the most deserving of attention (Dearing and Rodgers, 1996; Cairney, 2012). Policy monopolies limit policy debate and the scope for policy change. Support for policy change can be garnered by presenting new solutions to old policy problems to new and more sympathetic audiences. 'Venue shopping' is the term used in the literature to describe this process (True, Jones and Baumgartner, 2007; Cairney,

2012). In US politics support for anti-abortion and anti-smoking legislation have been won by using a 'venue-by venue' approach, with only minimal intervention from larger political organisations (Jones and Baumgartner, 2012, p. 5). Essentially PET describes the dynamic process of policymaking and how changes in the focus of attention can affect major policy changes.

3.4.6 Social Construction and Policy Design

The social construction of a target population framework was developed in the 1980s. It refers to the 'cultural characterisations or popular images of the persons or groups whose behaviour and wellbeing are affected by public policy' (Schneider and Ingram 1993; p. 334). For Schneider and Ingram this helps to answer Lasswell's question 'Who gets what, when and how?' (Laswell, 1936). Social construction theory is based upon the premise that there is no single view of reality, rather we interpret the world around us so we can gain insights into it and give it meaning (Mannheim, 1936). In the same way advocates of the social construction theory (SCT) view social problems as not being neutral or value-free; they are understood and read as issues that have been defined as problematic and require some type of resolution (Bacchi, 1999). Schneider and Ingram (1993) observe that political leaders like to do 'good' things for 'good' people and like to be 'tough' on bad people. In this way, they earn a lot of political capital and increase their probability of being re-elected (p. 341). 'Target groups' or 'target populations' are the terms used to identify groups in society selected by government to receive benefits and burdens through the mechanism of policy programmes or initiatives (Schneider and Ingram, 1993; p. 335). The policy design in addition to comprising benefits and burdens that affect the target population, can also include specified goals. These can include guidelines on how problems are to be resolved, mechanisms for changing behaviour rules for inclusion or exclusion to welfares benefits or sanctions. Some groups in society can struggle for years to be accepted by governments by a specific construct. In Ireland for example, the Travelling[11] Community was slow to be to be accepted as an ethnic minority. While other groups, and how they are socially perceived, has become so pervasive by the

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[11] The Travelling Community, also known as Irish Travellers, is a small, nomadic group indigenous to the Irish population. It has its own culture, language, traditions and customs. It was awarded ethnic minority status by the Irish state in March 2017.

courts, government officials and wider society that they are seldom questioned (Ingram, Schneider and Deleon, 2007).

How policies are designed and implemented can influence the experience of target groups in a positive or negative way and send embedded messages about how important their problems are to government (Ingram, Schneider and Deleon, 2007). This can influence the future participation and political affiliations of certain communities in the democratic systems. For the most part it is argued policy is designed to replicate the dominant power and cultural arrangements in society (Ibid). However, at times policymakers can make decisions that introduce radical change. Critics of this framework argue that the role of institutions in policymaking is not covered in this structure (Lieberman, 1995). Furthermore, how or why target populations move from a negatively constructed social group to a more positive one are not clarified (deLeon, 2005).

3.4.7 Multi-level Governance

The theory of multi-level governance was first conceived in the 1990s to help describe and explain the changes that were occurring in political and institutional arrangements in the European Union (Marks, 1992; 1993; Stephenson, 2013). It was considered particularly relevant in describing the European Commission's policy decisions-making processes in The EU Structural Funds and Cohesion policy (Hooghe, 1996; Adshead, 2014). Policymaking powers in this theory are viewed as being transferred from the Member States upwards to institutions in Brussels and downwards to institutions and policy actors working at the regional level (Tortola, 2017; Shore, 2011). Governments in western democracies were traditionally characterised by a strong central authority with hierarchical administrations, tasked with decision-making functions and policy implementation (Hooge and Marks, 2003). Multi-level governance refers to the diffusion of power and authority to construct and implement policy decisions away from central government. It involves a diverse range of actors, (e.g., individuals and institutions); both private and public that engage in policymaking activities at the local, national and international level (Stephenson, 2013; Beisheim, Campe and Schaferhoff, 2010). Two types of multi-level governance are identified (Hooge and Marks, 2003). Type 1 refers to a federal system where power is shared

between one central government and a limited number of non-intersecting subnational governments. Type 2 refers to authority that is task specific and operates in multiple jurisdictions and at numerous territorial levels. For example, public services such as health or transport that is provided to the citizen through a vast array of agencies and organisations, both private and public that overlap and interconnect.

Hajer (2003) suggests Multi-Level Governance (MLG) poses problems for the policy analysts in the traditional settings of policymaking in Western democracies. For example, the separation of politics and bureaucracy, public representation and Ministerial responsibility as described in chapter two are changing. It is argued an 'institutional void' has emerged with new institutional rules and customs being negotiated, at the same time as policy solutions to societal problems are being deliberated (Ibid). Multi-level governance is concerned with the diffusion of structures of negotiations, exchange, policymaking and implementation to NGOs, agencies and other societal actors outside of formal government structures (Hooge and Marks, 2001; Tortola, 2017). An understanding of multi-level governance (MLG) is important for researchers seeking to influence policy decisions. As the number of intersecting levels of policymaking increases at the local, national and supranational level in specific policy fields, so too does the challenges and opportunities for research knowledge to influence policy outcomes.

3.5 A summary of theories of policy and the policy process

The first three theories (pluralist, elitist and public choice theories) described power and the different views on its relationship with policymaking. Bounded rationality and incrementalism are the starting points for many theories of the policymaking process. Some theories seek to explain why there is relative stability in a policy area over several years by identifying the policy networks, interested groups and coalitions that seek to monopolise specific policy fields. Social construction theory identifies how the combination of power and ideas can justify policy decisions concerning specific groups in society. Through the policymaking process these ideas are then made legitimate, by the granting of either benefits or sanctions to these groups.

Punctuated equilibrium (Baumgartner and Jones, 1993) and the Multiple Streams Model (Kingdon, 1984) explore the dynamics of policymaking and how policy change develops. Punctuated-equilibrium explores why sudden change can occur in a hitherto monopolised policy area. The Multiple Streams Model seeks to explain how political actors can influence policy outcomes by exploiting opportunities for innovation in the policy process. Policy networks and the Advocacy Coalition Framework, including the frameworks and theories discussed above, highlight opportunities for research evidence to influence the policy process, by increasing our understanding of how beliefs and ideas can influence our interpretation of the world. These theories will be discussed further in Chapter Seven in relation to the findings of this study.

3.6 Evidence and Public Policy

This section explores the relationship between research evidence and health policy decision-making, describing the origins of evidence-based policy EBP. The different ways in which research evidence influences the development of policy are explored. Next it defines what evidence-based policymaking is and outlines the opposing views of many scholars on the appropriateness of having public policy evidence-based. Thereafter it reviews the literature on increasing the uptake of research evidence. It identifies the different models and frameworks used in analysing how the research evidence influences policy. The barriers and facilitators affecting research use, along with the many strategies that have been developed to increase the uptake of research by policymakers are discussed.

3.6.1 Meanings of research utilisation

In the 1960s, there was great optimism regarding social science and how it could contribute to government policymaking and thereby improving human welfare and providing a solution to many of society's ills (Wagenaar, 1982; Bulmer, 1987). By the late 1970s, this confidence was undermined by the first wave of empirical studies undertaken to evaluate how research was being used by public bureaucracies in the United States (Caplan et al., 1975; Patton et al., 1977; Weiss and Bucuvalas, 1980). Heretofore, it was believed that research had an 'instrumental' or a direct influence on the policy action taken (Weiss, 1982). The findings from the studies indicated that

there was no direct effect of research on policy decision-making. These findings were initially disappointing. Nonetheless, they prompted researchers to find out why research was not directly influencing policy outcomes.

In Carol Weiss's (1979) seminal work 'The many meanings of research utilization', the different ways in which research evidence influences the policy process was identified. Later researchers expanded on Weiss's conceptual frameworks to increase our understanding of how research evidence is used in the process of policymaking (Hanney et al., 2003; Buxton and Haney, 1996; Walt, 1994) (See Table 3.1).

The problem-solving and interactive models in the table represent an 'instrumental' or 'linear' relationship between the research evidence and policy decision-making. They have been found to be the least influential in the policymaking process (Weiss, 1982; Nutley et al., 2007; Sanderson, 2002). Despite this the problem-solving model is one of the more enduring models within policy utilisation research literature. Actors in this processual policymaking model are viewed as clients and customers, thus placing research at the centre of the policymaking setting (Elliot and Popay, 2000). In the UK during the 1990s, it was the model that underpinned the National Health Service's research and development strategy (Harris et al., 1999; Elliot and Popay, 2000). Critics of this model argue that that many policy problems are complex and not easily defined. Therefore, solutions from research evidence are not readily available or directly translatable into policy solutions (Bryant, 1995; Weiss, 1979; Elliot and Popay, 2000).

The next four models on the table (interactive, enlightenment, political and tactical) refer to the diffuse nature of research evidence. Research that did not have an immediate and direct effect on policy decisions would nevertheless percolate into the policy arena, through a range of informal routes and have a longer-term influence (Weiss, 1979; Sanderson, 2002). Conceptual use refers to the role of enlightenment in research evidence. The research knowledge can influence policymakers' perspectives and ideas on policy issues, by enriching their understanding of complex social problems (Aaron, 1978; Janowitz, 1970; Weiss and Bucuvalas, 1980). Symbolic use refers to the use of research evidence to support policy positions already decided. The

research evidence can also be used as ammunition by other actors in the policy process, to further ideological motives or self-interest (Hanney et al., 2003).

Table 3.1: Models of research utilisation

Models of research utilisation	Types of use in the policymaking process
Classic/knowledge-driven	There is a direct relationship between the findings of new research and the development of policy. In scientific research, new vaccines are developed to combat diseases, for example, the cervical cancer vaccine (Schiffman et al., 2007), and governments develop new health policies as a result.
Problem-solving/engineering/ policy-driven	This model also implies that there is a linear relationship between policy outcomes and research. Policymakers identify a problem, and if there is a knowledge gap, they either commission new research or examine existing research to find policy solutions to the problem.
Interactive/social interaction	In this model, policymakers seek information from a variety of different sources, planners, interest groups, practitioners and clients, including researchers, to find solutions to policy problems. Research evidence is only one of the types of evidence used in this process.
Enlightenment/percolation/ conceptual	The ideas, concepts, theories and perspectives generated by research evidence inform how policymakers think about policy issues and inform their policy solutions.
Political/symbolic	Actors in the policy process use research to justify, and often support, predetermined positions in addressing policy problems.
Tactical	Research is used here as a delaying tactic. If policymakers are unsure on how to progress a policy solution or if they want to delay policymaking in a specific area, they can argue that they need more research as there is not enough available evidence to support a decision.

The findings of empirical studies have demonstrated the enlightenment function of research evidence as the most prevalent in the policymaking process (Weiss 1977). Since the 1990s, many advocates have argued for a more instrumental evidence-based approach to policymaking. This is to establish transparency in how decisions are made

and to emulate the practice in evidence-based medicine (Brownson, Gurney, Land, 1999; Cookson, 2005; Milio, 2005; Bowen and Zwi, 2005). The models and frameworks reviewed here will be further explored in relation to the findings of this study in Chapter Seven.

3.6.2 Evidence-based policymaking (EBP)

The term 'evidence-based policymaking' 'refers to the view that policy ought to be implemented (or sustained) based on strong supporting evidence that the policy will (or does) work' (Oliver and McDaid, 2002, p. 183). Cookson (2005) believed that 'EBP should be thought of as a set of rules and institutional arrangements designed to encourage transparent and balanced use of evidence in public policymaking' (p. 119). He compares this to Sackett et al.'s (1996) definition of evidence-based medicine (EBM) as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (p. 71). EBP has the potential to make policy decision-making more transparent, thus improving the democratic process (Cookson, 2005). Advocates of this approach to policymaking argue that politicians and policy decision-makers unimpeded by the research evidence, might base their decisions on their own personal ideologies, political incentives or on the motivations of powerful interest groups (Milio, 2005; Bulmer, 1987). The move towards evidence-based policy was furthered strengthened by the Labour government in the UK in the late 1990s, as it called for the greater role of social science in policymaking (Parsons, 2002). Public policy would be underpinned by evidence in demonstrating 'what works' and in identifying what were the most effective policy initiatives (Blunkett, 2000). There has been a strong tradition in the Republic of Ireland of developing policy based on evidence for many years (Kennedy et al., 2010). This will be discussed further in Section 3.7.

The initial wave of enthusiasm for EBP was met by scepticism among those for whom policymaking was not a rational, mechanical process (Black, 2001; Greenhalgh and Russell 2009; Davey Smith et al., 2001). Frequently the goals of policymakers are social and financial, rather than relating to clinical effectiveness. Black (2001) gives the example of the safe sex campaign by the UK Government in the 1980s which targeting the whole population. The campaign was not based on research.

Furthermore, it was undertaken to prevent a potential backlash against gay and black people. Other arguments put forward against evidence-based policymaking are that evidence may be dismissed as irrelevant if it comes from a different speciality or different sector of society (Black, 2001). Lack of consensus regarding the research evidence can also be an issue. Equally the research evidence must compete with other knowledge that the policymakers are exposed to, such as personal experience and local knowledge (Ibid). It is argued that 'evidence-based' thinking can lead to debased policymaking, and the success rate of the use of research evidence in the UK in influencing policy to reduce inequalities in health has been questioned (Davey Smith et al., 2001; Smith, 2007).

The question of society's values, and the ethical and moral questions inherent in the policymaking process, cannot be answered by research evidence alone (Greenhalgh and Russell, 2009). The champions of EBP appear to suggest that 'if we do enough research, we will abolish situations in which the available evidence is irrelevant, ambiguous, uncertain, or conflicting; that evidence from research is value-free and context-neutral: and that such evidence is of greater value than evidence from personal experience or opinion' (Greenhalgh and Russel, 2009; p. 308). In situations where the research evidence is not applicable to the policy problem in question, the authors contend that the concept of evidence-based policymaking appears to accept that this is due to methodological flaws in the design or execution of the research study, rather than the evidence. Policymaking is viewed as a process requiring several technical steps; a problem is identified; a research study is conducted; and the findings/evidence are/is implemented at the policy level. It is presumed that there is a direct and linear course of action from problem identification to implementing research findings from the study (Greenhalgh and Russell, 2009).

Similarly, political theorists are unconvinced of the concept of evidence-based policymaking (Hammersley 2001; Parson, 2002; Sanderson, 2003). Parson (2002) compares the beliefs of the advocates of evidence-based policymaking to the public policy writings of Harold Lasswell (1951) and Donald Schon (1983). For Lasswell, in democratic states, the challenge for governments was to ensure that policymaking could be continually informed by the interaction between the producers and users of knowledge (Torgerson, 1985). Policy analysis was not about producing evidence to

direct policy, but rather to assist in the clarification of values and contexts (Parson, 2002). The metaphor of a swamp was used to describe the process of policymaking. In the swamp problems are present that are not easily solved by the research evidence, but which are of the most concern to societies (Schon, 1983). Meanwhile, on firm high ground, there are problems that are conducive to being solved by the research evidence or technical solutions, but are often relatively unimportant to wider society. Schon states that when policymaking practitioners are asked how they go about developing policy, 'they speak of experience, trial and error, intuition, and muddling through' (Schon, 1983; p. 42-3).

Advocates of evidence-based policymaking believe that there is undeniably a firm, high ground that they can occupy to lay down their 'hard facts' to support modern-day policymaking (Parson, 2002). Policymaking in this process it is argued is professionalised and reduced to a technical process where evidence is critical. Parson writes, 'values, like naughty children, must be seen but never heard: Evidence-based policymaking is about what works rather than what you believe' (Parson, 2002; p. 54).

This approach to policymaking has resulted in the development of international enterprises whose goals are to improve and understand the uptake of research evidence for health policy. The World Health Organisation (WHO) Evidence Informed Policy Network (EVIPNet) is working to improve public health and reduce inequities, particularly in low- and middle-income countries. It provides access to research that is of high quality and relevant to health policy development in these countries (WHO, 2008). The SUPPORT[12] Programme is an international collaborative project funded by the European Commission to provide tools to support policymakers and their supporters in using research evidence in developing health policy (Lavis et al., 2009). The research evidence is fundamental for many international organisations that influence health policies at the country level, as assists in directing and prioritising goals, and in using its resources effectively. The council on health research for development (COHRED), a non-governmental organisation (NGO) aims to improve

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[12] SUPPORT refers to 'SUPporting Policy Relevant Reviews and Trials', and the tools are designed to support evidence-informed policymaking by identifying the need for research evidence, assisting in finding and accessing the evidence and helping in translating the research evidence into policy decisions (Lavis et al., 2009).

health systems in developing countries by conducting research with different agencies at country level. It provides tools and technical expertise to help strengthen the countries own institutions for health research (COHRED, 2012). The Bill and Melinda Gates Foundation, established in 2000, is now a major actor in improving the health status of populations in developing countries. In 2011, its expenditure for global health was greater than the WHO's annual budget (Buse et al., 2012). It has supported evidence-based policymaking through grants provided to universities, think tanks and policy research institutes. It supported the establishment of a Global Health Policy Research Network whose working groups produce influential analytical reports (Buse et al., 2012).

3.6.3 Increasing the impact of research evidence

The previous section reviewed the relationship between research evidence and health policy. It discussed how it has become increasingly important for governments as well as organisations like the WHO, NGO and large civil societies to have health policies and programmes more evidence-based. More recently too academic researchers are being asked to provide evidence of the impact of their work, for example in tendering research proposals to funders of research, to completing institutional research assessment exercises. The term 'impact' here refers to the wider influence of research beyond the academic outputs of the intellectual contributions to one's field of knowledge.

One of the research questions explored in this study is how do researchers think through the wider impacts of their work outside of their fields of academic inquiry. To this end this section reviews several models and frameworks from the scientific literature that have been developed to measure the impact of research outputs. The barriers and facilitators to the use of research evidence are explored together with strategies to increase the use of research in public health policymaking.

3.6.4 Methods, models and frameworks for assessing the use of evidence

Several conceptual frameworks and empirical approaches have been used to assess the impact of health research (Buxton and Hanney, 1996; Kuruvilla et al., 2006; Canadian Academy of Health Sciences, 2009). Earlier models focused on the outputs and

processes of large research projects and how impacts were achieved in its area of concern (Hanney, Grant, Wooding, Buxton, 2004). Owing to the requirement of researchers too being asked to demonstrate value for money of the impacts of their work, the models of research impact are evolving (Greenhalgh, Raferty, Hanney et al., 2016; Rivera, Kyte, Aiyegbusi, et al., 2017). There are numerous definitions of research impact (UK REF, 2014; Canadian Academy of Health Sciences, 2009; LSE, 2011). The definition we use here is from The Research Excellence Framework Submission Guidelines. It defines the broader impacts of research to include;

> `any identifiable benefit to, or positive influence on, the economy,
> society, public policy or services, health, the environment, quality of life, or
> academia' (HEFCE. REF, 2014: p. 26)

Over the last decade, the models and frameworks employed in the literature to measure research impact have been the subject of several reviews (Greenhal, Raftery, Hanney, et al., 2016; Milat, Laws, King, et al., 2015; O Kok and Schuit, 2012; Banzi, Moja, Pistotti et al., 2011; Grant, Brutscher, Kirk, et al., 2010; Boaz, Fitzpatrick, Shaw, 2009; Rivera, Kyte, Aiyegbusi, et al., 2017). Some reviews focused on the conceptual models and approaches used in evaluating the impact of biomedical and health research and the development of reliable indicators of impact (Banzi et al., 2011). Others have reported on the underlying philosophical assumptions of the different approaches; on the nature of research knowledge; what part values plays in research knowledge; and how knowledge is interpreted, used and implemented (Greenhalgh et al., 2016). In the positivist tradition, knowledge is viewed as involving facts, which are independent of the researcher's views and opinions, and can be transferred into new settings and situations. Whilst in the realist position, knowledge is assumed to be the interpretation of people's external reality, and it varies based on individuals and circumstances (Ibid). The more established approaches to measuring impact are reviewed here.

The Logic Model in combination with a case study is used in many of the methods to studying the impact of research on policymaking (Greenhalgh et al., 2016). This model helps in the identification of research inputs and the influence of research on procedures, outputs and impacts. The case study method aims to capture the complex

nature of policymaking, by identifying the interactions between different stakeholders and how knowledge is used and interpreted in the process (Oliver et al., 2014; Lomas and Brown, 2009; Lomas, 2007).

The Payback Framework (Buxton and Haney, 1996) was the most frequently employed approach in the empirical literature. The Payback Framework contains the logic model, which traces the study from conceptualisation to impact. Five separate categories are used to identify the outcome impacts of the research study. Three of the categories are concerned with knowledge production (e.g. academic publications and reports), benefits to the research profession (e.g. training researchers in new skills, career advancement, impacts on policymaking) and informing clinical practice and policy. The remaining two categories measure benefits to health systems (e.g. introducing new knowledge on how the cost of healthcare delivery can be reduced or how equity within the system can be improved) and wider economic benefits (e.g. commercial innovations) (Buxton and Haney, 1996). The methods of enquiry are both quantitative and qualitative. Interviews with researchers are combined with document analysis to categorise evidence of impacts. It has been used by several organisations to assess the impacts of the research they fund; for example, the National Breast Cancer Foundation in Australia (Donovan, Butler, Butt et al, 2014). In the UK, it was used to survey all the projects funded by the NHS Health Technology Assessment (HTA) Programme (Haney, Buxton, Green, et al., 2007), and to assess the impact of Asthma UKs funding programme (Haney, Watt, Jones, et al., 2013). The strength of this framework is its ability to capture the multitude of ways in which research knowledge can have an impact. However, it is quite labour-intensive and expensive to do. It can generate an enormous amount of data that is not always essential for the appraisal (Greenhalgh et al., 2016).
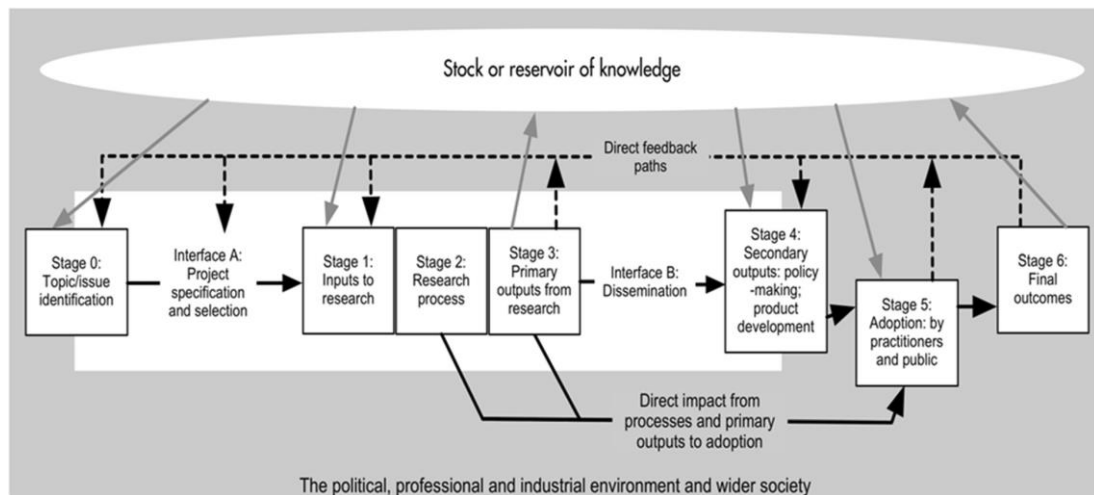
Figure 3.1: The Payback Framework developed by Buxton and Hanney (reproduced under Creative Commons Licence from Hanney, Watt, Jones, Metcalf, 2013)

The second most popular model was the Research Impact Framework, developed by several researchers at the London School of Hygiene and Tropical Medicine (Kuruvilla et al., 2006). The Research Impact Framework can be used as a guide for researchers to identify the impacts of their own work. Four categories of impact are described: i) research-related impacts, ii) policy impacts, iii) service impacts and iv) societal impacts. In this model, the nature of research use is defined under the following headings; instrumental use, conceptual use or symbolic use (Weiss, 1979). It was used in seven out of 110 studies reviewed by Greenhalgh, Raftery, Hanney and Glover (2016), usually in combination with other frameworks and most specifically with the Payback Framework. A strength of this approach is that it can be used by individual researchers without having specialist knowledge in research impact assessment (Kuruvilla et al., 2006).

Other models include the Canadian Academy of Health Sciences Framework (CAHS, 2009), which is an adaptation of the Payback Framework. It incorporates a systems approach in assessing the impact of research. The complex influences at play in health systems and the feedback loops that influence directions in future research are emphasised in this model. The CAHS Frameworks is regarded as a more comprehensive model than the Payback Framework, and can be very expensive to use (Greenhalgh et al., 2016; Milat, Bauman and Redman, 2015). It has been used to evaluate the impact of a large randomised control trial on new treatment for breast cancer (Montague and Valentim, 2010), and to appraise the impact of clinical and

health services research for funders in Catalonia, Spain (Adam, Solans-Domenech, Pons, et al., 2012).

The Societal Impact Assessment Model is used in social science research and public health (Bozeman and Rodgers, 2002; Spaapen and Drooge, 2011). It was developed to form the Social Impact Assessment Methods for Research and Funding Instruments through the Study of Productive Interactions (SIAMPI). The SIAMPI Framework includes an assessment by the research team of communications, influences and interactions that connect it with the other elements of the research system; for example, its links with practitioners, policymakers and industry. It was adapted and used to evaluate how social science research in a Welsh university was used to support local businesses (Molas-Gallart and Tang, 2000). The Research Excellence Framework (2014) in the UK, was developed to appraise the research performance of UK universities. It requires each institution to submit an impact template, with details of an impact strategy for their research outputs. It comprises case studies of research programmes with documentary evidence of impacts achieved within a specific period. This model has proven popular with other countries seeking to recreate the framework (Greenhalgh et al., 2016; HEFCE, 2014; Morgan, 2014).

In recent years, economic or monetisation models have been developed to express in financial terms a cost benefit analysis of the returns on investment in research for society (Greenhalgh et al., 2016; Milat et al., 2015). These models are influenced by the economic evaluation literature and seek to measure outcomes of national research in specific disease areas; for example, cancer or cardiovascular disease (Deloitte Access Economics, 2012; NICE, 2013). There are several challenges to these models; for example, how to determine the appropriate time lag between the research implementation and impact; how to distinguish between the impacts of the funded research study and other influences on individuals' behaviour, such as societal trends or the impact of other innovations (Greenhalgh et al., 2016)

New approaches and models for measuring the research impact are continually being developed and updated (for example, the electronic database Researchfish (MRC, 2015) and Contribution Mapping, which is a variant of the Societal Impact Assessment Model). The models described, for measuring research impact are designed for

different purposes. What model's researchers choose to use will depend on several factors, including the purpose of measuring the impact, the timescale and what resources are available. The more sophisticated models considered can produce comprehensive and detailed quality studies. Nevertheless, they are often labour-intensive and can be expensive to conduct. The current study is interviewing producers of research in the field of drug and alcohol policy on the impact of their research. For this purpose, the Research Impact Framework is deemed the most relevant (Kuruvilla's et al., 2006).

3.6.5 Barriers and facilitators to the use of research evidence in policymaking

To increase research utilisation in policymaking, many scholars have conducted studies to identify what the barriers to research use are and how they can be overcome (Behague et al., 2009; Bedard and Ouimet, 2012; Bunn and Kendall, 2011). Barriers and facilitators to research use have also been the subject of several systematic reviews (Oliver et al., 2014; Innvaer et al., 2002; Orton, Ffion, Taylor-Robinson, et al., 2011). The most frequently reported facilitators of the uptake of research evidence by policymakers in the studies were personal contact between researchers and policymakers, timeliness and the relevance of the research (Oliver et al., 2014; Innvaer et al., 2002). Behague, Tawaiah, Rosato et al.,'s (2009) study of maternal and neonatal healthcare programmes in developing countries, found that close working relationships between researchers and policymakers were important for the adoption of international research for context-specific problems. Similarly, studies in the UK, the US and Canada have found that research evidence was most likely to influence health policy when there was a lengthy period of communication and consultation between policymakers and researchers (Brownson, Chriqui and Stamatakis, 2009; Black, 2001; Dobbins et al., 2007, 2009). In one Australian study, it was found that frequent contact between researchers and policymakers was conducive to research evidence being employed for informing local policies. Most of the policymakers interviewed had attended forums to hear the latest findings from research in their respective policy areas, and 50% of policymakers reported how they had invited researchers to become members of a policy committee (Campbell, 2009).

Other studies have emphasised how the timeliness and relevance of the research evidence was the most important factor influencing its utilisation (Mercer et al., 2010; McBride, 2008; Jewell and Bero, 2008; Innvaer, 2009; Petticrew, 2004). Campbell et al., (2011), in their exploration of the use of knowledge brokers to commission research reviews to inform policy, found that the timeliness and relevance of the review of evidence had the greatest impact on whether the evidence would be used to inform policy decision-making. In the US, demonstrating the relevance of the research by connecting the findings to the costs and benefits of a policy outcome was considered important (Jewell and Bero, 2008). Correspondingly, the findings of a study conducted in the UK on the effectiveness and cost-effectiveness of different strategies was found to be a factor in the uptake of research evidence by policymakers. The policymakers interviewed suggested that researchers demonstrating the costs of alternative approaches would better enable policymakers to make informed policy decisions (Petticrew, Whitehead, MacIntyre, et al., 2004).

The most frequently reported barriers were the absence of relevant research and an inability to access the research evidence (Lavis et al, 2001; Orton et al., 2011; Oxman, Lavis, Fretheim, 2007; Uneke, 2011). In Uneke, Ezeoha, Ndukw, et al.,'s (2011) study of the perceptions of health policymakers on their ability to develop health policies based on evidence, they found that individual policymakers with higher levels of educational qualifications were more likely to consult the research evidence in comparison to other respondents. This contrasts with a Danish study where it was found that individuals with higher levels of education were less likely to use the research findings, particularly at the local level in public health (Larsen, Gulis and Pedersen, 2012). At the organisational level, a lack of opportunities to access the research evidence through library or Internet facilities, or with research institutions, was found to hinder the use of research evidence in policymaking (Uneke, et al., 2011). In Contandriopoulos et al.,'s (2010) review of knowledge exchange processes, found that the cost of accessing the evidence can impact on whether research will inform the policy decision-making process.

Nearly two decades after Innvaer et al.,'s (2002) study of the barriers and facilitators affecting the use of research evidence in policy, the factors have remained remarkably similar. Orton et al., (2011) for example, reported that barriers to the use of research

evidence included how research evidence was perceived by decision-makers, and the relationship between researchers and policymakers. The use of evidence was influenced by the culture of decision-making in the organisation and the time and other practical constraints that impacted on the policymaker (Orton et al., 2011). In Oliver's et al., (2014) most recent, updated review of Innvaer's study, access to timely and high-quality research was an important barrier to the use of research in policymaking, and the most frequently reported facilitator was collaboration between researchers and policymakers.

Criticisms of the studies included in the reviews indicated that they were written for researchers, and not policymakers, with researchers being the population of interest in the study (Ettlet, 2011; Bunn and Kendall, 2011; Haynes, Derrick, Chapman, et al., 2011). It also found where both researchers and policymakers were the focus of the study, interviews with researchers frequently outnumbered those with policymakers (Martin et al., 2011; Smith and Joyce, 2012). Oliver et al., (2014) suggest that conducting and designing similar studies in combination with policymakers may result in innovative strategies to improve the uptake of research in policymaking. Lomas (2000) had already described these types of initiatives in 2000. In his essay, he described how one Canadian organisation had used linkage and exchange mechanisms for establishing collaboration between policymakers and researchers in developing research to inform policy (Lomas, 2000). The significance of relationship building and contact between researchers and policymakers in increasing the uptake of research evidence by policymakers has resulted in several strategies to increase research utilisation being advanced.

3.6.6 Strategies and approaches to improve research utilisation

The term 'knowledge transfer' emerged in the 1990s to describe a process by which research messages were 'pushed' by the producers of research to the users of research or stakeholders (Lavis et al., 2003). 'Knowledge exchange' is now the term most frequently used in the research literature. This is because of the growing evidence that the successful uptake of knowledge requires more than one-way communication; it entails genuine interaction among researchers, decision-makers and other stakeholders (Lavis et al., 2003). The Canadian Health Services Research Foundation suggests that

for knowledge exchange to be successful, it requires 'interaction between decision makers and researchers and results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision making' (Graham et al., 2006, p. 15). Implicit in this term is the assumption that research and policymakers normally reside in separate worlds, with different views and opinions on research and knowledge (Graham et al., 2006). The 'two community's theory' is frequently used to describe this phenomenon (Caplan, 1979). In this context, knowledge transfer and exchange bring together researchers and decision-makers, facilitating their interaction. This helps to a build a language familiar to both parties and this supports the transfer of ideas and evidence (Lavis et al., 2003a; Ward et al., 2009). It suggests that ongoing exchange and knowledge transfer collaborations can ensure that the knowledge generated is relevant and applicable to policy decision-making, as well as useful to researchers (Graham et al., 2006). The 'linkage and exchange model' developed by Lomas (2000) emerged from the two communities' theory of researchers and policymakers (Caplan, 1978). This model helps to conceptualise the interactive process, flow of information and ideas between researchers and policymakers, with the common goal of solving policy problems (Lomas, 2000). It is suggested that the cultural differences regarding values, goals and belief systems between the researchers and the users of research can be overcome with regular contact and effective communication. The *knowledge-to-action* process illustrated by Graham et al., (2006) represents the Canadian Health Services Research Foundation's definition of knowledge exchange (see Figure 3.2) (Graham et al., 2006, 2009). The funnel at the centre of the diagram symbolises knowledge creation. The cycle describes the activities and processes leading to the implementation or application of knowledge. The producers of knowledge at the different stages of knowledge creation can adapt their outputs to meet the needs of potential users. The action cycle represents the activities that need to be taken to apply the knowledge. The phases are dynamic and can influence each other (Graham et al., 2006).
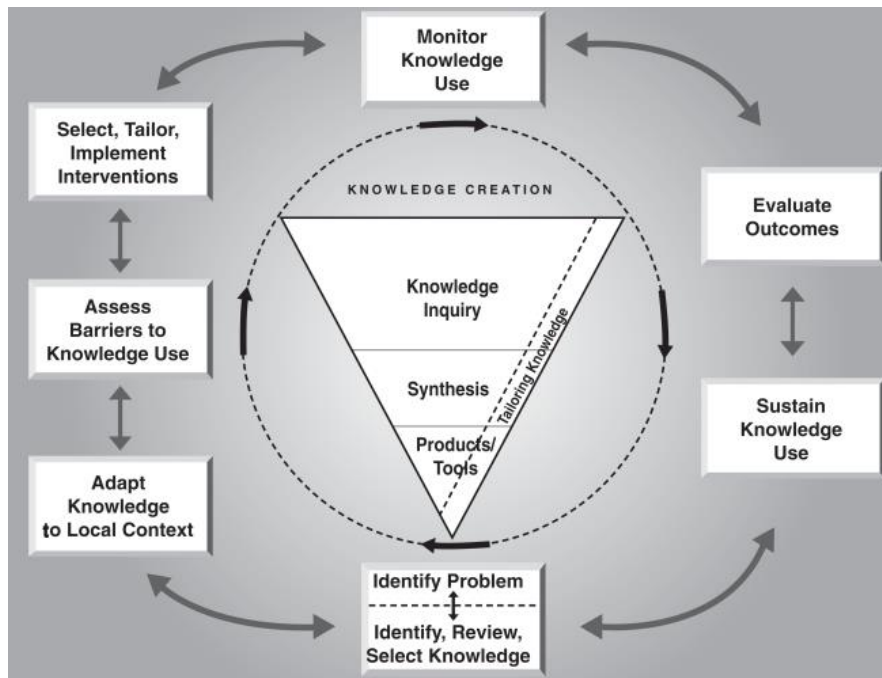
Figure 3.2: **The Knowledge to Action Process**, **Graham, I.D., Logan, J., Harrison M.B., Straus, S, Tetroe, J.M., Caswell, W. et al. (2006).**

Tailoring outputs from research to specific audiences also underpins the work of Lavis et al., (2003b) and Grimshaw et al., (2012). Researchers use systems thinking to understand the use of knowledge in the dynamic and complex field of policymaking (Best and Holmes, 2010; Bowen and Zwi, 2005; Greenhalgh et al., 2004). Transferring knowledge is an interactive, dynamic and multidirectional process. It involves many actors and activities that are embedded in a system, which is largely fashioned, by culture, structure priorities and capacities. Methods of transfer can be influenced by how ideas diffuse through the system ((Best and Holmes, 2010; Bowen and Zwi, 2005; Greenhalgh et al., 2004). The use of research in this milieu can be highly dependent on context and relationships within the process (Nutley et al., 2007).

Several studies have highlighted organisations where there is a lack of specific capacities to access and process research knowledge (Liverani, 2013; Smith, 2007). Other studies have explored the absorptive capacity in organisations to embrace new knowledge and information to improve the organisation's performance. This comes from the literature on organisational management and has been primarily studied in the private sector (Harvey et al., 2010). Absorptive capacity refers to the ability of

individuals in an organisation to absorb and use new knowledge from the wider environment. The ability of an organisation to acquire and use new knowledge can depend on individual factors and institutional factors. Individual factors relate to a person's willingness to accept new knowledge and ideas. This can relate to their prior learning and experience (Cohen and Levinthal, 1990; Ouimet et al., 2009). At the organisational level, how new knowledge and innovative ideas are valued and communicated throughout the organisation can be an influencing factor. In organisations, it has been observed that key individuals can be pivotal to how new information and ideas are accepted (Jones, 2006). These key individuals are comparable to policy entrepreneurs and knowledge brokers in policy research. Easterby-Smith et al., (2008) have also identified key individuals with influence and power as being critical to how new knowledge is acquired and assimilated into an organisation. The key processes and elements regarding how this occurs may help to explain how linkages can support the use of research in policymaking.

Knowledge brokering, which refers to the use of go-betweens, or 'brokers', as facilitators between researchers and intended users is one of the ways to increase the use of research (Canadian Health Services Research and Foundation, 2003; Dobbins et al., 2009; Lomas, 2007). The use of knowledge brokers can both increase the use of research to inform decision-making and improve on the quality of the research that is used in those situations (Dagenais et al., 2015; Ridde et al., 2013). In a review of knowledge brokering in public health, it was found that the relational and interactive nature of knowledge brokering was an important factor in knowledge use (Dobbins, Robeson et al., 2009; Haines, Kuruvilla and Borchert, 2004; Thompson et al., 2006).

This subsection has reviewed the relationship between the research evidence and policymaking. Models and frameworks of research utilisation were examined to help in understanding the diverse ways in which evidence can be used in the policymaking process. The importance of measuring the impact of research outputs and demonstrating accountability and value money for governments, funders of research and institutes of higher education was discussed. An analysis of the more popular models and frameworks developed to measure research impact was presented. The barriers and facilitators to research use was discussed with a review of the strategies devised to transfer the knowledge from research evidence to policymakers. The next

section will review some recent research conducted in Ireland in this field to provide a rationale for the current study.

3.7 Research studies in Ireland

Ireland has a tradition of research informing government policy dating back to the 1960s. The Irish government a relatively young democracy following its gaining of independence in 1921, established the Economic and Social Research Institute (ESRI) in 1963. Its remit was to inform government policy on a programme for the liberalisation of trade and economic reform (Kennedy et al., 2010). The ESRI continues to provide policy-relevant research to government departments (Ibid). Joining the European Union (EU) in 1973 was also instrumental to Ireland's development of an evidence-based focus on public policy (Whelan, 2005). After joining the EU, The National Economic and Social Council (NESC), the Combat Poverty Agency (CPA) and the National Economic and Social Forum (NESF) were established to help inform government policy on programmes to combat poverty (Kennedy et al., 2010). It is suggested that the development of the social partnership models further strengthened the role of consultation in government circles for developing policy (Kennedy et al., 2010).

In addition to the agencies cited above, Irish academic institutions have been at the forefront of producing research evidence to inform public policy (Kennedy et al., 2009; Nason et al., 2008). Many of the universities have a focus on research relating to health and public policy funded by public and private monies (Kennedy et al., 2009); for example, The Health Promotion Research Centre at the National University Ireland, Galway and the Irish Centre for Social Gerontology at NUI Galway, the Migration and Citizenship Research Initiative at University College Dublin and the Children's Research Centre at Trinity College Dublin. The Irish government's support of Irish universities producing research that informs public policy was stated at the NESF Conference in 2005 by then Taoiseach, Mr. Bertie Ahern.

In addition, many initiatives have been developed to increase linkages between academia and policymakers. For example, academic researchers frequently work with

policymakers on a consultative basis by contributing their knowledge and expertise to inform policy (Kennedy et al., 2010). Close stakeholder relationships between researchers, policymakers and other stakeholders working together have been observed in relation to identifying research needs for policymaking in the fields of migration, health and social inclusion (Ibid).

Ireland, as in other jurisdictions is required to demonstrate accountability and performance in its research outputs because of resource constraints and political requirements (HRB, 2008). To this end, several studies have been conducted to explore how research evidence impacts on public health and practice in Ireland (Kennedy et al., 2010; Buckley and Whelan, 2009; Richardson and Carroll, 2009; Currie and Clancy, 2010). The Health Research Board, in 2008, explored the impacts of eight of its funded grant research programmes, using the Payback Framework from the mid-1990s (Buxton and Hanney, 1996). As explicated under section 3.6.1 this framework uses the logic model to describe the research process for each case study included in the review (for the purposes of research evaluation). This model provides a structure for analysing the progress of a research idea from inception, through the research process, into dissemination and on towards its impact on people and society (Donovan and Hanney, 2011). It facilitates a cross-case analysis by ensuring consistency in research techniques used across case studies. Five main categories of payback can be identified: knowledge; research benefits; political and administrative benefits; health sector benefits; and broader economic benefits (HRB, 2008).

Of the eight studies selected for inclusion in the research project, four concerned basic biomedical or early clinical research, while the remaining four were focused on health service research, public health and primary care research. The findings from the study demonstrated an impact on a wide number of areas, in peer-reviewed articles and citations, the development of research techniques used in further research and the development of training courses. An impact on health policy and practice was found in relation to a range of sectors, for example in developing clinical guidelines and increasing efficiency in the health system. The research studies examined were found to have contributed to the development of products and devices for commercial sale, in addition to the establishment of spin-off companies (i.e. companies established to manufacture or distribute products or technology that were originally developed by

the research institution) (Nason et al., 2008). Although this study does identify the impact of research on policy, it does not describe the strategies adopted by researchers to influence the health policy agenda, or the factors that contribute to the successful uptake of research by policymakers.

Other studies have examined the types of knowledge used in developing health and social policy, and have identified the factors that contribute to placing specific policy areas on the policy agenda (Richardson and Carroll, 2009: Kennedy et al., 2010). Kennedy et al. used a case study methodology, in 2010 to explore the role of stakeholders' expectations in developing maternity policy and men's health policy in Ireland. The study identified that the evidence used came from a broad range of sources. These included the views and experiences of service users and practitioners, as well as evidence from randomised control trials (RCTs) and data from cost benefit analyses (Kennedy et al., 2010). The two case studies included in this research accentuated the importance of consulting with service users to obtain details of their experiences and expertise in the process of policy development. It was found that interpersonal linkages and relationships between the researchers and the policymakers were important factors for the utilisation of research by policymakers (Kennedy et al., 2010). However, the barriers to the use of research evidence in policymaking are not addressed in this study. In contrast, Richardson and Carroll's (2009) study on the advancement of men's health policy in the government policy agenda describes the very political nature of policy development. The authors illustrate the competing demands on policymakers, such as departmental and economic priorities, and reveal how the process necessitates numerous meetings with several stakeholders to persuade them of the importance of this policy area. Unfortunately, this study does not adequately explain the strategies they used to persuade and communicate the research evidence to policymakers.

Additional studies have focused on how research evidence is used to inform practice in the health and social services, revealing that context are important to how and when research is used (Buckley and Whelan, 2009). The individual's personal interest and motivation was found to be a key factor that promoted the use of research among practitioners in the delivery of children's services. The organisational culture was considered important too, in that the research material was easily accessible, and the

organisation allowed time for the service practitioners to source and read the articles (Buckley and Whelan, 2009). The focus of this study was on research users rather than research producers. Consequently, it is difficult to know whether the findings would be applicable at the government policy level. Studies conducted on the development of smoke-free legislation in Ireland found the political model of research utilisation was the model that most closely resembled how the research evidence was used in developing smoke free policy legislation (Currie and Clancy, 2010). Other findings from the study reported on the contextual nature of policymaking and how the wider political, economic and cultural environment at the time was considered important for how policy developed around smoke-free legislation (Currie and Clancy, 2010).

3.8 Reflections - Gaps in the academic literature

The key academic literature concerning the relationship between research evidence and health policy, both internationally and nationally was presented in this chapter. Many of the studies reviewed defined the barriers to and facilitators of the use of research in public health policy. The exchange strategies currently being advanced to increase the uptake of research evidence were examined. Close working relationships and the relevance of the research evidence were key factors in facilitating the utilisation of research evidence by policymakers. However, what is not clear from the literature is whether close working relationships and the relevant research together are what increase the uptake of research evidence by policymakers, or whether close working relationships is the only factor that increases the utilisation of research evidence. Much of the literature also highlights the importance of contextual factors in the utilisation of research by policymakers. These factors can change from one specific policy area to another and in different cultural contexts. Policymaking is complex, involving a diverse range of issues that at any one time, policymakers need to take into consideration.

In Ireland, many of the studies have been conducted in niche areas. This makes it difficult to transfer the findings to what is happening in areas where personal ideologies, culture and economics play a major role. Issues such as alcohol and drug misuse in society are often considered one of the ʻwicked problemsʼ of

policymaking. The term 'wicked problem' was first used in the 1960s by a German researcher at the university of Berkeley, California (Churchman 1967). 'Wicked' is used here not in in an evil or unethical sense but to depict societal problems that are often ill defined, involving several decisions-makers and clients with conflicting values and ideology; they are highly complex and difficult to resolve (Wildreidge, Childs, Cawthra, et al., 2004; Rittel and Weber, 1973). This study aims to contribute to the knowledge in this field by examining what factors are influencing the utilisation of research evidence in alcohol and illicit drug policy in Ireland. The views and opinions of both policymakers and researchers who work at the frontline of alcohol and drug policy are explored. Specifically, it seeks to determine the unique barriers to and facilitators of research uptake in policy decision-making and ascertain the most applicable strategies used in this context. These two dynamic areas of public health policy are subject to continually changing societal values concerning their regulated use in Irish society.

The central literature on the use of research evidence in public policymaking was reviewed in this chapter. What constitutes evidence, along with the theories and current debates on the use of research evidence in public health policymaking that are fundamental to this thesis were explored. How the theoretical models of policymaking increase our understanding of the policymaking process will be revisited in the discussion chapter together with the findings of this study (Chapter 7). Previous studies in Ireland on research evidence influencing public health policy were critically reviewed to provide a context and rationale for the current project.

The following chapter will now provide the rationale for the methodological approach adopted and the theoretical foundations for this thesis.

Chapter 4: Methods

4.1 Introduction

This chapter gives a detailed account of the methodological techniques employed in investigating the impact and influence of research evidence on alcohol and drug policy in Ireland. A review of the academic literature reveals that there are multiple methods of data collection and study designs employed to explore this field of study (Hanney et al., 2003; Hanney and Gonzalez- Block, 2009; Greenhalgh and Russell, 2009; Oliver et al., 2014). The current project adopts a case study research design method with document analysis and qualitative interviews.

In this chapter, the first section outlines the rationale for the research design engaged in the current study. The philosophical orientations are explicated. How issues of validity and reliability are addressed in the qualitative methods employed is discussed. In section two a rationale for the selection of the specific policy fields investigated in this study is given. Next a detailed explanation of the data sources and procedures for collection and analyses in phase one is presented. This is followed by a discussion on the data sources, recruitments procedures and data analyses techniques employed in the qualitative phase of the study.

4.2 Research Design

Knowing what you want to find out leads inexorably to the question of how you will get that information (Miles and Huberman, 1984, p.42)

The purpose of a research design is to guide the researcher in decision-making, during the data collection process, and to determine the rationale by which he or she arrives at interpretations in the end (Creswell and Clark, 2011). The case study approach is particularly relevant, when the aim of the study is to explore a contemporary phenomenon in the context of real-life (Bryman, 2001; Cresswell, 1998; Robson, 2002; Yin, 2014). As in this research whereby the influences of academic research on

alcohol and drug policy are being explored. Tellis (1997) suggests that ideally the case study aims to provide an understanding of culturally based systems of action. Therefore, the selection of the case or cases to understand the phenomenon of interest is of utmost importance (Tellis, 1997). Its unique features are that the case is bounded, endeavouring to give a detailed and exhaustive exploration of the phenomenon in a specific environment (Merriam, 1998; Stake, 1995; Smith 1978; Yin, 2014). Multiple methods of data collection are involved from multiple sources to get different perspectives of the occurrences under investigation (Cresswell, 1998; Merriam, 1998; Robson, 2002; Stake, 1995; 2000; Yin, 2014).

Sources of evidence for case studies identified by Stake (1995) and Yin, (2014), are documents, archival records, interviews, direct observation, participant observation and physical artefacts. There are strengths and weakness associated with each of these data sources (Stake, 1995; Yin, 2014; Tellis, 1997). Documents are stable over time and can be viewed repeatedly (McCullock, 2004; Merriam, 1988; Bowen, 2009). They are non-reactive to researchers' bias[13] as the documents were prepared for reasons other than research (Bryman, 1989). Nonetheless bias maybe an issue in selecting the documents for inclusion in the research project. The selection of documents, for example may be incomplete, or the only documents that are available are closely aligned with the organisations' corporate policies and values (Bowen, 2009; Yin, 1994). Official documents are usually publically available and with the advent of the World Wide Web can be inexpensive to collect (Merriam, 1988; Bowen, 2009). On the other hand, insufficient detail in the documents can pose a problem for the researcher and access to some documents maybe intentionally blocked (Bowen, 2009). Interviews are one of the most fundamental sources of evidence in case study research (Tellis, 1997; Yin, 2014). Combined with other sources of evidence interviews provide richer and more in-depth detail of the topic under investigation (Creswell et al., 2003; Rubin and Rubin, 1995). They are however prone to vulnerabilities in that subjectivity can be an issue in how the data are interpreted and analysed (Bowen, 2009; Yin, 2014). Issues may also arise with what the participant has said, or what they may not have

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[13] Researcher bias refers to instances where the individual conducting the research may influence the results to represent a specific outcome

told the researcher. During the interview process, social desirability bias may occur, as participants perhaps deliberately filter out specific information or adjust purposely or inadvertently their presentation of the information in some way (Van de Mortel, 2008; Kaushal, 2014). Green and Thorogood (2009) suggest there is always a tension between precise procedure and informal judgment in qualitative research. The researchers' role is to differentiate between the participants' descriptions of the process, how the participant interprets the process, and how the researcher interprets both these aspects, leading to a 'triple hermeneutic' (Flick et al., 2004; Weed, 2005).

These matters are particularly relevant to policymaking and the use of research evidence in this process. Policymaking is a political process in that the interests of specialist groups and economic constraints must be considered. Cooperation and collaboration in arriving at agreements on these and other issues all must be negotiated (Cairney, 2012). Therefore, it is prudent to assume that politics has a role in the real world of policymaking where individuals are subject to influence by their own political views and parties.

4.2.1 Philosophical orientations of the Case Study Approach

Varied philosophical orientations are associated with the case study method (Merriam, 1998; Stake, 1995; Yin, 2014). Merriam and Stake describe how their qualitative case study research is informed by the constructivist epistemological tradition (Merriam, 1998; Stake, 1995). Constructivist philosophies on knowledge and reality assert that knowledge is socially constructed through the interactions of individuals in their social world (Merriam, 1998; Stake, 1995). Researchers coming from this epistemological background seek to understand and explore a phenomenon in context from the perspective and experience of those involved (Denzin & Lincoln, 2011; Merriam, 2009). Yin refrained for many years from specifically stating the epistemological orientations of his work (Yazan, 2015). He preferred instead to highlight the commonalities between the qualitative and quantitative traditions (Yin, 2002: Harrison, et al., 2018; Yazan, 2015; Crotty, 1998). Nonetheless the influence of the positivist tradition in Yin's work is evidenced by the instruments he developed to address many of the criticisms of qualitative research (Neuman, 1997: Harrison et al., 2017: Yazan, 2015). Yin encouraged the use tools and guidelines in conducting case

studies, to minimise bias and to ensure integrity and meticulousness in the collection and analysis of research data, for example the research protocol and an audit trail (Yin, 2014). Merriam similarly advocated the use of processes to convey order, clarity and quality in conducting case study research (Harrison et al., 2017).

In 2014 Yin proclaimed the 'realist perspective' as the epistemological orientation of his work (Yin, 2014, p.17). From this standpoint, the case study is viewed as a form of empirical inquiry with the emphasis on objectivity in the method of design and collection of data (Yin, 2014). Realism perceives that a true and accurate picture of the world can be constructed through scientific methods (Chia, 2002). Researchers from this tradition contend that there is an external reality but concedes that it can be difficult to measure (Gray, 2013). Naïve, critical and scientific are three distinctive realist epistemologies (Madill, Jordan and Shirley, 2000). Naïve realism accepts that the world can be understood and explained provided the scientific methods and tools of measurement are available (Niiniluoto, 1999). Scientific realism argues that a true knowledge of the world can be assembled by scientific methods, however this knowledge may be imperfect (Gray, 2013). Critical realism asserts that our views, expectations and experiences influence our perception of the world, and as such, there might not be one single truth (Bunge, 1993). Realism comes from the post-positivist tradition where objectivity and generalisability of the results are the goals of the researcher (Ellingson, 2011). To overcome inaccuracies in the data and to arrive at an objective reality or truth multiple methods of data collection and triangulation are encouraged (Lincoln et al., 2011). In the current study, the analysis of policy documents and interviews with researchers and policymakers are the methods employed.

Other epistemological traditions like constructivism understand the production of knowledge to be subjective (Merriam, 1998; Madill et al., 2000: Guba and Lincoln, 1994). Thereby it is only through the individual's interpretations and observations that the social world is constructed (Bryman, 2008). Public health traditionally comes from the epidemiological[14] perspective and is based on the quantitative paradigm which

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[14] Epidemiology is a quantitative science that studies the causes, patterns and effects of diseases in human populations.

understands that an independent reality exists outside of human interpretation or influence (Guba and Lincoln, 1994; Sale, LohField and Brazil, 2015).

This thesis explores the environment of public health policymaking. The author accepts that her world view is influenced by her medical training, and that there is an independent reality (i.e. scientific medical tests). However, another reality exists that is constructed through the subjective feelings and perspective of the individual (i.e., lay health beliefs and the understanding that good health is outside of the control of the individual). Critical realism therefore is the approach adopted in the current study. The perspective of the author is that an independent social world exists outside of the individual's reality (a realist ontology). However, the individual's knowledge of that world is fallible (Sayer, 1992). The author also considers that data collected from interviews is knowledge socially constructed between the interviewer and the interviewee and is subject to contextual factors (a social constructivist epistemology). The critical realist position accepts that different researchers investigating the policy process on the formulation of policy on the misuse of drugs and alcohol may arrive at different but nonetheless legitimate findings. This perspective also takes in to account the contingent nature of causation, for example the wider economy; politics as well as the research evidence are assumed to have real effects on the policy process (Sayer, 1992; Easton, 2010). These mechanisms may operate differently in other contextual situations. Consequently, the findings of this case study may not be generalisable unless there is a shared context.

4.2.2 Study Design

This study is a single case with multiple units of analysis. See Table 4.1. The outer rectangle represents the context of the study, which embodies the political, social and economic background. The second rectangle signifies the policy area (the case) under investigation. The dotted line between the case and the context illustrates how the phenomenon that is the focus of the inquiry cannot be separated from the background of where it is unfolding (Harrison et al., 2017; Yin, 2014).

Table 4. 1: Units of analysis – adapted from Yin, 2014

The Context Political/social/economic

Alcohol and drug policy		
Unit 1 Policy documents	Unit 2 Interviews with policy makers	Unit 3 Interviews with researchers
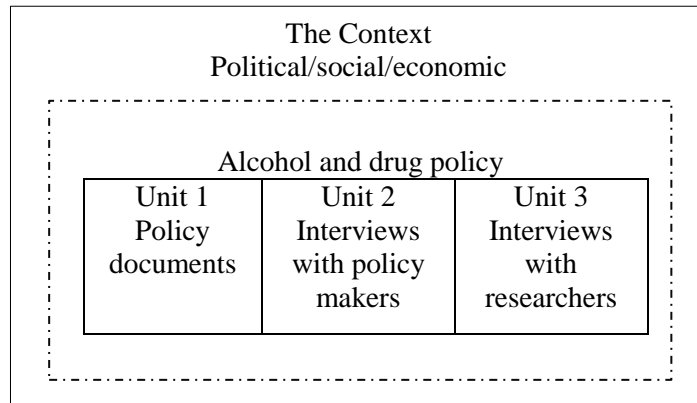
The three inner rectangles symbolize the units of analysis of the current study; alcohol and drug policy documents, interviews with policymakers and academic researchers. To maximize reliability a case study protocol was developed (Yin, 2014; Tellis, 1997). It contained the instrument, the procedures and guidelines to be followed in conducting the research, for example, the project objectives and patronages, issues and relevant readings. The actions to be followed while out in the field, for example, the presentation of credentials, access to the case study 'sites', the language pertaining to the protection of human subjects, sources of data, and the procedural reminders are all documented. It lists the specific questions that are being addressed in the case and the possible sources of information for answering each question. The protocol helps the researcher stay focused on the study topic and to anticipate problems or setbacks in the collection of data. In addition, it assists in identifying the audience for the case study report. (Please see appendix A for the protocol for this study).

4.2.3 Quality in qualitative research

Ensuring quality and reliability in case study research, is considered more problematic than in other methods of qualitative research. This is primarily due to researcher subjectivity in data analyses (Tellis, 1997; Riege, 2003). Evaluation methods used to ascertain the quality of empirical social research are construct validity comprising internal validity and external validity, and they apply equally to case study research (Yin, 2014). The techniques recommended to address construct validity are to use multiple sources of evidence, establish a chain of evidence, and have key informants review draft case study reports (Tellis, 1997; Yin 2014). This takes part during the data collection and composition stage. One method of addressing internal validity to

explanatory case study research is pattern matching. This is linking several pieces of data to the propositions of the case (Campbell, 1975). External validity can be guaranteed by using theory in single case studies and by using replication logic in multiple case studies. These tasks take place during the research design phase. The creation of a study protocol (introduced earlier) and the development of a case study database strengthens the reliability of the case study. Please see in Appendix A and B. When assessing the rigour of qualitative research, researchers from the positivist tradition (Behling, 1980; Cook and Campbell, 1979) frequently use four criteria: internal validity, construct validity, external validity, and reliability (Campbell, 1975; Campbell and Stanley, 1971; Gibbert, Ruigbrok, Wicki, 2008).

Internal validity is concerned with the data analysis and identifies whether there is a causal relationship between variables and the results (Cook and Cambell, 1979; Gibbert, Ruigbrok, Wicki, 2008). Developing a research framework that illustrates how certain variables lead to specific outcomes can enhance internal validity. *Pattern matching* can be used by researchers in demonstrating how empirically observed patterns can be compared to patterns found in previous studies under different conditions (Denzin and Lincoln, 1994). *Triangulation* is concerned with a researcher attempting to validate the findings of a study by examining it from multiple perspectives (Hammersley, 2008; Flick, 2004). Construct validity refers to the extent that a study is researching what it claims to be researching. It is of major concern during the data collection phase. The tools developed to investigate the phenomenon of interest are required to be appropriate to answer the research question, and the process leads to a correct conclusion of the reality (Denzin and Lincoln,1994). The two strategies recommended to address this concept are *to establish a clear chain of evidence* and to *triangulate.* Both strategies have been employed in this study.

4.2.4 External validity and reliability

External validity refers the 'generalisability' of the study. Case studies do not allow for statistical generalisations as would be the case in survey research (Gibbert, Ruigrok and Wicki, 2008). However, Yin (2009) argues that analytical generalisations are possible as the researchers are frequently attempting to '*generalize a particular set of results to some broader theory'* (p.43). Replicating the study in similar contexts can

test this hypothesis (Denzin and Lincoln, 1994). This section presented a detailed account of the research design and philosophical orientations of the study. The development of a case study protocol and a database (see appendix B) enhances the reliability of the study as well as ensuring a transparent audit trail throughout the research process.

4.3 Data Collection

All data were collected between August 2013 and April 2015. There were variations in the collection methods, sampling strategies and analysing methods employed for each phase of the study. This section describes the methods employed.

4.4 Selection of policies to use in the case study

Several policy areas were considered for inclusion in this study. The early years' children's policy, mental health policy, drugs and alcohol policy were all discussed as possible cases. Ultimately it was decided to focus only on the alcohol and drug policy as this was an area that had received a lot of attention in government and societal circles in the preceding decade as described in Chapter Two. The overconsumption of alcohol among the younger population, drunk driving and the hidden harms of alcohol use had become a real concern for many sectors of society (Hope and Butler, 2010; Hope, 2014; Bedford, O'Farrell, and Howell, 2006; Nic Gabhainn et al., 2007). Furthermore, a well-coordinated and multi-sectorial drug policy had been developed and implemented in the previous decade in Ireland (Department of Tourism, Sport and Recreation, 2001).

4.4.1 Document selection

To be included in the study i) documents had to be produced in response to a mandate from government between 2001 and 2012, ii) address the areas of alcohol or drug policy, iii) and have a strategy or a call to action in the policy areas under investigation. Reports that were based solely on a review of services or activities were excluded from the study. It was believed they would not address the research question on how

academic research evidence informs public health policy. Other information such as reports and studies in the policy documents were checked for accessibility and accuracy of reference in the document. This analysis was conducted to understand the different types of knowledge cited in policy documents and how policy developed over time. Phase one of the study informed phases two and three.

The most frequently employed research method in empirical studies for investigating the use of research evidence in health policy is the analysis of public policy documents (Hanney et al., 2003; Banzi et al., 2011; Oliver, et al., 2014). Documents relating to drugs and alcohol policy were collected and reviewed from the Department of Health[15] website and reports from the drugs and alcohol[16] website published between 2001 and 2012 (See appendix C for a full list of documents). Six documents were included from the Department of Health website and one report from the Drugs and Alcohol website (Report on The Misuse of Alcohol and Other Drugs January 2012). Three of the documents were national policy statements on drug policy. The remaining documents were alcohol reports published by government to inform discussion and debate on the development of a national alcohol policy.

4.4.2 Analysis of policy documents

The aim of this section is to present the methods of analysis of the policy documents. Essentially, it details the different strategies and techniques employed in data analyses and give a thorough account of the methods employed.

Different approaches to analysing the data are advocated by preeminent researchers in case study research (Merriam, 2009; Stake, 2006; Yin, 2014). Central to their approach is the drive to understand a complex phenomenon in its natural setting (Harrison et al., 2017). The approach to data analyses that informed this study is that of that of explanation building (Yin, 2014). This was preferred to Stake's (1995) categorical aggregation and direct interpretation approaches, or Merriam's (2009) phenomenological analysis and constant comparative methods. Yin, (2014) recommends beginning with the research question, and identifying the evidence

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[15] www.doh.ie
[16] www.drugsandalcohol.ie

collected to address the specific objectives of the research. The documents selected for analyses were to answer wholly or in part the research questions: *In what context was academic research successful in making an impact? and to identify the pathways/linkages and exchange models that best describe how academic research impacts in this area of policy in Ireland?*

The first unit of analysis in this case study was public policy documents in alcohol and drugs published between 2001 and 2012.

4.4.3 Categorisation and Coding

Following retrieval and the critical reading of the documents, a data extraction sheet was developed in excel using the 'Framework' method. This is a well-established methodical and efficient tool for managing data in policy research (Ritchie and Spencer, 1994; Deas et al., 2013). The coding and categorisation of the documents was conducted using deductive coding and codes derived from the extant literature. The data extraction sheet contained several headings that corresponded to the items that were extracted from the document. The headings were as follows; 'name of policy document', 'title of research study' 'authors' 'commissioning body'. Headings were also included for 'synopsis of information' indicating type of information, and 'where it was cited' in the policy document (See Appendix D).

A codebook was developed containing the variable name, the SPSS variable name and the coding instructions. The variables were 'type of policy', 'document type' 'type of information' and 'purpose of reference' to the policy document. The codes employed were comparable to other relevant studies on policy documents (Zardo et al., 2014).

Coding for Type of Policy: Each policy or report was coded as either 'drugs' or 'alcohol'. Documents defined as 'drugs' were produced specifically to address the use of illegal drugs in Ireland. Documents defined as 'alcohol' were explicitly produced to tackle the use and misuse of alcohol in Ireland. Each document was given a unique identifier, see table 4.2. Coding for type of information on each policy document was conducted by identifying the name, author and purpose of the information referenced on the policy document or report. Table 4.3 gives a description of the eight types of information identified in the policy document.

Table 4.2: Coding for document type

Unique Identifier	Alcohol documents	Drug documents
1	Strategic Task Force on Alcohol Interim Report, May 2002	
2	Strategic Task Force on Alcohol Second Report 2004	
3	Report on The Misuse of Alcohol and Other Drugs, January 2012	
4	Steering Group Report on a National Substance Misuse Strategy Feb 2012	
5		Building on Experience National Drug Strategy, 2001 - 2008
6		Mid-term Review of the National Drug Strategy, 2001-2008
7		National Drug Strategy (interim) 2009 - 2016

4.4.4 Coding for purpose of information

Most government policy documents and reports are written to a particularly formula; executive summary, background/review of current practices or trends in the policy area, and conclusion/recommendations. Codes in the background/review of current practices or trends section of the policy document/report were coded as supporting the need for policy. Codes in the recommendation section were coded as supporting policy development.

The documents were analysed to identify the basis for citing the research literature for example:

- Justification for policy - did the writers of the document reference research in supporting the need for policy in this area.
- Recommendations – did the writers of the document clearly reference research to support the recommendations

Table 4.3: Coding for type of information

Name of information type	Description of information
Irish academic/Scientific research	research published by Irish Universities - this includes research commissioned by government departments, government agencies and NGOs.
International research	research published by International Universities.
International Reports	defined as WHO reports, United Nations and International Government Reports referenced on the document.
Internal Information/legislation	this includes references to Departmental Acts/policy documents and reports produced by the government department that has ultimate responsibility for the policy area.
External information/legislation	comprises Acts, policy documents, strategies and reports produced by other government departments. The ESRI was put into this category.
Industry research and reports	this is defined as research commissioned or carried out by the alcohol industry.
Commissioned studies by Governments Agencies	defined as studies carried out or commissioned by government agencies such as the HRB, NACD, HSE, and Charity Organisations. If a university carried out the study it was put into the category 'Irish academic/scientific research
Other	defined as any other information that did not fit into the above categories such as personal information

4.4.5 Validity of coding

To test the consistency of data coding at least two independent assessors are required. Three types of reliability for content analysis were identified by Krippendorff (1980); stability, reproducibility and accuracy. Krippendorff considered stability the weakest of the reliability tests, as it involved a test and retest procedure by the same coder. If the results are identical the method is considered consistent. Reproducibility refers to several coders coding the same text. The number of errors between the different coders is assessed and the measurement is referred to as inter-rater reliability (Krippendorff,

1980). The accuracy measurement of reliability refers to a predetermined set of codes. The codes are established by a panel of experts or have been already validated in other studies (Milne et al., 1999).

In the current study, a second researcher and the authors' supervisor reviewed the data to detect differences in the coding. Following the review a question was posed on how the distinction was made between reports and academic research published by academic institutions. It was agreed that large pieces of research/reports published by academic institutions would be coded under academic research if the reports gave rise to articles published in peer-reviewed journals.

The data were coded in Excel and exported to the Statistical Package for Social Sciences version 21 for analysis. Descriptive analyses were performed to provide an overview of the data set. Frequency tables were employed to illustrate the number of references to 'types of information' 'document type' and references to policy for 'purpose of information' in the policy documents. Chi-Square tests for association were performed to determine relationships between types of knowledge and purpose in the policy document.

4. 5 Qualitative interviews with policymakers and academic researcher

4.5.1 Data collection methods for key informant interviews

Phases two and three of the study were undertaken to answer the research questions: *what are the barriers and facilitators to research use in Ireland? and how best can the barriers be overcome and the facilitators enhanced*? The semi-structured and in-depth interviews were carried out with participants in the research and the policymaking fields. The interviews involved structured and open-ended questions, intended to obtain the views and opinions of the participants on the influences on alcohol and drug policy in Ireland. The emphasis here was on depth, detail, and the perceptions of the key informants in the policy-making process. Dicicco-Bloom and Crabtree (2006) write that frequently the basic research question will serve as the first question in the interview. This is then followed by more specific questions designed to explore the issue under investigation in more depth. Qualitative interviews to be

successful must be flexible, iterative and continuous (Crabtree and Miller, 1999). This allows for the altering of questions as the researcher learns more detail of the area under investigation (Dicicco-Bloom and Crabtree, 2006). Ineffective questions that do not elicit the information needed to answer the research question may be dropped and alternative ones added. The interviewee may also depart from the planned interview schedule, as digressions can be beneficial in that they follow the informant's interests and knowledge of the subject area (Dicicco-Bloom and Crabtree, 2006).

4.5.2 Development of the interview schedule

Three factors that can help shape the development of the interview schedule are a comprehensive literature review, a cultural review, and a self-review (Crabtree and Miller, 1999). In combination with the interviewers' personal knowledge and experience of the area and the literature review, informal discussions with individuals who have personal experience in the subject of interest, can assist with the development of the interview schedule (King, 1994).

In the current study the literature on how evidence-based health policy was measured in several empirical studies was reviewed. The recurrent themes in the literature on the facilitators and barriers to the use of research evidence by policy decision-makers and how they could be overcome informed the interview schedule. In terms of personal knowledge and experience of the area, the researcher conducting this study had worked as a nurse practitioner in the public health service in Ireland and as a health services researcher for over twenty years, earning formal qualifications in both professions. Accordingly, the researcher has acquired an in-depth knowledge and experience of how evidence-based research has informed medical practice. An innate curiosity and interest in how policy is formulated, guided the researcher instinctively to the subject area of this research study. The perspective of the researcher can impact on all stages of the research process from the development of the research question to the reporting of the findings.

Informal discussions took place with individuals who had knowledge of or were at present working the area under investigation, who were known to the author. This was to acquire an impression of the landscape, and understand the constraints that

conceivably could be encountered in researching such an area. Together with the analysis of phase one of the policy documents, these three sources of information informed the interview schedule.

In case studies, interviews take the format of a guided conversation rather than a highly structured interview. Even though there is steadfastness in the purpose of questioning there is more variability in style of how the questions are probed (Rubin and Rubin, 1995). The dual aims of the interviewer in the case study interview are to pursue the topic under investigation as dictated by the study protocol, and to ensure that the questions are asked in an unbiased manner. This can be achieved by using prompts and asking a 'how' question of the informant of how something occurred, rather than asking 'why' it occurred (Yin, 2009). Becker (1998) contended that asking 'how' questions were less threatening to an informant and it was less likely for the informant to become defensive.

4.5.2.1 Policymakers interview schedule

The policymakers' interview schedule comprised open-ended and closed questions. The questions were structured to reflect the use of academic research in policymaking, principally alcohol and illicit drug policy. To establish the socio-demographic background of the target respondents several questions addressed their role in the organisation, their educational level and the number of years employed in the service. A total of 13 questions were asked. Please see Appendix F for full details of the interview schedule.

4.5.2.2 Researchers interview schedule

The researcher participants' interview schedule was created from Kuruvillas et al., (2006) Research Impact Framework. It included questions relating to their areas of research interest, how familiar the researchers were with the impact of their academic outputs on policy, society and the health and public services. A total of 16 questions were asked with the final three questions analogous to the questions put to policymakers, on what types of evidence policy decisions makers preferred, and how the existing evidence could be improved. Please see Appendix E for full details of interview schedule.

4.5.3 Sampling

The sampling method employed in qualitative research is dependent on the research question, the area being investigated and the research design (Higginbottom, 2004). Its purpose is to collect in-depth detailed knowledge of the phenomenon under investigation, rather than collect data that is generalisable to a larger population (Miles and Huberman, 1999). The purpose of case study research is to investigate a phenomenon in its real-life context (Yin, 2009; Tellis, 1997). Consequently, research samples are selected purposively to 'obtain the broadest range of information and perspectives on the topic of the study' (Kuzel, 1992: p.37). Kuzel advises deliberately selecting participants whom you suspect might hold opposing views on the phenomenon being explored.

Phase two of this study recruited key informants working at the mid and senior level in the Irish civil service (levels 1-7; Irish Civil Service, 2008). Key informants were selected because of their unique knowledge and experience of their organisation or subject area under investigation, rather than being statistically representative of that organisation (Kumar et al., 1993). In the Irish civil service, senior servants are viewed as key informants regarding policymaking, given their unique position in the organisation (Walker and Enticott, 2004). Their role in policy decision-making, implementation and close working relationship with politicians, renders their views as fundamental to understanding public policymaking (Christensen and Lægreid, 1999; Ridder et al., 2006). Snowballing[17] occurred during the interview process as interviewees in the organisation identified other possible candidates with relevant information to the study. Yin (2011) avers that snowballing is acceptable when you have a purposive reason for conducting the interview, for example, the interviewee has pertinent information to the study. Moreover, recruitment is not purely motivated by convenience.

In phase three the participants were selected from a review of the published work in the field of alcohol, drugs and children studies in Ireland. Many of the participants were also cited in government policy documents. To protect the anonymity of the

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[17] Snowballing –sometimes described as chain referral or reputational sampling. It is a method used for identifying potential interviewees/cases in a specific network (Neuman, 1997).

participants the names of the researchers or the title of the research studies are not included.

4.5.3.1 Sample size

In qualitative research the goal is to select a sample size that will allow theoretical saturation to be achieved (Morse, 1995). Kuzel (1999) suggests that 5-8 interviews are thought to be sufficient when a sample is homogenous, while 12 – 20 are recommended in heterogeneous samples. The results of Guest, Bunce and Johnson (2006) review of sixty studies using in-depth interviews found that saturation had been achieved following analyses of the first twelve interviews with essential meta-themes being observed by the sixth interview (Guest et al., 2006). Dey (1999) contends that saturation is an ill-suited concept as frequently researchers complete data analyses before all the data are coded. Similarly, Strauss and Corbin suggest that the longer the time researchers allow themselves to become familiar with the data there is always the potential for new ideas to emerge. However, they argue this can be counter-productive in that the new findings may not always add to the overall results. Equally, it is important for the researcher to know as a picture begins to emerge from the data when to stop (Strauss and Corbin, 1998). Guest, Bunce and Johnson (2006) found in their review of the literature that there were no practical guidelines or advice on how to determine when saturation was achieved. Sixteen interviews were conducted in this study – eight with key informants in the policymaking field and eight with researchers working in academia.

4.5.4 Ethics and confidentiality

This study was governed by the research and ethics policy of the National University of Ireland Galway (library.nuigalway.ie/handle/10379/6493). It explored a unique area of public interest with a limited number of possible participants. Therefore, extra care had to be taken with issues of anonymity and confidentiality in procurement and reporting of the findings of the interviews. Researching elite individuals or studying in unique areas of interest participants may be easily identifiable to members of the population due to their exclusive interests, or their positions of power in local, national and international communities (Bickford and Nisker, 2015; Baez, 2002; Kaiser, 2009).

Accidental deductive disclosure can be a challenge when disseminating research results (Tolich, 2004). This is further compounded by the tradition in qualitative research of using 'thick descriptions' (Geertz, 1973). Detailed and in-depth descriptions of events and locations are usually encouraged. It adds to the authenticity of the research findings and aids the reader in interpreting the results. Bickford and Nisker (2015) argue that removing this type of information may call the quality of the research into question, and undermine the ability of the reader to understand the findings. Previously researchers (e.g., Weiss, 1994) have managed this problem by reporting information that was deemed unnecessary in an obscure way, for example, changing the occupation of the respondent or the number of children. Other strategies have involved describing individuals in the research arena as a 'new character' by ascribing to them attributes of many different individuals in the field (Hopkins, 1993). Some researchers have left data unpublished altogether for fear of accidental disclosure causing harm or embarrassment to the respondents (Baez, 2002; Kaiser, 2009).

To decrease the challenge between the twin goals of good descriptive methodologies and ensuring the anonymity of the participants a few strategies are advanced. These include using language alerting researchers and ethics boards at the outset that absolute anonymity might not be possible, and allowing strategies for an informed-choice process within the research protocol (Bickford and Nisker, 2014). Primarily it is at the researchers' discretion in deciding how or what details of a respondents' narrative needs to change to maintain confidentiality, and yet not to undermine the integrity of the study (Kaiser, 2009). Nevertheless Baez (2002) asserts that concealment is '*rarely watertight*' and certain individuals or institutions because of their unique status in society are very difficult to cloak and may be recognised by insiders (Punch, 1994). In this study to ensure confidentially in the reporting of the interviews the participants are referred to only as 'policymaker' or 'researcher' with the number of the interview. The participants' educational background, field of study or what level they are at in the organisation will not be stated to minimise the risk of disclosure.

4.5.5 Recruitment and Interview procedure

Recruitment, scheduling and conducting of interviews took place between September 2014 and May 2015. An email was sent to each participant with the words 'Invitation to participate' in the subject heading. It stated the name of the study and the purpose of contact. A letter of invitation was attached printed on the institutions notepaper and signed by the researcher. It stated that if no response was received a follow up phone call would be made within two weeks. If the participant declined to be interviewed or did not respond to requests to participate, communication was made with the next person on the list.

Pilot interview questions were tested prior to commencement of interview scheduling and data collection. Weaknesses, flaws and limitations in the design were detected and revised prior to implementation (Kvale, 2007). Pilot testing is an integral stage in designing the research schedule (Creswell, 2007, Sampson, 2004, Van Teijlingen and Hundley, 2002). It allows for modification of the research questions, identifies what kind of data the questions will yield, and the practice of using the recording equipment in the interview setting is piloted. Two pilot interviews were conducted; comprising one policymaker and one researcher. Following initial contact with a key informant in the Irish civil service and a senior researcher a formal letter was penned. It contained the following information; the researchers name, the purpose of the researcher contacting them, the nature of the research study and the name of the institution sponsoring the research. The research supervisor's name and an estimated length of the interview were also included in the letter. The potential participant was informed of how the data would be used and ensuring them of their anonymity and confidentiality in the process. In order to build trust and rapport with the participants of scientific studies transparency concerning the nature of the researchers' work is paramount (Harvey, 2011; Ostrander, 1993).

The letter was signed by the researcher, scanned and sent as an attachment to the prospective participants. A proviso was included in the letter that if they agreed to take part in the study, they would be emailed the interview schedule several days before the interview. In the event of the recipient of the letter being unable to participate in the study, they were asked to recommend someone who they thought would be able to contribute. At the end of the two pilot interviews the participants were asked to give

feedback on the process. They audio recordings were evaluated to critically assess the interview schedule and the appropriate uses of prompts. No adjustments were required for the interview schedule with the participant researchers. However, on feedback of the policymaker's interview schedule the question on the participants' age was changed to how long they had worked in the civil service. Both participants felt it was a good idea to review the interview schedule before the meeting. The pilot interviews ranged in length from 30 – 45 minutes. The optimal time recommended for qualitative interviews will depend on the type and nature of the research questions. For example, in-depth interviews on sensitive issues may require longer with fewer participants, whereas with semi-structured interviews and a larger population group a shorter interview time maybe sufficient. Rowley (2012) recommends interviews of 30 minutes in length for studies involving 12 participants and 60 minutes for studies with six to eight participants. However, this appears rather formulaic and frequently subject matter and the time potential interviewees can make available will also be a factor.

4.5.5.1 *Interviews with policymakers*

In phase two of the study in-depth semi-structured interviews with key informants from the Irish civil service were conducted between August 2014 and April 2015. These interviews explored the real-life context of policymaking and the perspectives of policymakers on how academic research is used in the process. Also discussed were the barriers and facilitators to the use of research and how the uptake of research by policymakers could be increased.

First contact was made with participants through email inviting them to participate. A scanned letter of invitation was attached with an outline of the research project. The letter included a request for an interview with permission for it to be recorded. Consent was obtained when the participant agreed to be interviewed. Anonymity was assured and the interviewee could choose between a telephone or a face-to-face interview (see Appendix E). Verbal consent was again sought and received from the participants at the beginning of each interview. Interviews with the eight policymakers were conducted by telephone. The initial questions on the interview schedule were questions concerning the length of time the participant had worked in the civil service, their educational background and the how long they were in their present position. The questions were designed not only to give context to the study, but also to put the

interviewee at ease and to build rapport. The remainder of the questions inquired about policymaking and the use of research evidence in the process, most specifically in relation to alcohol and drug policy. The participants at times could divert from the interview schedule but were gently brought back with the use of prompts. All recordings were secured in a locked filing cabinet in line with NUIG data storage guidelines. The media files of the interviews were anonymised and together with Microsoft (MS) transcripts were held on a password secured personal computer (PC).

4.5.5.2 Interviews with academic researchers

In phase three the author conducted in-depth semi-structured interviews with key informants from the research fields of alcohol and illegal drug research in the Republic of Ireland. It explored their perceptions and understanding of the use of academic research in the policymaking process. In addition, it explored the participants' knowledge and awareness of the broader impacts of their work using the Research Impact Framework (Kuruvilla, et al., 2006). (please see Appendix G). The procedures were identical to phase two for making initial contact with key informants from the research arena. One interview was conducted through Skype, two were conducted by telephone and the remainder were conducted with participants in their place of work.

The data from the three sources of evidence were triangulated to answer the research questions:

- How academic research is used in developing public policy in the fields of drug and alcohol misuse?
- What are the pathways /linkages and exchange models that best describe how research impacts in this area of policy in Ireland?
- How can the barriers to the use of research be overcome and the facilitators enhanced?
- To test the Research Impact Framework (Kuruvilla, 2006) in exploring how academic researchers think through the impact of their work.

4.6 Triangulation

Case study research frequently involves using multiple sources of data to accumulate connecting evidence and to triangulate over a phenomenon of interest (Patton, 1990; Yin, 1999, 2014). The different data sources can provide a comprehensive picture of an issue under investigation (Kaplan and Duchon 1988). Distinct forms of triangulation were identified by Denzin (1978) and later expanded on by Patton (1999); i) *methods triangulation,* using quantitative and qualitative approaches; ii) *triangulation of data,* connecting data collected from different sources or at different time periods; iii) investigator triangulation, includes using a number of observers or interviewers in collecting the data to reduce bias; and iiii) *theory/perspective triangulation* is where a number of different theories or perspectives are used to interpret the data. Critics of using triangulation for validation argue that problems can occur in both theory and practice (Bloor, 1997). Employing different methods to collect data may result in the issue being defined in very specific ways. Accordingly, the outcome may be inconsistent with conflicting information amassed (Miles and Huberman, 1994). In addition, it may be inappropriate to pool methods from alternative paradigmatic orientations (Blaikie, 1991). Triangulation is now largely viewed as an approach to gaining additional information on the phenomenon under investigation, rather than a validation strategy (Denzin and Lincoln, 1994; Flick, 1992, 2004).

Triangulation is employed in this thesis is to gain a deeper understanding of *how academic research impacts on substance misuse policy.* A tangible example of the types of knowledge/evidence that informs policy was obtained from the data collected from the policy documents. An understanding of the policy development procedures and the use of evidence in that process was learned from the interview data.

4.7 Data Management

A formal case study database was developed in Microsoft Excel for the management of data in this project. Data management is concerned with the documenting and organising of all data collected; the documentary data, the interview data, the field notes, and the summary reports. This was available to the supervisor for inspection.

All documents used in the study were stored in the database and links to the method of analysis are visible on inspection. Contact with participants was made through email, with the date, time and mode of interview recorded. The subsequent interviews were transcribed verbatim, numbered and stored with the relevant field notes according to university policy and best research practice. An audit trail can be drawn between the research question being addressed, the interview schedule, how the interview was analysed and the interview participant as per the case study protocol. This was to make the process as explicit as possible and to address the construct validity and reliability of the study.

4.8 Analysis of qualitative interviews

Qualitative research can produce vast amounts of rich data, including verbatim transcripts, field notes, discussions and audio recordings. However, whilst these materials are rich sources of data and provide a detailed descriptive record of the issues under investigation, they cannot provide explanations. Crabtree and Miller (1999) suggest that the interpretation of the data is influenced by the interplay between the researcher's subjective assumptions and the objective facts of the data collected, and this iterative process continues towards a contextual truth. Dicicco-Bloom and Crabtree (2006) describe several approaches and categories used in the analysis of qualitative data as defined by Crabtree and Miller (1999), 'editing' (the grounded theory approach), 'templating' (coding and categorising segments of text), and the immersion/crystallisation approach ('*the analysists repeatedly immerses himself in the text in reflective cycles until interpretations intuitively crystallise')* (p. 316). These different approaches provide a framework for identifying meaningful, analysable units and categories for connecting and corroborating the evidence to produce a representative account. The strategies are flexible and are distinct from one another by the timing of the classification and the process of organising the data. The approach adopted in this study is 'templating' which employs King's (2012) Template Analysis Framework.

4.8.1 Rationale for Template Analysis

Template analysis emanated from the US in the 1990s and was primarily associated with the field of organisational research. It emerged from the structured approaches of Grounded Theory and Interpretative Phenomenological Analysis (IPA) (Waring and Wainwright, 2008; Crabtree and Miller, 1999). King (2012) defines template analysis as '*a style of thematic analysis that balances a relatively high degree of structure in the process of analysing textual data with the flexibility to adapt it to the needs of a particular study*' (p.426). It is more flexible than framework analysis (Ritchie and Spencer, 1994) as the *a priori* codes can be changed and revised as the analysis progresses. Template analysis is a technique rather than a methodology and can be used by researchers from varying philosophical positions (King, 2012). It is particularly suited to researchers coming from a 'contextual constructivist' position (Madill et al., 2000). The fundamental assumption is there will always be multiple interpretations made of any phenomenon depending on the perspective of the researcher and the context of the research (King, 2012). Therefore, anxieties concerning coding are considered irrelevant. The emphasis is on the skill of the researcher in reflexive practice, the attempt to approach the topic from the different perspectives and the richness of the description produced (King, 2012: Wimalasiri et al., 2008).

Template analysis is comparable to IPA when used within a broadly phenomenological approach; nonetheless, it differs in its use of *a priori* codes and the balance within and across case analysis. The use of *a priori codes* makes this type of analysis less time consuming and assists greatly in the analysis of larger sets of data (King, 2012). One of the objectives of this study was to explore the different views and opinions of key informants of the policy-making process. Template analysis expedites this exploration of views and opinions across the cases to be examined (King et al., 2004).

4.8.1.1 Analysis of policymakers interviews

In creating a template of themes for coding, the *a priori* coding corresponded closely to the interview topic guide, and as King (2004) suggests, questions that were used as probes to explore the topic further served as second order codes. Comprehensive

sections of text were used in the initial coding. Large sections of text are considered invaluable to the researcher as more text can interpreted in rereading the data (Crabtree and Miller, 1999). Following subsequent readings of the text the initial second order codes were merged and new ones identified. It is difficult to know when the task of modifying and redefining codes is completed (King, 2004). However, if no text has been left un-coded it usually indicates that optimal coding has been achieved. Table 4.4 displays the final template for the policymaker's data.

Table 4.4: Template of *a priori* coding for the policymakers interviews

Topic	First order code	Second order code
Descriptive profile/ biography	Profile of participants	**Job title**- *level in the organisation* **Educational attainment** – *secondary, tertiary* ***Number of years working*** *in the organisation*
Job description and role in the policy process	policymaking	**Types of policies** – *specific policy involved in, role in the process,* **The policy process** –*procedural steps – authority to make decisions – types of knowledge considered - influences on agenda setting* **Other issues** – *ideology/ concerns of stakeholders, legal constraints, political, economic constraints.*
Policy areas	Alcohol policy Drug policy Other	**Influencing factors** – *industry, financial considerations –jobs/excise duty/taxes – tourism/culture, level of public concern/crime/ anti-social behaviour, pressure from voluntary, health sector* **Level of priority** *on political agenda,* *- level of public concern, /crime/ anti-social behaviour, pressure from voluntary, health sector* **The use of research evidence** – *level of influence in specific policy areas, methods of use,*
Research evidence	Types of research evidence preferred How can the existing evidence be improved? How can researchers help the users of evidence?	**Methods** - *quantitative, qualitative, quasi-economic studies* **Communication** - *dissemination of information – channels of communication, effective/non-effective communication techniques, barriers, facilitators, presentation of results* **Policy outcomes** – *independent critique – highlighting future policy issues,* *Role of the researcher – independent bystander/ engage with policymakers –* *Engagement with the media*

The final question of the interview schedule (coloured in blue), was asked of both participant researchers and policymakers. It addressed the use of research evidence and is coded similarly for both groups.

4.8.1.2 Analysis of participant researchers interviews

In the analysis of interviews with key informants from the research arena Template Analyses paralleled the framework developed by Kuruvilla et al., (2006) to explore researchers' knowledge of the impact of their work. In both frameworks, *a priori* set of codes were developed that corresponded to the interview schedule

Table 4.5: Template of *a priori* coding for the researchers interviews

Topic	Operational codes

Research-related impacts	Types of knowledge/problems addressed
	    Methods used
	    Numbers of papers and citations
	    Grant funding and collaborations
	    Dissemination

Policy impacts	Level of impact
	    Subnational, national, international
	Nature of impact
	    Conceptual
	    Instrumental
	Member of policy networks/has your research been used for political capital

Service impacts	Influence on health/public service: *Workplace health/road safety* Influence on evidence-based practice/ guidelines
Societal impacts	Societal changes- *changes in knowledge and attitude about health behaviours* *Changes in health status/ health literacy*

Research evidence	Types of research evidence preferred
	    - quantitative, qualitative, quasi-economic studies
	How can the existing evidence be improved?
	    - dissemination of information – channels of communication,
	    effective/non-effective communication techniques, barriers,
	    facilitators, presentation of results
	How can researchers help the users of evidence*?*
	    independent critique – highlighting future policy issues,
	    Role of the researcher – independent bystander/ engage with
	    policymakers –
	    Engagement with the media

The researcher's interview data was coded using Kuruvilla et al.,'s (2006) Research Impact Framework. For example, the *a priori* code of '*research-related impacts'* for operational purposes was further refined to include '*types of problems the research addressed' 'methods used' 'papers and citations' 'dissemination' 'funding and collaborations' 'PhDs and other higher qualifications'*. This is in line with the advice of the authors of the Research Impact Framework that '*themes can be can be removed, added to, grouped, or modified as appropriate to the research being described'*

(Kuruvilla *et al.,* 2006; p.4). Table 4.5 presents the template for the *a priori* coding and the operational codes.

4.9 Reflection on the study design and research process

This study employed a case study design to investigate how academic research impacts on public health policy on substance misuse in Ireland. This form of scientific inquiry was found to be very effective addressing the research questions. Its unique characteristic of facilitating the in-depth investigation of a unit of analysis in context is important where a detailed understanding of the concept is required. The author evaluated the case study design in this project as an effective methodology for exploring the processes and procedures in the use of research evidence in the development of drug and alcohol policy in Ireland.

However, this method is not without its challenges. Accessing senior personnel working at government level can be difficult. Irelands' civil service would have a tradition of secrecy and being loyal to the service is viewed as an important attribute for career progression (Felle, Adshead, 2009). The snowballing technique employed in this study may have inadvertently included participants that are more interested in the topic under investigation than others. This is known as self-selection bias (Costigan and Cox, 2001). Due to the voluntary aspect of participation in research studies this cannot easily be avoided (Robinson, 2014). As the interviews with policymakers progressed attempts were made to select participants with opposing views and these were successful.

This chapter has outlined the epistemological and ontological perspectives of this study. A detailed account of the data collection methods and analysis procedures employed in each phase of the study to achieve the research objectives was given. The following chapters present the results of this study, and deliberate on the findings with due consideration to the extant literature and the theoretical approaches reviewed in previous chapters.

Chapter Five: Unpacking the policymaking process

5.1 Introduction

The results of the analyses of the drugs and alcohol public policy documents are presented in this chapter to understand how research evidence is utilised in public health policymaking. This is supplemented by the interview data from policymakers to describe the policymaking process and the different factors that impact on this procedure. An understanding of the policymaking process in Ireland is essential for later discussions on how the theoretical frameworks referred to in Chapter Three, apply to the empirical data presented here. These two sources of data are presented in sequential sections and each section is prefaced by detail of the sample and data sources.

Section one provides a descriptive overview of the data set developed from the analyses of the documents explicated in 4.4.2 of the methods section. Chi square tests for association were performed to examine relationships between types of knowledge in policy. The relationship between type of knowledge and its purpose in the policy documents was also explored.

Section two provides the context and perspectives of policy-makers on the process of developing the policy documents such as those included in section one. It is structured to mirror the policy process itself. Thus, their views on the context of policy-making are presented first, followed by specific information related to alcohol and drug policy that are explored in more depth to add detail. In reflection on the development process, policymakers' views on the barriers and facilitators to the use of evidence in policy is considered and this section ends with the views of policymakers on how the linkages and pathways between researchers and policymakers can be improved.

First a brief overview of the participants' professional profiles is given with due deference to maintaining their anonymity and confidentiality. Second the participants describe the process of policy development and how research impacts on and influences this process. Alcohol and drug policy are explored in-depth to add detail to this practice. Third the use of research evidence in policymaking is explored to identify what the barriers and facilitators are to its uptake. The fourth section presents the views of policymakers on how the linkages and pathways between researchers and policymakers can be improved.

Section 1

5.2. Results of the analyses of drugs and alcohol policy documents

In total seven policy documents were included. Three were drug policy documents (Building on Experience, National Drug Strategy 2001 – 2008; Mid-term Review of National Drugs Strategy 2001 – 2008; National Drugs Strategy (interim) 2009 – 2016) and four were government reports on alcohol (Strategic Task Force on Alcohol Interim May 2002; Strategic Task Force on Alcohol 2004 Second Report; Report on the Misuse of Alcohol and Other Drugs Jan 2012; Steering Group Report on a National Substance Misuse Strategy Feb. 2012). The documents ranged in length from 47 pages to 144 pages. See Table 5.1 for a description of the documents)

5.2.1 Types of information in the policy documents

The types of knowledge found in the policy documents were grouped into three broad categories; statutory, academic and industry. The statutory category comprised reports and policies from international bodies like the WHO, the EU Commission; governments of other Nation States; policies and statutory documents from the Irish Government, for example the Dept. of Health and the Dept. of Community, Rural and Gaeltacht Affairs, and from other government departments. Reports and commissioned studies from the agencies like the National Advisory Committee on Drugs (NACD), the Economic and Social Research Institute (ESRI), the Health Research Board (HRB) and Combat Poverty Agency for example are included in this category.

International peer reviewed studies and research conducted by Irish institutions published in Irish and international peer reviewed journals are categorised as academic research. This category contains studies commissioned by the Irish Government and those conducted by Irish academic institutions. These studies frequently but not always give rise to academic papers being published in peer-reviewed journals, for example the SLÁN study 2007 (Harrington et al., 2010) and the HBSC Survey 2006 (Kelly, Molcho, and Nic Gabhainn, 2010).

Table 5.1: Policy documents analysed in this study

Government policy documents	Type	Description (all documents are available on the DOH and DOHC website 2001 – 2012)
Building on Experience National Drugs Strategy 2001-2008 Dept. of Tourism Sport and Recreation (2001)	Government policy document	This is a key government report documenting a review of the policy on drugs in 2001. It is 144 pages in length. It assesses and analyses current issues on drugs misuse in Ireland, and sets out a framework for the next seven years to address the issues.
Mid Term Review of the National Drug Strategy 2001-2008 Dept. of Community, Rural and Gaeltacht Affairs (March 2005)	Government policy document	This 78-page document reviewed the progress of the National Drug Strategy to date in achieving its goals and identified emerging trends or gaps in the strategy. Recommendations on how these issues might be addressed were presented.
The National Drugs Strategy (Interim) 2009 – 20016. Dept. of Community, Rural and Gaeltacht Affairs (June 2009)	Government policy document	This is a 125-page document mapping out the strategy to be employed for tackling drug misuse in Ireland over the next 7 years.
Strategic Task Force on Alcohol Interim Report May 2002 Dept. of Health and Children, (2002)	This report was presented to government by the Strategic Task force on Alcohol. The Task Force comprises representatives of government Depts. State agencies, the Drinks Industry Ireland and others who have a key role in addressing alcohol issues in society	This is a 47-page document. It reviewed the international evidence on effective measures to reduce alcohol consumption in society. It documents changes in behaviour and attitudes to alcohol consumption in the preceding decade and made specific recommendations to government on measures to reduce alcohol related harm in society. It also contains a Minority Report by the Drinks Industry Ireland who were also represented on the Task Force

Strategic Task Force on Alcohol Second Report September 2004 Dept. of Health and Children, (2002)	This is the second report by the STFA.	This 60-page report documented the current trends in alcohol consumption patterns in Ireland among children and adults. It produces the evidence for the burden of alcohol related harm in society and describes the measures that have already been implemented after the 2002 report. It provides further recommendations under the public health approach in reducing alcohol related harm in Irish society.
Report on The Misuse of Alcohol and Other Drugs January 2012 Houses of the Oireachtas, Joint Committee on Health and Children (2012)	This report was prepared by the 'Houses of the Oireachtas Joint Committee on Health and Children".	The committee and the Minister of State at the Dept. of Health reported on the misuse of alcohol and drugs in society in January 2012. This 76-page report highlighted the problems of alcohol misuse and supported the Government's decision in March 2009 to include alcohol in the National Substance Misuse Strategy.
Steering Group Report on a National Substance Misuse Strategy February 2012 Dept. of Health	This policy document was developed by the New Steering Group under the auspices of the Department of Health. *	The Substance Misuse Strategy concentrated on alcohol consumption in society and made recommendations to align the alcohol strategy with the National Drug Strategy 2009-2016. This report was 84 pages in length.

*The original Steering Group was chaired jointly by the Department of Health and Children, and the Department of Community, Rural and Gaeltacht Affairs (later reformed into the Dept. of Community, Equality and Gaeltacht Affairs). In May 2011, the functions of the Office for the Minister for Drugs was moved into the Dept. of Health and the subsequent Steering Group was chaired by the Dept. of Health.
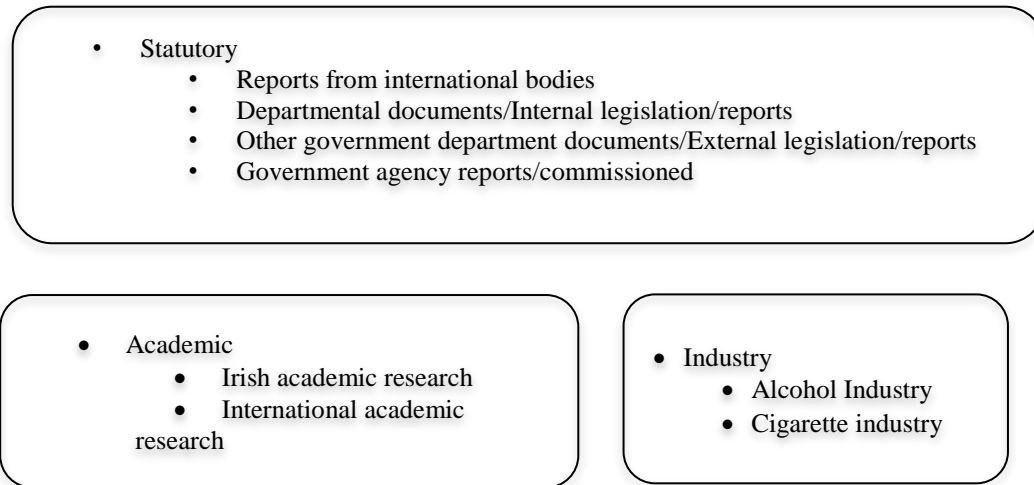
Figure 5.1: Categories of information cited in government policy documents.

There were 423 instances of 'knowledge' referenced on the seven policy documents. Clarification on how the types of knowledge were coded can be found in the methods section under 4.4.3. *'International academic research'* (16.5%, n=70,) and '*other government documents'* was cited (16.8%, n=71) times. The most frequently referenced type of knowledge was *'government agency reports'* (18.9%, n=80). There were (15.4%, n=65) references to '*Irish academic/scientific research'* on the 7 policy documents. (Please see Figure 5.1).
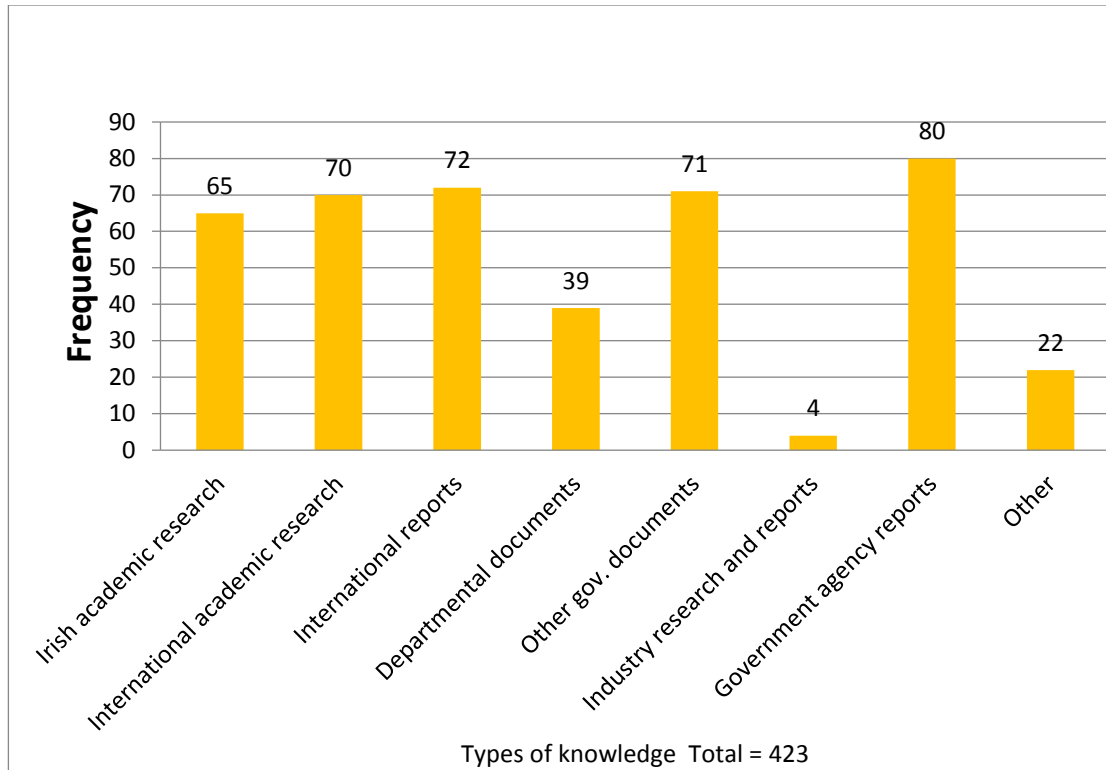
Figure 5.2: Type of information cited on government policy documents and reports

5.2.1.1 Drug policy documents

The most frequently cited type of information on drug policy documents was other government documents (29.1%, n=44), followed by government agency reports (27.2%, n=41), and international reports (10.6%, n=16). Irish and international academic research combined made up (26.5%, n=40) of all the information cited on the drug policy documents.

5.2.1.2 Alcohol policy documents

On alcohol policy documents, international academic research was the most frequently cited information (20.7%, n=54), followed by international reports (17.6%, n=46) and Irish academic research (16.9% n=44). The departments own documents accounted for (15.3%, n=40) of the citations on the alcohol reports, and (11.9%, n=31) were the number of instances of other governmental documents cited. Industry research was cited (1.5%, n=4), while government agency reports were mentioned (10.3%, n=27) times. Information

categorised as other was cited (5.7%, n=15) on the alcohol reports. The term 'other' was used to code any type of information that did not come under the categories in Table 5.1. This table provides an overview of the frequency of citations. Under the category 'other' information received from conference attendance, submission documents from non-governmental organisations (NGOs), or personal information was placed. This category appeared more frequently on the alcohol reports than on the drug policy documents.

In 2002, two agency reports were recorded on the alcohol documents. This had increased to 20 on the document 'Steering Group Report National Substance Misuse Strategy (NSMS) February 2012' representing a 10-fold increase over the four reports. Most types of knowledge cited increased between 2002 and 2012. Irish academic research increased from 11.6% of the type knowledge cited on the report to 18.2% in 2012

A greater number of Irish and international research was used on the alcohol reports than the drug policy documents. A Chi-Square test for independence (all variables were categorical) explained the existence of an association between the origin of the academic research used and the type of document. Chi-square test for independence (with Yates' Continuity Correction) indicated no significant association between origins of academic research and policy type, X^2 @1df = 0 .22, p = 0.64,

Table 5.2: Type of research cited on each policy document

Types of Knowledge	Strategic Task Force on Alcohol Interim Report May 2002 N (%)	Strategic Task Force on Alcohol Interim Report May 2004 N (%)	Report on the Misuse of Alcohol and Other Drugs Jan 2012 N (%)	Steering Group Report on a National Substance Misuse Strategy Feb 2012 N (%)	Building on Experience National Drug Strategy 2001-2008 N (%)	Mid-term Review of the National Drugs Strategy 2001-2008 N (%)	National Drugs Strategy (interim 2009-2016 N (%)	Total N (%)
Irish academic research	5 (11.6)	10(12.7)	11(26.2)	18(18.2)	10(12)	3(25)	8(12.3)	**65(15.4)**
International academic research	5(11.6)	23(29.1)	3(7.1)	20(20.2)	12(14.5)	0(0)	7(10.8)	**70(16.5)**
International reports	8(18.6)	13(16.5)	11(26.2)	15(15.2)	22(26.5)	0(0)	3(4.6)	**72(17)**
Departmental documents	13(30.2)	8(10.1)	2(4.8)	11(11.1)	0(0)	2(16.7)	3(4.6)	**39(9.2)**
Other Gov. documents	8(18.6)	9(11.4)	3(7.1)	10(10.1)	19(22.9)	3(25)	19(29.2)	**71(16.8)**
Industry research	1(12.3)	0(0)	1(2.4)	2(2)	0(0)	0(0)	0(0)	**4(0.9)**
Gov. agency reports	2(4.7)	4(5.1)	10(23.8)	20(20.2)	16(19.3)	4(33.3)	24(36.9)	**80(18.9)**
Other	1(2.3)	12(15.2)	1(2.4)	3(3)	4(4.8)	0(0)	1(1.5)	**22(5.2)**
Total	**43(100)**	**79(100)**	**42(100)**	**99(100)**	**83(100)**	**12(100)**	**65(100)**	**423(100)**

5.2.2 Purpose of reference to information

The main purpose of reference to all types of information on the documents was the justification for policy development in the policy area, (58.6%, n=248). See Table 5.4. Irish academic research (70.8%, n=46) was referenced most frequently for justification for policy development in alcohol and drug misuse across the seven documents. The most cited type of knowledge was government agency reports (61.3%, n=49) followed by other government department documents (67.6%, n=48) under 'justification for policy development'.

International academic research was the most frequently cited under recommendations (54.3%, n=38). The least type of knowledge referenced on the policy documents was industry research and reports (50%, n=2) under both 'recommendations' and 'justification for the policy'.

Table 5.3: Purpose of Information on the policy documents

Types of Knowledge	Justification for policy development N (%)	Recommendations N (%)	Both N (%)	Not specified N (%)	Total
Irish academic research	46 (70.8)	9 (13.8)	8 (12.3)	2 (3.1)	**65 (100)**
International academic research	29 (41.4)	38 (54.3)	0 (0)	3 (4.3)	**70 (100)**
International reports	45 (62.5)	20 (27.8)	4 (5.6)	3 (4.2)	**72 (100)**
Departmental documents	15 (38.5)	24 (61.5)	0 (0)	0 (0)	**39 (100)**
Other Gov. documents	48 (67.6)	21 (29.6)	1 (1.4)	1 (1.4)	**71 (100)**
Industry research	2 (50)	2 (50)	0 (0)	0 (0)	**4 (100)**
Gov. agency reports	49 (61.3)	24 (30)	4 (5.0)	3 (3.8)	**80 (100)**
Other	14 (63.6)	8 (36.4)	0 (0)	0 (0)	**22 (100)**
Total	**248 (58.6)**	**146 (34.5)**	**17 (4)**	**12 (2.8)**	**423 (100)**

5.3 Reflections on types of knowledge cited in the policy documents

An overview of the types of knowledge cited in government alcohol and drug policy documents was presented in this subsection. The frequency of research produced by Irish academic institutions cited in the documents compared to other sources of knowledge was identified. It also explored the origins of the knowledge reported in the documents.

Several difficulties were encountered when coding for 'types of information'. For example, commissioned studies that were conducted by universities were coded under 'Academic research'. If the study was carried out by a government agency it was coded under 'government agencies'. As explained earlier the rational for placing studies commissioned and conducted by academic institutions under academic research is that frequently they generate publications in peer-reviewed journals. However, studies coded under government agencies although not peer reviewed would also claim to be of academic standard (ESRI 2017). Figure 5.3 provides an overview of the most frequently cited organisations in the policy documents and how they overlap. A key function of these organisations is to provide policy relevant advice to government based on research evidence.
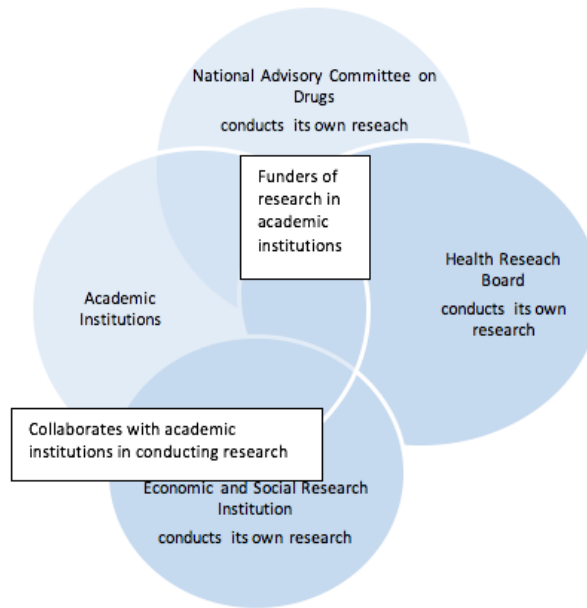
Figure 5.3: An illustration of the agencies involved in health research cited on the policy documents and how they overlap

To gain a more in-depth understanding of how decisions are made in formulating policy and deciding what goes into the policy documents the next section will now explore the policymaking process with key informants from the Irish civil service.

Section 2

5.3 Participants profile

Eight key informants from the Irish public administration service were interviewed. An overview of the participants' educational qualifications is given in Table 5.3. To retain the anonymity and confidentially of the informants where they work in the organisation, or what current position they hold is not referred to in the reporting of the results. All informants had worked or were presently employed at mid-to-senior level in the national civil service. They were recruited across several government departments. The key informants discussed policymaking from the viewpoint of the role they played in the process. The number of years they had worked in the civil service ranged from 12 – 37 years, mean = 23.12 years. All the policymakers interviewed were female, this was not intentional.

Table 5.4: Participants profile - policymakers

Occupation	No.	Gender	Educational Level National Qualifications Framework (http://www.nfq-qqi.com/)
Policymaker	1	Female	Level 10
Policymaker	2	Female	Pursuing level 10 qualification
Policymaker	3	Female	Level 10
Policymaker	4	Female	Level 10
Policymaker	5	Female	Level 8
Policymaker	6	Female	Level 9
Policymaker	7	Female	Level 5
Policymaker	8	Female	Level 7

Participants gave the field of study they had qualified in, of those mentioned social policy, children studies, corporate governance and community development were the most frequent answers. Some of the respondents (n-2) had recently retired from the service. Two candidates felt their current position was not as relevant to the policymaking process, so they spoke from the viewpoint of the previous position they had occupied. The respondents were involved in developing or implementing and evaluating a range of policies over the years, in social welfare, health and the community (i.e., the National Play Policy, the National Health Promotion Strategy 2000 to 2005, the National Drug Strategy 2001 – 2008, and the National Drug Strategy 2009-2016, the Fair Deal Strategy, the Disability Strategy, Sports Capital Programmes, Housing and Rural Development Policy) were all cited.

5.3.1 The policy process

The type of policies the respondents were involved in are listed under the participant's profile. This section reports on the policymakers' views and opinions of the policymaking process. The practices and procedures involved in developing policy are discussed together with a reflection on the contextual factors that impact on this task. No distinction was made by policy-makers in their discussion of the process of policy-making between information to justify the need for a policy or information on how

best to respond to policy problems. In the text an amalgamation of all the policymakers' interviews in the study are presented; quotations are included to represent the views of the respondents and are used for illustrative purposes only.

The process of policymaking

Lack of transparency at government level in the practice of developing policy is a frequent topic in the academic literature on policymaking (Relly and Sabharwal, 2009; Fenster, 2005; Cairney, 2012). To understand this complex, often considered obscure procedure the respondents described the role civil servants in the policymaking process. Mid-level servants are tasked with sourcing the research evidence and reporting the findings to senior level where decisions are made in determining what goes into a policy document. In the Republic of Ireland, this can involve civil servants at the assistant principal (AP) level or the higher executive officer level (HEO) in the administration. Executive officers are employed through the public recruitment process. It is a competitive process that requires an educational qualification to honours degree level (NFQ level 7/8). Heretofore an honours degree in any subject was sufficient; however more recently, explicit qualifications in subject areas such as economics and law are required. The Secretary General is head of the Department and underneath that there is the Assistant Secretary, who is responsible for a considerable amount of work in the Department. Several principal officers report to the Assistant General and are responsible for specific policy areas. The principal officers (PO) are supported in their preparation work for policy development by assistant principals (AP). One interviewee described their world:

> … they could be working on legislation … they would do all the scoping out, and all the research and all the preparation of papers and briefs and all of that … everything goes up the line then, and part of their job would be finding whatever research was done and abstracting from it …
>
> (Policymaker, 1)

How important research evidence was to a civil servants' work depends on the role they have in the organisation. For those working in research specialist unit's reviewing academic studies and research reports was viewed as an important first stage in developing policy. It was considered essential to review the evidence in a specific area

to define the issue. Statistics were considered critical to establishing the extent of a problem and to help in determining goals for the policy that would ultimately be developed to address the issue. Often this required commissioning targeted pieces of research to answer explicit questions that would feed into the policy decision.

For senior civil servants, the technicality of writing policy documents and what factors impacted on that process was most discussed. It was explained that many policies areas cut across different government departments and this required steering groups to be established to develop and guide the policy. The establishment of steering groups, also known as policy 'forums' 'policy committees' and 'advisory groups', have become a feature of many government organisations over the past 30 years (Fischer and Leifeld, 2015; GV314 Group, 2017; Krick, 2014). They are made up of elected representatives, scientific experts, interest groups and civil servants (Fischer and Leifeld, 2015). The policymakers explained how the research evidence might not always have as big an impact on the final document as one would expect. Many other factors needed to be considered. It was explained that a great deal of policymaking is about looking at what has been implemented in previous strategies and identifying what progress has been made in a specific policy area. Important factors to consider in developing policy included whether the area is a priority for government; whether there were monies available to implement the policy and how active lobbying and interest groups were on certain issues. This senior policymaker described how;

> ... you never get a situation where, you would have a piece of research that gets accepted and gets implemented … it just does not run like that, what the research would do is it just informs the thinking … what actually gets done in the political world sort of depends on what else is happening, whether it is a priority, whether you can get the money for it, what the lobby groups out there are saying about it or not saying about it, whether it is top priority for the government …
>
> (Policymaker, 5)

Legal issues and factors outside of the jurisdiction too were reported as having a significant influence on policy. It was explained that European Union (EU) regulations on specific issues can determine a policy course of action, as can policy developed in other countries around similar problems (e.g., harm reduction approaches to illegal

drug use). The discourse around policy issues by the policymakers accentuated the importance of identifying the advantages and disadvantages of pursuing a specific course of action to address a problem. In addition, ensuring there was ministerial support for the policy developed and confirming that it was not in contravention of the State's own constitution was critical., It was explained;

> … a whole pile of issues come in to play in relation to, [policymaking}… I mean legality works both ways in that you wouldn't want to be doing anything illegal, but equally if you have been found in the courts to be not doing something you should doing, so there might be an onus on you to act …

> (Policymaker, 8)

The scientific evidence was considered important, but its influence many respondents believed, was more nuanced. Policymakers spoke about why a policy is developed in the first place and the essential role individuals or groups have in driving policy. The civil servants viewed their work as drafting the policy document for politicians to endorse. Policymaking was described as:

> … the art of the possible, it's like politics, it is not clean, it is highly complex and it is as much art as it is science … so it is about what you can manoeuvre through in a given set of circumstances …

> (Policymaker, 6)

It was said that much of the critique of government policy is that a policy is put in place and it is not implemented or only partially implemented. The Cardiovascular strategy (DOH, 1999) was given as an example of a policy that was well coordinated and implemented, other policies such as the Sexual Health Strategy (DOHC, 2006) they believed had suffered from the outset because of a lack planning and accountability. In contrast to the policy areas that are the focus of this study, the Cardiovascular Strategy could be regarded as a straightforward problem that is amenable to being influenced and guided by the scientific research with a minimum number of prominent stakeholders (Head, 2019). Sexual health would fit into the definition of a 'wicked problem' in that responses to this issue requires cooperation

and engagement across multiple government agencies and the engagement of various stakeholders, who may have very diverse views and values on the priorities of the issues involved, and the most appropriate methods of implementation (Ferlie, Fitzgerald, McGivern, et al., 2011).

The political nature of policymaking

Policymakers who were at the forefront of policymaking for many years described the real struggle in getting agreement around policy issues. The very political nature of policymaking was contemplated by several of the participants. Interviewees expressed frustration about the difficulty of reaching agreement on policy goals among the different stakeholders. It was stated that the policy issue at the centre of the discussion was not always to the forefront of people's minds. Instead how the policy was going to impact on them individually or on their organisation was paramount. Many of the participants described how this was a very difficult situation for civil servants when they were trying to develop and mediate policy. They believed the decision-making process was hindered by individuals and organisations self-interest "… what organisation is this going to collapse most … that is going to fight back the hardest but how do you deal with that … what is going to be the most politicised …" (policymaker, 2). It was at this stage in the policy process that the civil servants reported that the facts and the scientific evidence around issues became important. It helped to bring calm and logic to the discussions by unequivocally defining the extent of the problem "… by putting the facts on the table, what are the policies, whose implementing them, how many people are being impacted, how much money are we spending, what are the options for doing it better …" (policymaker, 6). As this policymaker asserted:

In a whole host of situations people have an agenda … you are trying to develop and mediate policy, and everyone wants their own bit of the jigsaw ... very few people to be honest are in that space, they are all in, I want this for my section or my group, or my this or my that …

(Policy maker, 6)

To illustrate the difficulty at times encountered in getting government departments to work together, the policymakers referred to children's policies. They reported how no single service or Department could attend to the needs of children. Input was and is required from multiple sources, for instance different government departments as well as government agencies and services. The policymakers recounted how difficult it was on occasions to get people to work together on issues. Senior civil servants were most comfortable working in their own nominated areas. As one interviewee explained, in order to ensure that children coming from disadvantaged backgrounds achieve in the educational system, both housing and welfare services needed to be working successfully. Considerable effort was employed in encouraging the relevant government departments to work together on specific policy issues. It was explained:

> … if you get them [Departments] to work in harmony, the policies would be more successful … what I was trying to do was to try and get away from the silo approach of both policy and services, and try to get people to join up, but that is easier said than done … what I learned in order to get anyone to work with you, you have to make their policy objectives your policy also, and not be seen as a threat … so you can do a lot of networking, a lot coaxing, cajoling ...
>
> (Policymaker, 5)

Accessing the research evidence

In exploring the policymaking process policymakers were asked how they accessed the research evidence. It was explained that research was not really part of a policymakers remit unless the civil servant worked in a specialist research unit. One interviewee described while working as a senior research officer in a specialist unit, her role was supporting different units in the department in their use of evidence. This included collating the empirical research and building evidence for the development of policy around specific policy areas. Most Departments would only have limited access to the most recent studies. It was more usual to commission outside agencies to conduct the research, the *National Longitudinal Study of Children growing up in Ireland* (Williams, J., Greene, S., Doyle, et al., 2009) was given as an exemplar of the type of studies that would be commissioned. However, the participants reported certain departments like the Department of Health would have a professional librarian and well established links with major universities. The importance of these types of

linkages and exchange mechanisms was emphasised by the civil servants. It was stated professional networks and good relationships with University Departments were crucial in times when information was needed quickly:

> … from time to time as requests come in from different departments or how something is, an issue of the day, maybe around Traveller children … around children from ethnic minorities, you can pick up the phone to them and ask them, to run an analysis or update the figures that we have … we have built up a very good relationship with people who collect data, or undertake research and really, they've been a massive resource to us …

> (Policymaker, 4)

One senior interviewee described how they had organised knowledge transfer seminars over the years, to inform civil servants how to access and identify good research evidence. The topics discussed were *"how to ask a good research question", "what makes a good piece of research"* and *"how to read a research paper"* were included. Most frequently if there were large piece of policy being developed the research would be specifically commissioned.

How policy is developed and the role of civil servants in this process, were described in this subsection. The many contextual factors such as the role of individuals and issues outside of the policy area that can have an impact on this process were discussed. The use of research evidence and how policymakers access the information was described.

Next the two policy areas that are the focus of this study are explored in more detail to deepen our understanding of the influence of research evidence on policy process.

5.3.2 The views of policymakers on alcohol policy

The discourse around alcohol policy by the civil servants was that policy in this area was underdeveloped for many years. However, some argued that this view was predicated on how policy was defined. They suggested if policy could be defined as *"a statement of government intent"* progress has been made. They gave examples of

the government signing up to the Declaration on Young People and Alcohol in 2004 and the two Strategic Task Force Reports on Alcohol in 2002 and 2004 (DOH, 2002; 2004). All participants agreed that we have a very serious problem with alcohol in Ireland and that the research evidence supported this view. Many believed it was not a priority for government. Others considered the Irish population was not sufficiently concerned about this issue to make it a priority on the policy agenda. Alcohol policy was compared to policy development in other areas, for example drug policy:

> … the drug policy was very developed because…. the people pushing policy were very vociferous, very strong and really made it happen ... communities and key people were exercised and politicized ... and it was driven, alcohol policy suffered from that all along ... there were generally only one or two voices ... and it hasn't had the same type of push, the same type of investment at NGO level, community voices are seen to be much lower …
>
> (Policymaker, 2)

The Irish population's strong cultural relationship with alcohol was discussed many times. This included the failure of society in a comprehensive way to come to terms with the social norms of the overconsumption of alcohol. The participants reported that part of this reluctance was because alcohol consumption permeated every level of society *... we just have a culture we drink too much, and we binge drink ... its woven into the fabric of society ...* (Policymaker, 8). This was contrasted with the consumption of drugs, where it was regarded that only a small disadvantaged group in society were most affected by drug misuse. The participants reported how Ireland portrays itself to the world as alcohol being part of the Irish heritage. Images of visiting dignitaries photographed at the Guinness Storehouse, or *raising a pint in the local pub* were popularised in the mainstream media. It was suggested that this image of alcohol ignored the serious harms caused by its overconsumption to the individual and to society (Mongan, Hope and Nelson, 2009). According to the policymakers we were failing to tackle this very serious public health issue:

> … there is a huge cultural predisposition in Ireland towards alcohol … and the combined efforts, of very well intentioned researchers and medics and

administrators, have failed to grasp and grapple with those very deep seated cultural norms in our society …

<div align="right">(Policymaker, 6)</div>

The strength and importance of the alcohol industry to our economy was highlighted by many of the participants. The prominent role it had in providing employment in the production, retail and marketing of alcohol were outlined. Primarily it was a valuable revenue stream for government. This was illustrated by one participant who had been working at a senior level in the administration for many years. The interviewee recalled how in the depths of the economic recession there were many demands for the alcohol sponsorship of sport to be stopped. The scientific evidence had demonstrated an irrefutable link between the alcohol industries sponsorship of sport and young people drinking … *there is all this research about the drinks people supporting sport ... we have to get rid of that, and for a long time, health was going up the path of we must get rid of them …* (Policymaker, 5). The interviewee claimed that the Minister for Sport took a very rational approach to the evidence and policy at that time … *the then [Minister] makes a pragmatic decision, we can't get rid of them because there is no money to replace them ... (Ibid).* The alcohol industries sponsorship of sport was not banned because there was not adequate funding in the government's coffers to replace the sponsorship of sport. The Minister appeased the interest groups on the health side at that time by accepting some of their recommendations, for example increasing the taxes on alcohol. More commonly policies are watered down due to difficulties of governments finding alternatives sources of revenue. This policymaker stated:

> … so, a few (recommendations) have gone up the line now of just increase the prices, because that is easier to do, cause less hassle and it will upset far fewer people, and we will keep the other crowd in which is keeping sport going, which is good for our health anyway, policy you know must be easy to implement, doesn't upset important people, and get some good out of it …

<div align="right">(Policymaker, 5)</div>

Other participants reported how over many years the alcohol industry had frustrated and obstructed any meaningful progress in alcohol policy. Different stakeholders had

used evidence and other issues to advance their own views on this policy area. It was suggested that the evidence on alcohol harm was never advanced in strong enough terms to usurp the power of the alcohol industry:

… there was always a tension and remains to this day between the strength of the alcohol industry and the health issues in alcohol … it was a highly-contested space, highly contested and no matter what evidence was put forward in this area, it seems to me it was always trumped by the alcohol industry, with a whole other set of issues …

(Policymaker, 8)

More policymakers welcomed the fact that there is now a combined drug and alcohol strategy (National Drugs Strategy, 2009-2016) under the patronage of the Department of Health. The policymakers view was that there should not have been separate strategies for drugs and alcohol, as the fall out for families and communities were very similar. However, they went on to reiterate what many of the other policymakers had already said that alcohol problems permeate all of society:

… we were definitely of the view that the two strategies, should be joined, because a lot of the fallout from both the addictions of drugs and alcohol and the impact on families and society were very similar… the industry lobby wouldn't have liked that … they wanted to keep alcohol a legitimate drug, and on the face of it [the industry] were promoting more responsible drinking … they did not want the two strategies to be joined up … and ultimately it was …

(Policymaker, 7)

In the above quote the policymakers are referring to the approval made by government to a Combined National Substance Misuse Strategy to cover both alcohol and drugs on the 31st March 2009. The 2009-2016 National Drugs Strategy (interim) established the context and rationale for alcohol misuse in society to be incorporated into an overall National Substance Misuse Strategy (Dep. of Community, Rural and Gaeltacht Affairs, 2009). A subsequent report published in 2012 (Dept. of Health, 2012) made recommendations of how alcohol policy could be inserted into the existing policy structures of the National Drugs Strategy.

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5.3.3 The views of policymakers on drug policy

Unlike alcohol policy, illegal drug strategies were quite well developed and formulated in Ireland because of the heroin crises that plagued Dublin in the 1980s (Butler, 1991; O'Gorman, 1998). By the late 1990s the policies that were in place were inadequate to deal with a second heroin epidemic that beset Dublin in those years. From the late 1990s onwards, a more collaborative and coordinated approach to illegal drugs began to emerge from government circles (Department of the Taoiseach, 1996). Policymakers suggested that this was due to the drive and push for policies that was prompted by community activists and concerned citizens because of the illegal drug activities in their communities. One policymaker described how when she came into the civil service in 2001:

> … the crisis had gotten to such a level of difficulty that this could no longer be avoided, the non-governmental sector had become very exercised, they were well able to put a push on, to keep pressure on, they had access to decision makers and access to power … the 2001 strategy is about bringing people together getting the right people around table, of having a coordinated approach as opposed to a piecemeal approach …

> (Policymaker, 2)

In the Department of the Taoiseach[18] a Cabinet Committee on Social Inclusion was established in 1997. Its mandate was to "give political direction to the government's social inclusion policies, including the national drugs strategy" (Dept. of Tourism Sport and Recreation, 2001-2008; p. 1). It is also responsible for reviewing trends in the misuse of drugs, evaluating the progress of the implementation of the National Drug Strategy, and dealing effectively with any organisational or policy barriers to the successful implementation of the policy. The reporting structures of the different levels of Interdepartmental Group on Drugs (IDG) were discussed under section 2.3.3. Many of the policymakers believed the effective implementation of the drug strategy

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[18] The Taoiseach is the head of government in Ireland. The Department of the Taoiseach is the headquarters of the Government. It works with other government departments in implementing government policy through the cabinet committee structure. The main policy areas it is responsible for are Economic, International, EU and Northern Ireland, Social Policy and Public Service Reform and Data Protection.

was due to the level of representation of government officials at local level. As one interviewee explained the government departments representatives on the national drug strategy teams (NDST) were at Assistant Principal Officers' level. The remit of the Drug Strategy Team came under the control of the Department of Tourism and Gaeltacht Affairs and it was responsible for funding services through the Drug Task Force process (NDS 2001-2008; NDS 2009-2016). The policymakers described how the weekly meetings with members of local task forces resulted in a better understanding at government level of the issues that the services were struggling with at community level:

> … we met every Tuesday … assisting the local drug task forces in identifying responses in relation to the different strands, the prevention, rehabilitation … the crime side and the research … so that was for five years … we developed projects, we submitted them to the Department of Tourism and Gaeltacht, Affairs … they were the budget holders for the money … by the time I left they would have been investing about 23 million in projects, community based projects …
>
> (Policymaker, 7)

The National Advisory Committee on Drugs (NACD) was set up in 2001. It comprised of researchers from the Health Research Board (HRB)[19], representatives from academia, the health service executive and policy makers. Its function was to advise and inform the government on policy in relation to illegal drug activity. Prior to the establishment of the NACD participants reported there was very little research being conducted on drug issues in Ireland. Initially the NACD conducted prevalence studies on the use of heroin and other drugs across the population (NACD and PHIRB, 2003; 2008). Notwithstanding the foundation of this research organisation and its role in advising government, the participants stated that the research evidence was only one of the many other factors that needed to be considered in developing policy:

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[19] The Medical Research Council and the Medico-Social Research Board were merged in 1986 to create the Health Research Board. Its function is to conduct and sponsor research in the areas of medicine, epidemiological research, health and health services research.

> … I wouldn't want to overstate it, there is maybe ah strange relationship sometimes between research and policy (chuckle) they don't always follow on as neatly as you would like … the recommendations in terms of some of the stuff that was coming out of the research were expensive, cost money and departments maybe weren't always necessarily in a position to be able to meet those demands …

> (Policymaker, 8)

Many policymakers felt that even though the drug policy was well coordinated and implemented, it was difficult to say if it was successful or even if they were getting to grips with the whole illegal drugs area. It was acknowledged that a lot of progress had been made but the nature of the illicit drug use in society made it very hard for policy to stay one step ahead of the problem. New psychoactive substances were constantly being sold in 'head' shops and legislation often lagged behind the types of substances that could be bought and sold. The European Monitoring Centre for Drugs and Drug Abuse (EMCDDA) (www.emcdda.europa.eu/) was established in 1990s to provide fact-based, unbiased and reliable evidence on drugs and drug addiction to policymakers and to health professionals working in this area. In 2005, the early warning system (EWS) was established. The EWS provides for the rapid exchange of information between member states on risk assessment and the control of new psychoactive substances that emerge on the international drug scene. The HRB is the focal point in Ireland for liaising with this body:

> … the problem with the drug [issue] is you are always reacting rather than being proactive in relation to it, the nature of the problem changes so much … in 2001 heroin was the biggest problem we had, by 2008/2009 … it was much more of a kind of poly drug use problem … I think if you look back in the last 15 years there has been huge strides made in terms of treatment, the prevention side has been taken much more seriously, and the research side … a huge body of research done over the last 10 -15 years as well …

> (Policymaker, 7)

Some interviewees reported that in the present economic climate drug issues were not a priority and in terms of the health agenda they are well down the list of urgencies for government. In an economic downturn, the economy and unemployment are the

dominant issues. Interviewees said it was difficult to remember the last time a Minister for Health was heard talking about drug related issues. The present concerns were waiting lists in hospitals, trolleys and cancer treatment. Furthermore, it was argued that if the drug problem was easy to solve it would have been resolved long ago and the real issue for policymakers was maintaining a commitment to it:

> … it is quite intractable, a lot of people who have drug problems also have other problems, they are homeless, they have mental health issues … it is not easy, they are not an easy cohort to deal with, they are messy in that sense, … we can say well look, we will fire a lot of money at it and we will sort it … part of the problem is just maintaining that level of commitment to it … I could be very cynical and say to you drug users don't vote and they are not seen as critical in that sense … (chuckle)

> (Policymaker, 8)

It was evident from talking to the policymakers that there was originally a feeling of energy and purpose in implementing the drug misuse strategy. However, their feelings of apathy were palpable when they discussed the increasing number of drug misusers and homeless people they were now seeing on the streets of the capital city. Policymakers suggested that those kinds of problems never seem to get solved and fall down the political agenda when other issues in society are prioritised.

This section has reported on the findings of how policy is developed and the role of civil servants in this process. Contextual factors and their impact on policy for example individuals' personal ideologies, economic and political constraints and other issues outside of the policy area were deliberated. The use of research evidence in the formulation of policy was explored by taking an in-depth look at the development of drug and alcohol policy from 2001-2012. The next section will explore the views of policymakers on the utilization of research evidence and how it can be improved.

Section 3

5.4 Views of policymakers on the use of research evidence

This section reports on the perspectives of the policymakers on the type of evidence ministers and senior policy makers found the most convincing, how the existing evidence could be improved and how researchers could help the users of evidence.

Types of evidence

Responses to this question were mixed with some respondents suggesting *very strong evidence* ... where the evidence is ... *not ambiguous* ... and a solution to a problem is clearly demonstrated. While others suggested it was the evidence that was put in front of them. Several policymakers believed that researchers did not spend enough time or effort in disseminating or communicating their work. Many reported that there was a perception that researchers viewed policymakers' work to be less demanding than researchers work and therefore that policymakers should have the time to look for the evidence. They stated that policymaking was a demanding job and due to time constraints, many senior civil servants would only have time to consult research that came across their desk. Other participants reported that the type of evidence that would have the most impact was research evidence that was conscious of the context in which it would arrive. For example, one policymaker stated:

> … what will sell, or what the public are able to swallow … the types of evidence that would get listened to very easily, would be if it is easy to do, and it upsets nobody and there is some payoff out of it…
>
> (Policymaker, 5)

There was a strong belief that medical and scientific evidence was preferred over other types of evidence. It was observed that basic scientific evidence was more quantifiable and the findings could not be easily disputed. The influence of randomised controlled trials, the gold standard of research evidence was mentioned several times. The participants suggested that it was possible to draw inferences from quantitative data and say if it was representative or not, where there was a belief that this was not true

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of qualitative evidence. National evidence was preferred over international evidence and particularly so if it was contextual and current:

> the medical profession is scientific, so that is much easier. I am more used to social policy … oh scientific evidence is a different ball game, scientific evidence is usually based on scientific evidence which is irrefutable ... the evidence around social policy is far more scattered … you can never be sure that it is that one particular thing that caused it, it could be something else ...
>
> (Policymaker, 5)

The importance of context and the circumstances in which policymaking was developed was underlined several times. One policymaker described how in her long career in the civil service she has been through two booms and three busts. It was much easier to make policy in a recession as it is about cutting resources, for example in services or employment numbers. She described how the research evidence had little impact in those circumstances. In contrast when the economy is growing making policy could be much more difficult:

> … decision-making is much simpler in a bust … because you are just cutting, whether its pay or numbers or programmes … so no amount of research or evidence assembled at that point could have helped …
>
> (Policymaker, 6)

Equally policymakers reported that research concerning those issues that were highest on the government agenda would receive most attention. To exemplify this fact, the policymakers described how in an economic downturn any research evidence that demonstrated investing in more facilities, or a specific area of education, would improve the employment prospects for individuals would be considered in greater depth. One interviewee stated how over the years she had witnessed a huge improvement in how the evidence was assembled. It was now prepared in a more systematic way, for example in demonstrating outcomes in performance, financial and other impacts. It was suggested that policymakers were now looking at other types of evidence not just the quantitative studies:

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> … so that is the kind of evidence, strong, factual, qualitative evidence, I think we need to move towards … qualitative, usually the focus is on quantitative evidence, my own sense is that the system needs to move towards a much more nuanced sophisticated view on qualitative evidence ...

> (Policymaker, 6)

Research demonstrating that a specific approach works was also considered influential in policy development. For example, harm reduction programmes and needle exchange programmes that were empirically evaluated in other countries were contemplated for implementation in Ireland. This relates back to the earlier discussion of examining policy approaches to similar societal issues in other countries. As one policymaker explained:

> ... it is about showing where in situations someone has cracked the problem, that is not always readily available … free needle exchanges things like that, things that would have been tried in other countries, we would have talked to the people who would have been running the clinics in Bern in Switzerland, just to get a bit of a feel for their experiences … so a lot of it is about what works, what doesn't, you know what's cost effective …

> (Policymaker, 8)

The interviewees reported how in the early stages of developing the drug strategy, heroin injecting rooms were considered. Ultimately a decision was made not to pursue this approach as the then Minister for Justice and the Department of Justice were not supportive of these harm reduction measures.

5.4.1 How can the existing evidence be improved?
Some participating policymakers thought improving the evidence was difficult for researchers as they would have to be invited in and become part of a team in the policymaking process. The interviewees opined that researchers needed to understand the constraints that policymakers worked under and how the research evidence is not always a priority for policymakers. It was suggested that research could be improved

if its recommendations were costed, as budgets were a big factor when policy options were being considered. It was articulated that with:

> … the best evidence in the world … budgets must be taken into account, so even though there's a will, and the desire to improve services or deliver services … bring in a new policy and all the evidence behind that, if the money is not available I mean that is kind of a big factor at the end of the day, government implementation …
>
> (Policymaker, 4)

How lines can be blurred between the role and function of researchers and policymakers was also discussed. One policymaker remarked that researchers do and should stand apart from policymaking. The function of researchers was viewed as the producer of evidence and to make recommendations. To influence the policy process was not viewed as a researchers' role. They could disseminate the information to relevant bodies and individuals who wanted or needed to be informed of this type of knowledge. An example was given of a much-respected researcher who it was believed was in danger of crossing the line between research and the policy process. This researcher had become much exercised about the direction a policy issue was developing in, which had a lot of political support. The researcher stated that the policy as it was unfolding was not supported by the research evidence. The advice given to the researcher by one policymaker was:

> … if you cross any more lines now, you are just getting political and you will be less effective if you get into the middle of the political goings on … you become a lobby group, you are not a lobbyist you are a researcher and ah so (name) thanked me for my advice and I think took it …
>
> (Policymaker, 5)

It was the opinion of the policymakers that … *lobbyist should take the research and flog it* … but the researcher would stand outside of it and be independent of the policymaking process. Another long serving senior member of the policy environment felt there was a huge disconnect between academics in Universities and the policy-making system. This policymaker believed that academics had very little interest in

the key policy areas and frequently it was now government agencies, the ESRI, and private consultants that would fill that void:

> … on the plus side, governments departments are better at doing this themselves. On the negative side, there is a real disconnect between policy-making and academia ... there is very few formal links between the Irish Public Service and the University System. There is no forum at all of which I am aware of where researchers come together to talk to policy-makers …
>
> (Policymaker, 6)

An interviewee working at a senior level in the service believed that in the past academics were more engaged with government policy and comfortable at critiquing policy directions on the public airwaves. In recent decades, it was suggested academics were now much more restrained in their critique of public policy and had withdrawn from public debate on many societal issues.

5.4.2 Improving knowledge transfer

The overwhelming majority of policymakers believed that the research evidence needed to be rendered accessible and more user-friendly. One interviewee suggested that it was about making the research available to individuals who were not researchers. She explained handing a 200-page report to a civil servant was not practical. It was important to outline the key messages from the report that would be the most useful to the policymaker.

Some of the suggestions the policymakers made were that the researchers needed to make the evidence relevant to specific policy issues in a user-friendly format. Short concise reports where statistical language was translated in to accessible language with recommendations and key points highlighted. They contended policymakers have neither the time nor the expertise to wade through many of the large volumes of documents that cross their desk.

Other issues raised by policymakers included that they often listen most to those who speak the loudest and most frequently. Similarly, research evidence that is delivered by respected members in society with high credibility in a relevant field would have

an impact. Policymakers suggested that researchers needed to be clearer in what knowledge they wanted to transfer to policymakers, and in making recommendations they should be conscious of what was possible and feasible in the broader context. Policymakers gave examples of some of the more unusual recommendations that researchers had previously given:

> … and we recommend a new department to be set up, which I have actually seen several times … we recommend the establishment of a new state agency to oversee the implementation of this, like that kind of stuff is of no assistance to anybody and it simply undermines the research …
>
> (Policymaker, 2)

More engagement between researchers and policymakers was proposed. Policymakers are essentially generalists, and while they work in a specific department they would have detailed knowledge about the issues of that department. However, at short notice they could be transferred to another department, and all that knowledge would go with them. Policymakers suggested that finding a common language to communicate with each other would greatly help the users of evidence. It was also stated that it should be essential that there was respect for the attributes and knowledge that each side brings to the process:

> … I do think it is very important to have more engagement and interaction, I think there needs to be a great deal more respect between the two communities, and I mean that both ways … respect for the different kinds of roles that people play and the different attributes and characteristics that people bring to the table …
>
> (Policymaker, 3)

Policymakers suggested increasing the awareness among researchers of the constraints on policymakers due to legal and regulatory systems. It is not always possible to adopt policies and intervention programmes that may have proven successful in other countries:

> … start with other jurisdictions to see what is there, we would always start with the UK ... bearing in mind that jurisdictions are different, they have different legal

systems, you are not always able to transpose stuff from one to another … we also have a constitution, so part of your work as a policy maker would be ascertain things we can't do because of our constitution, that they do in other jurisdictions and vice versa …

(Policymaker, 5)

Policymakers and researchers very often have different set of questions that they want addressed. Policymakers believed that senior civil servants needed to know why something was an issue and why it should be put on the government agenda. Could the issue be addressed in a forum other than at the national level? What was the likelihood of things happening if the problem was not addressed? Examples were given of the type of questions policymakers wanted answered. For example, conducting research in an area that may not be a major problem currently in society and extrapolating from the data, what the issue would be 10 years hence if the issue was not addressed. To illustrate this, the increasing levels of obesity in Irish society over the last two decades were discussed. Senior civil servants would have liked researchers to have highlighted this issue in the early 2000s. The participants believed that this type of evidence would have captured the attention of policymakers, by it demonstrating what problems would ensue for the health service, if this issue was not acknowledged.

5.5 Reflections on the policy process

A clear understanding of the policy process has emerged from the interviews with the policymakers in this study. This contrasts with the frequently described opaque nature of public policymaking in the academic literature (Relly and Sabharwal, 2009: Cairney, 2012). A range of factors were shown to have an influence from the scientific evidence to the wider political, cultural and economic climate.

The views of the participants on the use of research evidence was notable different between the mid-level civil servants and senior level administrators involved in policymaking over many years. Mid-level administrators believed the use of research evidence was fundamental to the development of policy, however more experienced and senior administrators considered it to be only one factor among many that

influenced policy development. If the research evidence for example, was not compatible with the political ideologies of the elected representatives it would not be considered. Similarly, economic factors had a significant influence in that the monies may not be available to implement the policies the science was recommending. Powerful stakeholders were also considered important influencers on policy and this was markedly illustrated by the participants' discussion on alcohol policy. This will be discussed further in Chapter Seven.

The findings of the interviews with the policymakers supported the findings of the analyses of the alcohol and drug policy documents. The policymakers described how in the first stages of developing policy it was important to find evidence of the extent of a problem or issue to aid in the formulation of goals and solutions to address the problem. In the policy documents the most frequent use of all types of knowledge was to substantiate the development of policy in a specific field. Equally the policymakers discussed how it was important to explore how similar issues were addressed in other jurisdictions. Its purpose was to identify how the approach adopted could help in addressing the problem at home. Under section 4.1 of the Drug Strategy document 2001-2008 several national drug policies were reviewed, for example the Netherlands, England, Scotland, Spain, Sweden, Australia and Switzerland (Dept. of Tourism, Sport and Recreation, 2001). This is known as policy transfer. This is defined in the academic literature as 'a process through which policy choices in one country effect those made in a second country" (Marsh and Sharman 2009, p. 270: Simmons and Elkins, 2004, p.171). Several mechanisms have been identified in the policy literature on diffusion and transfer of policy ideas (Marsh and Sharman, 2009). The mechanism of *learning* is concerned with adopting the policy designs in other countries because of established effective and efficient policy outcomes (Rose 1991; Weyland, 2004; 2005). *Mimicry* describes a how civil servants or politicians like to emulate policy ideas from countries that they perceive as more socially advanced or morally good (DiMaggio and Powell, 1991; Marsh and Sharman, 2009; Stone, 2012). Coercion can also be used to influence policy ideas in other jurisdictions. For example, more powerful states or influential international organisations such as the World Bank can attach conditions to their lending practices to influence or direct policy in a specific area (Marsh and Sharman, 2009; Stone, 2012) In this study the frequency of

international academic research and international reports cited in the documents were second only to the government's own documents and agency reports.

The policymakers reported how the observance of the governments owns internal legislation is mandatory for decision-makers. An exemplar of this compliance in the NDS 2009-2016 is the citing of The *Education Welfare Act, 2000* and the *Youth Work Act, 2001* in how early school leavers were defined (Dept. of Health, 2009). In addition, the importance of bringing all youth services under the Office of the Ministry of Child and Youth Affairs (OMCYA) (now the Department of Children and Youth Affairs) to ensure a more coordinated and efficient approach to the provision of youth services across the country was highlighted. The methods to address substance misuse in new communities and the homeless were discussed citing the relevant strategies in the specific areas of concern (Dept. of the Environment, Heritage and Local Government 2008; DOH, 2007). This has also been reported in other studies, for example Ouimet et al.'s (2010) exploration of policy analysts working in ministries in Quebec, Canada found among the most frequent types of documents consulted by participants, were laws and regulations, policy statements and programmes, government action plans and strategies respectively.

Policymakers are also required to ensure compliance with EU regulations or other international agreements and guidelines the government have signed up to, in developing policy. In the current study, for example, in the Alcohol Report 2004 (DOHC, 2004) under recommendations and the 'Involvement of Young People' it described how giving youth a voice in matters that affect them is a key goal of the National Children's Strategy and supports Ireland International Commitments (p.34). For international commitments, it cited the United Nations (1989), the World Health Organization (2001) and the European Union (2001) in this paragraph. Increasingly it has been found international organizations and nation states are having an influence on policy at the national level (Stone 2004; Knill 2005).

To conclude the findings of the alcohol and drug policy document analyses and the findings of the qualitative interviews with policymakers were presented in this chapter. The policymakers were very clear on where or why research evidence was influential in making an impact on policy, for example in establishing the extent of a

problem in society. However, in research influencing the development of policy solutions the problem was more complex. Where the evidence is incontrovertible such as in medical science the research would have an impact. However, in areas where the research evidence could be disputed or challenged it was more difficult for research to influence policy. The policymakers in this study did not describe an archetypal situation of the most effective use of research evidence in policymaking to address social issues. Nonetheless, an ideal model of policymaking was suggested in their description of how to ensure that children from disadvantaged backgrounds could progress in education. This would involve working collaboratively with policymakers and voluntary sectors in housing, education and welfare as the problems are often interlinked. This is redolent of the recommendations of how policymakers could address societal issues that are often described as 'wicked problems (Head and Alford, 2015; Ferlie et al., 2011).

The impact of research evidence in the specific policy areas of alcohol and illegal drugs will be discussed in greater depth in chapter seven together with the findings of the qualitative interviews with academic researchers. The findings of the researcher participant interviews will be presented in the next chapter.

Chapter 6: Perceptions of researchers of the policy process and the use of evidence

6.1 Introduction

The qualitative approach to data analyses and the rationale for using template analysis was discussed in chapter four. Template analyses corresponded to the framework developed by Kuruvilla et al., (2006) to explore researchers' knowledge of the impact of their work. In both frameworks, several *a priori* codes were developed that reflected the interview schedule. The focus of this chapter is the findings of the interviews with academic researchers. First a profile of the participants is provided. This is followed by the results from the interviews with researchers on how the empirical evidence has influenced drugs and alcohol policy over the previous decades, and the perceived barriers to its uptake. The next section presents the views of researchers on the different types of evidence preferred by policymakers. The diverse strategies employed by researchers to increase the awareness among policymakers of the outputs of their work are considered. In the final section the broader impacts of the work of the participant researchers is presented under the Research Impact Framework (Kuruvilla et al., 2006).

6.2 Researchers profile

The participant researchers were recruited from third level Institutions in Ireland offering programmes in Health Promotion, Public Health and Children's Studies. The first eight researchers invited to participate were identified from the policy documents. All replied positively to the invitation to participate. After receiving the interview schedule one replied to advise they might not be the best person to be interviewed as their experience of the alcohol and drug policy areas would not be as "broad or in-depth" as other researchers. Two alternative names were identified from the policy documents. Two unsuccessful attempts were made to contact the first person named on the list. The second person responded positively. All researchers worked at a senior

level in academia. Several were principal investigators for large national studies, while others were employed as senior lecturers or senior research fellows in their respective departments. Their dominant fields of research were health promotion, public health and children's' studies (see Figure 6.1).
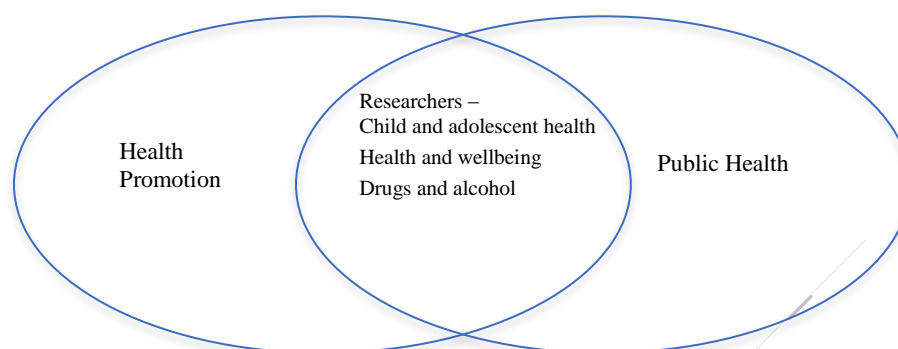
Figure: 6.1: Participant researchers' fields of research interest

Three of the participant researchers were at professorial level and five were senior researchers. There were 3 male and 5 female respondents.

Table: 6.1: Participants profile - researchers

Identification	No.	Gender	Title/Role
Researcher	9	Female	Senior Lecturer/ researcher
Researcher	10	Female	Senior researcher
Researcher	11	Female	Senior researcher
Researcher	12	Male	Associate Professor
Researcher	13	Male	Professor
Researcher	14	Male	Senior Lecturer/ researcher
Researcher	15	Female	Senior Lecturer/ researcher
Researcher	16	Female	Professor

6.3 Alcohol policy – researchers views

The views and opinions of the participant researchers on alcohol policy were elicited through their responses to the policy and the service impacts of their work, as well as

through their responses on what types of research evidence influences policy. The strength and influence of the alcohol industry was highlighted, as well as the lack of coordination of policymaking around alcohol in government circles. The participants described how several departments in government have different responsibilities in relation to alcohol; the Department of Health is responsible for National Alcohol Policy; the Department of Finance is for responsible excise duty and taxes, and the Department of Justice is responsible for licensing outlets for the retail and sale of alcohol beverages. Therefore, Departments have legitimate concerns and competing interests around alcohol policy. Accordingly, the lack of agreed goals and priorities across government was believed to impede progress in this area:

> … the biggest problem is that in government there is no joined up thinking across government departments … and it is a hugely important issue of why we have not been able to get our act together around Alcohol Policy
>
> (Researcher, 11)

6.3.1 Alcohol's strategic importance

Respondents reported how politicians were afraid to confront the alcohol industry because of its strategic importance to the Irish economy. The significant number of people that were employed in the alcohol industry, and the importance of jobs in a time of economic recession was discussed several times It was stated that the alcohol industry had large budgets that enabled them to lobby governments and spend a considerable amount of money on marketing. Furthermore, the alcohol-lobbying group continuously denied that alcohol was a problem for many in the population. Instead the industry proposed solutions, and sponsored activities to address the overconsumption of alcohol among what they believe are a small percentage of the population. Public health professionals on the other hand did not have large budgets to lobby governments, and researchers reported that progress in alcohol policy was slower than required due to this disproportionate distribution of power:

> … they are obviously afraid at one level to tackle the big drinks companies because they might pull out of the country, one of them threatened that last year, drink companies have a lot of money, they buy respectability, and spend it to buy

acceptance … Industry of course will deny it is a problem, they have a lot of people
employed, PR people to lobby the governments heavily … everybody is susceptible
to lobbying, now the industry can afford to pay lobbyists, we can't so that slows
down change, it is not just about alcohol, the same with tobacco, junk food, stuff
like that, sugar it is a similar thing in all of those

(Researcher, 13)

Researchers reported on the conflicting messages that children receive due to the over
dependence on alcohol sponsorship for many of local and national festivals and
sporting events. Children are taught in school about the harmful effects of alcohol and
yet frequently there are local festivals or sporting events sponsored by popular alcohol
brands. Researchers alleged that efforts to stop the sponsorship of sports events by the
alcohol industry were frustrated by lobbyists pointing to the lack of evidence of such
sponsorship being harmful. Researchers argued that both politicians and the public
used such arguments to justify inaction. In addition, it was believed that even if
evidence of harm was presented some other approach would be used to dismiss it:

… Children in schools might get a message about the evils of drink but that is more
than wiped out by the fact that when they go to play GAA, there is a bar in the local
GAA club or the sponsor is Murphy's pub down the road and … on the television,
big international soccer and rugby and things, the main drinks industry sponsorship,
it is everywhere …

(Researcher, 12)

6.3.2 Ideological reasons and values of their constituents

According to one senior participant researcher the failure of politicians to regulate in
this area was for ideological reasons. Politicians did not want to appear to be part of
the 'Nanny State'[20]. It was suggested that many politicians believed that personal
autonomy and free will were paramount. It was not the responsibility of the state or
public health practitioners to tell individuals how to live. Nonetheless the researcher
participants acknowledged that it was the responsibility of politicians to legislate in

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[20] The term Nanny State refers to a Government introducing laws and regulation that are deemed to
be overprotective and interfering with the individuals' personal autonomy (Calman, 2009).

this area. Furthermore, they were in possession of well-researched scientific evidence of how under public health the problem with the misuse of alcohol in society could be managed.

Equally explanations from the participants, as to why politicians had failed so far to implement effective policy in this area was the belief that the public were not pushing for more regulation. Politicians do not only listen to the academic research evidence, they conduct their own 'research'. Focus groups are conducted in their constituencies to identify what people want or are willing to accept. Several participants reported how politicians are not willing to lead, even if they themselves are convinced of the right course of action to take. This was particularly evident when they are unsure of how the public would respond to a policy change. Adverse consequences for them at the ballot box in the next election would be an issue for politicians. As one participant averred:

> The problem actually with modern western democracy … politicians no longer believe in leadership they believe in 'followship', even when convinced of something themselves, that it is the right thing for Ireland to do they won't do it if they think the public haven't understood the message yet …
>
> (Researcher, 14)

Nonetheless there was some optimism among the researchers concerning progress on the public health approach to alcohol policy. They felt public awareness around alcohol issues had changed and policy was moving in the right direction albeit slowly. The debate on alcohol issues in Irish society was now more than15 years old, from the first alcohol report published in 2002. It was also accepted the recent economic downturn had played a part in delaying progress in this area. Drink driving laws were given as an example of where progress was made. As more evidence was presented on the harmful effects of drunk driving, there was an escalation in drink driving legislation. This participant reported on how the public now have accepted the increased regulation, though it had taken several decades:

> Things do change, and I take comfort from that, if you look at say drink driving in Ireland … legislation came in incrementally, as more and more evidence was

presented … this needs to be a little bit stricter and tougher and the levels of alcohol involved were pushed downwards … random breath testing eventually came in with a hugely beneficial effect but it has taken three or four decades … the public have accepted, the policy was put in place and no one is talking about reversing it …

(Researcher, 14)

The researchers understood that the present economic climate was having a significant influence on policymakers' approach to alcohol policy. They believed that policymakers were acquainted with the research evidence of the most effective policy measures to implement to reduce alcohol consumption in society. However other issues were a priority for government policy in the present economic and political context specifically employment and revenue generation.

6.4 Drug policy – participant researchers view

Participant views on drug policy were greatly influenced by media reporting on drug issues at the time of the interviews. Headlines such as 'Research shows that Ireland has 'Lost the War on Drugs' (www.independent.ie/irish) and the number of people on methadone for over 10 years had been appearing in national newspapers over the previous year. In addition, there were demands for an increase in rehabilitation services. The participants reported that these kinds of headlines were appearing because journalists did not understand originally why the National Drug Strategy was established. In Ireland, it was explained there was never a 'war on drugs'. Ireland had a National Drug Strategy which perhaps could have been more appropriately called the 'Dublin Heroin Strategy'. Ninety percent of all the resources of money and energy that went into this strategy were implemented in the Dublin region. Subsequently, from the time of the enactment of the strategy in the early 2000s the heroin problem in Dublin had been brought under control. The view was that the strategy had … *been staggeringly successful* (researcher, 14). It was suggested the more recent controversy around drugs was due to the dissemination of ideas from abroad on rehabilitation and recovery.

6.4.1 Perspectives on approaches to intervention

The harm reduction approach to drug use introduced in the mid-1980s was in line with best international practice. This was a direct result of the fears around the contagion effect of HIV and AIDS. However due to the discovery of new pharmaceutical drugs for the treatment of AIDS, those who were HIV positive could now expect to live an ordinary lifespan. National discourse in this area had returned to topics of abstinence based approaches and a focus on rehabilitating drug users to become drug free. The participants discussed how internationally these ideas were gaining traction and influencing the debate in Ireland. One participant researcher who had conducted research in this field over many years, averred that there was no new evidence to prove that it was possible to stop people misusing drugs:

> … have we more evidence about how we can get people drug free, the answer to that is no we don't … the phrase they use about methadone is the state is keeping people parked on methadone ... this is just ridiculous stuff, we don't have the technology to keep people drug free, we can't even keep people drug free when they are in prison …
>
> (Researcher, 12)

Many of the participants considered the recent debates on rehabilitation and recovery as futile unless the social causes of drug misuse in communities were addressed. They described how a disparate number of young people involved in the riskiest of behaviours, concerning the most addictive drugs, disproportionately came from backgrounds of enormous disadvantage. In communities where drug misuse was most prevalent, there were households with second and third generation unemployment. Problems with addiction and literacy were commonplace with early school leaving the norm. It was alleged that many of the young people would also have problem with mental health issues and early involvement with drugs. According to one participant it would be very difficult to expect the drug services as they were presently structured to rehabilitate these drug misusers:

> … rehabilitation means linguistically moving people back to kind of a position of health that they enjoyed previously … most of these people never had any health

even without drugs, and we have all these impoverished services and we have expectations that they are going to do miracles …

(Researcher, 12)

It was specified that in many countries maintaining people on methadone and engaging with the services was considered a success, as treatment retention is a major predictor of how people progress in treatment.

6.4.2 Policy and evidence

The issue of scientific evidence and drug policy came up for discussion several times. All the participant researchers understood the relationship to be complex and imprecise. It was stated that there was no evidence-base for the actual drug framework that was presently in place. Furthermore, no new evidence had emerged to suggest a certain method was more effective than others. Throughout the 20th century as the movement towards an international prohibition system grew, no original scientific evidence had emerged for distinguishing between licit and illicit drugs. It was suggested that regulating and controlling the use of all illicit drugs maybe a more viable option than continuing with the strategy of prohibition.

Participants reported that it is very difficult for researchers to influence policy with scientific research if that research runs contrary to political or societal thinking at a point in time. Most specifically it was argued if an agreed policy position has already won political support. To highlight this issue a senior researcher participant who had worked in the field of drug research for many years described an incident that occurred in the UK in relation to scientific evidence and drug policy:

> … all through the first decade of the noughties there was a lot of agitation about the role of cannabis and its impact on health … and the Advisory Council on the Misuse of Drugs advised early in the decade … cannabis was in Class B… the advice to government was that this was an exaggeration of the risk posed by cannabis. Cannabis was demoted to a Class C drug and there was a huge rumpus, a huge public outcry, cannabis was pushed back up, not based

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on any great scientific evidence but purely that this was the government sending out the wrong message to our young people …

<div align="right">(Researcher, 14)</div>

This event is based on research conducted in the early 2000s by the UK advisory committee on the misuse of drugs (ACMD, 2002) and the Police Foundation Report (Police Foundation, 2000; MORI, 2002). Under the 1971 Misuse of Drugs Act (MDA) drugs are classified into three categories A, B and C. The category Class A represents the most seriously harmful addictive drugs and class C the least harmful (Monaghan, 2010). On the advice of the Advisory Council on the Misuse of Drugs (ACMD) cannabis was downgraded from a class B drug to a class C drug in 2003. However, in 2008 due to public concerns cannabis was reclassified as a class B drug against the advice of the ACMD (Monaghan, 2010). Sir David Nutt had argued for a more scientific basis for the classification of drugs based on a hierarchy of harms to the individual and society. The subsequent fate of Sir David Nutt[21] as chair of the ACMD in 2007- 2008 was recounted as an example of what can happen if a researcher's scientific evidence challenges government policy. As the participant explained:

… a lecture he [Sir David Nutt] gave talked about a condition called equasy - horse riding … he dragged up the statistics and he looked at the figures, he argued there is far more damage done to human health every year in Britain by people falling off horses than by using ecstasy … he was making that point and he was teasing … they sacked him!, he was seen to have overstepped the mark because he was a scientist, he was teasing and provoking the politicians, if you really want to promote human health maybe you should ban horse riding … make more sense that banning ecstasy …

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[21] Sir David Nutt is an eminent researcher in the field of drugs and neuropsychopharmacology. He was critical of the classification of drugs by the ACMD. In a paper published in 2007 an attempt was made to bring a more scientific approach to how drugs were classified relative to the harm they caused to the individual and society (Nutt, King, Saulsbury and Blakemore, 2007). Several legal drugs were also included in the matrix such as alcohol and tobacco (Nutt et al., 2007). The categories of harm employed to assess the impact of the drug misuse on the individual and society were; the physical harm to the individual's body from using the drug, psychological and physical dependency produced by the drug, and the social harms caused by persistent drug misuse to the family, the community and to the health and social care services. The ranking order of the drugs assessment of harm and danger produced by Nutt et al., (2007) did not correspond to the ranking order of the UKs Advisory Council on the Misuse of Drugs (ACMD).

It was the perspective of this participant that the government were correct in removing Sir David Nutt from his role on the ACMD. The researchers' argument was the scientist had crossed the line between researcher and policymaker. Politicians are elected to represent the views of the electorate whose values and beliefs systems they embody.

Similarly, in Ireland examples were given of how scientific findings can be rejected if they are not in agreement with the government's own perception of an issue. In the late 1990s estimates of the prevalence of heroin use in Dublin were published. It was found they were double the original estimates of studies conducted in the early 1990s. One participant described how his findings were refuted and there was real denial in political circles at that time of the true extent of the heroin problem in Dublin:

> … these original estimates, they were not politically acceptable ... the work had been commissioned and we had to produce estimates for Europe … that report wasn't published for six months and we were not allowed to write it … we were not allowed to speak about it, we couldn't speak on the radio and we couldn't speak out … what we didn't realise by producing those estimates that we were naming was shaming in a sense, we were naïve, but it stood … we had to take personal criticism of the methods and everything in public … and they have stood to this day …
>
> (Researcher, 16)

It was explained that Ireland is a small community and it was important to be able to communicate knowledge in a diplomatic and tactful manner as not to generate offense or embarrassment to powerful individuals or political organisations.

6.4.3 Disillusionment

A theme that had emerged from interviews with the policymakers reoccurred in interviews with the researchers, for example non-governmental organisations not acknowledging when success had occurred. Several of the researchers reported that

this resulted in the general population becoming disillusioned with many of society's problems. Some gave examples of the housing crises in the 1980s and the housing crises currently being reported in the media. Current and past drugs issues were also discussed. It was suggested by researcher participants that the public are reluctant to support more government spending in specific problematic areas, if the perception was no matter how much money was spent on a problem, nothing appeared to change:

… there is no acknowledgment when success has occurred and even if you listen to the clinicians, you listen to [Name] and so on they seem to be endlessly saying the problems are worse than ever, that does not help then to persuade the public. If a politician says well we put a 100 million into this, you are telling us the problem is worse than ever, where are we wasting our money …

(Researcher, 14)

However not all researchers were as dismissive of the recent focus on rehabilitation services. It was observed how policy and the philosophy around drug misuse had changed over time in Ireland. It had moved from an abstinence only approach in the early 1980s to a harm reduction approach by the last decade of the 20th century. The health services were taking a closer look at the numbers and length of time heroin users were on methadone maintenance, as they were investing millions of euros. One researcher participant advised that in the current drug service regimen, there was also room for a recovery philosophy. It was now believed that both the government and the health services were beginning to adapt to this philosophy.

6.5 Views on research evidence – participant researchers

This section reports on the final three questions put to the researchers. These were identical to the questions asked of the policymakers: What were their perceptions of the type of evidence that ministers and senior level civil servants find convincing. How can the existing evidence be improved and how can research help the users of evidence?

6.5.1 Types of evidence policy makers preferred

On the type of evidence policymakers preferred the researcher participants overwhelmingly answered quantitative research. Researchers explained how in the government committee they were involved in they were constantly trying to increase policymakers' understanding of qualitative data. In conducting drug research for example, the respondent explained that the numbers attending drugs services was not enough. It was important to know how satisfied were the clients with those services and how this could impact on the frequency that drug misusers would engage with these services. It was stated that Ministers and senior civil servants liked clear and concise numbers and did not really value the qualitative stuff.

Some participants proposed that mixed methods of research were now the preferred approach. The quantitative data was considered essential as statistical facts are critical to the evidence. However, it was explained that by combining the statistics with the human story, for example personal histories and vignettes the research evidence would have a greater impact. The statistics were deemed to be very important for senior civil servants in understanding the extent of a problem. However, for politicians the narratives and the poignant story were considered more effective as one researcher observed:

> People like anecdotes oddly enough more than they like stats … you could do a survey of five thousand people … and that is quite a problem, but if the politicians happen to have met one upset mother whose experience the previous week with her cannabis addicted son was different they are much more swayed by that encounter with the upset mother, than they will be by you providing very strong evidence that the opposite is the case …
>
> (Researcher, 14)

Most the participants stated that research needed to be clear, concise, accessible and unambiguous for policy makers. Yet, results from scientific studies are rarely reported with absolute certainties. This ambiguity and imprecision in the reporting of scientific evidence by researchers was considered problematic for policymakers who required certainty from the data that the decisions they would make would have the required effect:

We have this ability of vagueness beyond belief everything is you know … we are 95% certain that da de da, … what we I mean to say that scientifically we can't say anything else, if you want to talk to policymakers you need to understand that they need certainties … you must make it accessible … I don't think it compromises the scientific work, it compromises the scientific finesse of the presentation

(Researcher, 10)

The other types of 'research' that policymakers listen to other than the conventional evidence produced by scientific researchers and academics, for example, local knowledge and the values of their constituents was also discussed. Furthermore, many of the researchers believed the influence this type of research had on policy was as important as the scientific evidence. Recent debates in the media of safe injecting rooms for drug misusers, and the medicinal use of cannabis, were given as exemplars of the acceptability by the public and politicians of policies that would have been unheard of in a previous decade. It was suggested that public opinion had a major influence on politicians and policy decisions. The medical benefits of using cannabis were the same ten years ago as they are today, but there would not have had public acceptability for its introduction. Politicians discern what is tolerable to the public by conducting their own 'research' in their constituencies. Before the smoking ban legislation was implemented in 2004, the politicians would have done their homework and were very aware that most of the public were now accepting of the ban. As one researcher observed, the evidence of the negative effects of smoking had been available for over fifty years:

... in the Irish context if we asked about Michael Martin, why as Minister for Health he did [introduce the smoking ban] … my suspicion is that the research evidence did have an impact on him, he was influenced by that, but that he also probably had done enough or had others do enough focus group research or whatever to understand that the voting public would now tolerate it …

(Researcher, 12)

Researchers reported on how policymakers had increased their knowledge and familiarity with scientific evidence over the years. One researcher participant spoke about in the early part of her career, if there was a poignant story, a family story that

would hold more sway. At that time, most policymakers would have been accepting of the research and did not question its quality. However, in more recent years they had begun to ask very apposite questions concerning the; *…quality of the research … errors in the data collection … randomization, they will ask about the validity and reliability of questions ….* (Researcher, 15). In previous years in consultation with policymakers these types of issues would never have come up for discussion.

6.5.2 How can the evidence be improved?

Responses to this question from the researcher participants were very mixed. Researchers reported that strong methodologies were considered very important as they would stand up to criticism. Participants also recommended communicating better with policymakers about the science of their methods and how their findings correlated with other types of data from diverse sources. It was evident from the responses of the researchers that they understood the constraints and time pressures many policymakers were under. The recommendations made for increasing the transfer of knowledge were clear, concise and accessible information for policymakers. Methods considered for transferring research findings effectively were; bullet points, charts with clear concise information, information that policymakers peruse and comprehend speedily, without spending more than 10 minutes reading a brief.

One participant researcher with many years' experience as a principal investigator, explained that in the past boxes of briefings and reports were sent to all the senior policymakers. Now mailing lists were compiled with the names of key people from the relevant policy and service environs. The practise now in place was as they published papers, factsheets and reports from their research, these were disseminated among the relevant government departments and agencies. This had resulted in the development of a trustworthy and reliable relationship over several years, as the research department was now the primary source of information for policymakers when a pertinent issue arose.

Identifying the different ways individuals like to receive information has helped to inform the methods researchers use to communicate their work. Instances were given

of how some people like numbers while others prefer information being presented to them in diagrammatical or narrative format. One senior researcher participant reported how they worked collaboratively with policymakers to develop appropriate disseminations tools for their research. It was clarified that policymakers preferred the word 'research' in the title of research reports and briefings and the information written in full sentences rather than bullet points. This was a crucial issue for policymakers as phrasing research results in full sentences cuts down the workload for civil servants. Complete sentences could be copied and pasted into a report for the Minister or in answering parliamentary questions. It was accepted that policymakers were frequently under time pressures, and it was important for academics and researchers to acknowledge this:

> … we put a lot of effort into making our research look very attractive, colours, the type of language we use, the use of visual images, logos, diagrams that kind of thing … recognising that some people really like pages and pages of number ... other people hate that and they won't spend the time it takes and or they don't feel comfortable with it … they want something they can use … we worked with policymakers on the format that works best for them …
>
> (Researcher, 15)

Frequent population surveys to identify whether public behaviour reacts to policy changes were suggested by some researchers. It was agreed that this would require funding. Nonetheless the participants suggested with relatively small amounts of funding more frequent population surveys could be carried out. This would enable researchers to document trends in behaviour change in the population and between different sectors in society. Examining drinking behaviours among different social groups and how they were affected by tax increases was suggested as the type of research that would benefit from this proposal. Surveys conducted on an annual basis to track and monitor changes would inform appropriate policy decisions.

Funding was also an issue for researchers. It was believed that exploring and analysing the existing evidence in more depth could improve the research evidence. Examples of the type of large studies that would benefit from this initiative were the 'Growing Up in Ireland study' (William, Greene, Doyle, et al., 2009). This would be

possible with a small amount of additional funding from the original funders such as the Atlantic Philanthropies and the Department of Children.

Using different types of evidence from multiple sources and approaching an issue that required a policy response from many different angles was another strategy proposed by the participant researchers to increase the uptake of research. It was described how the statistical evidence that exposed the link between the large number of homicides and suicides in society attributable to the misuse of alcohol did not impact on the decisions of policymakers. However, when the economic evidence revealed the cost to the health service of alcohol misuse this did impact on policy decisions. As this participant explained:

> … you do need the statistics, the statistics that have the biggest impact are the ones showing the impact of the health services, or the bed days used … horrific stories of homicides and suicides doesn't impact usually …
>
> (Researcher, 13)

The participants were very aware of the importance of timing as an element that influenced the use of research evidence by policymakers. It was understood that research conducted today may have no impact. Nevertheless, the same research maybe very significant two or ten years hence, when the current prevailing norms and values in society, or the political or economic context had changed.

6.5.3 How can researchers help the users of evidence?

Many researchers were unsure of how to respond to this question. One suggestion was to adopt the Canadian model of policymaking. In this model researchers are invited in to government departments as technical experts on policy issues. The civil servants and the research experts work together on solutions to societal problems to inform government on those issues. It was also suggested that researchers when writing up their findings and submitting papers would always have a section on what are the implications for policy of these research findings. This was particularly relevant for researchers who were reluctant to engage with policy makers or get involved in the policy process.

Researchers suggested qualitative research could be 'incredible wordy' and this was not attractive to politicians. It was felt that reporting the themes of the research with clarity, and indicating the key messages could address this issue. It was also stated that policy makers themselves needed to be prepared to listen and engage with the findings of the research and be willing to present the findings to Ministers without editing them to support the policy story the Minister might want to hear.

Building relationships with policy makers was considered important if a researcher wanted their research findings to have an impact on policy decisions. It was believed that many academic researchers did not fully understand the work pressures of policymakers and regularly they were perceived as having a lower educational status. One participant recounted how over many years of observing policymakers and academics interacting, he had noticed academics being standoffish, patronising and sometimes being downright rude to civil servants:

> some of these academics, when you see them interacting with the policy makers it is so inappropriate, you know it is patronising telling them in a way that assumes that they don't understand the most basic things, really offensive, so it is about making yourself accessible, and doing what it takes ... the issue of equality is actually crucial here, I think a lot of academics would see themselves as superior to the policymakers and that is incredible patronising, policymakers hate it …
>
> (Researcher, 15)

The importance of researchers promoting their work was advocated through media releases and concise messages. It was acknowledged that many researchers were not good at this as they were more familiar working with solid reports. Large reports were considered important for the academic's own publications and for keeping records of the detail of the research. However, the respondents suggested where researchers needed to improve were on producing policy briefs and the shorter messages:

> we need to promote our work in a more succinct way … the media releases, the bite size message, we are not good at that … the tomes of reports are great I actually always produce a really detailed report, so then if there is any questions about, oh I don't want you to publish that aspect of it, it is already in the report … but you do

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need then your policy briefs, or your shorter messages, and researchers need to improve upon that … so that is where the researchers maybe could help users of evidence

(Researcher, 16)

A minority of researcher participants were of the view that the role of researchers was not to influence policy. The task of the researcher was to inform policymakers and concerned individuals of alternative, new and an in-depth set of ideas to assist in defining the boundaries of political debates. It was then up to the individual to decide how to use this information. It was argued that current popular discourse on the role of universities considered its primary function to serve the needs of industry. However, he himself did not subscribe to this utilitarian view of universities and felt at times that the public health advocates were too aggressive in their approach to public health issues:

I don't really go along with the notion that a University should have a very utilitarian function in society, I mean most of it now is about serving the needs of industry and I don't agree with that at all ... I am broadly in sympathy with public health ideas but I mean I am also a bit repulsed by the aggression of public health …

(Researcher, 12)

This section has reported on the views and opinions of policymakers and researchers on the research evidence. The policymakers opined that it was clear unambiguous quantitative evidence that decision makers required. They suggested that researchers taking into consideration the context in which the research would be applicable could improve the uptake of research. The researchers agreed that quantitative research had a greater influence on policy, particularly quasi-economic data. However, they suggested that the emotional personal story was also important to politicians. This was particularly evident when the stories related to the populations they represented. It was believed the uptake of research by policy decision-makers could be improved by using different types of evidence from multiple sources; this would include qualitative, quantitative and econometric data. Alternative views were expressed by a minority of

researchers. The task of actively engaging in and influence policy outcomes in their opinion was not part of the researchers remit.

The following section will now explore the extent that researchers think through the broader impacts of their work, outside of the political and academic influence.

6.6 Results of Kuruvilla et al., (2006) Research Impact Framework

One of the objectives of this study was to report on the relevance of Kuruvilla et al.,'s (2006) Research Impact Framework in assessing the impact of Health Promotion and Public Health research in the field of alcohol and drug misuse. The results are reported under the four key areas of the framework and to the extent the researchers were knowledgeable of their impact in the specific areas.

6.6.1 Respondents knowledge of research impact

Under research related impacts the participants were asked questions in relation to what types of problems/knowledge did their research address. This included the research methods used, how their work was disseminated and their sources of funding.

The most frequent topics of investigation by the participant researchers in public health were alcohol and drug misuse, inequalities in disadvantaged communities, child and adolescent health, childhood injuries and bullying. The types of methods used were varied; surveys on large populations, interviews, focus groups as well as qualitative and quantitative methods. Most researchers used all the methods with some focusing only on quantitative or qualitative. For one researcher analysing secondary data was a key part of her work.

Dissemination

All participants had disseminated their work widely. Many different avenues of dissemination were employed. These included publishing in peer-reviewed journals and presenting at conferences and seminars, both nationally and internationally. Presenting at national seminars was considered essential to their work for informing research communities. Publicising their work by writing reports for government

agencies, government departments and through public engagements were also considered important. A range of different distribution approaches were employed in circulating the findings of scientific enquiry, for example research bulletins, conference presentations, and with the publication of formal documents accompanied by media press releases. As one researcher explained the dissemination of research findings was crucial to her work:

> … we take dissemination of our research incredibly seriously, in fact we see it as an ethical imperative, if children are giving us information then it is our responsibility almost to translate that information into digestible formats for different audiences … in line with most academic researchers we place a large emphasis in writing scientific papers, so we publish a lot of papers …
>
> (Researcher, 16)

Publishing in peer-reviewed journals was critical for many of the participant researchers. They reported keeping up to date with their number of publications but not always with the number of times they were cited. One participant explained that he had only recently become aware of how important publications and citations were to an academics' reputation and career progression. He was now paying more attention to Scopus and Google scholar. It was also important for several of the participants to make large data sets they had collated available to other scientific researchers for analyses and publication.

Being part of research policy network groups was a significant part of some of the participants work. They viewed it as an essential channel for disseminating their scientific findings, as one of the functions of the policy network groups is to design and develop more effective tools for disseminating the findings of research to policymakers. A minority of the participants worked collaboratively with research policy networks in other countries. One considered her work meaningless if she did not engage with policymakers.

Another avenue considered important in the dissemination of research findings was to engage with the media. It was viewed as part of their role on certain public health issues to give lectures to the public and participate in discussions with the print and

electronic media. Others related some very negative experiences of media engagement:

> To be honest, I do as little as possible I find that they distort your results, they misquote you, they exaggerate ... personally I do all the research and I let my colleagues do the PR on it …
>
> (Researcher, 11)

Collaboration and funding

Collaboration and funding was also viewed as important to a researcher's work, with varying levels of success reported in attracting funding. It was reported that the area of alcohol research did not attract a lot of funding in Ireland compared to the money invested in this area internationally. The major sources of funding were the HSE, HRB, Dept. of Health and Children and the Irish Research Council. One participant researcher advised that when it came to attracting funding, success builds on previous success and it was important to build your work into current and expanding areas of research. She explained:

> … if someone has only 50,000 to invest, their linking this into a 500,000 Euro study, they know that their 50,000 is actually getting the benefit of the 500,000, so you are much more likely to get that 50 because you are adding value, … I am big into this adding value …. study in such a way that it can be built on to, don't build you research into dead ends …
>
> (Researcher, 16)

The importance of conducting pilot studies for funding opportunities was emphasised. Pilot studies were used as leverage to attract further study in a specific area. As a senior participant researcher explained successfully completing a pilot study in an area of interest can help to attract more funding to this area. In this scenario the funders are not exposing themselves to excessive risk. In effect pilot research studies were very helpful in promoting your work and building on what you have already achieved in your area of interest.

Other researcher participants found working with other researchers, collaborating, was a good strategy for researchers who wanted to develop their reputation to access more funding. It was explained:

> … working with other people that are more successful than you, collaborating with them, that is a start, develop reputation and so sometimes funding just comes your way, your commissioned to do studies just because you have the reputation …

> (Researcher, 14)

Most of the researcher participants interviewed regarded collaborating with other researchers both nationally and internationally as integral to their work. Collaborations were conducted through grant applications and publications. One researcher described how she had collaborated with over two hundred researchers around the world, as well as collaborating with all the main research institutions in Ireland. The reciprocal process of collaborating was regarded as an important mechanism for the learning and sharing of new knowledge. To be successful in attracting collaborations and funding the participants discussed how it was important to be active in publishing and presenting in the right places. Achieving the right balance between proper scientific publications where the researcher earns their scientific reputation, and demonstrating the wider dissemination of your work were considered an important factor in funding applications. It was stated that some funding organisation, for example the EU now required a work package on dissemination when applying for EU projects.

6.6.2 Respondents knowledge of policy impacts

In the earlier section of this chapter the researcher participants discussed policy and research evidence in relation to drug and alcohol policy in a broad context. In this subsection under the research impact framework (RIF) the policy impacts of their work are explored in greater detail, focusing on the level and nature of impact. Under 'nature of impact' researchers were asked whether their impact had been *instrumental* or *conceptual.,* Many respondents were aware of some level of influence, however others replied it was not always possible to identify where your work had an impact.

One participant researcher described how her research helped to frame alcohol policy under a public health approach. It was believed that much of the research conducted by her over the years had led to a growing awareness around the dangers of alcohol to society. Different groups were now disseminating this message, for example NGOs and Health professionals emphasising the wider impacts of the misuse of alcohol. Similarly, in alcohol studies researchers could demonstrate how their research was a factor in alcohol policy being incorporated into the illegal drugs strategy. This was notwithstanding the considerable opposition to this course of action at that time. Other examples given were how research findings had influenced the National Alcohol Policy 1996 and the subsequent taskforce reports in 2002 and 2004:

… the [research] I believe was very instrumental in trying to shape where policy should be going … the Department of Health and the HSE, I would conduct research for them ... that I think is relevant for policy ... in the [name of report] we called for an increase in alcohol taxes … so that brought down consumption and harm … we brought in the taxes and it came down and it [consumption] has never gone back up to that level since …

(Researcher, 11)

Likewise, when researchers could demonstrate the cost of alcohol misuse to the exchequer and to society, policy makers were more receptive to their work. Researchers in the misuse of illegal drugs described how their research had influenced the philosophy and policy around the treatment of heroin users in Dublin. Methadone treatment clinics were now considered as standard practice for those suffering from heroin addiction; however, this did not preclude services that focus on rehabilitation. Researchers could also identify the use of research findings by advocacy groups involved in the Citywide drugs campaign and in local community drug programmes. Others could highlight how the findings from their research outputs were instrumental in influencing the Department of Health to increase the expenditure on drug treatment services in Dublin. It was accepted that many of the findings from research can have a subtle impact, and are contextual., Over time ideas expand and disperse and percolate down into society. One researcher reported how in the early part of her career she really did not view making an impact as part of her role as a researcher:

… I was sceptical about that at the beginning of my career … having an impact ... I initially thought that my business was to do the research as good as can be, to disseminate it, it was somebody else's job to translate that … the interest came not from me pushing it initially but from other people wanting to use it … policy makers … approaching us … and once we realised the impact of that … it started to become quite enticing to see your work a being cited in policy documents …

(Researcher, 15)

In matters concerning children's welfare researcher participants could demonstrate how their research was used in many different government strategies, for example, the National Drug Strategies, the National Children's Strategy, The National Health Promotion Strategies, the National Obesity Taskforce, Cardiovascular Strategy, among others. The work was not always attributable to their research group, but from reading the reports they could decipher that it was based on their original research.

A minority of participants claimed not to know what policy networks were – some spoke about different organisations they were part of such as the NACD or Alcohol Action Ireland, drug task forces and the HSE. Others spoke about the difference between being a researcher and a policy advocate. One participant stated that it was the role of researchers to be objective and to be critical of their research in identifying what the data can and cannot tell us. The responsibility of researchers was to relate that information then to policymakers, NGOs and policy advocates to inform policy proposals.

6.6.3 Researchers knowledge of service impacts

In this section researcher participants discussed the service impact of their work, for example had their findings an impact on health or public services. For many of the participant's service impacts were considered a by-product of their work, as most of the time they were focused on influencing policy. Nonetheless they could relate community groups to advocating for more services, or better services in their communities due to their research findings. Practitioners and service providers would periodically have contacted key researchers in specific fields to say they had used their

research findings to inform practice. Researchers described how guidelines to address cyber bullying presented at a conference were picked up by the media and resulted in the roll-out of an anti-bullying campaign a year in advance:

> … I presented something at a conference in Ireland … guidelines on how to deal with bullying mainly cyber bullying, this was picked by the media ... by the minister and within days … the government decided to roll out their anti-bully campaign policy a year in advance …
>
> (Researcher, 9)

Other participant researchers could isolate developments in alcohol and drugs services, including children services that stemmed from their research findings. For example, the treatment options now available for individuals addicted to heroin were highlighted, (i.e. benzodiazepine prescribing and methadone treatments) thus reducing the overall number of deaths in the population because of drug misuse. Findings from studies on the prevalence of hepatitis C in different population groups influenced the development of screening services. Other services identified as being directly the result of research findings were the development of aftercare services, for those following treatments in a residential detoxification centre. Offering continued support to individuals moving on from addictive substance treatment centres were found to be critical in preventing relapse. Some researchers reported on how they were commissioned by a government department to write reports on knowledge brokering and how evidence-based practice could inform to a greater degree the provision of children's services. However, it was stated by one senior research in child services that:

> … You can have oodles of evidence, but clinicians are always slow to change, that translation problem from research to practice seems to be ubiquitous across all specialties and across every country in the world …
>
> (Researcher, 14)

6.6.4 Researchers knowledge of societal impacts

Participants researchers were asked if they able to identify the societal impacts of their work, for example changes in knowledge and attitude concerning health behaviours. The participants found this question more difficult to answer. Nonetheless one researcher who had worked in child and adolescent health over a long period felt they were involved in was *"a zeitgeist, part of a developmental period in Irish or European society ... over the past 20 years"* (Researcher, 15).

The use the media was regarded as essential to disseminate information and to empower parents and professionals working with children that what they do impacts on children's lives. The participants were very aware of the media's influence on society and believed disseminating their research through newspaper articles, radio interviews and television appearances could influence change.

Formerly one participant described how discoursing and debating her research findings on TV, radio or in the national print media to be the pinnacle of her career. Now she found that having your research discussed in the local newspaper or radio often had much more of an impact:

> we absolutely wanted to have a societal impact, because if you think of the model of child health and wellbeing, which is where most of our work is, we recognise that those concentric levels of influence on children, families, and peers, … the local context in which children live their lives, neighbourhoods, communities, schools, youth clubs and so on, they are the things that have the most impact on children …
>
> (Researcher, 15)

Likewise using the media was reported as being very important to other participants who worked in alcohol and drug research. Participating in national debates and discussions on issues relevant to their field of study was important in educating the public. This could facilitate change in attitudes and behaviours in society, and ultimately be the stimulus in persuading politicians to act. Delivering talks and public lectures to parents and community leaders at local and national events also helped in influencing change. Many of the participants asserted that they could gauge through conversations that took place with parents at these events whether their research was

making an impact. The participants also believed that their academic role in scientific enquiry added credibility and weight to their voice when communicating at these events.

6.7 Reflections on the researchers interviews

This chapter has provided the results of the interviews with academic researchers. It explored the use of research evidence in two specific areas of policymaking – alcohol and drug policy. The views of the researchers on the use of research evidence in the policy process was explored and how other factors influenced and impacted on this area of policy was deliberated. Strategies to increase the utilisation of research evidence by policymakers were considered. The Research Impact Framework (Kuruvilla, 2006) was adopted to explore the knowledge and awareness of researchers of the broader impacts of their work.

Alcohol policy

One of the major issues for researchers on the use of research evidence in alcohol policy was the lack of joined up thinking at government level. It was believed that more progress could be made if departments came together to agree goals and priorities in this area. This was reminiscent of the interviews with policymakers where it was stated departments like to work in silos and it is difficult to get departments to work together. One of the arguments previously made for why joined-up government is difficult to deliver is that over many years individual departments build up an ''accumulated wisdom' (Kavanagh and Richards, 2001; p. 2). This experience is gathered from working with specialised interests' groups in society and negotiating successfully with the Department of Finance and other departments to achieve their goals. From the perspective of public choice theorists, it is rational behaviour for bureaucracies to seek to expand their influence and power by increasing staff numbers, budgets and developing special relationships with client groups. However, these special relationships can be achieved to the disadvantage of service consumers and the taxpayer (Kavanagh and Richards, 2001).

As discussed in chapter two there have been several initiatives to increase joined up government (JUG) in Ireland (Hardiman and MacCarthaigh, 2008). However, rather that our public services working more co-operatively the reverse occurred (MacCarthaigh and Boyle (2011). There was an unprecedented increase in the proliferation of public sector agencies and fragmentation in the delivery of services from the 1990s to 2008. The now disbanded social partnership model of policy-making from the perspective of JUG appeared to represent a well-co-ordinated model of joined up government (Doherty, 2011; MacCarthaigh and Boyle, 2011). The public-sector agencies and Departments worked together on many issues (Ibid). Nonetheless it was considered undemocratic. As certain sectors of society had undue influence over policy decisions that were favourable to their own economic interests (O' Cinnéide, 1999; Butler 2009).

The prominence of the alcohol industry to the Irish economy afforded it considerable political leverage. Researchers conceded the Alcohol Industries economic import to the economy. Nonetheless, they argued the industries financial strength enabled it to spend large amounts of money in lobbying government. This included advocating for self-regulation and advancing their own initiatives to tackle the misuse of alcohol in society. Consequently, the alcohol industry had a disproportionate influence over alcohol policy amidst the serious concerns of public health practitioners. One of the findings of this study was all four policy documents had adopted similar recommendations that of '*the need to manage drinking patterns and strengthen industry/government/public health partnerships*' (p.25). Nonetheless despite this evidence, conflicting approaches of narrowly targeted interventions were proposed to reduce alcohol harm in society rather than a whole population approach (Babor et al., 2003; Room et al., 2002).

Drug policy

The key issue for researchers in drug policy it was how the drug problem was portrayed by the media. The media's influence on discourse around the direction of drug policy was facilitated by external contextual factors such as the banking collapse of 2008 and the subsequent strain on Ireland's financial resources (Comiskey et al., 2012; Pike, 2012). Similar, to this study other studies have reported on how the media

itself can influence policy outcomes on how they report on drug issues (Lancaster et. al., 2011; MacGregor, 2013). Politicians have been known to use the media in their timing and announcing of drug policy decisions to divert attention away from other matters (MacGregor, 2013). Duke and Thom, (2014) report how in the UK media helped to redefine opioid substitution treatment as a problem in 2005. This ensued from the media reporting of killer facts on the numbers of drug misusers exiting treatment drug free (Lancaster, Duke and Ritter, 2015). This broadening of the debate on drug treatment services permitted stakeholders who did not agree with the harm reduction approach to influence policy in moving towards an abstinence based framework.

In the current study researchers suggested this 'new' philosophy of recovery and rehabilitation in drug misuse was not evidenced based. Furthermore, the underlying causes of much of the drug misuse in society, inequality and deprivation were being ignored. This study also found the type of research knowledge that had the most influence in policymaking was research evidence that was consistent with the values and ideology of the policymakers. Other studies have recorded similar findings in the field of drug research. For example, in one UK study on the type of scientific evidence that has the most impact on drug policy was research that was in alignment with *the mood of the time, answers the questions at the top of the agenda and fits with the assumptions with the key policy players* (MacGregor, 2011, p.46).

The current study employed the Research Impact Framework (Kuruvilla, et al., 2006) in assessing researchers' knowledge of the impact of their work. It found under the four headings of the framework 'research impacts', 'policy impacts', 'service impacts', and 'societal impacts', many participants could find evidence of where their work had had an impact. They were most comfortable talking about the research impacts of their work. The metrics available to measure the number of citations or journal articles published by academic are well established (Carpenter, Cone, Sarli, 2014). However not all researchers kept up to date with the number of citations their work had received. Again, many respondents could refer to the instrumental (Weiss, 1979) impact of their work, for example where it had been cited on policy documents to justify policy development or where it had influenced practice in the delivery of

services. However, the conceptual impact of their work they found harder to pinpoint, for example a change in societal attitudes or behaviours.

A few of the were critical of this emerging trend of researchers having to identify the impact of their work. It was argued that due to the rise in neoliberal ideas in society how universities and institutes of higher education are perceived has fundamentally changed (Warren and Garthwaite, 2015). The dominant concerns now for academics were to increase the output of publications. This was considered important to achieve personal and institutional status and to secure research funding in the future (Ibid). The present economic climate also influenced where academics sourced their funding for academic studies. Academics tender for large projects in competition with other research organisations, to evaluate public services and policy initiatives. This is particularly evident in the field of health and social care, and has resulted in closer relationships between policymakers and academics (ibid). One argument advanced for recruiting academics rather than other third parties, is the work produced has a higher degree of validity (Warren and Garthwaite, 2015). Government departments or service providers can also exploit to their advantage how the service or initiative was assessed by a university department. This is due to their standing in power relations in society or their 'hierarchy of credibility' (Becker, 1967).

One of the challenges for academic researchers working closely with government departments was highlighted by a study conducted by London School of Economics Gv314 Group (2014). It described how the commissioners of research had tried to get politically favourable results from the research. Nevertheless, academics reported they could resist these pressures. The reputation of academics is founded on objectivity and the ability to resist political interference. Furthermore, their work is made credible due to the integrity awarded to them by their academic status (Warren and Garthwaite, 2016; LSE, Gv314 Group, 2014). It is also argued that the pressure on researchers to produce policy relevant research impacts on their time and space to develop new ideas (Smith, 2010).

This section has discussed the use of the Research Impact Framework (Kuruvilla, et al., 2006) by participant researchers to describe the impact of their work. Many the respondents reported it was a useful tool as it made them think through the impacts of

their work, and this was becoming increasingly important in their professional careers. However, issues on the role of the researcher persist, for example should they be involved in advocacy or leave it to other groups in society to promote their work. There is also the danger of researchers focusing only on research that is acceptable in the present political and economic climate while ignoring more radical research innovations that may result in greater health gains for society (Smith, 2013).

The focus of this chapter was the interviews with researchers who worked in the fields of public health and health promotion. The data revealed an in-depth understanding of the process of policymaking. Many of the participants were very clear on how evidence could be used to address the issues of drug and alcohol misuse in society. However, they also understood that solutions to address societal problems had to be acceptable to policymakers, acceptable to the public and be cost effective to implement.

The participants in this study did not strictly consider what an adequate use of evidence in policy would look like. However, they could give examples of instances in policies developed and services augmented, where the findings from their research had made an impact. Among the strategies, they considered to increase the impact of evidence on policy decisions was to demonstrate how the empirical evidence correlated with knowledge from other sources. An example given of how this could be achieved was by presenting quantitative evidence to policymakers together with qualitative stories from individuals on the issues involved. Researchers also reflected on the importance of disseminating the findings of their research to a wider audience such as advocacy groups, the media and NGOs to effect policy or societal change.

Chapter 7: Discussion

7.1 Introduction

This thesis explored the impact of academic research on the formulation of alcohol and drug policy between 2001 and 2012. Phase One analysed public policy documents to identify the different types of knowledge cited on the policy documents. Phase Two and Three built on the findings from Phase One and obtained the personal views and opinions of policymakers and academic researchers on how the research evidence impacts on health policy. What was the context in which the research evidence was successful in making an impact? What were the different linkages and pathways that are employed by academic researchers to influence policy in the fields of alcohol and drugs? How can the facilitators to the use of research evidence be improved and the barriers can be overcome? It is also explored how effective the Research Impact Framework was in identifying how researchers measure the broader impacts of their work.

To address the first objective of this thesis 'how does research impact on health policy in Ireland' section one discusses the findings of the interviews with policymakers and researchers on how policy is developed. The role of academic evidence in this process is explored regarding two specific policy areas - alcohol and drugs. The second objective is explored in section two; the barriers and facilitators to research use in Ireland are examined together with how the different knowledge translations mechanisms can be employed to increase the uptake of research. In section three, the theories of the political process that help to explain policymaking in Ireland are outlined. The Research Impact Framework is discussed in section four, and in the final section, the strengths and limitations of this study are presented together with recommendations for policy and practice. The chapter concludes with a discussion on the strengths and limitations of this study.

7.2 The use of research evidence

One of the key findings emerging from this study was that research plays a role in the early stages of policy development. In the initial phase of the policymaking process policymakers require information to establish the extent of an issue or problem in society. Subsequent phases involve establishing what types of solutions there are to address the issue, and how similar problems are tackled in other jurisdictions. Research evidence is used at this level in an instrumental way (Weiss, 1979; Amara et al., 2004). Decisions are then discussed and debated by more senior civil servants and stakeholders in the policy process. Evidence is used to give a broad understanding of the policy area or issues under consideration. This is the conceptual use of research (Weiss, 1982). The findings in this study compare favourably with the findings of the use of academic research in a study of two Public Health Government agencies in Australia (Zardo and Collie, 2015). Academic research was predominantly used for conceptual purposes followed by instrumental and symbolic use. A simple linear relationship between scientific research and policy formulation where '*a piece of research that gets accepted and implemented*' rarely occurs. Many other factors impact on the process, for example the political and organisational environment, the wider economy, the media, and lobbying and specialist groups.

The analysis of policy documents was fundamental in revealing the different influences and different sources of evidence that the policymakers are subject to in the course of their work. Many studies have used the analysis of policy documents (Deas, Mattu, Gnich, 2013; Duke, & Thom, 2014; Bunn & Kendall, 2011; Invaer, 2009), to explore the use of research evidence in policy making. Fewer studies (Zardo and Collie, 2014; Ouimet et al, 2010) have reported on the other types of research evidence cited on policy documents and the validity of the use of this information. This study reported on all the information cited in the documents. For example, under 'commissioned studies by government agencies' the Health Service Research Board (HRB) appears frequently in this category and this is anticipated as *'it is the lead agency in Ireland supporting and funding health research'* (Nason et al., 2008). It funds researchers carrying out research in other institutions in addition to conducting their own research in the organisation. It is responsible for the maintenance of health information systems that are an important source of information for Government

policy, such a The National Drug Treatment Reporting System, The National Drug-Related Death Index and The National Psychiatric In-Patient Reporting System.

It is also important that governments developing policy in one area observe their own internal legislation and ensure consistency across government policies. The National Youth Strategy 2008-2010 for example in Chapter 3 of the NDS 2009-2016 is cited under educational and awareness programmes in non-school settings. It describes how in compliance with this strategy the aims of the strategy under the NDS 2009-2016 the Irish Youth Justice Service collaborating with An Garda Siochana intend implementing programmes to increase the effectiveness of programmes already in place. This would be achieved under the Young Peoples Facilities & Service fund in diverting and preventing young people from engaging in substance misuse. Essentially what the government is doing here is referencing its own prior policy decisions. This supports findings from earlier studies that research information that originates from within an organisation is a significant predictor of research use in policy decision-making (Oh and Rich, 1996; Oh, 1998; Zardo and Collie, 2014).

Additional influences identified in the policy documents were government policies in other jurisdictions. For example, in the substance misuse policy document (NDS 2001-2008) references were made to national drug strategies and policies in the UK, Switzerland, the Netherland and Sweden. The diffusion of political ideas from one jurisdiction to another is known as policy transfers. Policy transfer is defined as 'knowledge about how policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting' (Marsh and Sharman 2009, p. 270). However, policies or laws are rarely directly copied but are adapted or modified by jurisdictions to suit the local context (Stone, 2012). Similarly, the influence of international governmental oganisations (IGOs) on national policies was demonstrated in this study in the policy documents. This topic is discussed further section 7.8.6 Multi-level Government.

Policymaking was described as a very political process and many of the issues that the policy makers had to grapple with were the personal beliefs and motivations of different stakeholders on a policy issue and how the policy may impact on them

personally as well as on their organisation. These factors are further explored in the development of alcohol and drug policy between 2001 and 2012.

Section One

7.3 Alcohol policy

The current study found policy on the legal drug alcohol was not as amenable to being influenced by the research evidence as drug policy. The single most important reason proposed was the strength and influence of the alcohol industry. Other factors reported were that many policymakers believed that the electorate did not want any more regulation in this area. The economic climate was also a factor as the revenue generated from the production and sale of alcohol was important in an economic recession. Other factors proposed were the reluctance of politicians to regulate in this area, considering it a matter of personal autonomy.

In contrast drug policy was reported as being well developed and implemented up until 2008. It was supported by the evidence base. However, policymakers described how the illegal drug landscape was constantly changing and it was difficult to keep up with many of the new drugs coming on to the illegal drug market. Alcohol integrated into the drugs strategy was considered a positive development in policy in this area. Overall the use of illegal drugs in society was not considered a priority area for government, as it was felt it was a small cohort of the population were most affected by it and those who were, probably did not vote.

7.3.1 Strength of the alcohol industry

The strong relationship of the Drinks Industry in Ireland (DIGI) (made up of producers, distributors and vintners) with the principal political parties have been written about by several Irish scholars (Hope, 2006: Butler, 2009). A unique feature of the Irish policymaking landscape from the 1980s up until to its demise in 2009 was the social partnership model of policymaking (Doherty, 2011). This model of policymaking was regarded by Butler (2009) as contributing to the considerable influence of the alcohol industry on policy in Ireland. Social partnership originated

from the late 1980s, when the government of that time created a forum for negotiating with farmers, trade unions and employers on wage agreements for a fixed term policy programme (Adshead, 2011; O'Donnell and Thomas, 2006; Doherty, 2011; Stafford, 2011; Roche, 2007).

Social partnership developed in response to the economic climate which was characterised by high levels of unemployment, high national debt and inflation (Cassells, 2003). The forum facilitated agreement in several social and economic issues and later expanded to include partners from the community and voluntary sectors (Adshead, 2011; Doherty, 2011). Scholars have suggested that the social partnership approach to government contributed to Ireland's economic prosperity in the subsequent years (Fahey et al., 2007; Cassells, 2003). However, critics describe this approach as undemocratic, where decisions are made by committees behind closed doors, and issues were not publically debated or discussed at the political level (O' Cinnéide, 1999). Butler (2009) contends that this helped the alcohol industry in keeping issues around alcohol off the policy agenda. This occurred despite the mounting research evidence of the escalating levels of alcohol consumption in Irish society and the damage to the health of the population (Hope, 2006; Barry et al., 2007).

Policymakers and researchers interviewed for this study were very aware of the importance of the alcohol industry in providing a valuable revenue stream in a time of severe economic crisis in Ireland. Researchers stated this permitted the alcohol industry to have disproportionate influence over alcohol policy amidst the serious concerns of public health practitioners. It was claimed the industries financial strength enabled them to spend large amounts of money in lobbying government, advocating self-regulation and advancing their own initiatives to tackle the misuse of alcohol in society. Policymakers did acknowledge that there was very good evidence on how the industries sponsorship of sports influenced the drinking behaviours amongst young people (O'Brien et al., 2014; Kelly et al., 2015). Nonetheless, it was believed that policymakers must be pragmatic and in a time when the state could not find alternative arrangements for the funding of sports the alcohol sponsorship could continue.

The Alcohol Industries influence in policymaking in Ireland and the privileged position they have been afforded by government, have been recorded in several other

studies (Baggot, 2006, 2010; Anderson, 2007; Babor, Robaina, 2013; Jernigan and Babor, 2014). The Portman Group is one of the United Kingdom's major alcohol producers. It has worked previously with the UK Government in drafting alcohol reports (Marmot, 2004; Room, 2004). It was found to have offered fees to academics to critique a WHO sponsored book on alcohol policy in the 1990s (Edwards, Anderson and Barbor, 1994). In 2008 research evidence funded by the alcohol industry was used in the industry's submission papers to the Scottish Government in opposition to the introduction of minimum unit pricing (McCambridge et al., 2013). The research evidence cited by policymakers to promote a population based approach to alcohol policy was critiqued and undermined by the alcohol industries own evidence. The alcohol industry promoted strategies that would target select individuals or specific population groups who they believed misused alcohol in society in place of a whole population approach (Babor et al., 2003; Room et al., 2002). These strategies had the least impact on the Alcohol Industries own economic interests.

There are several exemplars of how the Alcohol Industry has for many years negotiated its way into partnering governments in developing alcohol policy. Many of these practices would be unthinkable for other industries (Casswell, 2013). For example, when the industry expands into new markets, it very quickly establishes itself in partnerships with local business and policymakers (Bakke and Endal, 2010; Babor and Robaina, 2013; Caswell, 2013). One study analysing policy documents in several sub-Saharan African countries found that the drinks industry had established a significant role for themselves in the drafting and development of national alcohol policies (Bakke and Endal, 2010). The themes of the initiatives proposed by the industries sponsors SAB-Miller and the International Centre on Alcohol policies (ICAP), were the promotion of commercially produced alcohol as an alternative to illegal breweries (Babor and Robaina, 2013). In outlining the benefits of the alcohol industry to the local economy through revenue contributions and job creation, SABMiller stated that "our significant tax (excise) contribution gives us a place at the table" (SABMiller, 2012 as cited in Jernigan and Babor, 2014; p.558). This is reminiscent of the partnership approach to policymaking in Ireland discussed earlier.

Understandably the business sector and corporate actors must be cognisant of how government policies and regulation can affect their business interests (Hillman and

Hitt, 1999: Lindblom, 1977). They are regularly required to make decisions on how they will address policy outcomes that may deliberately or inadvertently affect their industry (Hillman and Hitt, 1999). These decisions can be reactive where the corporations tackle policy issues as they arise or proactive where the sector takes an active hand in public policy shaping (Weidenbaum, 1980). Popular strategies employed by the corporate sector and identified by Hillman and Hitt (1999), are informational, financial and constituency building. These range of strategies have been added to recently to include legal and policy substitution, as well as development and implementation tactics (Savell, Fooks, Gilmore, 2015).

This study found several of these tactics were used by the Alcohol Industry in Ireland. For example, representatives from the alcohol Industry have been present on all the Strategic Task Force Committees on Alcohol from 2002 to 2012. In addition to providing technical expertise and information to the policy process, membership of these committees allows the industry to influence policy outcomes. In 2002, following the submission of the STF committee on alcohol report to government underlining a Public Health approach to the over consumption of alcohol in society, the alcohol industry submitted their own Minority Report. In this report, they challenged many of the proposals endorsing a whole population approach. Instead the Alcohol Industry emphasised their considerable contribution to society through revenues generated by taxes, excise duty, income tax and corporation tax (DOH, 2002).

Financial incentives are the second strategy employed by businesses to influence policy (Hillman and Hitt, 1999). This is achieved by aligning the priorities of the policymakers with the interests of the industry. This strategy is evident in the establishment of 'social aspect groups' to fund public health and education campaigns on alcohol misuse and drinking responsibly. Anderson, (2004) describes social aspect groups as a public relation undertaking on behalf of the drinks industry. The drinkaware charity established and funded the alcohol industry is an example of such groups (McCambridge, Kypri, Miller, Hawkins and Hastings, 2014). Diageo[22] provided 1.5 million Euro for a research project into excessive alcohol consumption

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[22] Diageo is a multinational alcohol beverages company. Its headquarters are in London England and it has offices on six continents (www.diageo.com).

in University College Dublin in 2006 and disclosed it was intended to dissuade policymakers from increasing taxes on alcohol beverages (Babor and Robaina, 2013; The Irish Times, April 8, 2006). In Ireland, the organisation the *Mature Enjoyment of Alcohol in Society* (MEAS) was established by the alcohol industry in 2002 and has had representatives on the STF committees from 2004 to 2012. It is suggested that governments sometimes welcome support from these industries, as they provide financial resources to Departments who are perhaps struggling with limited funds (Hillman and Hitt, 1999).

The third tactic engaged by corporations to influence policy is known as 'constituency-building strategies' (Hillman and Hitt, 1999; p. 834). This involves building support for a policy direction through influencing individual voters and citizens. The public will in turn express their policy preferences to the policy decision-makers. This is an indirect way of influencing policy.

Hope in (2006) investigated how the alcohol industry influenced alcohol policy in Ireland. She describes how in the first alcohol misuse report (DOH, 2002) whole population approach to reducing the harm caused by alcohol in society based on the research evidence was recommended (Room, 2001). The measures advised were an increase in taxes on alcohol beverages, random breath testing, no increase in availability of retail outlets and lower blood alcohol levels (BAC) (DOH, 2002). As alluded to earlier the Drinks Industry Group of Ireland (DIGI) submitted their own minority report opposing many of the recommendations. The industry favoured more educational programmes, despite evidence demonstrating that educational programmes have the least impact on alcohol consumption (Babor, 2003). The government ignored the proposals of the Drinks Industry and proceeded to increase taxes on many alcoholic beverages with a resultant decrease in consumption levels of -6% in 2003 (Hope, 2006). In the second STFA report in 2004 (DOH, 2002) recommendations again were made for the increase of taxes on alcohol products. Proposals were also made to enact legislation on the marketing and advertising of alcohol products to protect children. These were again opposed by the Drinks Industry of Ireland (DIGI). In its press release the industry claimed that there was no confirmed links between increased levels of excise duty and reduced levels of alcohol misuse in society (DIGI, 2004).

The Alcohol Industries lobbying efforts on this occasion were successful. The STFA proposals on tax increases and marketing regulations strategies to reduce alcohol misuse in Irish society were delayed or reduced by the Irish Government (Hope 2006). Recommendations to combine alcohol and drugs into a new National Substance Misuse strategy in 2009 were also delayed due to strong opposition from the Vintners Association (Butler and Hope, 2015).

In the current study, several public health practitioners reported that the tobacco and food industry particularly in relation to junk food and sugar would use similar tactics to the alcohol industry in influencing policy. Furthermore, they reported that the Alcohol Industry threatened to move its operation overseas. This threat to relocate overseas gives an added incentive to governments to develop business-friendly policies (Farnsworth, 2004). Political scientists contend that the favoured position held by certain industries in government circles is understandable in view of the tax revenue generated through employment, production, sales and the use of resources within the economy ((Lindblom, 1997; Dahl and Lindblom, 1992).

Comparable to Ireland the Alcohol Industry in the UK has established long-term close working relationships with key decision-makers in parliament (McCambridge et al., 2013; Holden and Hawkins, 2012). Many of the strategies include offering key information to policymakers and assisting in the delivery of policy outcomes by establishing self-regulatory systems and co-operating with government on regulatory matters (Hawkins and Holden, 2014). Hastings argues (2012) that by promoting their corporate responsibility to society and accentuating their ability to self-regulate, the alcohol industry promotes their industry as part of the answer to alcohol harms in society rather than the problem. Using many different avenues of access and communication the alcohol industry engaged with key members of the civil service and the political parties. Most specifically individuals who were at present and who would be in the future involved in policymaking. Through these channels, they ensured they had frequent access to policymakers both formally and informally and thus could influence the framing of the alcohol issue (McCambridge et al., 2013). Similar to the findings in this study the Alcohol Industry argued that only a minority of the population drank irresponsible. They advocated for policies to target the culture

of binge drinking and the small percentage of the population who had a problem with alcohol misuse (DIGI, 2002).

In the event of the industry not being successful in their efforts in developing a partnership approach to policymaking and lobbying activities failing, they will use other methods to ensure the interests of the industry are not harmed (McGrady, 2012; O'Brien, 2013). McCambridge et al., (2013) suggests they have learned from the experience of the tobacco industry. Both industries have worked together in the past for mutual benefit (Jiang and Ling, 2013; Bond et al., 2010). Legal challenges have been made for example to policies that violate trade laws, at the national level, and the European and global level (McGrady, 2012). The introduction of explicit warning labels on alcohol packaging in Thailand was opposed by the WTO and the EU (O' Brien, 2013). The legal argument made for challenging this policy was that it imposed excessive restrictions on trade. This is comparable to the arguments made in Australia challenging the introduction of plain packaging laws for tobacco products (O' Brien, 2013). Moreover, the industry's ability to move decision-making on alcohol policy outside of national boundaries where they have more influence can undermine the public health interests of Nation States (McCambridge et al., 2013; Drope and Lencucha, 2014).

One of the most intriguing facts about the alcohol industry is to the extent it has negotiated its way into very influential policymaking circles. This has occurred to such an extent that its presence around the policymaking table is rarely questioned (Hawkins and Holden, 2014). This authority and power projected by the alcohol industry is illustrated by their presence at the UN (201I) High Level Meeting on non-communicable diseases (NCDs). This is notwithstanding it being one of the main risk factors for the development of NCDs (Parry, Patra, Rehm, 2011)). Casswell (2013) suggests that framing the alcohol problem as one of irresponsible drinkers rather that the supply and marketing of alcohol has contributed to this success. The WHO (2010) too has displayed an ambiguous approach to alcohol in society. On the one hand, they have allowed the industry to participate in global strategies on alcohol harm, and at the same time emphasised the important role of the WHO in developing health policies protected from commercial or vested interests (Chan, 2013).

7.3.2 Organisational factors

The structure of government and how policy decisions are made were highlighted in this study as a significant factor impacting on how the research evidence is used in policymaking. The respondents described how the responsibility for coordinating the National Alcohol Policy is under the remit of the Health Promotion Unit in the Department of Health and Children. However, 11 other government departments have several responsibilities in relation to alcohol policy. Each department develops policy according to their specific concerns and interests. It is argued this is one of the main reasons why progress on the whole population approach to alcohol policy has been slow to emerge in Ireland. Consequently, the drinks industry can exert undue influence in lobbying across the different departments (Hope, 2006). Alcohol has been described as one of the 'wicked issues' of government (Wildridge et al., 2004). Wicked issues are defined as 'problems that are both complex in themselves and cross traditional organisational boundaries, so that agencies can only hope to tackle them adequately by working together' (Wildridge et al., 2004; p.6). Hence, it is very understandable why alcohol policy is such a contentious issue, when one considers the competing demands on health, employment, generating revenue and security by the various departments (Toner et al., 2014).

Nonetheless, in the UK a whole population approach to alcohol policy emerged under the Labour Government. This included educational and public awareness campaigns, the development of brief intervention strategies and community-based detoxification programmes (Loyd, 2010). A major influence on the development of the whole population approach was the creation of the advocacy group, the Alcohol Health Alliance. The group comprised researchers, public health professionals, the Royal Colleges, hospital Accident and Emergency Consultants and 'advocacy' charities (Toner et al., 2014). It produced and disseminated research and epidemiological data to support their demands for alcohol policy to address health issues. Toner et al., (2014) suggests that the combination of the research evidence together with an advocacy group, that used power and influence in media, medical and political circles, contributed to a public health policy agenda for alcohol to emerge. The Alcohol Health Alliance employed many of the strategies described by Hillman and Hitt (1999). For example, as well as using the research evidence the members used their influential relationships and contacts with powerful organisations to influence change in policy.

7.3.3 Research making an impact

In the current study, many participant researchers gave examples how and where the scientific evidence was making an impact on policy. Nonetheless it was happening slower than they would have liked. It was reported that sometimes it was difficult to know what kind of knowledge/evidence had the most effect on policymakers. It was believed that poignant personal stories could have more of an impact on politicians than the scientific evidence. The cost effectiveness of an intervention was considered a significant factor in influencing the uptake of research. Evidence for example that demonstrated the number of hospital bed days occupied by patients due to alcohol related health problems were very effective in getting policymakers to listen. This was consistent with findings in the UK. Studies on alcohol policy demonstrated that evidence of cost savings to the health sector on alcohol related hospital admissions (ARHAs) was the most effective in raising awareness of alcohol problems. Moreover it was getting local and regional agencies to support and promote spending on 'best practice' interventions ((Toners et al., 2014). Other findings from the UK study revealed that evidence collected locally was influential in how alcohol issues were prioritized and addressed in specific areas. Pawson and Tilley (1997) have argued in their realist approach to evaluation, contextual factors that contribute to what works, and for whom and in what circumstances need to be considered in developing policy interventions. Not all the strategies selected for implementation by the UKs Department of Health's Alcohol Improvement Programme (AIP) were evidence based and it was argued that the strategies that had the least evidence relevant to the alcohol field was the most popular with Ministers, for example social marketing (Toner et al., 2014).

7.3.4 Values and political ideology

The political nature of policymaking in the Irish context was an issue for many participants in the current study. It was reported that many stakeholders in the policy process were influenced by their own personal beliefs around an issue. Stakeholders in the process could likewise be influenced by how the policy may impact on them personally as well as on their organisation. Personal beliefs and ideology have been found to influence policy in other studies. For example, in the United States a study on the population wide vaccination of the human papilloma virus (HPV) reviewed

arguments that were advanced either to support or oppose the compulsory implementation of the school-aged girls' vaccine program. It found the recommendations were based on 'moral, religious, political, economic, and socio-cultural arguments' rather than on the scientific evidence (Vamos, McDermott and Daley, 2008: p.302). Exploring how evidence was used in an AIDS Relief programme in Uganda (PEPFAR Programme), discovered the same evidence was selected and interpreted differently by the different parties, those supporting PEPFAR and those opposing the HIV prevention strategy (Parkhurst, 2012). The study examined predominantly the ABC element of the strategy that focused on Abstinence, Be faithful, and Condom use. It was able link the policy arguments and recommendations that were advanced to the core beliefs on morality and sexual behaviour by those who both supported the Bush administration and those who were critical of this approach.

Other studies use the analogy of assisted human reproduction to illustrate the type of issues at policy level that can only be approached by deliberation and debate rather than the scientific evidence (Greenhalgh et al, 2009; Lomas and Brown, 2009). Frequently what is at the centre of the debate is what are the priorities for healthcare and the values of a population that politicians are elected to represent. Difficult choices must be made. For example, deciding whether to use public funds to improve access to healthcare and immunization programmes for children, or to provide in-vitro fertilization (IVF) services to childless couples. Deciding what population sub groups would be eligible for these services is far more complex and difficult than the clinical decisions made at the individual level, on whether to treat or don't treat a child or adult regarding immunization or infertility (Lomas and Brown, 2009). These types of policy decisions on values and issue priorities are more likely resolved only through reasoned argument and debate.

An explanation given for the widely divergent held views on policy issues is that 'policy practitioners seek stability and act in a social world that is a kaleidoscope of potential realities' (Hajer and Laws, 2006; p. 252). The human mind when encountering complex situations employs several techniques; such as association and previous experiences and beliefs to make sense of the social world around them (Goffman, 1974). This is known as *framing* (Rein and Schön, 1993). Policymakers frame complex social issues by perceiving the problem through a conceptual lens

based on their own previous experiences and beliefs. The importance of core beliefs (Sabatier and Jenkins, 1993) and how we construct the social world around us (Schneider and Ingram, 1993) have been explored by several political writers. Unlike strongly held political interests' frames are not flexible. Schön and Rein, (1994) suggest how policy actors view and interpret the world becomes part of their identity. In this way framing (Rein and Schon, 1993) complex social issues allows policymakers to select, organize, interpret and make sense of the reality around complex social problems. Framing can also provide guidance on how to analyse, persuade and act on complex issues. In the political process the different stakeholders defend viewpoints/frames and advocate for their frames to become the dominant political interpretation (Dekker, 2017). This helps to explain why moral and ethical issues in public health policy are highly contested and are not readily influenced by the scientific research. This was evident in this study on discussions on alcohol policy. For example, many of the policymakers and researchers interviewed believed that issues pertaining to alcohol control policy were influenced by politicians own beliefs.

A minority of researcher participants and policymakers argued in this study that politicians have the right to base their decisions on values. They suggested political parties state their stance and outline their strategies for dealing with many social and public health issues in their programme for government. This programme is accessible to the public to review. Through the democratic system politicians are elected to make decisions for the public they represent. In the current study the role of evidence was viewed as setting the parameters of the debate. This view on research evidence compares favourably with several other scholars. For example, it has been debated the move towards a technocratic mechanism of policymaking fails to acknowledge the legitimacy of politicians democratically elected to make policy according to the beliefs and wishes of the electorate they represent (Hawkins and Parkhurst, 2016; Greenhalgh et al, 2009; Smith, 2013; Sanderson 2009; Russell et al., 2008). It is suggested that proponents of the evidence-based policy movement believe that 'evidence from research is value-free and context-neutral' and the uptake of research evidence can be improved by better research design, execution and dissemination (Greenhalgh and Russell, 2009; p. 308; Lavis et al., 2008; Campbell et al., 2009; Mitton et al., 2007). Nonetheless, there has been a growing recognition of the fundamental role of politics in the policy process and its legitimacy (Sanderson 2009; Russel et al., 2008; Cairney

et al., 2016). Fittingly the language around evidence based policymaking has become more nuanced with the term evidence informed policymaking now more accepted (Oxman et al., 2009). Therefore, acknowledging that the scientific evidence is only one of the many different types of knowledge considered by policymakers (Oliver et al., 2014; Russell et al., 2008).

7.4 Drug policy

The findings on the use of research evidence in the development of drug policy in this study were predominantly for the justification of policy development. This was similar to the findings in alcohol policy. The factors considered most influential by the respondents were lobbying by concerned citizens of public representatives to implement policies to address drug issues in society. The media coverage of illicit drug use and related problems was also a significant factor in getting policymakers attention. These contextual factors allowed the illicit drug issue to climb to the top of the political agenda in the late 1990s.

7.4.1 Organisational issues

The organisational factors that facilitated the development of the drug misuse strategy were a coordinated approach at senior level in government. The cross-department collaboration and cooperation with government agencies were instrumental in its successful implementation. The philosophy around the use of illicit drugs in Ireland had already moved from an abstinence only policy in the early 1980s to a harm reduction approach which included treatment and substitution policy (O'Gorman, 1998; Butler, 1991; Marlatt, 1996). This philosophical shift from a moral/criminal or disease model of drug use was prompted by the outbreak HIV in the mid 1980s and the identification of the sharing of needles amongst injecting drug users as one of the key routes of transmission (Butler 2005: Robertson et al., 1986). The primary focus of harm reduction is to reduce the harms caused by drug use to the individual and society without expecting the drug user to become abstinent (Rhodes et al., 2010). This is achieved by providing a range of services, for instance access to clean needles and syringes, opioid substitution treatment, and access to antiretroviral drugs for HIV (United Nations, 2006).

The policymakers in this study stated that in the early years of the drug strategy it would not have been greatly influenced by the research evidence. They described how the previous and current strategy 'Building on Experience: National Drug Strategy 2001-2008, 2001; National Drugs Strategy *(interim)* 2009-2016) were founded on the recommendations of the *First Report of the Ministerial Task Force on Measures to reduce the Demand for Drugs* (Department of the Taoiseach, 1996). Early indications were that the research evidence would be considered valuable in developing drug policy, for example, research demonstrating the relationship between poverty and serious drug misuse (Mayock and Moran, 2000). It is also safe to assume that it did impact on the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (Dept. of the Taoiseach,1996). However, this was not borne out in subsequent policy development. Following the establishment of National Advisory Committee on Drugs in 2000 to advise and inform government on policy, scientific evidence became much more integral to government drug policy. Much of the research in the intervening years commissioned or undertaken by the NACD, was in response to gaps in the evidence for the strategy that was already in place. Other studies have found that once a certain position on drug policy is established by government and is made legitimate through the scientific research, it is very difficult for alternative views or opinions to be heard (Duke and Thom, 2014).

Furthermore, the participants reported that policy decisions-makers could be selective in what they choose to implement from the research evidence due to financial constraints or personal beliefs. In the 2001-2008 strategy, they did not introduce drug treatment rooms. This was despite reviewing their successful introduction in other jurisdictions, as not all stakeholders, for example the Department of Justice were not supportive of this idea. Studies in Australia found that information garnered from accessing the internet, technical data and consulting policymakers in other jurisdictions were common sources of information for policymakers (Ritter, 2009). Ritter (2009) suggests that this can pose a dilemma for researchers. For example, do they concentrate on writing papers for peer reviewed journals for which they will receive academic rewards, or do they disseminate their research results more broadly on the internet, where it will have a higher probability of being viewed by policymakers.

7.4.2 Media

At the time of the collection of interview data in 2014 and early 2015, the media published several stories on the numbers of drug misusers in the population parked on methadone. Questions were asked as to why the government did not take a different approach to drug misuse in society, founded on an abstinence based framework (Irish Times, 28/06/2014; Sunday independent 14/08/2014). Arguments were advanced for drug services to focus on rehabilitation and recovery treatments. Other studies have found the media reporting of social issues can shape how they are constructed and perceived by the public (Beckett, 1994; Hughes, Lancaster, Spicer, 2011; McArthur, 1999; McCombs and Shaw, 2005). This influence on the attitudes and beliefs of the public and can determine the level of urgency the issue receives on the political agenda. In chapter two the media's influence in bringing the serious heroin problem in Dublin in the 1980s and again in the late 1990s to the attention of the wider public and the politicians was discussed. In 2008 and 2009 the media again were influential in changing the discourse around the direction of drug policy in Ireland. Other contextual factors too had an impact. The banking collapse of 2008 and the subsequent strain on Ireland's financial resources led to a reduction in community-based drug projects between 2008 and 2012 (Comiskey et al., 2012; Pike, 2012). It could be argued that this new emphasis on rehabilitation and recovery allowed the Irish Government to justify their reduction in funding of the drugs services as they were structured at that time. Between 2008 and 2012, community based drug projects in Dublin experienced a 29% reduction in government funding (CityWide, 2012). Researchers in the current study discussed how the present discourse on recovery and rehabilitation in drug misuse was not evidenced based. The debate was ignoring the underlying causes of much of the drug misuse in society, inequality and deprivation (Marmot and Wilkinson, 2005; Wilkinson and Pickett, 2010). Stevens, (2011) writes however even when the evidence is presented to policymakers in a credible and convincing manner it can still be ignored.

Ideas on rehabilitation and recovery came to prominence in the UK following the media reporting of only 3% of drug misuser emerging from drug treatment a year later drug free (Ashton, 2008: Duke and Thom, 2014). Opioid substitution treatment was redefined as a problem. The research underpinning the opioid substitution approach began to be re - interpreted with the emphasis on the numbers of drug misusers fully

recovered and rehabilitated back into society (Duke and Thom, 2014). A window of opportunity opened for stakeholders in the drug policy process who were not in agreement with a harm reduction approach to drug misuse (Duke, Herring, Thickett et al., 2013). Policy responses moved towards abstinence based framework focusing on rehabilitation and recovery. Ensuing from this new direction in drug policy, research began to emerge which underlined the limitations of upload substitution treatment. The focused moved to counselling and other therapeutic regimens (Best and Lauded, 2010; Best, Wood, Sweating, et al., 2010). Methadone as the gold standard of treatment and the research evidence that supported it began to fall out of favour (McKeganey, 2012; Duke and Thom, 2014).

Where the media itself has been identified as an actor in the policy process (McCombs, 2005), politicians too have been known to use the media in their timing and announcing of drug policy decisions to divert attention away from other matters (MacGregor, 2013). The British Prime Minister Tony Blair used the media to announce a new strategy for a 'war on drugs in 1999 to divert media attention away from his power struggles with Gordon Brown (MacGregor, 2013). Again in 2001 to garner support for the war in Afghanistan Tony Blair framed the justification for the UK's involvement in the war as helping to destroy the countries illegal drugs trade (Ibid). In this study, there was no evidence of drugs being used in a similar manner by Irish politicians. Policymakers stated the issue in Ireland on drug misuse were not viewed as a priority for government. More often it was the media that brought the governments attention to the misery and distress illegal drug activity brought to this neglected sector of society.

7.4.3 The research evidence

The policymakers in this study reported that the research that has the most influence on policymakers was research that offered solutions on priority issues for government. Equally it was important that the solutions did not cost a lot of money, were easy to implement, and acceptable to important people. This is comparable to the findings in the UK on the kind of evidence that has the most impact "is that which fits the mood of the time, answers the questions at the top of the agenda and fits with the assumptions of key policy players" (MacGregor, 2011: p.46). Harm minimisation approaches for

example were introduced in the 1980s because of the fear of the spread of the HIV virus from intravenous drug misusers (McClelland report 1986; Stimson 1995). This fear had now subsided with the developments of new treatments. Governments in an era of economic restraints can now review the cost of opioid substitution services to the exchequer, and explore alternative treatment services (Duke and Thom, 2014).

In the UK, the research evidence was found to have supported decisions already made by political actors and policy decisions makers in the 1980s in introducing the harm minimisation approach to drug misuse (McClelland report 1986; Stimson 1995; MacGregor, 2011). Research was again instrumental in the late 1990s in supporting a policy shift towards the criminalization of drug use where it demonstrated the link between drug-taking and crime (Ramsay and Percy, 1996). Karim Murji (2009) described how his research impacted on drug policy but not in the way that was envisioned. His work had demonstrated the chaotic nature of the illegal drugs market where the dominant view at the time was that drug markets were hierarchical and pyramidal in structure. Murji, (2009) suggests policymakers interpret and select from the evidence the information that is aligned best with their personal ideology or views.

Narratives and how they influence the development of drug policy is a recurring theme in the literature (Stevens and Ritter, 2013: Boyd, 2013; Hall and Carter 2013). The types of evidence that is selected is what best suits the dominant narrative of specific epochs. For example, in the current study researchers discussed how at steering group meetings civil servants could be selective in what evidence they would present to the senior decision-makers and politicians. The civil servants believed that they needed to be mindful of the prevailing views of government and prepare policy briefs that would be accepted by elected representatives. The themes around a policy issue can change overtime. Equally debates take place in different forums, and at different levels of government in which the use of evidence varies according to which venue the policymaking is taking place. In Ireland drug misuse was initially associated with artists and students (Report of the Working Party on Drug Abuse, 1971; Glynn, Curtin, Clarke and O'Muireartaigh, 1973) but later discourse on drug use in society focused on the poor, the underprivileged, and the socially excluded (Dean et al., 1983; O' Kelly et al., 1988; O'Gorman, 1998).

In the mid-1980s harm reduction measures to address the drug crises became the dominant narrative due to the fear posed by the spread of HIV and AIDs. Evidence that carried the most influence in those years was the epidemiological data, as it could predict the probability of the spread of the disease and the harm reduction approaches that would counterweight these problems (Macgregor, 2013). Furthermore, the evidence of addiction experts and personal in the treatment services was paramount. In the 1990s as the second heroin epidemic erupted in Dublin among young people and spread to other urban centre's there was a greater emphasis on the socio-economic origins of illegal drug in conjunction with the criminal aspect (O' Gorman, 1998). Butler and Hope (2015) argue that despite the epidemiological data demonstrating over many years that the highest levels of intravenous drug use and other associated risky behaviours around drugs located in areas that had the highest levels of deprivation, it was only in the late 1990s that the government accepted this evidence. This further emphasises how the evidence is only accepted and acted on when the government believes it is ready to tackle the problem.

Over the decades' drugs have been frequently associated with vice and evils and viewed as a threat to the security of society (Musto, 1991; Berridge; 1984). In the UK in the 1980s it was framed as a Public Health issue and this was reflected in the policies developed (McGregor, 2013). In the 1990s the narrative moved from a health issue to a law and order issue associated with criminal activity (Bennet, 1998; Ramsay and Percy, 1996). Macgregor (2013) observed that the reframing of the drug problem in the mid-1990s as a criminal one rather than a health one was instigated by the New Labour party to win support from the electorate and away from the conservative party. The evidence used to support its argument was from prominent criminologists and economists (Bennet, 1998; Ramsay and Percy, 1996). Since 2008 the narrative again has changed to a recovery philosophy and one of rehabilitation and abstinence (MacGregor, 2013; Ashton, 2008). The topic of rehabilitation and recovery were dominant themes in the interviews with researchers in this study. Nonetheless many of the participants suggested that there was no new evidence of effective measures to achieve abstinence in a drug misusing population. It was suggested that these services could be added to the services already in place.

A more recent narrative which is now only beginning to come the fore is the use of illicit drugs among the middle classes (Delaney Wilson, 2007; Salinas, 2018: Askew, and Salinas, 2019). In this study, it was found that interviewees were very willing to discuss illicit drug use among the disadvantaged and middleclass adolescents experimenting with drugs specifically cannabis and ecstasy. However, they were much more reluctant to discuss the recent death of a very popular media celebrity found with elevated levels of cocaine in his body (Irish Times, Sat. Dec. 10th 2010). Now however, with the recent legalisation of cannabis use (Hall and Lynskey, 2016), politicians and celebrities are more willing to talk about their own drug use[23].

7.4.4 Values and political ideology

Values are fundamental to the discourse and debates on drugs (Valentine, 2009; Ansell and Geyer, 2017). Besides as discussed earlier it is very difficult for the research evidence to compete with deep-seated values and norms in society (Greenhalgh et al, 2009; Lomas and Brown, 2009). The extension of the evidence-based medicine movement to evidence-based health policy is complicated as many authors have argued (Dobrow et al., 2004; Brownson et. al, 2009; Greenhalgh and Russell, 2009; Hawkins et al., 2015). In the UK, the MP D David Blunkett MP (Home Secretary from 2001 to 2005) stated that evidence alone cannot rule partly because 'the scientific views heard by politicians differ' (page, 228). More importantly, since the role of politicians is to link to the wider public, values and sentiments are crucial, 'politicians' he said, 'have to carry the population' with them (speaking at UKDPC conference, 19th November 2012 as cited in MacGregor, 2013; p.228).

The findings in this study demonstrate that politicians could be more influenced by meeting one distressed mother about her cannabis addicted son rather than the statistical evidence demonstrating that the numbers in the population using cannabis that are not addicted. Politicians often ignore the research evidence preferring to base their findings on their own personal experience and the views and opinions of their constituents. Other studies have also found causative allegations expressed in personal

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[23] "Cocaine, cannabis and opium: which politicians have used drugs and what did they take" 8th June 2019, The Guardian; "Dunphy: Gerry Ryan's death a warning to me about cocaine", 13th June 2019 ,The Irish independent.

stories can have a significant impact on policymakers and may linger long after the causal link had been disproven by the scientific evidence (Jewell and Bero, 2008)

Other political constraints highlighted by MacGregor (2013) are the pace at which politics moves. Frequently policymakers must respond to demands for action to address serious societal issues in short timeframes. This does not allow time for the type of evidence that would have the most impact. For example, RCT and cost effectiveness studies that require time to be evaluated appropriately. Some studies have reported that the behaviour of politicians wanting to be seen to be doing something leads them into making headline grabbing statements to attract media attention (Ibid). This was viewed as an obstacle to practical policymaking. More commonly MacGregor (2013) argues drugs are used by governments to indicate their overall stance on a set of priorities and beliefs for political expediency. It was important to be perceived as 'sending the right message' to the electorate. As described in chapter two politicians when in government work under the principle of collective decision-making and shared responsibility. They cannot speak independently of the government of which they are a member. Their views and actions must embody the governments manifesto as well as that of their constituents. Politicians acknowledge that evidence matters, however this interpreted through their own values and experience as well as being aware of the values of the public they are elected to embody (MacGregor, 2013). It can also be argued that knowledge too is not value-neutral, and is produced and disseminated according to whose problems are being addressed and the context in which it is being produced (Ansell and Geyer, 2017).

This study found that is the research evidence is frequently ignored if it runs contrary to the prevailing values of government and what they believe the public will accept. A good exemplar of this is the sacking of the Professor David Nutt the Chairman of The Advisory Council on the Misuse of Drugs in the UK in 2009. After several reviews of the scientific evidence requested by government on the links between 'skunk' a potent form of cannabis and the development of psychosis, Professor Nutt advised government that cannabis should remain a class C drug. However, this was ignored and cannabis was re-classed as a B drug. Subsequently he published a paper, and in several public engagements compared the number of injuries from horse riding per year to the number of injuries to those taking ecstasy. This was reported widely by

the media. Professor Nutt was considered to have crossed the line between researcher and policy decision-maker. MacGregor, (2011) considers his sacking to be defensible as 'the role of the Chair was to advise and not to criticize government policy' (p.48). It is the privilege of government after due consideration to accept or reject advice.

This example illustrates how facts do not speak for themselves, rather they are interpreted and evaluated through the values and world views of the decision-maker and the constituents he/she is elected to represent (MacGregor, 2011). Examples were given in this study of research evidence that was at first rejected and later accepted by government as at the time it ran contrary to government thinking (Comiskey, 1998). In comparison to other policy fields, the influences on drug policy are multifaceted and complex with personal ideologies, values, the media, politics, pragmatism, public opinion and funding all competing with the research evidence (Ritter, 2009; MacGregor, 2011, 2013; Stevens and Ritter, 2013; Monaghan, 2010).

7.5 Models of research Utilisation

Several of the models of research utilisation can be applied to help us to understand the use of research evidence in drug and alcohol policy. The policymakers reported that basic scientific evidence was far more influential than qualitative evidence. This is a consequence of the unassailable proof that randomised controlled trials can produce effective evidence that a drug does or does not work. For example, the introduction of human papillomavirus (HPV) vaccination programme in Ireland in 2010 (Corcoran, Clarke, Barrett, 2018). This responds to the classic, knowledge driven model of public policymaking, where a direct relationship is clear from the production and dissemination of the evidence to its uptake by policymakers.

For many social problems, the policymakers suggested the evidence was more equivocal. Frequently the conviction was not in the research on how to address the policy issue. In this context, the other models of research utilisation appear more relevant. Reflecting on the influence of the research evidence influencing illicit drug policy in Ireland, the analyses of policy documents and interviews with policymakers the interactive/social interaction appears pertinent. Investigating the area of drug

policy illuminated a process that involved consultation with many different interest groups in society. Different types of knowledge were considered including the research evidence. Since the implementation of the strategy the succeeding research that was undertaken would fit into the political/symbolic model of policymaking. For example, most of the research commissioned would have supported the drug strategy that was already in place.

In the development of alcohol policy, the tactical model helps to explain the slow progress made in this area over the last two decades. This is evident from the numerous reports published on alcohol policy since 2002. All the reports have recommended a public health approach tackling the misuse of alcohol, but to date the government have delayed in fully implementing this strategy for motives outlined earlier in the chapter.

Reviewing the fields of both alcohol and drug public policy over the decades the enlightenment/ conceptual function of research utilisation is the dominant model for explaining the use of research evidence in policymaking. For example, post prohibition, research evidence emanating from the United States was responsible for the disseminations of ideas on the disease concept of alcoholism throughout Europe. This was later rejected when several research studies in the early 1970s demonstrated the link between the consumption level of alcohol in society and the risk of the individual in developing alcoholism (Christie and Bruun, 1969; Cahalan and Room, 1974). This research led to a much wider range of options being available to policymakers to address alcohol misuse in society under the public health approach. Similarly, research evidence in the misuse of illicit drugs was at the forefront in broadening the range of options available to policymakers in addressing the use of illicit drugs in society. As this research demonstrates research evidence that is at first rejected is later accepted if the contextual situations change. For example, the introduction of harm minimisation programmes in Ireland in the 1980s and more recently drug treatment rooms.

To conclude this section discussed how the research evidence had only a limited impact on alcohol and drug policy. Academic research in the policy documents was most frequently cited for validation of policy development in a specific area. The most influential stakeholders in the policymaking process often rejected recommendations

based on international best evidence of how to tackle problems of alcohol or drug misuse in society. Contextual factors embracing the political, economic, the personal ideology of politicians and the values of a population were found to be a major factor influencing the development of policy. Two of the research utilisation models were most relevant to the use of research evidence in Ireland, the social interactive model in the development of drug policy and the tactical political model in the development of alcohol policy. However over time the enlightenment model was found to be the most influential, Ideas and beliefs concerning policy options were found to change and evolve over time influenced by the wider dissemination of research evidence.

Section 2

7.6 Barriers and facilitators to the use of evidence

In this study the factors that were the most conducive to the uptake of evidence in this study were strong factual data where the information was unambiguous. Policymaker's preferred quantitative scientific data. Evidence from medical research that demonstrated a vaccine worked against certain diseases was considered very important for health policy decision-makers. It was also believed that research that was quantifiable had more of an impact as the findings were incontrovertible. The policymakers discussed how qualitative findings were easily refuted on the basis that the outcome could be influenced by many different factors in the environment which were impossible to regulate and measure. Quantifiable evidence in contrast could adjust for many of the confounding factors in the analyses phase. These views are not uncommon.

Equally other studies have found that policymakers find scientific facts more certain and convincing that the findings of qualitative studies (Jerrim and deVries, 2017; Allen and Preiss, 1997). Similarly, journalists and the media deem quantitative studies to be more accurate and exciting than qualitative research (Schmierbach, 2005). Quantitative social science is very attractive to policymakers as it can reduce complex social issues to an orderly and simple set of numbers ((Jerrim and deVries, 2017). Stevens (2011) in his ethnographic study of how civil servants use evidence describes the power of 'killer charts' (p.243). Killer charts are defined as 'instruments of

persuasion' carefully constructed through the judicious use of data to persuade the audience on immediate viewing of what course in policy direction to pursue (Stevens, 2011; p.243). Stevens found in his study that visual representation of the data was encouraged by the civil servants, in the way that allowed the graphs to speak for themselves. Stevens cites Prior, (2003) in arguing that this is in direct contradiction of the academic criticism that statistics are selected and constructed through our social reality and cannot speak for themselves. The attraction of quantitative evidence for policymakers is that it can reduce their level of uncertainty of what policy options to develop. Uncertainty is viewed as a major obstacle to decision-making (Sanderson, 2004; Stevens, 2011). The policymakers reported in this study that they had to be convinced that at some level the policy developed would address the issues, otherwise a lot of time, money and energy was wasted in developing the policy.

Nonetheless policymakers need to exercise caution in relying on quantitative evidence. Jerrim and deVries, (2017) outline several issues that need to be considered when reviewing the quantitative evidence. Statistical analysis involves long complex mathematical calculations where there are many opportunities for errors in the process (Ibid). To ensure confidence in the method transparency in how the results are arrived at is vital. This important issue is often overlooked by policymakers. There are several examples where policymakers have cited quantitative studies to support public policy, which were later found to be inaccurate due to errors and omissions in data analysis (Reinhart and Rogoff, 2010; Jerrim and Vignoles, 2013). The data must be available to the public, and the methods of analysis published in detail so that other researchers can verify the results obtained. This does not always happen in practice. There are issues with not clearly reporting concerns around uncertainties in the statistical significance of results being arrived at by chance. Publication bias is also an issue, for example, studies with statistically significant results are more likely to be published in high impact papers (Dirnagel and Lauritzen, 2010; Jerrim and de Vries, 2017)

In this study participant researchers views on the types of evidence preferred corresponded with that of the researchers; quantitative, clear, accessible evidence. Quasi-economic evidence or research evidence that had conducted a cost-benefit analysis was found to be a significant factor in influencing the use of research by policymakers. Public Health researchers for example, described how statistics on the

number of deaths due to alcohol misuse had little impact on policymakers. However, when the cost to the health service of the number of beds occupied each year due to alcohol misuse was demonstrated, they listened. In conducting research on the cost benefit analysis of early childhood interventions Bowen et al., (2009) uses the term 'killer facts' to describe how specific facts emerging from the research evidence influenced policymakers. The study found that for every dollar invested in early childhood interventions it yielded a return of $7.16 and had the most impact on child development policy in Australia (Schweinhart et al., 1993; 2005). Similarly, in the UK it was contended "how do you get the evidence to talk? … Answer money", evidence that demonstrated a cost savings to the health service by taking a particular course of action was found to be more influential with politicians (Petticrew et al., 2004: p.812).

Access to research evidence is reported in the literature as a barrier to the uptake of research by policymakers (Nutley et al, 2007; Dobbins et al, 2004). In this study policymakers reported commissioning research in specific policy areas as access to electronic systems and data bases would be limited. One government department, they did have a specialist research unit, however this was not standard across all departments (DoHC 2001). In a Canadian study investigating the use of evidence in health policy, found when civil servants interacted with academic researchers they were significantly more likely to consult the outputs of research (Ouimet et al., 2010). The findings of the same study also established that civil servants with a Master degree or PhD were more likely to consult the research evidence than those with an undergraduate diploma. In the current study, educational attainment and the frequency of accessing scientific journals and academic research reports was not measured. Researcher participants reported in this study that anecdotal evidence or the poignant story could have more influence than 'hard facts' or rigorous evidence. It was also stated that the research politicians conducted in their local constituencies was viewed as important to politicians as the academic and scientific research. Many scholars (Culyer and Lomas 2006; Glasby, Walshe, and Harvey, 2007) suggest what policymakers and civil servants view as evidence differs widely from that of research scientists. Two types of knowledge are proposed for effective decision-making in health and social care. The first is explicit knowledge that is collated in reports, policy documents and operational manuals. The second is tacit knowledge derived from experiential learning and the practical expertise of individuals (Williams and Glasby,

2010). In the United States, similarly anecdotal evidence and persuasive human stories were considered more comprehensible to some policymakers than the highly technical numerical reports (Jewell and Bero, 2008). Moreover, anecdotes were found to be more amenable to manipulation and fabrication by policymakers and lobby groups (Jewell and Bero, 2008). The importance of a good story was also highlighted by Petticrew et al., (2004) and presenting the evidence in an interesting and convincing manner to politicians was significant. It was argued that "what minister's call 'evidence' is what they get from their constituents at their Saturdays surgery" (Petticrew,2004; p. 813). Where this perhaps could be viewed as contrary to evidence based policymaking, the participant researchers in this study suggested that the personal stories could be used in conjunction with the research evidence to enhance its appeal to policymakers.

This study found the strategies believed to increase the uptake of research evidence were collaborations between policymakers and researchers, and the provision of policy relevant evidence in a timely fashion. This is in line with the findings from other studies (Oliver et al., 2014; Lavis et al., 2005; Innvaer et al., 2002). Court and Young (2006) suggests that the policy research interface is greatly influenced and shaped by the political context, as the process of developing policy and producing research are in themselves political activities. It has also been noted that politicians themselves maybe linked to powerful institutions that have specific religious or political ideologies and this may result in pressure to reject many ideas that are disapproved by the organisations leadership. For example, in the mid 1970s Margaret Thatcher's relationship with the Centre for Policies Studies influenced many of her economic policies (Massey, 2000). Court and Young (2006) advise the type of evidence that has the most influence is if it is credible and communicated well. Evidence had more impact if it was relevant to the topical issues of a particular epoch and had 'operational usefulness' (Court and Young, 2006; p.86) in solving a particular issue (Van de Goor, et al., 2016).

7.6.1 Context

This study found contextual factors namely budgets, political motivations, or the interests of key stakeholders could have a greater influence on policy decision-makers

than the research evidence. Issues that got attention in the political world were the priorities for government and not the concerns of researchers. Policymakers with many years' experience explained that the contextual nature of policymaking was particularly evident when going through a 'boom' or a 'bust' scenario. For example, in an economic recession the research evidence would have little impact on government policy if the priority for government is to cut budgets. Walt and Gilson (1994) identified context as an integral part of conducting analysis of health policies. Context was found to be a significant determining factor on whether policymakers will use research evidence in the policy process (Green and Bennet, 2007; Moat and Lavis, 2012). Mirzoev et al., (2017) defines context as 'combination of different influences on a policy' (p.60). Others defined it as 'all factors within an environment where a decision is made' (Dobrow et al., 2004, p.209). Conceptual frameworks have been developed to assist in the understanding of the contextual nature of policymaking and how it interacts with how the research evidence influences the process (Dobrow et al., 2004; Pawson and Tilley, 1997).

In Dobrow et al., (2004) study internal and external contexts are defined separately. Internal refers to the environment in which the policy is developed and formulated. Internal context includes the purpose of the policy and the different actors and their roles in the process of policymaking. The external context refers to the environment outside of the policy process which incorporates the wider environment where the policy will be implemented. This includes the political arena, the specific issue that the policy will address and the relevant experiences of other jurisdictions. External factors are fixed and not exposed to manipulation and control (Ibid). Nonetheless these factors do have an influence on the decision-making process. Dobrow et al., (2004) suggests that the internal contextual factors are the most important in the process of decision-making. The decision-making process involves the purpose, *'why'* the policy is being developed, the participants, the *'who'*, and the structures and mechanism. The actors involved in the role have a key influence on the method as they can influence what is considered as evidence. As has been alluded to earlier evidence is not value free, it is construed and viewed according to the individuals own personal experience, beliefs and culture. Therefore, the actors involved in the decision-making process have a significant influence in how it is interpreted and applied (Lomas, 2000; Weiss, 1983).

In this study, it was found that the personal issues or agendas of individual stakeholders involved in the policy process could influence the direction of a policy, or cause difficulty in arriving at an agreement on policy issues. Internal contextual factors influencing policy decisions were also highlighted in a study on HIV prevention in Tanzania (Hunsmann, 2012). It was found that research evidence demonstrating that upstream drivers of HIV needed to be addressed were not acted upon because any change in policy would have necessitated taking funds away from one organisation and directing them to others. This change in policy direction would put in jeopardy the former organisations reason for existence. This type of occurrence was also reflected in the current study. This finding supports the statement of Haynes et al., (2002) in that '[e]vidence does not make decisions, people do' (p.1350).

This study reported how contextual factors help to explain why the timing of research publications have a significant influence on the uptake of research by policymakers. For example, research evidence that addressed pressing issues highest on the government policy agenda, were more likely to influence. This reflects how frequently policy responses by governments are crises-driven with policy-decision makers having to react quickly to dramatic changes in the economic or natural environment (Baumgartner et al., 1993; Jones and Baumgartner, 2005). Policymakers discussed how in an economic downturn research evidence recommending how to deliver public services more cost effectively or increase employment levels would be considered by government. Other studies have found policy was determined more by the necessities of the moment rather than the evidence (Flitcroft et al., 2011). The time pressures of an election campaign in Australia were found to hinder the influence of research evidence in policymaking. For example, the pressure to develop competitive policy options could result in the proposals advanced not supported by the research evidence (Flitcroft et al., 2011). It was suggested that there is always an element of improvisation in political policy-making with policies designed under time pressures and for a specific purpose. Studies have also found elected representatives would base their policy positions on no or poor quality evidence if it meant securing extra resources or advancing their own constitutional agenda to remain in office (Jewell and Bero, 2008). Research findings in the current study were not considered if they were found to impact negatively on the governments' revenue sources, or jobs and enterprise. For example, the recommendations to stops the alcohol industries

sponsoring of sport were not implemented as this would have negatively impacted on the taxes and excise duties generated from the production and sale of alcohol beverages. This was an important revenue stream for the government when the country was in the depths of a recession.

The contextual influences of policymaking and the role of evidence was explored in the development of six health policies in India and Nigeria (Mirzoev et al., 2017). A three-tier conceptual framework of context was developed comprising the micro (individual), meso (organizational), and macro (system) in analysing the impact of contextual factors in using research evidence in policymaking. Macro-level factors that influenced the use of research evidence were; i) the acceptance and implementation of international agreements by national governments, ii) the drive towards evidence-informed policymaking globally, iii) a change in leadership at the national level with the potential for reforms, and iv) the environmental resources of individual countries. Meso-level influences identified were the countries own national organisations and the role they played in supporting the use of evidence informed policy. The level of involvement of international organisations, and the role they had in healthcare in that country was also found to be important. The enthusiasm and commitment of individuals, personal beliefs and values of what they perceived as effective evidence for health policy was influential at the micro level in supporting the uptake of research evidence by health policymakers (Ibid).

The current study similarly found factors at the micro, meso and macro level that can facilitate or restrict the use of research evidence in informing health policy. At the macro level policymakers described how they needed to be aware of international agreements that they government have committed to (for example with the WHO, the EU and the UN) when developing policy. Equally the policies formulated could not breach Ireland's own constitutional laws, and it was essential they complied with the government's own legislation. Other influences at the meso-level were how the issue was portrayed in the media. In addition, the public's views and acceptance of the solution to a societal problem was considered essential. The relationship the policymakers had established with research institutions and its past successes of research evidence informing public health policy was also a factor. At the micro level the stakeholders that were around the policymaking table were found to have a

significant impact on policy, for example, the personal agendas, views and ideologies of the individual stakeholders could influence the policy direction of social issues. The interrelatedness of these three levels of contextual influences on the development of public policy helps us understand the complexity and multi-component nature of the policymaking process. The research evidence is only one type of knowledge in this milieu and it too must compete and negotiate for influence.

This section discussed the findings concerned with barriers and facilitators to the use of research evidence in policymaking. Some of the barriers cited were politician's own personal ideologies and beliefs; powerful lobby groups and societal values all can act as barriers to the use of research evidence. Budgets and time constraints were also identified as barriers. Time and context specific research evidence was considered important factors in the uptake of evidence based research into policy. This study found the contextual nature of policymaking incorporates both the political and institutional factors that can impede or facilitate the use of evidence in policymaking. The next section discusses the types of strategies recommended by the participants to improve the uptake of research evidence.

7.7 Strategies to improve the uptake of research evidence

Researcher participants in this study reported the importance of ensuring the research evidence was packaged and communicated in a way policymakers found convenient and accessible. Understanding policymakers' preferences for specific methods of data presentation, as in a numerical or narrative format was found to be critical. Respecting the work of civil servants and the time pressures they were under was also considered to be essential. As discussed in the previous section under context the timing of the publication of the research evidence was a significant factor in its acceptance and utilisation.

This study found good relationships and links between academic researchers and policymakers in government departments were important factors for the uptake of research in policymaking. Many other studies have had similar findings with the lack of linkages being a key barrier to the uptake of research (Landry et al, 2001a; Landry

et al, 2001b; Innvaer et al, 2002; Mitton et al, 2007; Oliver et al, 2014). This study also found links to the media and campaigning groups were also considered significant in affecting policy change using the research evidence in this study. Academic researchers disseminating the research evidence through group talks and public health lectures were considered essential for many public health problems involving alcohol, drugs and children's issues. Community activists and concerned parents would then take up the evidence and advocate for more services or policy change through their local political representatives.

In the academic literature, how the research evidence was tailored to meet the needs of specific audiences had a significant influence on how the message was received (Court and Young, 2006; Lavis et al., 2003; Lavis et al., 2009). Court and Young (2006) give the example of how new products are marketed to people. They contend that frequently, how individuals react to new products is centred more on the packaging than the content. Framing the research ideas in familiar language, synthesising the evidence succinctly and not expecting the evidence to speak for itself, are recommended to ensure your audience readily understands the message (Court and Young, 2006; Cairney and Kwiatkowski 2017). Communication and decision-making is a demanding activity and individuals frequently employ cognitive shortcuts based on perceptions, experiences and emotional responses to make decision quickly (Cairney and Kwiatkowski, 2017).

Researchers conducting a cost benefit analysis of their recommendation's and connecting with policymakers in the early stages of research projects were advised in this study. This is consistent with findings from other studies (Oliver et al., 2014) of the importance of building relationships with key individuals, engaging with the work of policymakers and collaborating on projects (Cairney and Kwiatkowski, 2017). An alternative view was proposed by Murji, (2010) who argued that in encouraging close contact between policymakers and researchers, policymakers can influence the direction researchers take in their work. Therefore, is policy influencing research or is research influencing policy.

In this study, several of the policymakers and researchers argued that it was not the role of researchers to influence policy, but to present the research evidence to establish

the parameters of political discourse and debate. Hence the research evidence is there to help the policy actors in the policy process to conceptualise the policy issue. This relates to the enlightening use of research evidence (Weiss, 1982). An alternative view was to establish the policy arguments on the findings of research evidence, for example evidence-based health policy. This relates to the instrumental use of research evidence (Ibid). This was considered particularly salient for the issue of alcohol misuse in society. However, by employing this strategy researchers may be accused of moving into an advocacy role, and this was an issue for some policymakers in this study. The rhetoric between values and evidence in the policy process Contandriopoulos et al., (2010) suggests is dependent on the level of disagreement around a policy issue. The more a policy area is contested the more values will take precedence over the research evidence.

Using different types of evidence from multiple sources to address a policy problem was suggested in this study. It was deemed essential for policymakers to broaden their understanding of the different types of evidence. Focusing only on the 'hierarchy of evidence' where randomised controlled trials (RCT) are viewed, as the 'gold standard' may not be the most appropriate evidence for evidence-based policymaking (Padian et al, 2010). Privileging one type of scientific evidence over other scientific methodologies can bias decision-makers towards certain types of studies. These types of experimental studies may not produce the most relevant or useful type of evidence for understanding and evaluating policy issues and their proposed solutions (Mulgan, 2005). Several scholars (Greenhalgh and Russell, 2009; Lomas and Brown, 2009) assert that commonly the metrics are not available to measure many of the issues that are of the most concern to the population. Equally randomised controlled trials (RCTs) and systematic reviews of experimental trials do not capture the issues that are important to policymakers, for example, the social desirability of a policy, the human rights implications, and equity considerations (Pearce and Raman, 2014; Petticrew and Roberts, 2003).

Hawkins and Parkhurst (2016) assert that the research evidence be assessed on its *appropriateness* for use in tackling specific policy issues, rather than favouring a specific research methodology (p.582). Policymakers must be more transparent about the different factors that need to be considered in developing policy in conjunction

with the research evidence (Hawkins and Parkhurst, 2016). In Lennon's study (2014) on the meaning of evidence in Irish green infrastructure policy found that by adhering to the preferred order of the hierarchy of evidence, qualitative research and local tacit knowledge which was more context specific was relegated. In contrast policy actors engaging with the more objective language of scientific research and quantitative methodologies were more persuasive in their arguments and thus able exert more authority and influence over policy direction (Ibid).

The interview data in this study revealed that the policymakers favoured basic scientific evidence and quasi-economic evidence over qualitative evidence. However, irrespective of the type of methodology employed, all policymakers believed it was important for researchers to understand the contextual environment of policymaking. They suggested when writing the recommendations emanating from the research the values and ethos of the political party in power as well as the values and ethos of the community affected by the policies need to be considered. It was also important for the recommendations to be in accordance with budgetary constraints and the priorities of government. Nonetheless, those opposing the instrumental function of research evidence in policymaking contend that research studies are never fruitless. The justification being the evidence may not be applicable now but contextual situations change and the evidence in the future will be very relevant in another time and in another context.

The media was considered important by several researchers in this study for disseminating their work to the wider public. Particularly at the regional level participants reported using local radio stations and local print media as important mediums for publicising their findings. Other studies have found media exposure important for helping policymakers identify researchers who may contribute to their policy area (Oiumet et al., 2014; Haynes et al., 2012; Jacobson and Goering, 2006). Publications of results in daily newspapers were positively associated with knowledge mobilisation by researchers. However, participation in television programmes was negatively associated with requests to present to policymakers (Ouimet et al., 2014).

Participant researchers in this study reported that the findings of research evidence are sometimes filtered by policymakers, before being viewed by the senior decision-

makers or the minister. Researchers working on steering committees felt the evidence as it was, should be presented to the decision-makers. Policymakers stated that policy needs to be acceptable and have some possibility of being implemented. Otherwise they have spent many hours of unproductive work. In a recent systematic review the political and institutional factors influencing policymaking was explored (Liverani et al., 2013). The studies focused specifically at public health issues at the policy level. Centralised political systems were found to be less open to the findings of research evidence than de-centralised systems, as debate and argument were reduced due to the concentration of power (Beck, Asenova, Dickson, 2005). It was found when government agencies control expert advice, they are more susceptible to the influence of expert interest groups. In other studies where issue specific coalitions are formed and policy is made at the provincial level, research is used as ammunition to validate and defend decisions against the criticism of their opponents (Klein, 1990). Several studies found that financial and corporate interest groups exert pressure on decision-makers to either accept or reject research findings if they are in line with their own commercial interests (Thomson et al., 2007; Trostle et al., 1999). Other studies reported potential biases in how research was used for example delaying decision-making (Gordon, 2006) or to question and undermine adversaries in political debates (Bowen, 2009; Hughes and Hughes, 2007; Saguy and Riley, 2005).

Some respondents in this study saw the turnover of staff in several departments as a barrier to the use of evidence. However it was not considered a major issue. It was explained that if you worked as an Assistant Principal (AP) or Principal Officer (PO) in a specific policy area over several years you gained a lot of expertise in a policy field. Important working relationships would be established between individual civil servants and academics in research institutions. Smith's (2012) study of the work practices of policymakers found that they regularly work within short time frames and are transferred between different government departments. This movement of civil servants between different government departments can result in limited institutional memory within policymaking departments. Academics described how research commissioned by policymakers found on completion that the policymakers who had commissioned the study had moved to another department and were no longer interested in the results (Ibid). This allowed similar research to be later commissioned by other policymakers, perchance even from the same researchers. Smith (2012) does

not view this practice as damaging. In effect this process allows ideas to be constantly renewed and 're-contextualised' and presented in a continuously shifting policy landscape. Stevens study (2011) on the use of evidence in policymaking found that civil servants eager to progress in their careers were required to become competent in producing policy and in attracting support from superiors in their organisation. To become a specialist in a policy area was discouraged. A requirement for career advancement was to be able to move quickly between different policy areas, and solve policy problems through building connections and support within the organisation. The author cites Gendreau et al., (2002) in disparagingly referring to civil servants as 'fart catchers'; "*generalists who do not have enough expertise to resist whatever the minister decides will be the latest version of common sense.*" (Stevens, 2011; p.244). Discouraging specialist knowledge within the civil service Page and Jenkins (2005) suggests avoids conflict between those civil servants responsible for policymaking and the experts.

This section discussed strategies to improve the uptake of research by policymakers. The type of knowledge exchange strategies discussed by the participants of this study most closely resembles the *knowledge-to-action model* of the Canadian Health Services Research Foundation (Graham et al., 2006). The producers of knowledge tailor their outputs to address the needs of the different users at the different stages of the action to knowledge cycle. Several different mediums are used in disseminating the findings of research. The next section will explore several theories and conceptual frameworks of the policy process considering the findings of this study.

Section 3

7.8 Theories of the policy process

To aid in our understanding of the policy process this section draws on the political science theories explicated in Chapter Three. Traditionally these theories have been used by scholars in public policy and sociology to illuminate the process of policy development. More recently they have become popular among scholars of public health policy analysis. Applying the different theories to the practice of developing policy enables us to analyse this complex procedure from multiple perspectives. Each

hypothesis seeks to explain a different aspect of the process (Cairney, 2007; Sabatier and Weible, 2014). Many theories can be applied to the case study on drugs and alcohol policy. In this thesis six theories were included. The theories selected were considered because of their potential to offer a comprehensive explanation of the policy process in either drugs or alcohol policy. Three of the theories are applied to alcohol policy, the stages heuristic model, Kingdon's multiple streams model and the Advocacy Coalition Framework. This is followed by two theories that seek to explain the development of illicit drug policy in Ireland, Social Construction Theory and Punctuated Equilibrium. The decision to apply specific theories to either alcohol or drug policy was guided by the analyses of the data and the degree of explanation the theories could provide for the specific policy areas. A multi-level governance perspective is applied to the policy process in general in Ireland and is not applied to a specific policy area. This is based on the findings of the qualitative interviews with the civil servants and the analysis of the policy documents.

7.8.1 Stages Heuristic model and alcohol policy

The underlying tenet of the Stages Heuristic Model ((Lasswell, 1956; Brewer and deLeon, 1983) is that policymaking is rational process. It proceeds in a linear sequence from problem identification, to the consideration of alternative solutions. This is followed by policy formulation and implementation. This takes place in a few discrete stages. When you apply it to alcohol policy from 2001 at first glance it appears to explain the process. The research evidence, epidemiological data and expert opinion published in the early 2000s identified the increasing rates of alcohol consumption in Irish society and the consequent health problems to the individual and society (Friel, Nic Gabhainn, and Kelleher, 1999; Rehn, Room, Edwards, 2001; Ramstedt and Hope, 2005; Nic Gabhainn, 2003). In response to these concerns the misuse of alcohol was prioritised on the decision-maker's policy agenda. This was followed by the Strategic Task Force on Alcohol Reports (DOH, 2002; 2004). In the reports evidence-based recommendations were made to government on reducing and preventing alcohol related harm in society. Several of the recommendations were selected to be implemented, for example a tax increase on alcohol spirits in the 2002 budget and a commitment from government to introduce legislation on alcohol marketing (Hope,

2006). However, the new legislation was not passed and the drinks industry continued to establish new voluntary codes of advertising supported by the government.

The stages heuristic model is useful in the early stages of the policy process in defining why an issue in society requires a policy response. However, it does not sufficiently explain why the recommendations from the Alcohol Task Force Reports for a public health approach to alcohol misuse in society were not accepted. Instead the Irish Government focused only on specific areas of alcohol misuse, for example underage drinking, binge drinking and drink driving. The model does not explain either why some recommendations were considered by government while others were ignored. Alcohol policy in Ireland did not progress neatly from problem identification to policy implementation between 2001 and 2012. For example, the increase in taxes in 2003 on alcoholic spirits demonstrated a decrease of (-6%) in alcohol consumption in 2003 (DOH, 2004). This action was undermined in 2006 when the Groceries Order was repealed by government which allowed the below cost selling of alcohol (Butler and Hope, 2015). Influences on the policy-decision-makers are not adequately explained in this model, when choosing certain policy options over others. However, for some observers of the policy process it provides the ideal of how policy should develop (Millio, 2005; Cookson, 2005)

7.8.2 Multiple Streams Model and alcohol policy

In the multiple streams model of the policy process policymaking is not viewed as a rational process. It is a complex procedure, impacted on by the values and economic self-interest of different stakeholders. Frequently the process itself is surrounded by vagueness and ambiguity (Kingdon, 1984: 2011). This model comprises three streams. The *problem stream*; in this stream the epidemiological data was highlighted in the increasing number of published reports on the incidence of alcohol related-harms in the Irish population. As indicated in the following quote what was particularly significant in getting the attention of policymakers was the evidence that demonstrated the cost to society of the harmful use of alcohol (Byrne, 2011):

> ...statistics that have had the biggest impact are the ones showing the impact on the health services, or the bed days used …

<div align="right">(Researcher, 13)</div>

The *policy stream* refers to the solutions being proposed to address the problem and considered by policymakers. Several evidenced-based public health measures were recommended in the Steering Group Report of 2012 (DOH. 2012). These were comparable to recommendations made in the two previous reports (DOH, 2002; 2004). However, this time they were being proposed under the existing illicit drugs framework which required cooperation across all government departments for its successful implementation. The inclusion of alcohol in to the 2009-2016 National drug Strategy was a result of the advocacy work of Alcohol Action Ireland (Butler, 2015). The charity composed of public health doctors, psychiatrists, health promotion officers, researchers and concerned citizens sought to influence policymakers for a public health measures to be introduced to reduce the alcohol-related harm in society. As one interviewee said:

> … we were definitely of the view that the two strategies, two policies should be joined because a lot of the fallout from both the addiction of drugs and alcohol, and the impact on families were very similar …

<div align="right">(Policymaker, 7)</div>

According to the multiple streams model a window of opportunity opened for the advocates of a public health approach to tackle alcohol misuse in society. In drafting a new substance misuse strategy, they could recommend the introduction of public health measures under the framework of National Drugs Strategy. There was opposition from the drinks industry. However, unlike the previous reports (DOH, 2002; 2004) the minority reports outlining their opposition to the introduction of the public health measure were not included in the 2012 report (DOH, 2012). The Alcohol Industry submitted a separate report to the Minister for Health (DIGI, 2012). Taking the multiple streams model to the next stage, the *political stream* refers to policymakers making decisions on the best options to implement, which are most politically acceptable. In this study, the analysis of policy development concludes in 2012. In the interviews that took place with researchers and policymaker in 2014/2015

they explained how the momentum was growing to introduce public health measures however the wider economic and political climate impacted on policymakers' decisions. For example, one policymaker discussed the sponsorship of sporting activities by the drinks industry;

> …for a long time health was going up the path of we have to get rid of them, and then the Minister makes a pragmatic decision, we can't get rid of them because there is no money to replace them … we can't stop all our sports, so don't be daft we have to keep taking the money from them … very good policies get watered down …sport and alcohol… if you decide to cut down on alcohol you have to find a replacement for those taxes … to tax other things … that is why it always goes up the day after the budget drink cause it is the most lucrative and you get it in …

> (Policymaker, 5)

The researchers also believed that due to the economic recession, politicians and the public had prioritised other concerns over the alcohol issues. For example, unemployment, jobs, mortgages, the increase in taxes and charges on water and property;

> …there is kind of a silent majority that have a lot of things on their plate at the moment such as mortgages and worries about children, so okay they want something done about alcohol but it is not up at the top, you have water charges, property tax and safety in the neighbourhood and all that, public acceptance and public desire for change is higher than it was but it is probably not quite at a level the politicians … [need to act]   … there has been a recession for the last seven years and that probably been the politicians' priority. They are obviously afraid at one level to tackle the big drinks companies because they might pull out of the country, one of the threatened that last year …

> (Researcher, 13)

The multiple streams model helps to explain how alcohol policy in Ireland progressed from 2001 to 2012 and became an important issue on the policy agenda. For the policy recommendations to be accepted timing was the factor that was missing in this process

(Kingdon, 1984). Critics of this model claim it focuses primarily on agenda setting and it does not address the later stages of the policy process where the problem can be reframed or ignored by the policymakers (Colebatch, 2006; Jann and Wegrich, 2007). It does not sufficiently to explain the turmoil and complexities of governing in a recession when taxes, revenue and jobs are the priority for Government (Howlett, McConnell and Perl, 2015).

7.8.3 The Advocacy Coalition Framework (ACF) and Alcohol Policy

The Advocacy Coalition Framework (ACF) assumes that the policy process in made up groups of actors who promote their beliefs on policy solutions to problems in society. The assumptions of the framework are that scientific and technical information are at the core of the policy process. The policy subsystem is the unit of analysis the research analyst needs to explore to understand this process. A time frame of 10 years or more needs to elapse before it is possible to understand changes in policy (Weible et al., 2009). Beliefs are viewed as central to how political actors behave in the policy process. When Irelands' alcohol policy is viewed through this lens what emerges is the sophistication by which the alcohol industry was able to exploit links with policymakers and the voting public. The social partnership model of policymaking enabled the drinks industry to become closely involved with policymakers in developing policy (Butler, 2009; Hope, 2006). The drinks industry is represented on the employers group Irish Business and Employers Confederation (Ibec). Together with the trade unions, agricultural sector, traditional business and representatives from the voluntary and community sector, comprise the partners in the social partnership model of government (Doherty, 2011). The function of IBEC on behalf of their members is to lobby government, policymakers and other key stakeholders in Ireland and internationally to create favourably business conditions to achieve economic growth ([www.ibec.ie)](www.ibec.ie). The alcohol industry was represented on all the Steering Group Committees of the Strategic Task Force on Alcohol between 2002 and 20012 (STF, 2002; 2004; 2006; 2012). Corporate social responsibility by the industry is promoted through the organisation for the Mature Enjoyment of Alcohol in Society (MEAS) that was established in 2002. It too was represented on all the committees. MEAS is a social aspect group comparable to international organisations funded by the drinks industry to promote their business to the public as being a

responsible industry (Butler, 2015; Anderson, 2004). Using the concepts of ACF the alcohol industry is active at several different policy subsystems to influence policy outcomes, for example at the national, international and subnational level.

In this study policymakers discussed how the drinks industries presented their business and its importance in employment and tourism in a favourable way to government. The public health advocates did not appear to be able to present the research evidence on the harms caused by alcohol to society in a similar fashion. It was also suggested that our beliefs around the importance of alcohol to our culture among policymakers influenced their decisions. The researcher participants spoke about the belief among politicians that it was not their role to regulate in an area that was the personal autonomy of the individual. More importantly they believed that most the population did not want more regulation in this area. This is crucial as politicians' fear it would impact negatively on them in the next election.

An opposition to the dominance of the alcohol industry on alcohol policy began to emerge between 2001 and 2012. Alcohol Action Ireland, what could broadly be referred to as a policy community or policy network was established as a charity in 2002 (Kingdon, 2011; Butler, 2015). It is a coalition of public health doctors, interested public, and medical specialists in hepatology, gastroenterology, and cancer ([www.alcoholireland.ie)](www.alcoholireland.ie). The charity promotes a public health approach to alcohol policy. It advocates for policy change based on the research evidence. The charity works with stakeholders at regional, national, and the international level. It purpose is to increase the awareness of alcohol related harm in society and to garner support for policy change. Alcohol Action Ireland was represented on the Steering Group Committees of the Strategic Task Force on Alcohol from 2002 to 2012 (DOH, 2012). They make recommendations to government in line with a public health approach to the reduction of alcohol harm in society. Alcohol Action Ireland advocated for a coordinated approach across government departments to addressing alcohol harm in society under the structures of the National Substance Misuse Strategy 2009-2016 (DOH, 2012). The drinks industry documented their opposition to several these recommendations in two minority reports, the Alcohol Beverage Federation of Ireland and MEAS (ABFI, 2012; MEAS, 2012). In October 2013, the Minister for State in Health Alex White announced the introduction of a Public Health (Alcohol) Bill that

would include legislative measure on the introduction of minimum unit pricing and regulation of advertising and sponsorship in the alcohol industry (Department of Health, 2013, para 2). Sabatier and Jenkins-Smith, (1999) suggests policy change can only be discerned from a ten-year or more perspective. Consequently, the changes and developments in alcohol policy in Ireland are too recent to know if the ACF explains this area of policymaking.

7.8.4 Social Construction Theory and Drug policy

The development of illicit drug policy is considered here from the perspective of social construction theory. The social construction of target populations has been the subject of extensive research by Schneider and Ingram (1993, 2005). Fundamental to their theory is how particular groups in society are social constructed can become embedded in the policy process. How they are viewed can determine where their issues come on the policy agenda. Similarly, it can determine the kind of policy responses developed by policymakers to address these issues. This can in turn influence whether they a likely to participate in the political process in the future (Ingram, Schneider and Deleon, 2007). Lancaster (2014) argues that the social construction of target populations has implications for how evidence is used in the policy process. The argument is made that 'knowledge' and 'evidence' are not distinct concepts but are constructed through local practices and beliefs and the interests of different actors in the process (Green, 2000). As alluded to earlier in the discussion of the policy process individual actors can have their own agendas. How this plays out in drug policy is that those who deliver services in disadvantaged communities, can produce evidence that demonstrates the problem is increasing or intractable. This perhaps is due to their own personal beliefs or to further their own power and influence by advocating for more services and money. Alternative strategies to address the underlying issues that are causing the problems are then side-lined by policymakers who have many competing demands on their time.

In the current study the policymakers described how illicit drug problems in society were not a priority for the Minister for Health and this was more evident in a recession. The problem was viewed as intractable in policy circles with the target group having a lot of other problems outside of the drug issue, namely homelessness and mental

health problems. The language used by policymakers and researchers for example "not an easy cohort" "they're messy" "drug users don't vote" "social deprivation" "use drugs in the riskiest way" all serve to present a picture of those who misuse drugs as different from the general population. One policymaker suggested because the population that misused drugs was a specific cohort of society it was easier to get agreement across government departments on policy solutions. The ostracised role frequently occupied by drug misusers results in the implementation of evidence-based policy solutions that are acceptable to the policy decision makers, rather than what is most appropriate for the drug misuser (Lancaster, 2014; Green, 2000). For example, in this study the policymakers described when they were researching evidence-based policy solutions for the Substance Misuse Strategy 2001 to 2008, they considered drug injecting rooms. Drug treatment rooms were not included in the strategy as at that time they were unacceptable to the Minister for Justice.

The social construction theory of target populations (Schneider and Ingram, 1993; Imgram, Schneider, and deLeon, 2007) does helps to highlight how policy develops around a particularly marginalised group in society. Unfortunately, the theory fails to explain why this policy approach first developed, and continued unchallenged for several years. It also fails to explain why after 2008 the language around drug misuse changed from 'treatment' and 'maintenance' to 'parked on methadone' and rehabilitation.

7.8.5 Punctuated Equilibrium and drug policy

The punctuated – equilibrium theory emerged out of the observation that in many areas of public policy there is consistency and stability over long periods (equilibrium) followed by periods of rapid policy activity or shifts in policy direction (punctuations) (Baumgartner and Jones, 1993). Time constraints and the concept of bounded rationality result in policy decision-makers delegating responsibility for policymaking in a many policy areas to expert policy subsystems or communities (Cairney, 2012). This allows senior policymakers and politicians to focus on pressing issues that are attracting the most attention in the media or from concerned citizens at any one time. In a period of equilibrium policymaking is not static but rather it develops in an incremental and predictable ways (Pump, 2011). Radical shifts in policy only occur

when the issue comes to public attention due to external shocks or dramatic changes in the policy problem and more actors get involved in the process. This period of crises or instability often provides the 'window of opportunity' for policy actors who want to influence the policy area (Kingdon, 2003; 2011).

Viewing drug policy through the lens of Punctuated Equilibrium there was relative stability (equilibrium) in Ireland's drug strategy from 2001 – 2008. This strategy had built on the previous policy programme that was developed in 1996 (DCRGA, 1996). The policymakers described how the existing drug strategy emerged because of the dramatic happenings in the illicit drugs fields in Dublin in the late 1990s. The increasing crime rate and incidence of heroin misuse have been described in Chapter 2. These issues attracted media and public attention. As the policymakers described "the crisis had gotten to such a level of difficulty it [drugs crisis] could no longer be avoided ... NGO had become very exercised at that time ... so they were able to put a push on ... keep pressure on and had access to decision-makers" (Policymaker, 2). Consequently, the drug policy community attracted the attention of politicians and other actors in the political process. The drugs issue became a priority on the policy agenda. This resulted in a co-ordinated approach across government departments working with community activist in developing a comprehensive drug strategy in 1996 (Dept. of the Taoiseach, 1996). This policy community comprising civil servants, experts in the field of drug misuse and community activists developed drug policy with relative stability until 2008. The key informants described how the research evidence commissioned by the National Advisory Council on Drugs (NACD), and the HRB helped to inform and direct treatment and services in this area.

The end of the policy term for National Substance Misuse strategy 2001-2008 coincided with a very serious economic crash in Ireland. One key informant described how by 2008 they were spending 32 million on projects in the drug task force areas. However, in 2009 the inter-departmental groups were disbanded and the different types of projects that were being funded were incorporated back into their respective departments;

> … political people that came in afterwards were not as committed …there was a lot of administration and collaboration involved and … maybe you could say it was inefficient …
>
> (Policymaker,7)

Drafting the new strategy opened a window of opportunity for the policy actors who wanted to incorporate alcohol into the substance misuse strategy. Policymakers described how there was an increase in awareness among the public driven by debate and discussion by health experts of the alcohol problem in the media;

> … views of how alcohol should have been brought up to equal status with drugs too because of a combination in general terms we saw the effects of the combination of drug and alcohol … among young people …
>
> (Policymaker, 7)

This resulted in 2009 in the government approving the development of a combined National Substance Misuse Strategy to cover both alcohol and drugs (Dept. of Rural, Community and Gaeltacht Affairs, 2009).

Punctuated-equilibrium theory can assist in the understanding how drug policy has evolved to include alcohol policy notwithstanding the very strong opposition of the alcohol industry. In keeping with punctuated-equilibrium theory presenting the problem in a new venue to a more sympathetic audience can broaden the scope for policy change. The Steering Group Report on a National Substance Misuse Strategy 2012 was chaired by the Department of Health. The research evidence on the cost of alcohol misuse in society and to health care impacted on policy development (Mongan et al., 2009; 2007). Previously reports published under the auspices of the Department of Community, Rural and Gaeltacht Affairs, had recommendations by the drinks industry of Ireland on tackling alcohol misuse, included in the appendices of its reports. However, in the 2012 report, the minority reports published by the industry were not included in the final document (MEAS, 2011; ABFI, 2011). This may yet be considered a turning point in the influence of the drinks industry on alcohol policy in Ireland.

7.8.6 Multi-level Government

The theories applied above to the development of alcohol and drug policy help to build a picture of the policy process and the different factors that have an influence. These include understanding why there was such stability in drug policy over a long period of time and why this area had difficulty in staying on the government's policy agenda. However, it does not paint the full picture of the policy process as described by the civil servants and demonstrated by the analysis of the policy documents. Multi-level Governance assists here in observing the policy process from a broader perspective.

For example, in this study policymakers reported that the policies developed needed to comply both with their own internal legislation and EU regulation including international agreements. In the Alcohol Report 2004 (DOHC, 2004) under recommendations and the 'Involvement of Young People' it describes how giving youth a voice in matters that affect them is a key goal of the National Children's Strategy and supports Ireland's International Commitments (p.34). For international commitments, it cites the United Nations (1989), the World Health Organization (2001) and the European Union (2001) in this paragraph.

Increasingly International Governmental Organisations (IGOs) seek to influence national policy through 'soft' and 'hard' mechanisms of policy transfer (Axford, 2013; Stone, 2004). Soft mechanisms employed can be awareness raising, through shaping policy debates by defining the key terms of the debate and providing statistical data (Ward, 2004). Other examples of soft mechanisms are providing funding for cross-national research, and technical assistance to encourage the learning and sharing of best practice. An example of this is the evidence-based family skills training programmes by the UN office on Drugs and Crime (UNODC, 2010). Countries that have signed up to international treaties and then fail to abide by the standards set by those treaties can suffer embarrassment if they are seen to fail to comply with these standards. Examples of 'hard' mechanisms may include inducements or disincentives to encourage compliance and increase responsibility. Countries are monitored on their progress at implementing UNCRC (UNICEF, 1998) recommendations. As well as monitoring the UN Committee on the Rights of the Child, the UN can voice their anxieties about national policies and assess if they are in violation of the Convention (Axford, 2013).

Equally the policymakers reported the needed to ensure their policies did not breach any previous commitments they have agreed upon with the numerous agencies working at the subnational level. Viewing policymaking through the lens of multi-level governance increases our understanding of the policymaking process and the constraints within which policymakers must make decisions.

Section 4

7.9 Kuruvilla's Research Impact Framework

In exploring the use of research evidence in the development of alcohol and drug policy this study employed the Research Impact Framework (Kuruvilla et al., 2006). It found under the four headings of the framework 'research impacts', 'policy impacts', 'service impacts', and 'societal impacts', all participants could find evidence of where their work had made an impact. They were most comfortable articulating the research impacts of their work, as the number of citations or journal articles they had published were easily measured. Many of the participant researchers could refer to the instrumental impact of their work (Weiss, 1979), for example, where it had been cited on policy documents to justify policy development or where it had influenced practice in the delivery of services. However, the conceptual impact of their work they found harder to pinpoint, for example a change in societal attitudes or behaviours.

This conceptual tool was found to be an appropriate and efficient tool for researchers themselves to keep track of the impact of their work. Due to its lack of scientific measurement it cannot produce a detailed assessment of the impact of research outputs. Nonetheless, it is used with other more scientific and expensive models especially the Payback Models (Greenhalgh et al., 2016). Therefore, the Research Impact Framework (Kuruvilla, et al., 2007) is appropriate for informal assessment of impacts rather than impact assessment exercises carried out by professional bodies.

A small minority of the respondents were critical of this emerging trend of researchers having to identify the impact of their work. It has been argued that due to the rise neoliberal ideas in society how universities and institutes of higher education are

perceived have fundamentally changed (Warren and Garthwaite, 2015). The overriding issues for academics were to secure research funding and to increase the output of publications to ensure personal and institutional status. The present economic climate also influenced where academics source their funding for academic studies. Academics tendering for evaluation projects of public services or policy initiatives particularly in health and social care have resulted in closer working relationships between policymakers and academics (ibid). One argument advanced for recruiting academics rather than other third parties for the evaluation of public services is the work produced has a higher degree of validity (Warren and Garthwaite, 2015). Government departments or service providers can also exploit to their advantage how the service or initiative is assessed by a university department due to their standing in power relations in society (Becker, 1967; p.242).

The challenges for academic researchers working closely with government departments were highlighted by a study conducted by London School of Economics Gv314 Group (2014). It described how the commissioners of research had tried to get politically favourable results from the research. Nonetheless academics reported they could resist these pressures. The reputation of academics' rest on objectivity and the ability to resist political interference as their work is made credible due to the integrity awarded them by their academic status (Warren and Garthwaite, 2016; LSE, Gv314 Group, 2014). It is also argued that the pressure on researchers to produce policy relevant research, impacts on their time and space to develop new ideas (Smith, 2010). Other concerns have focused on how researchers may unwittingly focus on research that can produce short-term proximal impacts. This could occur to the detriment of scientific inquiry into politically sensitive areas, where impact is less direct and harder to measure (Greenhalgh, Raftery, Hanney, et al., 2016; Kelly, McNicoll, 2011; Hazelkorn, 2015).

This section has discussed the use of the Research Impact Framework (Kuruvilla, 2006) by researchers to describe the impact of their work. Most of the participants reported it was a useful tool as it made them think through the impacts of their work, and this was becoming increasingly important in their professional careers. However, issues on the role of the researcher persist, for example should they be involved in advocacy or leave it to other groups in society to promote their work. There is also the

danger of researchers focusing only on research that is acceptable in the present political and economic climate while ignoring more radical research innovations that may result in greater health gains for society (Smith, 2012).

7.10 Contribution to the knowledge base in Ireland

This study makes a considerable contribution to previous studies in how academic research influences policy development in Ireland. The findings presented illustrate the complex array of factors that have an influence on the policy process. The subject area that was at the centre of the case study; alcohol and drug policy are enduring societal issues for most governments. How policy in these fields adapted and transformed over the decades in response to societal changes and the research evidence has been documented in Chapter Two. The case study design employed was well structured with a reliable audit trail from the data analyses to the source of the evidence. The study design therefore has the potential to be used in other studies in investigating the influence of research evidence in policy. The analyses of the policy documents identified where and how academic research is cited in the policy documents. It also identified the other types of knowledge that was cited and the legitimacy of this knowledge in the documents. The qualitative interviews with senior civil servants, some, whom were for many years at the heart of policymaking, gives an exclusive insight into policymaking process. Contextual situations were found to be a significant influencing factor on the utilisation of evidence in the development of policy.

Many of the studies in Ireland exploring the research policymaking interface are researchers interviewing stakeholders or observational studies on the development of policy. Unique to this study researchers themselves were interviewed to obtain their own experiences and views on the use of research evidence in policymaking. Several of the researchers were of the view that the research evidence was essential to the development of alcohol and drug policy. Others saw their role as producing knowledge that would contribute to the debate and discourse around these issues. Other studies in Ireland have identified the importance of good linkages and relationships between researchers and policymakers in the uptake of research (Kennedy et al., 2010). The

findings from this study goes further and reports on the different strategies employed by public health and health promotion researchers to transfer knowledge to policymakers.

This study has also added to previous research by using several theories and conceptual frameworks to understand the policymaking process and the impact of academic research. In exploring how researchers think through the impact of their work The Research Impact Framework (Kuruvilla et al., 2006) was employed. This framework was found to be very useful in helping researchers identify the impact of their research outputs in several different fields, for example, in research, policy, in the health and social services and in society. Measuring the impact of research outputs has become increasingly important for academic institutions as well as the funders of research. Applying Kingdon's Multiple Stream Theory and the Advocacy Coalition Framework helps us to gain a fuller picture of how and why policy has developed as it has in alcohol policy. Equally applying the theories of the Social Construction of Target populations and Punctuated Equilibrium has given us a greater understanding of the development of policy in illicit drug use. As described in Chapter Three the many theories of the policy process allow us to understand policymaking from different perspectives. However, no framework sufficiently explains this complex human endeavour.

Section 5

7.11 Strengths of the study

This study provides a unique insight into an area of public health policy. Policy responses to the misuse of drugs and alcohol in society are particularly amenable to a population health approach, which is at the heart of Health Promotion. The case study on alcohol and drugs offered a critical insight into the policymaking process and the complex array of influencing factors on the process. It highlights how these factors can be a cause of conflict and contention or consensus on policy agreements, depending on whether the issue affects all of society or a marginalized group. The role of context is explored in relation to the specific policy areas and how it impacts on policy decisions. It contributes to the knowledge in this area by identifying the types

of information/knowledge that is cited on public health policy documents and the relationship between evidence and policy.

The study presents the views of some of the key actors (the civil servants) who are the centre of the policymaking process. The in-depth interviews allowed the participants to describe the policymaking process and the use of research evidence in this practice from their own perspective. To achieve a comprehensive understanding, it helped that the participants were from senior levels in the organisation and had a wide range of experience in their policymaking roles. Considerable authority is added to the findings of this study too by the interviews with the researchers. Their knowledge and expertise from the fields of Public Health and Health Promotion and their interaction with the policymaking structures of governments over many years were an invaluable contribution to the knowledge in this area.

Analysing the policy documents of alcohol and drug policy between 2001 and 2012 gives us an insight to how ideas evolve and change overtime. It provided the evidence of the different types of knowledge that influenced and had an impact on this process. It also helps us understand how the documents themselves helped to structure and guide the direction of policy in drugs and alcohol services between 2001 and 2012. As documents, themselves can help focus the minds of human actors to achieve specific goals (Prior, 2003; Guldbrandson et al., 2009). Using the Framework Method of analyses ensured that the process was systematic and transparent. However, document analyses alone do not provide the full story of how the research evidence influences policy. As frequently policy documents are specific statements of policies and strategies that are aspirational in specific points in time rather than actually exist (Shaw et al., 2004).

The case study approach of combining the interviews of the policymakers, the interviews of the researchers and the analyses of the policy documents further adds strength to the conclusions presented. It brings some transparency to a very complex area where a myriad number of factors can have an impact. A clear understanding of how these factors can impact on the policy process can help researchers devise more efficient and effective strategies for the transfer of research knowledge into the policy process.

Applying the theories of the policy process in drugs and alcohol further helps researchers, Health Promotion activists and public Health professionals to understand this complex procedure. Understanding when and how windows of opportunity open in the policy process can help the preparedness of those who want to influence its direction and subject matter to improve population health.

7.12 Limitations

There are several limitations to this study. Errors or omissions in the methodological analysis may have influenced the validity of the results. In order to overcome errors multiple methods were used to collect data from several sources. Selection bias may have been a factor in the interview sample as those who agreed to be interviewed may already be strong supporters of using research in policymaking. Therefore, alternative views may not have been heard. However, attempts were made in the purposeful sampling stage to interview policymakers involved in the different stages of the policymaking process and with a broad range of views to address this issue (Kuzel, 1992). Recall bias also needs to be considered as informants may overstate their use of the research evidence. The use of documentary evidence may have reduced this possibility.

Policy documents are a unique type of text in that they are public statements of how a problem is defined and outlines the possible policy responses to these issues. Atkinson and Coffey (2004) describes documents as 'social facts' that can shape the public consciousness and influence subsequent policy responses to these issues (p. 58). Quantitative content analyses of policy documents were conducted in this study. Consequently, it only answers where and to what extent research evidence has been utilised by the policy decision-makers in drus and alcohol policy. It does not answer how evidence is used to socially construct these issues in Irish society. Further studies could investigate how the problems of alcohol and drugs misuse are constructed using different techniques such as Critical Discourse Analysis (Fairclough (2000).

Research impacts on policy found in this case study may not be not be relevant to other policy areas as the contextual nature of policy is very time and place specific. Nonetheless the findings from this thesis highlight the conditional nature of the evidence and policy relationship and the multiple ways that research evidence can inform the process. This is in keeping with findings of previous research (Hill, 2013; McCambridge et al., 2013; Duke et al., 2013; Nutley et al., 2007).

There are multiple actors in the public policy process. This study only interviewed two; civil servants and public health researchers, consequently the complete picture of how policy is formulated and the myriad of perspectives that influence this process are not painted.

7.13 Summary and conclusion

This chapter while acknowledging the limitations of this study, it has highlighted the very complex nature of public health policymaking and the role of research evidence in this process. Understanding the multiplicity of factors that impact on policymaking can help researchers and practitioners better engage with the process. Alcohol and drug policy can expressly illustrate the limitations of the research evidence in informing policy. Solutions to address these issues are often highly contested and are frequently influenced by policy actors own values, beliefs and political ideology. Evidence here is more likely to be used in debate and discourse around the different policy solutions. The solutions that are eventually agreed upon by the policy actors will be strongly influence by the political and economic context of the specific period. For example, if the research was aligned with the issues that were at the top of the government agenda and were cost effective to implement they were more likely to make an impact.

Exploring the development of policy through the different theoretical lens demonstrated how different types of evidence/knowledge are used in the policy process. The theoretical frameworks highlighted the institutional and political factors that influence the policy process and emphasise gaps or 'windows of opportunities' in the process that can be exploited by researchers and practitioners seeking to influence

policy.

Among the knowledge mobilisation strategies employed by researchers in this study disseminating their research findings outside of the traditional avenues of academia was considered important; for example, publishing their empirical findings and recommendations on important societal issues in the local and national media, and disseminating their research to advocacy groups and policy network was also thought to be imperative to effect policy and social change.

One of the key strengths of the thesis is that it elicited the views and perceptions of actors at the frontline of policymaking. Many of the policymakers interviewed were in senior positions and already had several years of experience in developing policy. A unique insight was given on how the internal workings of government administration and the wider political and economic environment impacted on policy development.

The next chapter brings this thesis to its conclusion. It reviews the overall aims and objectives of this study with recommendations for further research.

Chapter 8: Conclusion

8.1 Introduction

This thesis increases our theoretical and empirical understanding of how academic research influences the development of public health policy. The study made a meaningful contribution to research in this area by exploring the processes and procedures involved in the formulation of public health policy in the fields of drugs and alcohol. The findings demonstrate the complexity and the multidimensional nature of the policymaking process. The research evidence is only one type of knowledge in the policymaking arena and is required to compete with many other factors for attention. A clear understanding of policymaking has the potential to increase the ability of researchers and public health practitioners to successfully engage with this process. This final chapter provides a reflective overview of this study. The next section summarises the key arguments and findings of the study. This is followed by an outline of the aims and objectives of the thesis to determine if they have been achieved. The chapter concludes with recommendations for further research.

8.2 Reflection of key arguments and findings

Chapter One sets the scene for this study by introducing the key concepts and outlining the specific questions that this dissertation addressed. It provided a broad context for this study by presenting an overview of the challenges associated with evidence-based health policy. An appreciation of the complex, haphazard and messy nature of policy decision-making is required to understand how contextual factors can impact on this process. The rationale for selecting alcohol and the use of illicit drugs as the case study for exploring this area of public health policymaking is provided.

Chapter Two explored how the structures of public administration evolved in Ireland and its role in public policymaking. An understanding of these structures was important to provide a context for the data sources for this thesis – the analyses of

public policy documents and qualitative interviews with civil servants. This was followed by a historical review of the development of public health policy in alcohol and illicit drugs. The literature reviewed came from a wide variety of sources including sociology, politics, medical history and public health. What emerged from the literature were the importance of context and the role of power and key individuals in the development of policy in alcohol and drugs. Public policymaking cannot be separated from the contextual norms and beliefs of the different epochs and these can alter across governments and between sectors. The use of research evidence in influencing policy began to have an impact in the second half of the 20th century. For example, in introducing harm reduction approaches to the use of illicit drugs in society and a shift from the disease concept of alcohol to a public health approach.

Chapter Three critically reviewed the dominant literature on the use of research evidence in public health policymaking. It introduced and discussed the many theories and conceptual frameworks that seek to explain the practice of developing public policy, and the utilisation of research evidence in this process. In addition, the conceptual frameworks developed to measure the wider impacts of research evidence, outside of the researchers' specific field of academic inquiry were also appraised. The theoretical framework that underpinned the analyses of the qualitative interviews from the researcher participants in this study was the research impact framework (RIF) (Kuruvilla, et al., 2006).

Chapter Four detailed the research methodology employed to conduct this study. It was a case study design employing document analyses and qualitative interview techniques to investigate how academic research impacts on the development of alcohol and drug public health policy. Critical realism was the philosophical orientation that underpinned the study and is derived from the personal perspective of the author. This chapter describes how the data from the three sources of evidence was analysed to build a picture of the policymaking process and the role of research evidence in this endeavour.

Chapter Five presented the quantitative and qualitative data on the evidence acquired from the analyses of policy documents, and the qualitative interviews with civil servants. The quantitative data gave an overview of the types of knowledge cited on

the drugs and alcohol policy documents and the sources of this knowledge. The qualitative data described the policy process from the perspective of the civil servants in the development of public policy at government level. The many different factors, such as political ideologies and economic constraints that must be considered in developing policy were discussed, predominantly in relation to alcohol and drugs policy. How the research evidence impacts on and influences the practice of policymaking was explored.

Chapter Six explored further the relationship between the research evidence and drugs and alcohol public policy from the perspective of academic researchers. The barriers and facilitators to the uptake of research evidence were debated. Several strategies were discussed that would improve the transfer of knowledge from researchers to policymakers. The researchers understood the time and economic constraints that policymakers were subjected to in their work. Some of the suggestions from the researchers were to work closely with policymakers in the early stages of policy development. This was to gain a greater understanding of the policy area and how the research evidence could be tailored to address the problem. Building relationships through formal and informal avenues were considered important to building trust with policymakers. Ensuring there was mutual respect for what each community brings to the process was essential to the maintenance of a productive research relationship.

Chapter Seven presented a discussion of the results of this thesis. The process of policymaking in the fields of alcohol and drug policy was debated. The importance of context was highlighted in this study as a significant factor in determining if the research evidence would make an impact or not. Several of the theories and frameworks devised to increase our understanding of the policymaking process and the uptake of scientific research in this undertaking were applied to the findings of this study. Viewing the development of alcohol policy in Ireland through the lens of Kingdon's Multiple Streams Model or the Advocacy Coalition Framework helps us to understand how policy has developed in this field. Similarly, the Social Construction of Target Populations and the Punctuated Equilibrium Theory assists in our understanding of drug policy. Overall the application of the Theory of Multiple-Level Governance helps us understand the constraints and limitations that senior policymakers are subject to in the development of policy. In addition, the purpose of

the different types of knowledge cited in the policy documents would support this theory. The conceptual modes of research utilisation increase our understanding of the use of research evidence in the policy process by policymakers.

8.3 Achievement of research aims and objectives

This section revisits the original aims and objectives to assess if they have been achieved. The research evidence was successful in making an impact in the development in public health alcohol and drug policy when it addressed issues that were a high priority for the policymaker and government. For example, when the policymakers wanted to understand the extent of a problem in society it relied on the academic evidence. Again, when the research evidence could identify the cost to society from the misuse of alcohol the policymakers listened to the evidence. As such the wider economic context was a significant influencing factor on the use of evidence. Good relationships and linkages between academic departments and government departments were considered important for the uptake of research. Unfortunately, not all the senior civil servants would have had the experience of close working relationships between its department and an Academic Institute. However, for those who did they found it essential to the operation of their work.

Barriers to the use of evidence by policymakers were research that did not take into consideration the contextual situation, in which the research would arrive, for example the broader political and economic context. Research not presented in a succinct and policy friendly format was also considered a barrier. Facilitators to the uptake of research by policymakers were research evidence that could address the issues that were a priority for government. If the research could recommend solutions to governments pressing issues in an effective and a cost-efficient manner they would be considered.

To improve the knowledge translation from researchers to policymakers the strategies proposed were to meet and discuss with policymakers how they would like the evidence presented to them, for example in numerical or word format. Inviting policymakers to conference where new research findings would be presented was

proposed. Policymakers suggested that researchers needed to improve their understanding of the policymaking process and the multitude of factors that have an influence. Linking with policymakers earlier in the research cycle and understanding the issues that were a priority for government would also facilitate uptake.

The final aim of this thesis was to investigate the effectiveness of the conceptual model the Research Impact Framework (Kuruvilla, et al., 2006) in exploring how academic researchers in Ireland think through the impact of their work. The framework was found to be an appropriate and cost effective tool in helping researchers identifies the impacts of their research outputs.

8.4 Implications for Policymakers and Researchers

It is important for policy-makers to understand how much researchers wish to contribute to the development of policy, and that researchers understand many of time and economic constraints that policymakers were subjected to in their work. If policy-makers are interested in taking an evidence-based approach to their work the development of good relationships with researchers is important. Such links would help researchers understand the issues that were a priority for government, and how these were determined. Policy-makers could also communicate with researchers about how they would like the evidence presented to them in terms of format and mechanisms. The goal would be to facilitate mutual respect for what each community brings to the process, as this is essential to the maintenance of a productive relationship. Policy-makers could also consider the use of the Kurvilla et al., (2006) Research Impact framework when reviewing their work and assessing progress towards policy goals.

Equally it is important for researchers to understand the policy process and the many competing demands that impact on a policy decision-makers time and energy. For researchers who want to have an impact on policy formulation, this knowledge of the policymaking environment can influence how and where to disseminate their research findings. For example, knowing your policymaking audience can determine what method you use in conveying your research findings. Specific situations and

circumstances may demand different methods. Concise quantitative data maybe appropriate in specific situations to reduce the intellectual burden on the recipients, where in other circumstances framing the evidence in anecdotal stories is required to persuade policymakers to pay attention to the evidence. A good understanding of the theories of the policymaking process will also help researchers to be able to identify opportunities for making an influence. Specific dynamics such as timing, changes in political leadership and alterations in public opinion are all opportunities that can be exploited to influence and alter the direction of public policy.

8.5 Recommendations for research

The specific case study presented in this thesis has highlighted several related areas that would benefit from further research. The role of the media in influencing both policy and the public's perception of alcohol and drug misuse in society would be worth exploring in further research. Research using similar methods to this study could be employed in other areas of health policy to identify if the research evidence has a greater influence on policy in areas that are less politically contested, for example the educational or transport sector.

8.5.1 Drug policy

Further research is warranted the area of illicit drug misuse particularly in relation to the impact of economic downturn on services. After the crash in 2008 many of the structures that were in place to address drug misuse in communities were reduced or disbanded. In this study for example an opportunity was missed by not interviewing service providers of how well the existing strategy was addressing needs of communities affected by drug misuse. The influence of international organisations and ideas on drug policy in Ireland would be worth investigating, for example are countries moving towards a consensus on how to treat and reduce the harm of illicit drug use in societies or do values, belief systems and cultures play a major role in policy in these specific areas.

8.5.2 Alcohol policy

While this research was being conducted, the public health approach to alcohol policy was still developing. Consequently, more research in this area would help to highlight how Irelands' culture and attitudes to the role of alcohol in society is changing. Previous studies have reported on the difficulties and obstacles to the development of a national alcohol policy and how the alcohol industries partner with government in the development of policy (Butler, 2015; 2009; Hope, 2006). Interviews with industry actors were not included in this study, however a study which involved interviewing actors from the alcohol industry and the tourism industry would be worth conducting to illicit their view on the harms caused by alcohol to society and its perceived importance to the tourist industry. A full public health approach to alcohol misuse in society has not yet been implemented, but policy is developing in this area. More research needs to be conducted on the influence of policy networks for instance *Alcohol Action Ireland* on the announcement of the Public Health (Alcohol) Bill in October 2013 and its subsequent passage through the Houses of Government.

8.5.3 The use of research evidence in the policy process

This thesis interviewed two actors in the policy process, academic researchers and civil servants, however the process is made up of numerous actors and stakeholders, for example, elected representatives, policy advisors, specialist interest groups and practitioners. It would be interesting to interview a wider range of policy actors using network analysis or discourse analyses methodologies to gain a fuller understanding of the policy process in the fields of alcohol and drugs.

8.5.4 Recommendations for practice

In areas of health and social care researchers who want to influence the policy development require an in-depth understanding of the political process and the many influences impacting on policy. This can be achieved by working closely with policymakers in the early stages of research projects. Researchers will be able to better understand the needs of policymakers in addressing many of the public health issues in society. Working in collaboration with health economists so they can get their recommendations costed as budgets are a major factor that must to be considered by policymakers. Conducting real life experiments on the changes in behaviours and

attitudes of population groups after the introduction of new policies and strategies would be beneficial to policymakers in assessing how policy make a difference. To develop modelling tools for the extrapolation of present health behaviours that may in the future become a population health issue. Devising ways of informing policymakers of the value of different types of research, for example of how mixed methods can generate contextualised and in-depth information of a phenomenon. Understanding how timing, policy windows and the importance of how the message is conveyed to policymakers can increase the impact of the research on policy is critical.

Researchers can also foster relationships with civil servants through informal meetings at conferences and scientific meetings. Haynes et al., (2011; 2012) in their study found that civil servants used conferences and scientific forums to identify researchers that would be relevant to their policy area. Policymakers selected researchers to engage with based on their credibility (Jacobson and Goering, 2006). Several studies have found the credibility of the messenger is viewed as an important component in the successful mobilisation of knowledge (Haynes et al., 2012; Jacobson and Goering, 2006). Credibility is defined as the how trustworthy is the knowledge produced by the researcher, the expertise of the researcher in knowledge, experience and skill, the professional standing of the researcher, and the neutral stance of the researcher, did they demonstrate objectivity in the findings of their research (Jacobson and Goering, 2006). Other attributes of researchers that policymakers found useful were researchers having a good understanding of government, good communication and collaborative skills, and able to authentically represent the research evidence (Haynes et al., 2012). To conclude this thesis makes a useful contribution to knowledge in the fields of public health policy, specifically in the areas of alcohol and drug policy research. In a continuously changing social environment it is important to understand the science of public policymaking and how scientific knowledge can have an influence. The study design employed was carefully structured to give a holistic view of the policymaking process. This could be expanded on in later studies to include many more actors from the policy environment. There remain many challenges to research evidence influencing policymaking. Nevertheless, this thesis has helped to illuminate this process, thereby increasing the knowledge of public health activists, researchers and practitioners who may wish to influence health policy for population health.

Chapter 10 References

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Appendices

Appendix A: Case Study Protocol

A. Overview of the Case Study
  1. Mission and goals:
  - Aim: To assess the use of research in formulating policy in drug and alcohol misuse

    Objectives; to identify:

  - in what context research was successful in making an impact.
  - the pathways/linkages and exchange models that best describe how research impacts in this area of policy in Ireland.
  - what the barriers and facilitators to research use in Ireland are and how best the barriers can be overcome and the facilitators enhanced.
  - To test the Research Impact Framework (Kuruvilla, 2006) in exploring how academic researchers think through the impact of their work.

  2. **Case study questions:**
    Analysis of policy documents; what kind of knowledge/information is referenced in government policies and reports on drugs and alcohol
    Policy-makers; who are the writers of policy documents?
    Who decides what information goes into policy documents?
    How do civil servants/policy writers access information?
    What types of information/knowledge do civil servants/policy-makers find most convincing?
    Researchers; Using the "Research Impact Framework" researchers are asked questions on their work in children, drugs and alcohol research:
    i)   Research –related impacts
    ii)   Policy impacts
    iii)   Service impacts - health and intersectoral
    iv)   Societal Impacts

    Similar to the policy-makers, the researchers are asked – what kinds of knowledge/information do policy-makers find convincing? How can researchers help users of evidence? And how can the existing evidence be improved?

The protocol illustrates how the researcher will go about answering the research question how research impacts on health policy in drugs and alcohol. The key papers relevant to this research are:

- Hanney, S. R., Gonzalez-Block, M. A., Buxton, M. J., and Kogan, M. (2003). The utilisation of health research in policy-making: concepts, examples and methods of assessment. *Health research policy and systems*, *1*(1), 2.
- Kuruvilla, S., Mays, N., Pleasant, A., and Walt, G. (2006). Describing the impact of health research: a Research Impact Framework. *BMC health services research*, *6*(1), 134.
- Ritchie, J., and Spencer L., (1994). *Qualitative data analysis for applied policy research*, Chapter 9 *pp.173-194* in: Bryman, A., and Burgess, R.G. (eds) (1994). *Analyzing Qualitative Data*, Routledge, London
- Yin, R.K. (2003). *Case study research: Design and methods* (5th ed.). Thousand
  Oaks, CA: Sage.
- Ouimet, M., Bédard, P. O., Turgeon, J., Lavis, J. N., Gélineau, F., Gagnon, F., and Dallaire, C. (2010). Correlates of consulting research evidence among policy analysts in government ministries: a cross-sectional survey. *Evidence and Policy: A Journal of Research, Debate and Practice*, *6*(4), 433-460.
- Weiss C. (1979) The many meanings of research utilisation. *Public Administration Review* 1979;**39**:426–31.
- Caplan, N., (1979), The Two- Communities Theory and Knowledge Utilization. *American Behavioural Scientist* 22:459
- Oh Cheol H., and Rich Robert F. (1996) Explaining the Use of Information in Public Policymaking, *The International Journal of Knowledge transfer and Utilization,* Vol 9, Number 1, pp.3-35
- Rich, R. F., and Oh, C. H. (2000). Rationality and Use of Information in Policy Decisions, A Search for Alternatives. *Science Communication*, *22*(2), 173-211.
- Kingdon, JW. (2003) *Agendas, Alternatives, and Public Policies* 2nd edition, New York: Addison-Wesley Educational Publishers Inc.

B. Data Collection Procedures:
Primarily policy documents and reports on drugs and alcohol will be retrieved from official government websites. As well as conducting an analysis of the types of knowledge/information that feeds into a policy document, potential candidates for interview in the alcohol and drugs research arena will be identified.

In the policy-making arena a person named B. in the Dept. of Health and Children will be contacted first – this will lead on to contacting other key informants using a purposeful snowballing technique. It is proposed to target key informants whom have been involved in the drugs and alcohol policy-making area.

An interview schedule for will be derived from the analysis of the policy documents and from a review of the relevant literature.

A letter of invitation will be sent by email to each candidate – introducing the researcher, the school they are attached to and the aims of the study. It will also contain the proviso that if they agree to be interviewed, the scheduled questions will be forwarded to them before the interview. Each participant is given the option of conducting the interview over the telephone or face-to-face. Their anonymity was assured and if they themselves were not willing to participate, they could recommend another suitable candidate. It was made clear that the researcher was adaptable and could fit in with their timetable. The published papers of the participant researchers and all the work they had conducted in the area of alcohol and drugs was read before the interviews.

C. Data Collection Questions: Why I am examining the documents – to identify what types of knowledge/information are referenced on policy documents and to measure the level of citations to academic research.

Why I am interviewing civil servants - to discover how policy-making is developed and what the influences that impact on policy are; to find out how the writers of policy access information and what their perceptions are on academic research; and to seek their views on the barriers and facilitators to the use of academic research on policy.

Why I am interviewing researchers – to assess the use of the conceptual tool 'Research Impact Framework' in researching how researchers describe the impact of their work.

D. Guide for the Case Study Report
- Keep a database of all evidence collected – Excel spreadsheets

- Writing short papers that will be presented at conferences and seminars to an audience of researchers, health promotion practitioners, academic teachers and researchers and PhD committees

Appendix B: Sample of audit trail of participant interviews (Researcher participants)

Interview Candidate	Profile	Date initial contact made	Date of Interview	Transcribed	Case summary	Notes
Interview 2 ▇ (R) res	▇▇▇	19/09/2014	15/10/2014 face-to-face interview	Transcribed	▇ (R.) area of expertise is in population health, with a specific interest in bullying and injuries in the adolescent population. Her methods of research are large population surveys using questionnaires but she has also used diaries in the past. Some of her papers have been cited 300 times although it is not something she would all the time be conscious of only when it comes to apply for jobs and she needs to give her H Index.	45 mins very interested in topic – interviewed in workplace
Interview 12 ▇ (R) res	▇▇	06/03/2016	16/03/2016 face-to-face interview	Transcribed	▇ Began by discussing his background is in sociology and social policy and his belief that the public policy process was not rational, it was never a linear thing constantly improving based on empirical research. The function of research was to enlighten people however these views maybe regarded as old fashioned now. He was not expecting his work to have an impact. The function of democratic government was discussed at length, …	1.5 hrs a long interview, difficulty at first in building rapport, could not see the relevance of the interview schedule to his work area – very engaged as int. progressed

Appendix B: Sample of audit trail of participant interviews (policymakers)

Interview Candidate	Profile	Date initial contact made	Date of Interview	Transcribed	Case summary	Notes
Interview 1 ▮ (P) pol	Dept. of ▮▮ ▮▮	19/09/2014	25/09/2014 Telephone interview	Transcribed	▮ (P.1). She talked openly about her work and the part she played in the creation of policy, she also offered some very good advice about whom to target for the interviews, particularly those who were higher up the staff grade as they would have more input into the policymaking process. Spoke about the role of specialist and generalist and her views on those roles. She herself would have preferred to stay a specialist, but as she was not directly employed as a specialist this would have been impossible. All civil servants can be moved at will in a department or to other departments. It is expected that their skills are transferable. All civil servants can be moved at will in a department or to other departments. It is expected that their skills are transferable, …	▮ was very interested in the study and was easy to interview 55 mins
Interview 3 ▮ (P) pol	Dept. of ▮▮ ▮▮	19/09/2014	26/01/2015 Telephone interview	Transcribed	▮ (P.3) discussed policymaking in alcohol and spoke about a specialist advisor in the HPU "who absolutely did Trojan work in this area". Described points in the policymaking process where research evidence can have an influence. In the field child poverty, it was discussed that no matter how much research that would have come out in the last number of years in this area, it would not have made any difference as cuts and austerity measures were the order of the day.	Very reserved at first, but as the interview progressed warmed to the topic and was very informative 1.15 hrs

Appendix C: List of Documents from the Department Website 2001 – 2012

2001 – National Drug Strategy 2001-2009

2002 – Strategic Taskforce on Alcohol Interim Report

2004 - Strategic Taskforce on Alcohol Second Report

2005 – Alcohol and Injuries in the Accident and Emergency Department: A
      National Perspective

2006 – Working Together to Reduce the Harms caused by Alcohol Misuse

2007 – First Annual Report on Alcohol Marketing (2006)

2008 – Annual Marketing, Communication and Sponsorship Codes of Practice

2008 – Report on the Implementation Group on Alcohol Misuse

2008 – Second Report of the Alcohol Marketing Communication Monitoring Body
      (2007)

2009 – Actions of the National Drug Strategy

      Annual Report of the Alcohol Marketing Communication Monitoring Body
      (2008)

      European Schools Survey Project on Alcohol and other Drugs ESPAD

      National Drug Strategy 2009 – 2016

      A profile of drinking patterns and alcohol related harm

      Women and Substance Misuse in Ireland: Overview

      Women and Substance Misuse: Alcohol and Women's Health in Ireland

      Women and Substance Misuse: Drug Misuse and Women's Health in Ireland

2010 – 4th Annual Report – Limiting the Experience of Alcohol Advertising and
      Young People

      Report on the Working Group on Sports Sponsorship and the Alcohol
      Industry

2011 – 5th Annual Report – Limiting the experience of alcohol Advertising

2012 – Progress Report on a National Drug Policy 2009 – 2016

      Drug use In Ireland and Northern Ireland, Bulletin 2.

      Minority report by the Alcohol Beverage Federation of Ireland

      Minority report Mature Enjoyment of Alcohol in Society

      Report on The Misuse of Alcohol and Other Drugs January 2012

      Steering Group on a National Substance Misuse Strategy Feb 2012

Appendix D: Coding for documents

Each policy document or report was coded either 'Alcohol' or 'Drugs'.

Coding for Policy

      1 = drug policy

      2 = alcohol policy

Coding for document type

      1 = drugpol01-08

      2 = drugpolrev01-08

      3 = drugpol09-16

      4 = STFalcohol02

      5 = STFalcohol04

      6 = ReportMisuseofAlcoholandDrugsJan12

      7 = ReportNSMstrategyFeb12

Coding for type of information

      1 = Irish academic/Scientific – research published by Irish Universities

      2 = International research – research published by International Universities

      3 = International Reports – WHO reports and International Government Reports

      4 = Internal Information - legislation/ Departmental Acts/policy documents and reports

      5 = External legislation – other Government department legislation/ policy documents and reports

      6 = Industry research and reports

      7 = Commissioned studies by Governments Agencies

      8 = Other – personal information

Coding for purpose of information

      1 = justification for policy

      2 = recommendations

      3 = both

Appendix D: Sample of policy documents extraction sheet – alcohol documents

Policy Document	Name of study	Author	Commissioning Body/funders	Synopsis of study	Code (Type of info)	Where cited in the policy document	Code (where cited)
Strategic Task Force on Alcohol 2004 Second Report	The impact of alcohol advertising on Teenagers in Ireland	Dring, C. and Hope, A. (2001) Health Promotion Centre, NUI Galway	Dept. of Health and Children	This paper gives an insight into the ways that alcohol advertising can impact on the pressures on young people in Ireland to drink. It was found that alcohol advertising has a strong attraction for Irish teenagers as it portrays lifestyles and images which are part of their social setting.	1	Section 5 - STFA 2004 recommendations- control promotion of alcohol	2
	Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002.	Long, J., Jackson, T., Kidd, M., Kelleher, T., and Sinclair H. (2004)	HRB	It is the first publication that reports on treatment demand for problem alcohol use in community settings. Most specifically residential services and supplements the data published in the annual reports from the National Psychiatric Inpatient Reporting System.	7	Section 3: evidence of alcohol related harm recent trends - under Health service demand	1

Appendix D: Sample of documents extraction sheet – drug policy documents

Policy Document	Name of study	Author	Commissioning Body/funders	Synopsis of study	Code (Type of info)	Where cited in the policy document	Code (where cited)
National Drugs Strategy (interim 2009 - 2016	Evaluation of Local Drug Task Force Projects, 2008	Horwarth Consulting Ireland Ltd	Dept. of Community Rural and Gaeltacht affairs	unpublished paper – this evaluation assessed the contribution of projects to LDTF plans and the implementation of the National Drugs Strategy 2001-2008. Its structures, effectiveness, efficiency and value for money components of the projects.	4	Chapter 3 – This paper is cited under "Education and awareness programmes" in non - school settings and development of diversionary programmes	1
	The Way Home: Strategy to Address Adult Homelessness in Ireland 2008 –2013" and "A Key to the Door 2007– 2010"	Dept. of Environment, Heritage and Local Government (2008) The Homeless Agency's (2007).		Problem drug and alcohol use among the homeless population is a serious concern. Significant number of homeless people require access to treatment and rehabilitation services. Significant increase in services in this area	5	The two strategies are cited in chapter 4 under 'Treatment and Rehabilitation' - access for drug misusers to treatment within one month	2

Appendix E: Letter of Invitation
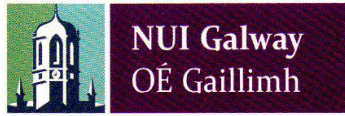
Health Promotion Research Centre
National University of Ireland Galway

Dear …,

I am a PhD student in the School of Health Promotion in NUI Galway under the supervision of Dr. Saoirse Nic Gabhainn. My study is investigating how research impacts on health policy in child and youth affairs. The focus is on drugs and alcohol research.

To date I have conducted documentary analysis on the policy documents published in this area since 2001. In order to complete the project, I am conducting semi-structured interviews with researchers and policy decision-makers seeking their views on how academic research impacts on health policy.

I would be grateful if you could answer some questions about your work in this area (or recommend someone who could help). The interview should take about 30-45 minutes. If you are willing to participate we will send an interview schedule by email prior to the interview. With your permission, the interview will be recorded and later transcribed. All data collected will be anonymous and confidential., I look forward to hearing from you and will follow up with a telephone call within 2 weeks.

Best wishes,

_____

Helen Grealish
PhD Candidate

Health Promotion Research Centre
School of Health Sciences
National University of Ireland Galway,

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F + 353 91 494 577
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Appendix F: Interview schedule for Policy makers

1. How many years have you been employed in the civil service ☐
2. How many years have you been in your present position ☐
3. Gender: Male ☐ Female ☐
4. Education: Diploma ☐ Degree ☐ Master's /PhD ☐

5. Grade/Employment Title:

   ....

6. Job description ....

   Prompts: are you involved in the (i) the formulation of new
   policies/programmes/measures:
   (ii) Implementation planning of new policies/programmes/measures: (iii)
   implementation of policies/programmes/measures: (iv) evaluation of
   policies/programmes/measures: (v) production and analysis of statistical
   data/production of literature reviews/other

7. What factors have been driving policies on Alcohol and Drugs since 2000?

   ....

8. Have the factors changed over time and what are the key reasons for this change?

   ....

9. Can you give examples of where the research evidence has influenced public health

   related policy around drugs and alcohol?

   ....

10. Can you describe how you would go about locating the evidence? Access to

    Bibliographic databases – scientific journals/university professors,

    researchers/journalists/ think tank researchers/ private sector consultants

    ....

11. What type of evidence do ministers and senior civil servants find convincing?

....

12. How can the existing evidence be improved?

....

13. How can researchers help users of evidence?

....

Appendix G: Kuruvilla's et al., (2006) Research Impact Framework

Interview schedule for researchers

Research-related impacts
   1. What types of problems/knowledge did your research address?

....

   2. What kinds of research methods do you use?

....

Are you aware of all the papers and citations that have been generated from your research in this area?

....

Where have the results been disseminated: Prompts specific conferences/seminars/media?

....

   3. Have you been able to attract grant funding and collaborations for your research in this area?

....

   4. Has your research led to many PhDs and other higher qualifications for those working on your projects?

....

Policy impacts
   5. Has your research had an impact on policy-making and if so at what level?

Sub-national level ....

National level ....

International level ....

   6. Are you aware of the nature of the impact of your research?

Prompts for example, (i)Weiss (1998) modes of influence: Instrumental – the research findings directly define or drive policy. Mobilisation of support – the research raises consciousness for new policy-making, or provides supportive evidence to back proposed or ongoing policy changes.

....

(ii) Conceptual use: has your research lead to new and innovative ideas in how policy is debated and discussed

....

(iii) Redefining, wider influence of your research in policy – making. Has your research lead to a change in accepted beliefs and practice, (i.e. encouraging adolescents to drink at home, the non-acceptance of alcohol in pregnancy).

....

Are you a member of any policy networks?

....

7. Political capital – has your research been used in political negotiations, for example between the Department of health and private health providers or health professionals?

....

Service impacts

8. Has your research had an impact on health or public service, for example workplace health or road safety?

....

9. Has your research influenced evidence- based practice and guidelines?

....

Societal impacts

10. Can you identify any societal impacts your research has had? For example:

    Has it led to changes in knowledge and attitude about health behaviours?

    ……………………………………………………………………………………………………….………

11. What are your perceptions of the type of evidence that ministers and senior civil servants find convincing?

    ……………………………………………………………………………………………………….……..

12. How can the existing evidence be improved?

    ………

13. How can researchers help users of evidence?

    ………