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'I could have went down a different path': Talking to people who used drugs problematically and service providers about Irish drug policy alternatives

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Abstract

Background

People who use drugs problematically are consistently left out of consultations and deliberation on drug policy. This article explores how people who formerly used drugs problematically and service providers view Ireland's current drug policy and if alternative policies could be successful in an Irish context.

Methods

Semi-structured interviews were conducted with eight people who used drugs problematically and six practitioners working with people who use drugs in Cork city, Ireland. All people who used drugs problematically had at least one year of abstinence and had been criminalised because of their drug use, all but one had served at least one custodial sentence. Participants were asked their opinions on safe injecting facilities, heroin assisted treatment, decriminalisation of drugs for personal use, depenalisation of cannabis and, the relationships between economic deprivation and problematic drug use.

Results

Respondents stressed that, in Cork city, problematic drug use is closely linked with economic deprivation and social exclusion. There was a near consensus that criminalisation and penalisation do not deter consumption and produce unintended consequences. All participants

supported safe injecting facilities and the decriminalisation of drugs for personal use. Participants were less certain about the utility of heroin assisted treatment and depenalisation of cannabis. Many discussions drifted away from alternatives policies towards the need for improved treatment provision.

Conclusion

Several participants were clear that none of the alternative policies discussed are silver bullets. Participates felt that, while they could reduce the harms caused by drugs and drug policies, the government's longer-term objectives should be increased treatment provision and, reduced social exclusion and economic deprivation.

Key words: decriminalisation; drug policy; Ireland; safe injecting facilities; heroin assisted treatment; people who use drugs; social exclusion; subterranean structuration.

Introduction

Since the 1980s, Irish drug policy has walked a line between harm reduction and a relatively conservative prohibitionist stance (Murphy, 2002). There is, however, support for alternative policies. The decriminalisation of drugs for personal use was supported, in 2015, by an Oireachtas (Irish Parliament) Joint Committee who emphasised the utility of the Portuguese model of decriminalisation (Department of Health, 2019:10). Safe injecting facilities (SIF) have been legislated for under the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 and, while Dublin City Council initially refused planning permission for a pilot SIF (O'Keeffe, 2019), the programme received strong government backing (O'Regan, 2019). Planning permission was eventually granted in December 2019. Ireland's drug strategy, *Reducing Harm, Supporting Recovery 2017-2025*, identifies that criminal sanctions can be stigmatising and impede recovery and desistance, whilst emphasising the need for a 'health-led and person-centred approach' (Department of Health, 2017:4).

The Strategy also recommended consideration of alternative approaches to criminalising simple possession. A government Working Group on the issue rejected decriminalisation whilst reporting, after public consultation, 'strong support for a change in the approach to simple possession offences' (Department of Health, 2019:50).[1] The Working Group suggested replacing criminal sanctions with adult cautions or diversion to health services (Department of Health, 2019). Consequently, Irish drug policy will, from 2020, involve a health diversion scheme whereby those found in possession of drugs for personal use will not be prosecuted

[1] The Working Group dismissed the recommendation of commissioned research by Caitlin Hughes and colleagues (2019): a hybrid of depenalisation for minor drug offences coupled with targeted decriminalisation for 'high-risk drug users'.

until their third offence: a policy that will have minimal impact on those using drugs problematically.

Drug policies are formed through consultation and deliberation between moral entrepreneurs, politicians and, bureaucratic and economic actors (Monaghan, 2011; Windle, 2018a), often from positions of authority (Becker, 1963). Drug users, especially those using drugs problematically, are seldom included in these processes (Askew and Bone 2019; Greer and Ritter, 2019). Marginalising the voices of people who use drugs problematically may be due to stigmatisation and criminalisation (Lancaster et al., 2013; Lynch et al., forthcoming).

This said, the government Working Group did endeavour to involve people who use drugs in their consultation process. They administered a national questionnaire in which 82% of respondents reported having previously used drugs. The questionnaire was, however, at the population level and did not specifically recruit people who used drugs, nor did analysis differentiate drug using from non-drug using populations. While the Working Group took submissions from organisations who work with people who use drugs problematically, Darke and Torok (2013) warn us not to 'presume to speak for them [drug users] without knowing their views'. Finally, the Working Group ran two focus groups with people who had been prosecuted for possession of drugs for personal use. Their views were, however, side-lined with just one paragraph of the 274 page report dedicated to the results of these focus groups. The key findings of the focus groups were a 'consensus … that criminal penalties have little impact on lessening the pervasiveness of drugs through society' and decriminalisation was 'seen as a positive alternative' (Department of Health, 2019:49)

That the voices of people who use drugs were involved in this process (to an extent) is a promising development. As they are 'deeply impacted by drug policies' (Greer and Ritter, 2020:2) they should have a voice in drug policy debates (Lancaster et al., 2013, 2018). Such

participation has been argued to 'promote democracy, social justice, and pragmatism' within drug policy (Greer and Ritter, 2020:2).

There has recently been an upsurge in academic interest in the opinions of people who use drugs, and less often people who use drugs problematically, on drug policy. This can be viewed as part of a global movement - often expressed under the banner Nothing About Us Without Us - to include those most affected by policies and practices in planning, implementation and evaluation (Lynch et al., forthcoming). The majority of these studies have been conducted in Australia (Darke and Torok, 2013; Greer and Ritter, 2020; Lancashire et al., 2013), Canada (Osborne and Fogel, 2017) or the UK (Askew and Bone 2019; Butler et al., 2018). Previous research has been directed at those who 'consume a range of substances' (Askew and Bone, 2019:34), consume cannabis (Osborne and Fogel, 2017), are receiving treatment (Greer and Ritter, 2019) or people who inject drugs (Butler et al., 2018; Lancaster et al., 2013).[2]

A consistent finding across these studies is that people who use drugs identify the complexity of drug policy options, are not homogenous and exhibit diverse opinions (Askew and Bone, 2019; Darke and Torok, 2013; Lancashire et al., 2013). Although participants in Askew and Bone's (2019:33) study were 'united in their discussions of human rights, health, economics and education'. Another consistent finding is that opinions are embedded in participants personal experiences and self-image (Greer and Ritter, 2018, 2020; Lancaster et al., 2018).

[2] A small number of studies have been conducted by Irish third sector organisations. These have focused on the views of service users on particular services (i.e. CityWide, 2014; Jennings, 2013) rather than more general drug policy discussions. Healy (2019) has conducted ethnographic research, in partnership with Service Users' Rights in Action, to gather the opinions of service user's experience of methadone maintenance.

This article adds to this growing international literature by comparing the opinions of people who used drugs problematically[3] with service providers in an Irish city to explore the relationship between relative deprivation and problematic drug use, decriminalisation of drugs for personal use, depenalisation of cannabis, safe injecting facilities and heroin assistant treatment. Unlike other studies our sample all came from one of Ireland most economically deprived areas and all had been criminalised due to their drug use. As such, this paper contributes to the international literature by focusing specifically on those who have experienced economic deprivation, social exclusion and criminalisation, and by focusing on Ireland: a country which remains under represented in the drug policy literature.

Methodology

The lead author conducted semi-structured interviews with eight people who used drugs problematically and six practitioners working with people who use drugs in Cork city. A similar

[3] Most participant's referred to themselves as addicts. This left us in a difficult position as, on the one hand, avoiding the words participants used to describe themselves felt dismissive of their experiences and right to self-determination. On the other hand, first person language focuses on the whole person and, may reduce stigmatisation and dehumanisation (Changing the Narrative, no date). All eight participants reported habitually using heroin and/or benzodiazepines and that their drug use caused harms, including impacting family relations, their mental health and bringing them in contact with the criminal justice system. As they defined their own drug use as problematic, this article will use the term people who *used* drugs problematically. This term best identifies the complexity of the issues our participants faced, and is used in Ireland's most recent drug strategy *Reducing Harm, Supporting Recovery 2017-2025*.

interview schedule was used for both sets of participants. Interviews were conducted at the participant's home or the University campus. As previous research has shown a lack of clarity around drug policy terminology (Askew and Bone, 2019), the interviewer defined key terms (SIF, HAT, decriminalisation and depenalisation) during the interview process. All transcribed interviews were analysed thematically to identify relevant patterns (Strauss and Corbin, 1997). Ethical clearance was provided by the University College Cork Research Ethics Committee. All names have been anonymized to reduce potential stigmatization and protect participants: former users are referred to as Mr/Ms and service providers as Practitioner.

Mixed purposeful and snowballing sampling was used (Babbie, 2008). Recruitment of people who used drugs problematically was supported by the Cork Alliance Centre, an organisation based in Cork city that work with offenders pre- and post-release from prison. The Centre only works with people who have been in prison and are from Cork or living in Cork. A poster to advertise the research was displayed in the Centre. Uptake was initially slow using this method, but earlier participants referred us to individuals who would fit our criteria: people who used drugs problematically who have been criminalised for their drug use. Similar recruitment methods have been used in comparable studies (Greer and Ritter, 2019, 2020; Lancaster et al., 2013).

Of the eight people who used drugs problematically, seven were male and one was female. The youngest participant was 25 and the oldest was 41, the average age was 34.5. All participants had at least one year of abstinence from drug use: this ranged from two to 15 years of abstinence. All had been criminalised due to their drug use: all had received at least one conviction and all but one had served at least one custodial sentence. The types of drugs used varied: all started their drug using careers with alcohol or cannabis before progressing to benzodiazepines and/or heroin.

Six practitioners were also interviewed. Three were male and three were female. All worked in Cork city in a variety of roles within state or third sector probation or addiction services: Practitioner A worked in a homeless hostel for over three years; Practitioner B worked for an organisation that supports prisoners in custody and in the community for two years; Practitioner C worked in a community organisation supporting men to abstain from drugs and reoffending for ten years; Practitioner D worked in probation for over fifteen years; Practitioner E worked in a community outreach program for men in addiction for two years; Practitioner F worked for an organisation that supports prisoners in custody for two years. While greater weight is given to the voices of those who used drugs problematically within the analysis, the practitioner interviews provided contextual foundation, further information and valuable comparisons: notably that all 14 participants agreed on some issues.

Bourgois (1995:12) has argued that drug users, especially those from already marginalised groups, can be distrusting of academics and warry of revealing 'intimate experiences of drug abuse'. Employing insiders as researchers can mitigate issues of trust. The first author used drugs problematically, including intravenous heroin use, spent over ten years in the criminal justice system and, has since worked in various roles supporting former prisoners and the homeless in Cork city. He grew up in the north side of Cork city, as did many of our participants. His biography, and cultural capital, was useful in quickly developing trust with participants.

Limitations

Our findings are limited by the relatively small sample size and many of our participants will have undergone therapy as part of their treatment for problematic drug use. Through treatment they will have spent time reflecting on the causes of their problematic drug use and the impact of criminalisation. As such, our participants may not be representative of all people who have

used drugs problematically in Cork city let alone Ireland. This was not, however, the aims of this paper. The aim was to explore the opinions of people who used drugs problematically and had been criminalised for their drug use. Wealthier people who use drugs problematically may not have come to our attention, possibly because they are less likely to be criminalised and because those that have been incarcerated may have less need of some Cork Alliance Centre post-release services (i.e. housing, employment). Nonetheless, as the first study of its kind in Ireland, it represents an important starting point that will provide opportunities for comparison with other small-scale qualitative studies or larger number surveys.

Findings

The following section will present the finding of the 14 interviews thematically. The themes that emerged from the interviews were: problematic drug use and economic deprivation; penalisation and criminalisation; and alternative policies.

Problematic drug use and poverty

Drug use is widespread across all socio-economic groups in Ireland. The expansion of the national market during the Celtic Tiger economic boom, for example, has been attributed to increased middle-class drug consumption (Hourigan et al., 2018). Irish research has, however, shown that problematic drug use tends to concentrate in Irelands most economically deprived areas (CityWide, 2014; Department of Health, 2019; IPRT, 2012; Jennings, 2013; O'Mahony, 1997; also Windle, 2019). In 2016, for example, 66% of people receiving treatment for opiate use in Ireland were unemployed and 10% were homeless (Department of Health, 2019:34) as were 33% of those attending a Dublin needle exchange (Jennings, 2013). This phenomena has been observed elsewhere (Pearson, 1991; Stevens, 2010). Seddon (2006:242) synthesised the research literature to suggest that while problematic drug use is 'encountered at all social levels

… the most serious drug problems have been visited upon those neighbourhoods already suffering from multiple socio-economic difficulties'.

Stevens (2010) subterranean structuration approach is a useful lens for explaining the concentration of problematic drug use in economically deprived areas (also Densley and Stevens, 2015). Combining Giddens (1984) with Matza and Sykes (1961), Stevens (2010) argues that subterranean values (i.e. dislike of work, hedonisms, search for excitement and adventure) were once a youthful phase before most moved into the workforce. Increasingly, however, some young people are denied the opportunity for meaningful employment while hedonistic consumption is promoted as a core economic activity. Subterranean structuration, in short, draws attention:

> To the constraints placed on the choices made by people who have been most affected by the withdrawal of employment in deprived areas. These people are forced to make choices in situations which offer them little hope for pleasure, purpose or respect, no matter how hard they struggle (Stevens, 2010:10).

Consuming and buying drugs allows those living in economically deprived areas to 'find purpose and company', a sense of identity, excitement and adventure, whilst dulling 'the pains of existence and exclusion' (Stevens, 2010:45).

In Cork city, economic deprivation is disproportionately centred on the north side of the city, and a smaller number of housing estates on the south side. These areas tend to have low educational attainment and, high unemployment and lone parent ratios. The most extremely disadvantaged area, for example, has a male unemployment rate of 45.10% and just 4.35% of the population have third level education (Pobal, 2016).

Each participant was asked their thoughts on why problematic drug use concentrates in economically deprived areas. Mr B identified the role of social exclusion:

> I think that living outside of society has an impact on drug use. Like not having a job, not feeling part of society. Like poverty is part of it but you also have nothing to do and you don't feel connected to society.

While Mr E similarly felt that:

> There's a feeling of alienation, there's no sense of future, you know leaving school early, there's no one in good employment around them. Only having little education, not having plans for the future, isolated really in life you know.

Studies in Ireland and the UK have noted how heroin consumption often increases during economic recessions (Pearson, 1991, Windle, 2018b). Mr D reported observing this trend in Cork:

> Drug use around here became really bad around the end of the Celtic Tiger. The recession and heroin hit Cork around the same time. We didn't have any opportunities, the work was gone, for those of us who didn't have the money to emigrate, all we had was heroin and tablets.

Without access to legitimate employment opportunities, and feeling excluded, several reported progressing their drug use to 'cope' and 'sooth the harsh realities of living on the margins' (Mr H). Mr E identified drink and drugs as 'a kind of soothing thing really', Ms H suggested people 'use drugs to cope with everyday life' in an 'area where there's nothing around for them' and Mr C felt they were a means of 'coping' with the 'trauma' experienced by 'a lot of people who come from poor or disadvantaged areas'. Two practitioners also mentioned 'escapism'

(Practitioner B) and 'coping mechanism' (Practitioner F) to explain why some engaged in problematic drug use.

Mr F draws together the themes of recession and joblessness, hopelessness, social exclusion and relative deprivation:

> Like, I think the bit of depression or anxiety that people feel who live in poverty, they might use drugs to help them. I read something before about the medicalisation of poverty. It was about single mothers who weren't working, they would go to doctors and get meds for anxiety whereas if they dealt with the real problem which was unemployment and money concerns and stuff then they probably wouldn't have anxiety or need meds from the doctor. So, in that sense the drug dealers are the doctors who medicate poor people who are struggling.

Both people who used drugs problematically and service providers highlighted the role of location in some drug using careers:

> Where I grew up when I was young, nobody was working, everybody was on welfare, the only people who had money were those who sold drugs… (Mr F).

This corresponds with MacDonald and Marsh's (2002:34) suggestion that the typical heroin user may simply have 'grown up at the wrong end of town'. Practitioner B reported:

> … the prison population is made up of people mainly from three or four neighbourhoods in Cork city as well as parts of Kerry and Waterford where there tends to be high concentrations of poverty… these communities see high-levels of drug use and anti-social behaviour… people from poor communities often use drugs to cope with life, a type of escape from reality.

Another service provider, who works with prisoners stated: 'the inmates I work with are generally from the Northside [of Cork city] and certain parts of the Southside' (Practitioner D). Practitioner C said that his clients 'all share similar stories with regards to poverty, generational unemployment and addiction'.

These findings correspond with previous research with Irish prison populations. O'Mahony (1997) found that Mountjoy prison was populated largely by young people who used heroin from five or six districts in Dublin. More recently, the IPRT (2012:6) found:

> Some young offenders…expressed how their social disadvantage directly led them into criminality as many came from poverty-stricken areas characterised by high levels of drug use and crime.

Subterranean structuration was used in this section to show how, for our participants, drug use allowed them to 'fashion a life which meets some of their needs for pleasure, status and meaning' (Stevens, 2010:51) while dulling the pain of exclusion and lack of employment.

Penalisation and criminalisation

Most of our participants believed that criminalising people failed to deter problematic drug use, however, Mr D felt that while being arrested did not deter him he knew others who 'were caught with drugs and they never touched them again'. Mr F felt that the middle class were more likely to be deterred because those from economically deprived areas expect to be arrested: 'for us it's just part and parcel of it'. Participant's opinions are consistent with the international literature which suggests that law enforcement against people who use drugs problematically has little deterrence effect (Hughes et al., 2019) and, that criminalisation and penalisation exacerbate many of the initial problems which make drugs attractive in the first place.

Several participants argued against the idea that criminalisation deterred consumption. Ms H reflected that 'when I gave up drugs later in life there was no connection between that and getting convictions'. This was consistent with our service providers who felt that 'prison isn't a deterrent for most addicts, and many have spent most of their adult lives in and out of prison leaving them institutionalised' (Practitioner E). Mr B and Mr H felt that arrest and incarceration were an 'occupational hazard' to people who use drugs problematically, with Mr B noting that having convictions was 'a side issue. It actually didn't affect me until I got clean'.

Several respondents identified unintended consequences of criminalisation. Previous research has shown that a record for simple drug possession can represent barriers to: employment, education, foreign travel, renting/buying a property (Department of Health, 2019:25) while criminalizing possession can prevent uptake of treatment and harm reduction services (Hughes et al., 2019).

For Mr A, Mr B and Mr C, imprisonment exposed them to more serious drug use and hastened their progression to heroin. Mr E reported a similar experience with benzodiazepines. Two participants said that they had not used heroin until they were sent to prison for minor offences, they both later became chronic heroin users:

> I know of people who didn't take much drugs but ended up going to prison and getting strung out on hard drugs. That's what happened me too. I first used heroin inside prison. I was up on charges of drunken disorderly. I was drinking alcoholically at the time and the judge sent me to prison because of my drinking and I ended up getting involved in heroin (Mr C).

> I don't think that method [prison] works, personally for me anyway because before I went to prison there was certain drugs that I hadn't taken and when I was in prison these drugs were available, one being heroin. And, eh, I

> would have first used that drug in prison and because prison was a different atmosphere, eh, that drug was more acceptable around the prison landings than it was back home. No one looked at you any differently if you were using it. So, it was kind of like, it was ok to do it (Mr A).

Mr B also noted how the prison context altered how he viewed heroin: it was normalised in prison but stigmatised in his neighbourhood:

> I went to prison when I was younger and it was for drugs charges and eh, my habit got worse there because I was introduced to heroin. I had a certain thought about heroin but that was broken down in prison because loads of people were on it in there… and when I got out then the taboo was gone for me.

The unintended consequences of criminalising people who use drugs are echoed by service providers. Practitioner B said:

> … prison should really be avoided at all cost because once a young person enters the system then they are likely to stay in it for years and if a parent is in prison then the children often grows up with issues with authority and trust.

Psychological and criminological studies have shown that early involvement with the criminal justice system can have significantly negative impacts on later life outcomes and may, in some cases, increase the likelihood of adult offending and problematic drug use (see Cullen et al., 2011; Lambie and Randell, 2013). Indeed, Mr C felt that many use drugs to cope with trauma and 'prison causes more trauma' which 'heightens the addiction'.

That the consequences of criminalisation falls upon families was picked up by several service providers during the interviews:

> Unfortunately there is always a ripple effect. The partner picks up the burden and the children are without a parent (Practitioner D)

> If there are kids involved then it gets messy as the children are without a parent and the connection is lost (Practitioner C)

There is a growing body of evidence that experiencing cumulative adverse childhood experiences (ACEs) is a risk factor for various physical and mental health issues, including an increased likelihood of drug addiction (Dube et al., 2003). Having a family member in prison is one of the nine broad ACEs, while the loss of income and stress of joblessness generated by criminalisation or imprisonment of a parent, can heighten the risk of the child experiencing other ACEs, such as verbal or physical abuse, emotional or physical neglect and mental illness in the family.

One participant reflected on what Lemert (1967) called secondary deviance, by suggesting that the label of criminal intensified his drug use:

> …it [criminalisation] gave me the label as well, the conviction for being a drug user so now I was in prison because of this. So, I kind of had this attitude of 'well, look I'm here, it can't get any worse than prison', so…It made me worse basically (Mr A).

The issue of labelling and stigma was also brought up by service providers:

> The self-esteem of the lads in here [homeless shelter] is pretty-low and as a result [they] have a fairly low estimation of themselves…their feelings of worthlessness are reinforced by labels like junkie…the negative labels they carry only further isolates them (Practitioner A).

While Mr D felt that 'if you start taking heroin you're looked at as a junkie' and the 'stigma doesn't help'. That is, the multitude of negative labels attached to heroin can ensure a double exclusion. The people who used drugs problematically already felt excluded from mainstream society through lack of meaningful work and geography. They used drugs to find status, purpose, and soothe the pain of exclusion from the mainstream, only for the stigma of heroin to result in exclusion from their own communities.

While drug law enforcement and preventive mechanisms against the supply of drugs do contain consumption at a macro-level (Windle and Farrell, 2012) our participants felt that criminalisation had little impact on drug consumption in their lives. There was agreement amongst all participants that criminalisation does little to reduce or deter drug use in their economically deprived areas and, imprisonment can hasten progression to more harmful drug consumption and can impact families, which evidence suggests can foster transgenerational patterns of substance abuse.

In terms of subterranean structuration, the goal of success in consumer society remained, but criminalisation and stigmatisation made it more difficult to access respect and pleasure through legitimate avenues. Furthermore, imprisoning parents creates a strain within the household, which further disadvantages children and imposes further constraints on them as they traverse their youth within economically disadvantaged locales.

Alternative Drug Policies

Participants were asked for their thoughts on four alternative drug policies currently not practiced in Ireland: decriminalisation, depenalisation, supervised injection facilities (SIF) and heroin assisted treatment (HAT).

Decriminalisation and depenalisation

Decriminalisation was defined to participants as 'the removal of sanctions under the criminal law, with optional use of administrative sanctions (e.g. provision of civil fines or court ordered therapeutic responses)'. Depenalisation was defined as 'the decision in practice not to criminally penalize offenders, such as non-prosecution or non-arrest' (Hughes and Stevens, 2010:999). The Dutch and Portuguese models were then explained to participants. Overall, the Portuguese model of decriminalisation was popular among *all* participants but there were mixed views on the Dutch model of depenalisation. Importantly, many discussions drifted away from legislative changes towards the need for improved treatment options and the need to reduce economically deprivation.[4]

Dutch model

Dutch drug policy centres upon the separation of cannabis from other drugs whereby selling and possessing cannabis is illegal but the state designates that 'it is never in the public interest to prosecute where relatively small amounts are concerned' (Chatwin, 2016:3). While the commercialisation of cannabis, through the coffee shop distribution model, may have 'significantly increased cannabis prevalence' (MacCoun and Reuter, 2001:123) the Netherlands have very low rates of incarceration (Pakes and Holt, 2015) and problematic drug use. Drug related deaths are lower than the European average (Chatwin, 2016:5) and the country has the lowest rate of intravenous drug use amongst people using opiates in Europe (Hughes et al., 2019). It's unclear, however, what impact depenalisation had on these positive

[4] In Ireland, treatment includes a broad range of services, ranging from harm reduction to abstinence-based interventions (see Department of Health, 2017:39). While participants often discussed treatment in quite broad terms, they tended to differentiate harm reduction from treatment, which they viewed as primarily rehabilitative.

outcomes, as Dutch policy also has a strong focus on harm reduction and rehabilitation (Chatwin, 2016; Stevens, 2010).

Some of our participants offered muted support for depenalisation. Mr A and Practitioner A favoured depenalisation as a way to divert people from synthetic cannabinoids: 'at least in Amsterdam you know exactly what's in it and it's relatively safe'. Mr B, Mr E and Mr F supported depenalisation because 'people are going to smoke it anyway' (Mr B). Mr H offered cautious support but felt that the policy only worked because the 'Dutch have a more liberal frame of mind' than the Irish.

Others opposed depenalisation. Mr C objected to depenalisation because:

> I wouldn't like my own 18-year-old going to the coffee shops smoking anyway. I'm for decriminalising cannabis but I wouldn't like to see it freely available legally at all.

Mr D offered some supported with the caveat: 'I don't know if it would work in Ireland, we're a country of excess, we drink to excess, we eat to excess' (also Ms H). While Practitioner D was 'not a big fan … I've been to Amsterdam and to say it isn't a drug destination would be a lie'.

Portuguese model

In 2001, Portugal decriminalised the possession of all drugs for personal use. Anyone found to possess less than a 10 day supply of any drug can receive a warning, a fine or be ordered to appear before a local commission; who can advise or order treatment, harm reduction or other support services (Hughes and Stevens, 2010). The evidence is mixed. Between 2001 and 2007, overall drug consumption and once-in-lifetime consumption increased, although there were reductions in youth consumption, problematic drug use, drug-related deaths, HIV infections and prison numbers. To what extent the more positive outcomes are attributable to

decriminalisation is unknown, as they were part of a coherent response involving improvements in treatment and social supports for users, attitudinal shifts in how people who use drugs are perceived and improved social welfare (Hughes and Stevens, 2010; Hughes et al., 2019).

All participants supported the decriminalisation of drugs for personal use. Mr C advocated for the interventionist nature of the Portuguese model:

> …I think if I was offered help, I could have went down a different path… I knew nothing about recovering from addiction, I knew nothing about self-worth or working on myself. I didn't know there was another avenue to go… It can be used as an intervention, more so for younger people.

Interestingly, much of the discussion around the Portuguese model revolved around drug treatment. Several participants highlighted that Irish drug treatment services are insufficient and that criminalisation without supports leads to a revolving door process for drug offenders. Mr H argued that decriminalisation is not the 'be all and end all' and should be one element of a more comprehensive approach that includes 'more rehab and detox beds, aftercare, housing options, education and training options etc'. Mr C felt that decriminalisation would work if it helped people enter treatment and find employment.

Mr B felt that social supports were instrumental in his desistance process and that if he had been offered support earlier it could have saved him a lot of trouble. According to Mr E, the consequences of short sentences for people who use drugs mean they slip through the services net while incarcerated:

> The way they do things here, like people going in and out of prison in Ireland, they're going in for a couple of weeks or a couple of months. They're not getting to see any addiction counsellors; they're not going to get to see

> anyone. It doesn't make any sense, it really doesn't… Like if you put, and I know it doesn't work this way but if you see the amount of money it takes to keep a prisoner in prison for a year. I always thought like even half that amount, and let that money follow him in the community with treatment, with addiction counselling with support.

A common trend among service providers and people who used drugs problematically was a frustration at the lack of services and, the long and slow process of accessing a bed in residential treatment centres: 'There's people screaming out to get into treatment centres and there's not enough beds there for them' (Ms H). Almost all participants emphasised the long waiting lists for treatment services in the community. Mr H reported waiting six months to get a bed in a residential detoxification facility and that the only treatment centre in Cork costs €6,000. Mr C reported that, out of desperation, some 'sign themselves into psychiatric wards saying they were mentally ill, just to detox'. Currently there are just 127 community-based residential detoxification beds in Ireland (HSE, 2018): Cork has two detoxification programmes and four rehabilitation projects (Drugs.ie., 2019), including just eight female only detoxification beds. Corks only residential treatment facility costs €6,160 per 28-day stay (Tabor Group, 2019)

In summary, there were mixed views on the Dutch model of tolerance of cannabis. The consensus on the benefits of Portugal's decriminalisation model was dovetailed by agreement on the need for improved drug treatment. Participant's opinions parallel Hughes and Stevens (2010) assessment that Portugal's successes are attributable to a combination of decriminalisation with expansions in drug treatments and the welfare state.

Supervised Injection Facilities

Ireland currently has the European Union's second highest rate of people who use opiates problematically (Hughes et al., 2019): in 2014 there were an estimated 475 (5.67:1,000) opiate

users living in Cork city (Hay et al., 2017). Irelands rates of overdose (224 in 2014) and HIV infection amongst people who inject drugs are also 'relatively high' by European standards (Hughes et al., 2019:13).

SIF were defined to participants as 'legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use' (Dolan et al., 2000:337). A number of evaluations of SIF have reported reductions in HIV, overdose deaths, drugs litter and public injecting, and increased uptake in treatment services (see Kennedy et al., 2017; Kilmer et al., 2018; KPMG, 2010 in Butler et al., 2018), while producing significant economic savings (Kennedy et al., 2017; also Irwin et al., 2017). In Ireland, the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 makes provision for SIFs and Merchants Quay, a homeless and drug service based in the centre of Dublin, secured planning permission to open a pilot site in 2019.

All participants were in favour of SIF and several benefits were explored. Ms H argued that SIF are needed because 'there's needles being found around the place [and] children are picking them up'. Mr A identified the risk that public injecting poses to both the user and public (see Keane et al., 2017):

> I did use places to inject like that would have been places like toilets, eh, alley ways, eh, anywhere basically, sitting down on benches in parks I did it, so basically eh, if there was a safe environment to do so it would not only be more eh, is suppose eh, safer for the public but it would also be safer for the addict.

Mr C also identified the health of the user:

> I just remember my own using and putting myself in dangerous situations. Using in squats and places that were dirty and filthy and rushed injections in case police came along or in case you would be done for trespassing.

Practitioner B reported:

> … seeing more and more clients presenting with hepatitis due to intravenous drug use… It's sad to see especially when you get to know them you soon realise that sometimes the criminals are also victims…victims of abuse, neglect, poverty.

These responses are consistent with Horan and Van Hout (2019) who found that, of 51 people who inject drugs surveyed in Cork city, 54.9% had shared needles or equipment, 72.55% injected alone and 89.3% recalled an overdose involving emergency services (also Jennings, 2013; Keane et al., 2017).

Mr E suggested that SIF could become hubs to inform drug users about where and how to find further help: 'You could have outreach workers there and support people, have leaflets and stuff there and signpost services and stuff like that'. SIF can indeed provide a point of contact with drug services as drugs and health workers are commonly on site to supervise drug use, provide sterile injecting equipment, attend to overdoses and medical emergencies, and signpost treatment options (Dolan et al., 2000:339).

All of these themes were persuasively summarised by Mr F:

> … for one you have fellas going in there, you're getting them off the streets. Mmm, like, it's obviously safe. Then, once you get them in you can start supporting them. You might be able to get them into the other services whereas if they're out there in squats and stuff…It would limit HIV as well.

Heroin Assisted Treatment

HAT is a harm reduction measure for people who have used heroin long-term and have not responded well to other forms of treatment whereby pharmaceutical grade heroin is usually taken under medical supervision. Methadone maintenance, which has traditionally been favoured for chronic opioid user, is founded on the objective of eliminating both withdrawal symptoms and the euphoric effect of heroin, which theoretically nudges users towards abstinence. The objective of HAT is not, however, abstinence but to 'stabilize the lives of people who use heroin' while reducing involvement in the illicit market and the harms associated with injecting adulterated heroin. HAT also 'aims to keep clients engaged with treatment and improve their physical and mental health' (Kilmer et al., 2018:5). Kilmer and colleagues (2018) systematic review suggests that HAT may be cost-effective, even if more expensive than oral methadone, primarily because, by leaving the street heroin scene and reducing illicit drug use those who engage with HAT reduce or eliminates their criminal activity (also Löbmann and Verthein, 2008). Several studies also indicate improved physical and/or mental health outcomes (Kilmer et al., 2018).

None of the eight people who used drugs problematically had heard of HAT and were surprised that such a policy existed. Overall, participants were cautious but most offered tentative support for its inclusion as part of wider reforms. Several participants did, however, express concern about the adoption of HAT. Mr E, Ms H and Mr H felt that street heroin may still be used to top-up prescribed heroin. Mr C felt HAT could enable people to stay in long-term drug use (also Ms H):

> … it will make it a lot harder for vulnerable people and addicts with mental health issues to get off the drug and it will keep them in a vicious cycle, and some addicts will abuse that it and use it as a cop out to never have to get

> clean as there isn't much consequences. The struggle every day to score is a motivator to get clean.

Mr B was critical of the lack of emphasis on abstinence under HAT based on his experience of heroin use as miserable, regardless of where the drug is sourced:

> On principle I would agree with this approach as anything that can safeguard a person's life must be considered…My own personal story is that I began linking in with the services through the harm reduction approach on methadone and then progressed to becoming abstinent so this approach could be used to link vulnerable users in with the services who might eventually get clean... At the end of the day it was what heroin was doing to my mental health and quality of life that made me get clean, not the price. I've never met a happy heroin addict (also Mr H).

Many of those who were cautious did, however, also suggest that HAT could work for a small number of 'older users' (Mr H). Mr B reflected that a 'lot of addicts are not able to get abstinence and they should not be excluded' and anything that 'can improve a person's life' should be considered. Mr D felt that they could work, but only if the emphasis was on treatment 'because I feel with methadone doctors are just ticking boxes. Nine out of 10 of them don't give a fuck about the addict/person'.

Mr A and Ms H agreed that HAT could reduce harms associated with acquiring heroin from street dealers. This would, they argue, 'reduce the risks associated with scoring drugs' (Mr A), provide users with 'clean heroin' (Ms H), reduce acquisitive crime because 'they won't need to go out and steal for it which only gives them more convictions' (Ms H.) and 'impact dealers too because they would have less business' (Mr A).

Discussion

The first part of this study asked participants for their opinions on the relationships between economic deprivation and problematic drug use. In the second, participants were asked for their opinions on four alternative drug policies not currently practiced in Ireland. We departed from our initial idea to publish these findings as two separate papers because the two dimensions of the study are so strongly connected. Personal experiences influence opinions on drug policy (Askew and Bone, 2019; Greer and Ritter, 2019): our participants experiences of economic deprivation impacted how they viewed the four drug policies they were presented with. Furthermore, during the drug policy discussions, many participants drifted from the topic to empathise the need for structural change. That is, drug policy and wider economic issues were inseparable for many of our participants.

Our findings support a large research base that those living in areas suffering economic deprivation and social exclusion are more likely to engage in problematic drug use than those from more affluent communities (Pearson, 1991; Stevens, 2010). For many living in affluent areas from financially secure homes, drug use may simply be an element of the risk taking, excitement and pleasure seeking central to contemporary youth culture (Measham et al., 2001). Those participating in this study, however, suggested that drugs were used to cope with, and provide relief from, the hardship of living in economically deprived and socially excluded areas. This situation was framed as subterranean structuration to highlight the wider structural issues constraining the choices of people using drugs problematically.

Since the 1990s, successive Irish governments have rhetorically identified that reducing problematic drug use requires tackling poverty and social exclusion. The development of local drugs task forces and Garda Youth Diversion Projects were designed to reduce problematic drug use in lower socioeconomic communities (see Swirak, 2018). The reality is that these well-meaning projects do not tackle the underlying structural conditions driving problematic

drug use in Cork city. Indeed, such measures cannot mitigate the harms caused by decades of neo-liberal policies.

Most of our participants, both people who used drugs problematically and service providers, agreed that penalisation and criminalisation do not deter problematic drug use and negatively impact those using drugs, their families and communities. Participants identified being exposed to more harmful drug use while in prison for minor offences related to their drug and alcohol use. Most rejected the deterrence effect of law enforcement, suggesting that imprisonment was an 'occupational hazard' and that repeat imprisonment became almost routine. One identified that economic deprivation weakened the deterrence effect of law enforcement. Service providers argued that criminalisation of people who use drugs often exacerbates an already sensitive situation and that the labels imposed on them further isolate already marginalised individuals. This can increase drug use and the chances of consuming more harmful drugs, and may contribute to transgenerational patterns of offending and substance use.

This paper partly supports previous international research findings that people who use drugs hold diverse opinions about drug policy (Askew and Bone, 2019; Darke and Torok, 2013; Greer and Ritter, 2019; Lancaster et al., 2013, 2018; Ritter et al., 2018). *All* participants supported the opening of SIF and felt that decriminalisation of drugs for personal use will go a long way to reducing the harms of drug use and drug policy. The high-level of support for SIF is consistent with findings from an Australian study of injecting drug users (Lancaster et al., 2013). There were, however, mixed feelings around the benefits of Dutch style depenalisation of cannabis and HAT. There was a level of consistency between practitioners and people who used drugs problematically, with both supporting SIF and decriminalisation, and mixed support for HAT and depenalisation.

Finally, many of our participants avoided identifying decriminalisation, depenalisation, SIF or HAT as silver bullets. Indeed, discussions tended to naturally drift away from alternative policy options towards the need for wider structural reforms and improvements in drug treatment. Consistent with previous research (Darke and Torok, 2013), this demonstrates that people who use drugs hold nuanced views about drug policy. This drift also highlights what participants thought was important for them – that which they wanted to discuss – was not necessarily drug policy reform but wider structural reforms which sit at the heart of subterranean structuration.

Conclusion

Our participants, in-line with a large international research base, linked problematic drug use to economic deprivation and social exclusion. For our participants, drug use functions as a coping mechanism whilst providing meaning and status in an environment where mainstream opportunities are lacking, framed here as subterranean structuration.

Previous research suggests that recommendations for legislative change often centre on personal experiences (Askew and Bone, 2019; Greer and Ritter, 2019). Our participant's experiences of economic deprivation, social exclusion and lack of access to treatment have strongly influenced the policies they support, and resulted in them talking around these policies to identify the limitations of any one policy devoid of wider structural change and treatment provision. Indeed, identifying the structural conditions facilitating problematic drug use can ensure that people who use drugs problematically are viewed as people in need of help rather than criminalisation: which our participants felt does not deter anyway.

The main conclusion to draw from this research is that our sample believed that SIF and decriminalisation could help, although there was uncertainty of the utility of HAT or depenalisation. Several participants were, however, clear that none of these interventions are silver bullets. They felt that while such policies could reduce the harms caused by drugs and

drug policies, the government's longer-term objectives should be increased treatment provision and, reduced social exclusion and economic deprivation.

These conclusions draw from a relatively small sample from one locality in Ireland and are not therefore generalizable to all people who use drugs problematically in Cork let alone Ireland. As the first study of its kind in Ireland, however, this paper represents an important starting point. Future research could widen the sample to include people who are currently using drugs problematically in other urban and rural areas of Ireland, those who have not been criminalised and wealthier populations. As the international literature suggests that personal experiences influence individual opinions of drug policy reform, comparing different backgrounds should offer rewarding results. Hopefully this paper provides a foundation for future research into how those most affected by Irish drug policy view drug policy.

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