Maynooth Department of Sociology

Controlling and Containing Drug Users: How Societal Perspectives Serve in Maintaining the Biopolitical Nature of the Dominant Irish Harm Reduction Modality, Methadone Maintenance Treatment

Student Name: Andrea Margaret Eakin

Special Topic Group: Sociology of Drugs

Advisor: Dr. Richard Healy

Date Submitted: 23/4/20

Word Count: 10,259

Table of Contents:

Acknowledgements

I would like to thank my advisor, Dr. Richard Healy for all the support he has given me. He was a constant source of inspiration and guidance to me during the academic year and this research would not have been possible without his hard work and dedication. I am extremely grateful to Richard for the time and effort he put into helping me develop my research idea and for his encouragement of not only myself but the whole class. Thank you, Richard.

I would like to extend my thanks to the Sociology Department for always being helpful and for encouraging me to advance my sociological lens over the course of my degree.

I also want to express my gratitude to my parents for their continued emotional and financial support during my three years in Maynooth. Thank you, Mam and Dad.

Abstract

This research makes a significant contribution to the current discourse and practice of Methadone Maintenance Treatment (MMT) in Ireland. Although MMT is the hegemonic response to problematic drug use in the country (EMCDDA), the practice of harm reduction in Ireland is an ambiguous area (Butler and Mayock 2005). The thesis examines MMT as a biopolitical technology, arguing that it is corrupted by an underlying strategy of power and governmentality. This approach serves in reimagining the way MMT is practiced in Ireland, demonstrating how it is not a harm reduction approach but rather an exercise of surveillance-based regulation and control. Combined with a Foucauldian framework, the research used quantitative methods to examine the societal perspectives on MMT. The opinions of the non-drug using population towards the drug-using population were collected in order to understand society's stance on harm reduction and methadone and to delineate the theory of biopolitics within Irish methadone provision. The findings depict a public disconnection with harm reduction, illustrating a lack of understanding that MMT is supposed to be a harm reduction initiative. In keeping with the research's argument that MMT is a latent form of social control, there was an evident need among the non-drug using population to control and contain the drug-using population through urinalysis, enforced detoxes and by providing methadone in dedicated clinics. Moreover, the non-drug using population approved of the operation of disciplinary power within MMT delivery, which contributes to an understanding of why harm reduction has not progressed fully in Ireland. The research concludes that drug users exist outside of the neoliberal ideals of Ireland's market-based society. Due to their lack of ability to benefit capitalist society through production or consumption, they are a marginalised population who become docile subjects through MMT in order for society to be protected from a socially delinquent class.

Introduction

The research is based on the concept of harm reduction, which is "increasingly recognised as an important tool in national and local drug policies" (EMCDDA 1999:12). Although it generates controversy, it is an approach that attempts to minimise the harms associated with drug use. The paper focuses on the Irish Methadone Maintenance Treatment (MMT) model in particular. MMT is a harm reduction modality that is the most common substitute treatment for opioid dependency in the country (Delargy et al. 2019). Carried out over 8 months, the research set out to examine the societal perspectives on MMT. It sought to understand the opinions and attitudes of the general population towards drug use, users, harm reduction and more specifically, methadone provision. The specific theme that the research addresses is methadone maintenance as a form of biopolitics.

The number of people receiving methadone maintenance in Ireland has grown steadily every year with 2,227 more people using methadone in Ireland in 2017 than there were in 2006 (EMCDDA), meaning that there was an average of 202 individuals starting methadone treatment every year in that eleven-year period (EMCDDA). This demonstrates the increasing prevalence of methadone as a harm reduction approach in Ireland. Existing literature contends that MMT is a form of social control, arguing that it is a biopolitical technology that is used to regulate the drug using population (Bennett 2011, Bourgois 2000, Harris and McElrath 2012, Miller 2011). The research adopted this Foucauldian lens to understand how MMT operates in Ireland. The framework of Foucault's theory was used to demonstrate how power processes such as enclosure, surveillance and reward and punishment play a role in MMT delivery.

I am interested in harm reduction because it is a controversial response to drug use that is highly criticised (Keane 2002), so I determined that researching societal attitudes

towards it would generate interesting sociological findings. Secondly, as harm reduction's application in Ireland is ambiguous (Butler and Mayock 2005), I set out to collect opinions on it to investigate if they could be influencing its practice in Ireland. Identifying the social contexts surrounding the area of drug use can indicate why drug use responses operate in the way that they do.

The research will contribute to existing literature as although there is a vast amount of literature on harm reduction, even in an Irish context, I haven't found any studies on societal perspectives on harm reduction in this country. Whilst Bryan et al. (2000) carried out research on drug-related attitudes in Ireland, this research will be more specialised in that it focuses on harm reduction and MMT in particular. Further, it will contribute to the literature as it uses a Foucauldian framework to analyse the Irish MMT model, linking its operation to societal perspectives. It is an important piece of research as the 'gaze' of society can be identified as influencing drug policies and strategies. This paper will advance scholarly understanding of the topic of harm reduction by developing theories related to Irish methadone provision. It will aid in understanding why harm reduction is practiced in the way it is in Ireland by connecting the societal gaze with methadone provision and providing an understanding of how a strategy of power is maintained in MMT. Moreover, it proposes a new understanding of the topic of methadone maintenance in Ireland by using the theories of biopolitics and governmentality to understand how power operates in MMT and how it is influenced by societal perspectives towards methadone.

The research asks '**What are the societal perspectives on methadone maintenance treatment in Ireland?**'. It seeks to find out if society is more in favour of a prohibitionist or a harm reduction approach to drug use. Furthermore, it questions if the societal gaze towards drug users influences the implementation of harm reduction strategies in Ireland. Moreover, it

sets out to investigate if societal attitudes towards methadone in particular influence the practice of MMT and to what extent MMT can be identified as a form of biopolitics.

To answer these questions, I first draw from key literature in order to depict what existing research and theories have to say on the areas the research is focused on. This is found in the literature review. I then detail the methodological approach taken, including the sampling method used, how the data was analysed and ethical considerations. The research used a quantitative approach by conducting surveys with the non-drug using population. Following the methods, I discuss the findings in the discussion and findings chapter. The research paper is then concluded, followed by a bibliography and appendices.

Review of Literature

Introduction to Literature:

The following literature review is split into four sections: the concept of harm reduction and its application in Ireland, methadone maintenance treatment as a harm reduction modality, methadone maintenance treatment as a form of social control and a Foucauldian perspective. The first section looks mainly at the philosophies of harm reduction and what the concept has been identified as by various academics. It also examines Ireland's history of harm reduction, mainly drawing on the work of Shane Butler (1991,2005) to do so. The second section reviews the writings of Dole and Nyswander (1980) and Newman (1976) that discuss methadone as an approach to reducing the harms associated with opioid dependency. Further, it investigates the Irish methadone maintenance experience, drawing on the work of Carlin (2005) and the 'Farrell report' (2011). The following section reviews the writings of Bennett (2011), Bourgois (2000), Miller (2011) and Harris and McElrath (2012) to explore the sociological insight of methadone maintenance as a way of controlling and containing heroin users. The fourth and final section looks at the Foucauldian theories of biopolitics, biopower and governmentality to offer a theoretical perspective on methadone maintenance treatment in Ireland. While most of the literature reviewed focuses on drug use, it can be sociologically interpreted in many ways and linked to sociological theory as explained below.

The Concept of Harm Reduction and its Application in Ireland:

According to O'Hare and Riley, the first priority of harm reduction is a decrease in the negative consequences of drug use (2002:2). It also "recognises that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term" (2002:2). O'Hare and Riley illustrate how some of the features of a harm reduction approach are pragmatism, humanistic values and a focus on harms (2002:6). They underline one of the main philosophies of harm reduction, stating that it "accepts that some use of mind-altering substances is inevitable, and that some level of drug use is normal in society" (2002:6).

Egan and Kiely (2002) depict how harm reduction is a recognition that prohibition is not enough to stop drug use as the idea of a drug-free society is unattainable (2002:10). They display the controversies that surround harm reduction, one being that it could be seen as "condoning rather than condemning outright drug use" (2002:10). Moreover, they discuss how harm reduction measures are designed to firstly increase understanding of drug users and secondly to reduce prejudice towards them as this can result in social exclusion, which can be a "greater source of harm to them than the actual drug itself" (2002:14). This literature contributes to an understanding of the concept of harm reduction as well as its relation to the marginalisation of drug users. Like O'Hare and Riley, they provide a general framework of harm reduction that can be applied to the context of Ireland to understand its harm reduction model. However, their arguments fail to create a link between the societal gaze towards users and its possible influence on the implementation of harm reduction strategies in Ireland, which my research will do.

Keane (2002) demonstrates how harm reduction is a highly controversial area by displaying the many critiques of the ideology, mostly consisting of a disappointment with its development. This suggests that in general, its current practice is not being implemented in

accordance with its ethos. My research will argue this point, as the harm reduction strategy of methadone maintenance treatment is not being practiced in Ireland in the way a true harm reduction philosophy would suggest.

Butler and Mayock (2005) use a sociological lens to analyse Ireland's harm reduction experience. In terms of its ideologies, they state that,

> "harm reduction facilitates the development of more tolerant and less moralistic attitudes…towards drug users, as well as an acceptance that users, even while continuing to use illicit drugs, can actively and successfully collaborate with professionals in reducing drug-related harm" (2005:415-16).

Butler and Mayock (2005) make a case for harm reduction being linked to broader sociological contexts. My research will also do this, investigating if the societal attitudes towards methadone influence its correct practice in Ireland.

In terms of harm reduction's history in Ireland, the upsurge of opioid use from 1979 onwards, in Dublin city in particular, meant that a solution to the worsening 'needle culture' was desperately needed (Butler:1991). The first 20 years of Irish drug policy consisted of the validity of a total abstinence strategy. Moreover, the only two treatment centres for opioid dependency in Dublin at this time both "insisted on total abstinence as the only acceptable goal for intervention" (Butler 1991:6). Butler highlights how there was a lack of conversation on harm reduction in this period. However, following the introduction of methadone maintenance treatment in Dublin in 1987 (Butler:1991) and a second opiate epidemic in the mid-90s (O'Gorman:1998), there was an ideological shift in the country as drug services switched from being centred around abstinence and instead focused more on harm reduction. However, there was a still a lack of debate surrounding harm reduction and a lack of real change in drug policy (Butler:1991). Those involved in the process of policy changes did not create a "national debate on the merits of harm reduction" or announce that "harm reduction

had now been enshrined as the new philosophical basis to Irish drug policy" (Butler and Mayock 2005:419). This demonstrates how Ireland's stance on harm reduction is shrouded in ambiguity, as ambiguity has provided the basis for all harm reduction initiatives in the country.

Butler and Mayock (2005) create a sociological link between the changes in drug policy and Ireland's Catholic history. Inglis (1998) argues that the Catholic Church played an important role in the modernisation of Ireland as its influence continued to grow late into the twentieth century. This consequently affected the creation of an effective response to drug use in Ireland. Butler and Mayock explain how Irish society "traditionally had such a strong emphasis on the moral importance of controlling the body" that it found it hard to accept that problematic patterns of drug use could happen here (2005:418). This provides an insight into the history of harm reduction in Ireland as well as why this country has implemented harm reduction strategies in the way it has.

Methadone Maintenance Treatment as a Harm Reduction Modality:

Methadone Maintenance Treatment (MMT) is a harm reduction initiative that has been used in Ireland to treat opioid dependency since 1987 (Butler:1991). Tober and Strang (2003) deduce how the four positive roles of MMT are to relieve withdrawal symptoms, to draw people into treatment, to retain them in treatment and to promote positive change while they are there.

Dole and Nyswander argue that the efficacy of methadone as a medicine must be measured by its ability or failure to achieve the pharmacological effects of eliminating heroin cravings. Meanwhile, "the goal of social rehabilitation of criminal addicts by a treatment

programme is a much broader objective" (1980:257). They are critical of methadone programmes putting an emphasis on achieving abstinence from drug use rather than the patient's ability to function as a responsible member of society (1980:260). Dole and Nyswander's argument provides an adequate understanding of MMT, with a particular emphasis on how it alone is not enough to reintegrate the opioid user into society. However, their argument fails to mention the controversy that surrounds methadone treatments and create a possible link between this and its implementation. My research will create this link, demonstrating how societal attitudes towards not only the harm reduction strategy of methadone but also the opioid user can affect its proper operation in Ireland.

Newman (1976) highlights the success of methadone maintenance as former heroin users have been able to live self-fulfilling lives following treatment. However, he explains how the practice of methadone provision is highly criticised, mentioning the "medical, legal, political and moral prejudices" against it (1976:183). His writing stresses how there are various methadone programmes such as "methadone-to-abstinence" and how "it must be unequivocally recognised that these efforts are *not* methadone maintenance" (1976:186). Newman's argument is straightforward - when done correctly, methadone maintenance is effective and safe. However, it no longer exists in the way it used to and has the potential to benefit many more opioid users if practiced correctly. This piece of literature further solidifies one's conception of how MMT is not being performed in the way it should be or the way it once was. Its essence has been transformed from being a pragmatic harm reduction approach to one of abstinence-based surveillance and regulation.

In terms of methadone in an Irish context, Carlin states that MMT "involves the provision of methadone in stable doses and is intended to reduce problematic behaviours associated with elicit drug use" (2005:90-91). He discusses how its ethos should not intend to be abstinence-orientated but rather involve the continuing use of methadone on a more

permanent basis. In Irish society, there is an ambivalence surrounding methadone treatments which Carlin suggests could be due to the controversy surrounding heroin users being on methadone for long periods of time. Carlin commends MMT as it has been "successful in retaining opiate-dependent people in treatment and providing a range of positive outcomes" (2005:91). His discussion of the Irish experience of MMT provides an understanding of its ambivalence in Irish society. The way he characterises its philosophy as a permanent feature of the methadone user's life rather than a step towards abstinence produces a familiarity with the idea that MMT is not being implemented in Ireland correctly.

Known as the 'Farrell report', *The Introduction of the Opioid Treatment Protocol* (2011) was commissioned by the Health Service Executive to evaluate methadone services in Ireland. Farrell argues that the methadone system needs to be updated. He states that MMT is "too entrenched in urinalysis", recommending a "fresh approach" to urinalysis and suggests a significant reduction in the frequency of urine testing and for it to be conducted on a more random basis (2011:29). Through its criticism, the report outlines the shortcomings that are inherent in the Irish methadone maintenance system. Furthermore, it brings the arguments of Dole and Nyswander (1980) and Newman (1976) into both a contemporary and an Irish context, which aided in formulating the research questions.

Methadone Maintenance Treatment as a Form of Social Control:

A sociological take on MMT is its practice as a form of discipline or social control. Bennett (2011) proposes that MMT is a practice that serves to discipline the recipient. His argument illustrates how it is justified on the grounds of providing better life chances to opioid users, but is actually a biopolitical technology designed to contain and control drug users for the benefit of the general population (2011:150). He conceptualises the idea of MMT as 'a ball

and chain' and 'liquid handcuffs', depicting how service users feel about it (2011:150). Furthermore, his argument draws on the Foucauldian theory of the subject and the agent to argue that medical authorities are agents of the state as they render drug users less dangerous (2011:151). He identifies MMT as "a limited freedom made possible by a micro-system of regulation and surveillance" (2011:151).

Bourgois' argument is similar, identifying MMT as the state's attempt to morally discipline "deviants who reject sobriety and economic productivity" (2000:167). Like Bennett, he describes methadone as "a biopolitical technology that facilitates a moral block to pleasure" (2000:169). He conceptualises methadone users as "disciplined and addicted-but heroin-free subjects" (2000:182). Bennett's and Bourgois' discussions serve in changing the way one thinks about MMT, making obvious the idea of power within drug services and how service users can become subjects of biopolitical power.

Miller provides an alternative insight in comparison to other voices in the field, communicating how harm reduction strategies "fail to address any of the controversial issues that arise from or lead to drug use in the first place" (2011:177). This is a particularly poignant point as it offers a critique of harm reduction strategies that other academics have not formulated. He expresses the importance of locating social phenomena within their historical genealogy (2011:168). The drug user used to be imprisoned, which then transitioned into the 'carceral' phase, which features surveillance of the drug user, as they are a subject. A current form of controlling drug users is 'risk management', one example of this being needle exchange. Miller is also critical of abstinence, explaining how it is "a rhetorical and discursive strategy designed to taint the more progressive harm-reduction strategies" (2011:169). This piece of literature is enlightening as it reconsiders the ethos behind methadone. Moreover, it ponders whether MMT actually benefits the methadone client or if it is a way to regulate drug users, who are among the most vulnerable in society.

Harris and McElrath (2012) also argue that methadone is a form of social control, paying particular attention to stigma and power within MMT delivery. They emphasise the "clean/dirty" dichotomy within methadone treatment that is associated with the practice of urinalysis (2012:814). They state that "urinalysis represents a powerful and intrusive form of surveillance" (2012:815). They further stress this 'clean/dirty' dichotomy by highlighting how different clients attend the methadone facility on different days as a form of segregation to prevent "the dirty from influencing the clean" (2012:815). This in itself is a perfect example of biopolitics in action as the 'dirty' opioid user is seen as contaminated and as having the ability to 'infect' the 'clean' methadone user. Therefore, the 'dirty' user is isolated and contained in order to benefit the 'clean' user, which identifies how bodies are controlled within methadone provision in Ireland. This hypothesis presented by Harris and McElrath (2012) provides an understanding of methadone that is rich in sociological analysis. Their argument fails, however, to create a tie between stigmatising societal attitudes and instead focuses on institutional stigma within methadone treatment. My research will investigate if societal perspectives on methadone affect its proper implementation in this country.

Overall, this literature that interprets methadone as a form of social control and as a biopolitical technology allows for the creation of a link between my research questions and social theory.

A Foucauldian Perspective:

The research will use the theoretical framework of biopower to re-imagine the way MMT is practiced in Ireland. It will be applied to my findings to understand how MMT maintains a strategy of power over drug users.

The concepts of Foucault's writing stem from "an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations" (1978:140). He highlights how biopower is involved in the development of capitalism as capitalism would not have been possible without the "controlled insertion of bodies into the machinery" (1978:141). His argument also displays an emphasis on the shift from sovereign power to governmentality in late modernity.

McKee explains how Foucault conveyed the emergence of a particular rationality of rule that was based around "optimising the well-being of the population, hence making this population more 'docile' and 'productive' (2009:466). Offering an insight into the notion of governmentality, she depicts how "the governable subject is discursively constituted and produced through particular strategies, programmes and techniques" (2009:468). She concludes that governmentality regulates humans and is "underpinned by a perspective on power that is fundamentally productive, facilitative and creative" (2009:470). McKee furthered my understanding of the regulation of subjects, which I can combine with my knowledge of drug use to develop an idea of how drug users are controlled in society, particularly in terms of MMT.

Foucault describes a prison inmate as being "seen, but he does not see; he is the object of information, never a subject in communication" (2012:211). This can be applied to a drugs service user as they too are being watched and regulated. They experience forms of disciplinary power in MMT such as urinalysis, where they are sanctioned for producing 'dirty' urine samples. Garland (1997) distinguishes between three practicable objects and three forms of power exercised over them. The methadone client can be identified as the 'criminal delinquent' who is "governed by discipline and required to conform or be conformed" (1997:188) MMT can be described as a programme of governmentality, which

Li explains is “the goal to be accomplished together with the rationale that makes it thinkable, and the associated strategies and techniques” (2007:280).

Biopolitics is a concept introduced by Foucault that examines the mechanisms through which the basic biological features of the human species become the object of a strategy of power. Biopolitics is related to the control of the methadone user as MMT is corrupted by an underlying programme of power and governmentality. Privacy and autonomy are issues linked to biopolitics that can be described as socially selective privileges that are granted to particular bodies, in this case the body of the non-drug user. The aforementioned practice of urinalysis can involve supervision which illustrates how privacy is not awarded to the methadone user. Furthermore, it embodies the nature of biopolitics as a basic bodily function becomes part of a larger strategy of power as the urine sample is an object that can be used as a reason to be sanctioned or rewarded.

Biopolitics is also linked to the controversy surrounding methadone users being on the drug for many years. The very existence of methadone-to-abstinence programmes indicates that although it is deemed acceptable by society for the opioid dependant individual to take methadone, their doses must be reduced over time as they must have a goal to abstain from drugs permanently in the future. In Foucauldian terms, for the MMT user to be ‘seen’ and ‘valued’ in society, they must eventually be able to conform to the qualities of the ‘object’, where they can eventually benefit neoliberal society through capitalist production. My research will investigate this idea, asking the general population if they think heroin users should only be given methadone if they intend to use it as step towards abstinence.

Conclusion of Literature:

There is clearly a vast array of literature and theory relevant to the topic of harm reduction and methadone in particular. The first section indicates why harm reduction is practiced in Ireland the way it is, concluding that the social context of Catholic Ireland made it difficult for problematic drug use to be tackled head-on. The second section depicts the shortcomings of methadone maintenance and the Irish MMT model in particular. The third section suggests that methadone is a form of social control while the fourth and final section provides the Foucauldian framework that the research is based on. It is evident that there a significant amount of literature that places the focus solely on the experiences of the drug service user to criticise the MMT model. Meanwhile, societal perspectives on MMT remain relatively unexplored, especially in Ireland. This illustrates the rationale to conduct research on the topic.

Methodological Approach

Introduction:

The literature review has served in highlighting how methadone is not being practiced in Ireland in consonance with a true harm reduction ethos. The objective of the research is to examine societal attitudes towards methadone to determine whether or not this influences its correct implementation. To do this, it was essential to explore the opinions of the general population on harm reduction, methadone and the methadone user.

Choosing the Research Method:

The methodological approach taken was quantitative. Regarded as a way to get to the truth, quantitative research is "an inquiry into a social or human problem based normally on testing a theory composed of variables, measured with numbers, and analysed using statistical procedures to determine whether the predictive generalisations of the theory hold true" (Abduali and Owusu-Ansah 2014:9). It involves the use of questionnaires where the questions are largely closed-ended and optional responses are provided. While a qualitative approach "views truthfulness or reality to exist in the world that can be subjectively measured", a quantitative approach objectively measures truthfulness (Abduali and Owusu-Ansah 2014:9). A weakness of quantitative research is that the researcher doesn't acquire the rich detail that can be achieved with a qualitative approach such as interviews.

I concluded that completing surveys would be the more suitable approach for the research as it would allow me to assess and measure participant's views on MMT as a harm

reduction initiative. Further, its statistical nature would allow for generalisation to inform the main findings of my research. I believed that it would be an effective way to get to the truth of how society perceives people who use drugs and people who use methadone maintenance services. I also chose this research approach as the data collected would be positivistic, which is useful for creating statistics. Moreover, using a quantitative approach to examine societal perspectives on methadone will contribute to the already existing literature. Many of the studies that have already been done on MMT have used a qualitative approach or have used quantitative methods with a more specific sample such as GPs. My research will make an original contribution to the already existing literature on methadone as it firstly uses quantitative methods but also looks at society in a general sense.

Selecting the Sample:

According to Wisker, a research sample "must be defined" and "chosen for a reason" as it "will affect the results and the applicability" of findings (2009:94). I used a non-probability sample, which is "a sample that has **not** been selected using a random selection method", meaning that "some units in the population are more likely to be selected than others" (Bryman 2012:187).

The specific forms of sampling used were quota and snowball sampling. Bryman states that "the aim of quota sampling is to produce a sample that reflects a population in terms of the relative proportions of people in different categories, such as gender" and age (2012:203). It was fundamental that I used quota sampling as I wanted to get a sample of participants that represented the general population. I consulted the National Census from 2016 to understand Ireland's age and gender profile. It depicts that in 2016 there were 978

males for every 1,000 females in the state (CSO.ie). This is an almost even gender division which justifies my reasoning behind having a sample made up of 25 males and 25 females. In terms of age categories, I carefully selected participants that would fill up each age group in order to represent the general population as accurately as possible.

Fig.1:

Age	Female	Male	Total
18-24	5	4	9
25-34	5	4	9
35-44	4	5	9
45-54	4	6	10
55-64	5	4	9
65 and older	2	2	4

Snowball sampling is the method by which "sample elements are selected as successive informants or interviewees identify them" (Chambliss & Schutt 2016:105). When it is used "the researcher makes initial contact with a small group of people who are relevant to the research topic and then uses these to establish contacts with others" (Bryman 2012:202). I found myself using this sampling method during the fieldwork process as I struggled to get access to particular age groups. After getting 16 participants to complete a survey in the form of a physical copy, I used social media to acquire the other 34 responses via Google Forms. This was necessary as the Covid-19 pandemic meant that I had to adhere to social distancing when finishing the fieldwork. After sending the survey link to participants, I asked them to forward it to someone they know who was firstly willing to take part, secondly in the age and gender category I needed for the sample and thirdly within the ethical boundaries of the research. Acquiring the correct sample was more time-consuming than I had initially anticipated but it makes for a genuine representation of society.

The survey began with four sentences informing the participant of what methadone is, what it is used for and why it is perceived as an effective harm reduction treatment for opioid dependency. I ensured that this was written in plain language and didn't include any jargon that would confuse the respondent. The first nine questions were "likert-type questions" (Birmingham and Wilkinson 2003:20) where respondents indicated how they felt about given statements. The rest of the questions were multiple choice where participants were asked to give their thoughts on issues such as drug use as a public health issue, the cost of methadone, abstinence in methadone treatment and urinalysis. Some of the questions included information to inform the participant's response. I used this approach when designing the survey so that the participant could interpret the question, articulate their response and transmit it effectively.

Analysing the Data:

Walliman depicts how "some of the primary purposes of quantitative analysis are to: measure, make comparisons and to "construct concepts and theories" (2011:113). Due to the quantitative approach used, the data was not produced through interactions between the participant and I but was rather collected.

I manually coded the data without the use of software as this was the most feasible option in terms of cost and time as I have no training or experience in coding software. Immersion in the data was essential as I needed to familiarise myself with the answers to recognise the main themes that were emerging. I began by looking generally at what answers were the most common before taking time to study the answers of each gender and age category to understand the most common attitudes of each group. I recognised the patterns that were emerging in the data and analysed if they may be driven from themes in the

literature review. I highlighted these ideas and broke them down into four thematic headings for the discussion of findings chapter.

Ethical Considerations:

According to Walliman, "the principle behind ethical research is to cause no harm and, if possible, to produce some gain for the participants in the project and the wider field" (2011:48). He also demonstrates how it is vital to carry out ethical research to ensure honesty is maintained but also in terms of treatment of research participants "relating to informed consent, confidentiality, anonymity and courtesy" (2011:43).

Due to the ethical limitations set out by the university, it was crucial that all participants were aged eighteen or older. Furthermore, none of the participants were drug users, former drug users or had family members who were drug users. I made sure of this by verbally communicating with those completing paper surveys. I also ensured that the participants reached via snowball sampling were aware of the ethical boundaries and did not fall into the category of individual I was forbidden to collect data from.

Participants were informed that their answers would be used as data that would be managed and stored securely before being destroyed once the research is complete. Because confidentiality was essential, respondents were informed that they were permitted to sign the survey with a 'fake name' and I turned each one into a pseudonym anyway before analysing the data to ensure complete anonymity. In terms of storing the data, the 34 electronic surveys that were completed on Google Forms were automatically secure with my email and password and were not stored anywhere on my computer. This ensured that if I lost my computer or if it was stolen, the data could not be accessed as my private password would be required. Further, I would still be able to access the data on my Google account on another

device. Because this was a secure way to store the data, I carefully transcribed the answers from the paper surveys onto Google Forms, meaning that all 50 surveys would be securely stored in one place online that only I had access to.

Overall, carrying out ethical research is extremely important for both the validity of the research but also for the well-being of participants. I adhered to the ethical protocol associated with social research in relation to the confidentiality of respondents, the storage of data and the ethical boundaries set out by the university.

Discussion of Findings

Introduction to Findings:

This research set out to examine societal perspectives on harm reduction and MMT in particular, investigating if attitudes of the non-drug using population relate to how MMT is practiced in Ireland. This chapter will draw out and discuss the literature that was examined in the literature review, highlighting how the findings contribute to this knowledge base. It will discuss general findings but is also broken down into smaller categories.

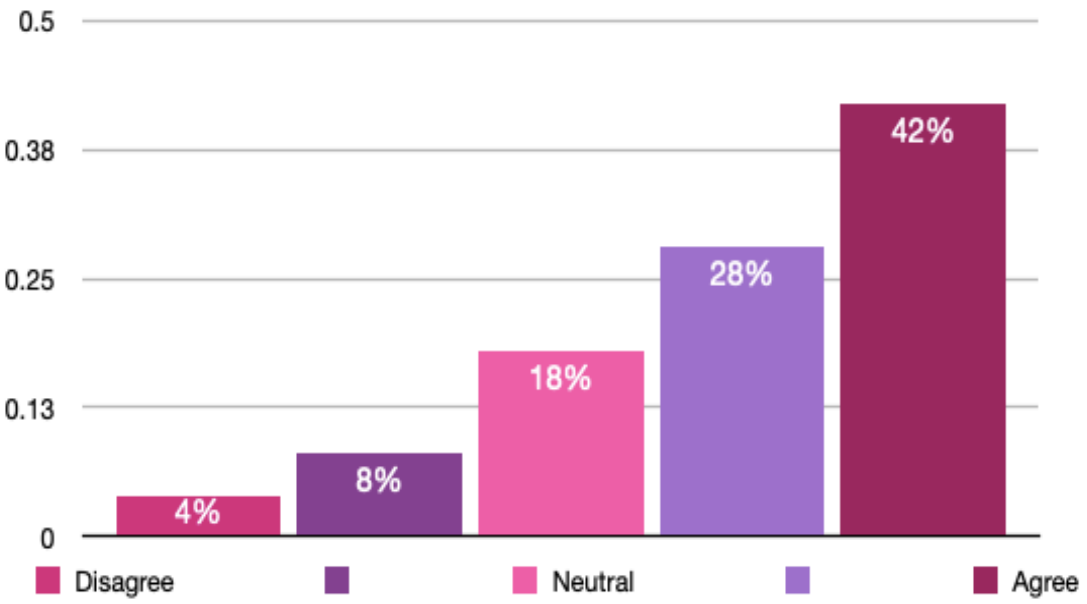
Public Disconnection with Harm Reduction:

As outlined in the literature, harm reduction is a pragmatic policy "which prioritises the aim of decreasing the negative effects of drug use" (Newcombe 1992:1) and is a recognition "that people always have and always will use drugs" (Duncan et al. 1992:1). It is an approach that acknowledges that a drug-free society is unattainable (O'Hare and Reilly 2002, Butler and Mayock 2005). As Egan and Kiely (2002) explain, harm reduction also recognises that prohibition is not enough to stop people from using drugs. Methadone maintenance is one of many harm reduction initiatives (Butler 1991). However, the literature reviewed has argued that it is not being practiced in Ireland in keeping with a harm reduction ethos. Harm reduction is supposed to be an amoral approach however, Irish MMT can be identified as a method of control that operates through sanctions and rewards. Butler and Mayock (2005) present a public disconnection with harm reduction that causes an ambivalence around the topic and its practices. Carlin (2005) also illustrates how there is an ambivalence surrounding MMT in Ireland.

The research found that the majority of participants (78%) acknowledged that individuals use or will use drugs regardless of their legal status. 74% believed that drug use is a problem that has to be addressed by health services such as the HSE. This means that most respondents firstly recognised that drug use is a problem that will continue regardless of legal consequences and secondly, is a public health issue.

70% agreed to some extent that harm reduction is a better approach than prohibition, meaning that the majority of participants were in favour of harm reduction (Fig.2).

Fig. 2: ***'It is a better idea to try to reduce the harms caused by drugs rather than criminalising drug users'***



In terms of gender differences in harm reduction opinions, women were more in favour as 88% of them favoured a harm reduction approach over a prohibitionist one in comparison to 56% of men. When asked to expand on their answer, 7 respondents who agreed with harm reduction further acknowledged the unattainability of a drug-free society:

People are going to use regardless, better to reduce the harm

(Nicole*)

People are going to use drugs whether they are legal or not, so it's better to reduce the risk of OD/infection where possible

(Fiona*)

Similarly, 16 participants stated that their reasoning behind favouring a harm reduction approach was that prohibition is not enough to stop drug use. These participants displayed a recognition that prosecution fails to help people who use drugs and is not the answer to problematic use:

Criminalisation doesn't help them, it only makes life harder and stigmatises them. They haven't committed a crime but just haven't been offered the services they need

(Julie*)

Criminalising drug users is not the solution; in many cases they are the victims. The suppliers are the criminals

(Seamus*)

Overall, most participants were in favour of harm reduction and many had an understanding of the concept. One respondent summed up the philosophy of harm reduction in a simple statement:

Because telling people not to take drugs doesn't work, people will anyway. It's better they know how to use them safely rather than take them without any knowledge

(Cian)*

When analysing the data, I noticed the emergence of language used to describe people who use drugs as "sick" or calling drug addiction an "illness" or a "disease". There were also several responses that believed that drug use should have legal consequences:

There needs to be a punishment for illegal drug use in my opinion

(Séan*)

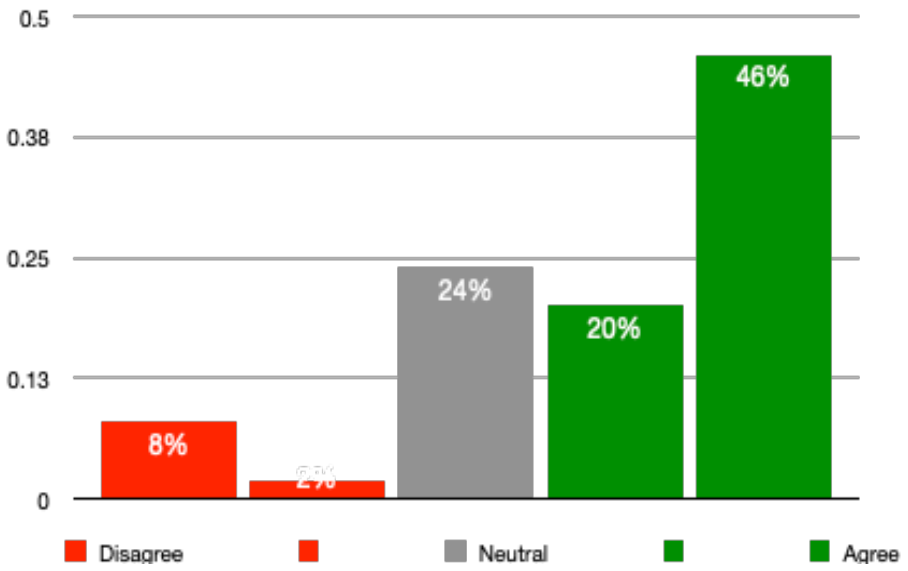
There should be some legal consequences for consuming drugs as you are supporting the drug trade, which is responsible for gang feuds and murders

(James*)

I was interested in these two groups of respondents because the way they viewed drug use was so different that I decided to examine the rest of their answers to see how they compared. The group of 5 participants who view drug use as an illness were all female and under 35. The group of 5 participants who view drug use as an illegal activity that requires punishment all identified as male and their age range varied. Those who view drug use as a crime were less likely to agree with harm reduction while those who viewed it as an illness were more in favour of it.

In relation to methadone maintenance, 66% of participants agreed to some extent with methadone as a form of harm reduction (Fig. 3).

Fig.3: The level to which respondents agreed with methadone as a substitute for heroin:

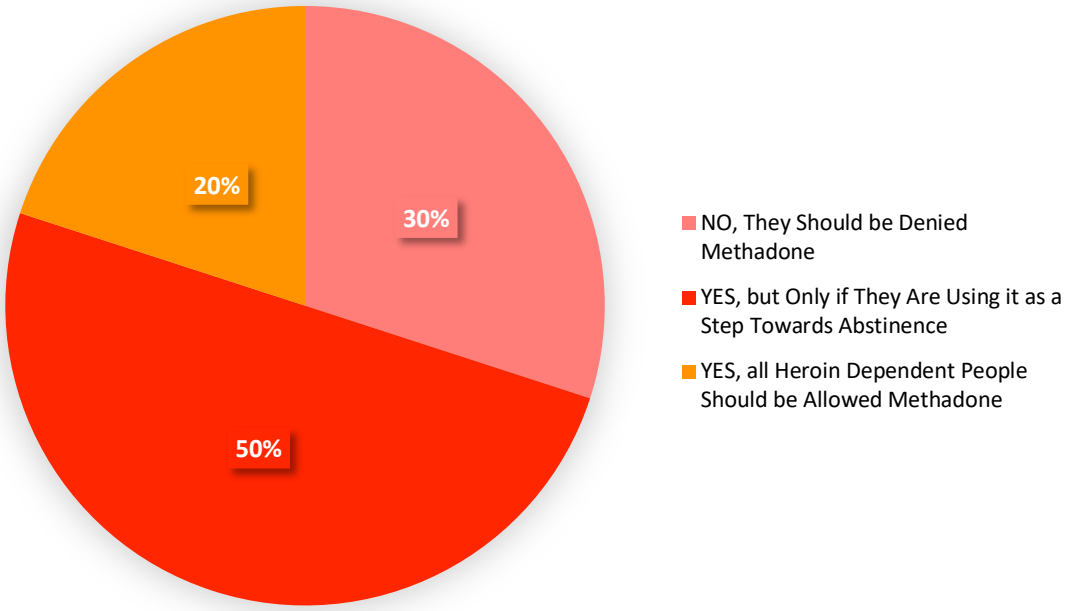


More women agreed with methadone than men did as 76% of women agreed in comparison to 56% of men. While 70% of participants were in favour of harm reduction, only 66%

agreed with methadone, which demonstrates the public disconnection with harm reduction that Butler and Mayock (2005) highlight. This illustrates a lack of understanding of what the ethos behind MMT is or what it should be in Ireland.

Poor understanding of methadone is also present in the question about pregnant women (Fig. 4). In general, 30% of participants believed that pregnant women should be denied methadone. Nobody in the group that view drug use as an 'illness' thought that pregnant women should be denied methadone while everyone in the 'criminal' group thought that they should.

Fig 4.: 'Should pregnant women be given methadone?'



Under a harm reduction philosophy, "any step towards harm reduction, no matter how small, is a step in the right direction" (Flavin 2002:976) so a pregnant woman shouldn't be denied methadone. She also shouldn't be forced to detox as few drug dependent women succeed in ceasing to use drugs entirely during pregnancy (Murphy and Rosenbaum 1991). These findings further outline the Irish population's lack of understanding of harm reduction and what MMT is supposed to be.

The way harm reduction is concealed within Irish society demonstrates a poor understanding that is firstly obvious in the opinions of the general population, and secondly, in the misapplication of methadone in Ireland. Therefore, I have discovered that there is a lack of understanding among Irish people that MMT is harm reduction, or is at least supposed to be. The lack of knowledge on MMT present in the data highlights a lack of conversation on harm reduction and an ambiguity surrounding it. This finding is consistent to that of Butler and Mayock (2005) who posit that the ambivalence surrounding harm reduction in Ireland is an outcome of broader sociological contexts. As suggested, this could be due to Ireland's Catholic history that was centred around the moral importance of wanting to control the body.

Containing the Methadone Client:

Methadone maintenance is not meant to be abstinence-orientated (Carlin 2005, Dole and Nyswander 1980) so therefore methadone-to-abstinence programmes are not harm reduction (Newman 1976). Instead, they can be identified as abstinence-based surveillance and regulation. The research found that although most participants were in favour of a harm reduction approach and viewed drug use as a public health issue, 74% were only in favour of methadone as a step towards abstinence (Fig. 5). When asked to explain their answer, 48% explained how they believe methadone is a temporary solution that users should be eventually weaned off or something similar:

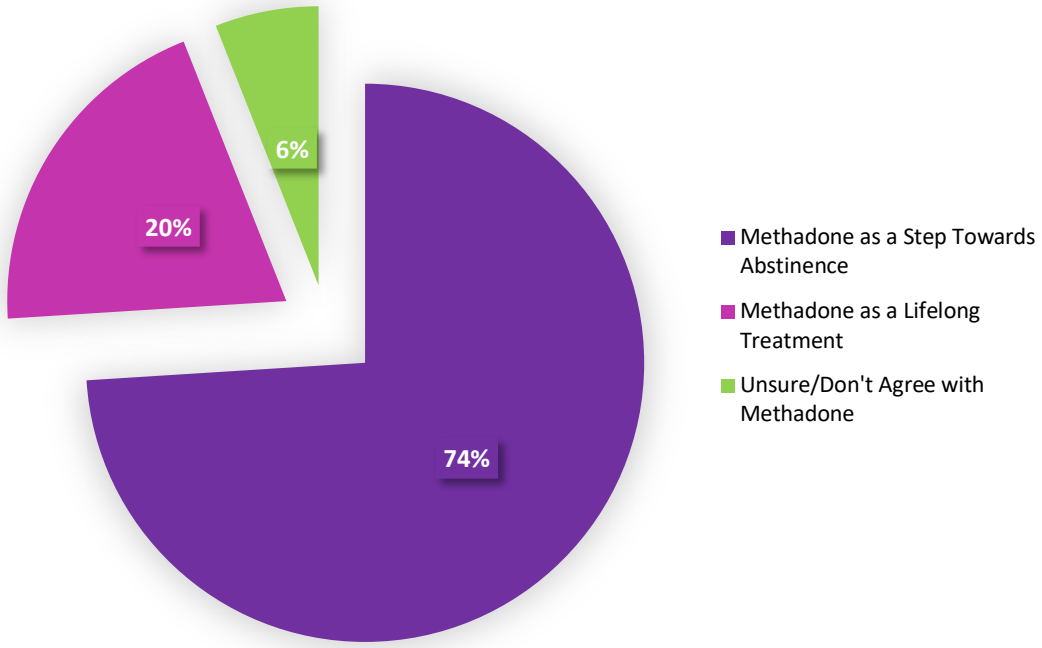
Methadone is meant to be a temporary replacement not a permanent solution. People change their addiction from heroin to methadone

(Robert*)

Methadone should be provided to help users to wean off drugs not to maintain their addiction

(Sorcha*)

Fig.5:

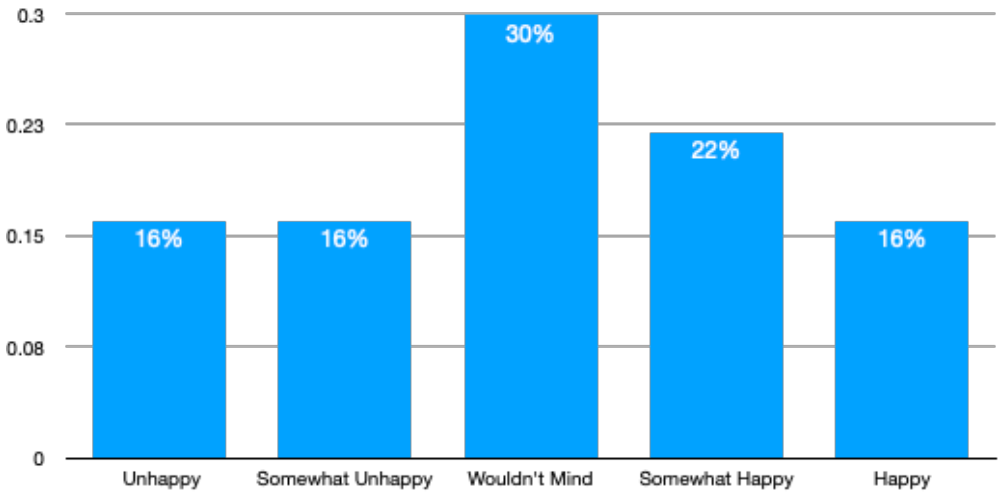


12% explained how every individual is different and should be treated in the way that suits them best. 10% responded that they had a lack of knowledge on the subject and did not feel informed enough to answer while 10% felt that it was good for methadone users to continue using the drug long-term or saw no issues with it. The point that the methadone user must eventually be 'drug-free' is underpinned by the data as the majority of participants agree with methadone-to-abstinence programmes.

This meant that the majority of respondents did not agree with methadone maintenance. Instead, they were in favour of methadone-to-abstinence programmes that do not focus on a reduction in the harms associated with opioid use but rather focus on making the opioid user 'clean' as an attempt to make society drug-free, which is an unattainable goal (O'Hare and Reilly 2002, Butler and Mayock 2005). For the MMT user to be 'valued' in society, they must eventually abstain from drugs permanently so they can benefit neoliberal society through capitalist production.

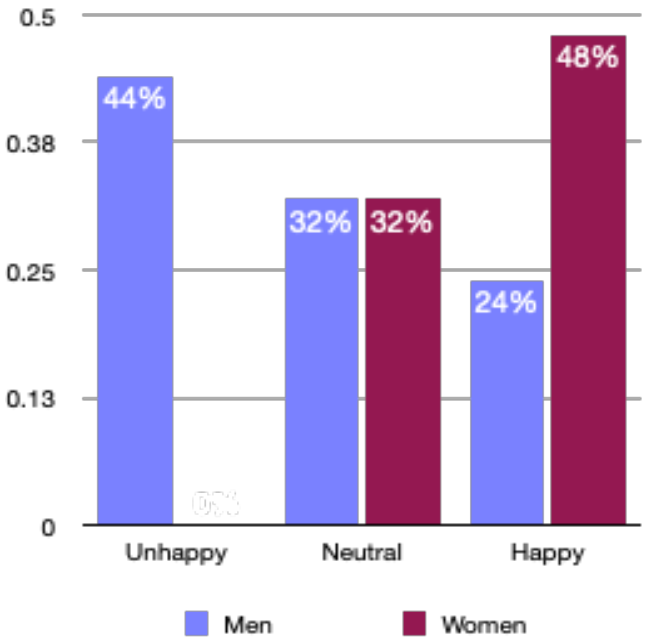
When participants were asked to indicate on a scale how happy they would feel about a methadone clinic opening within a 5-mile radius of their home, results were somewhat divided (Fig.6). I further analysed the data to investigate how each group responded. The 18-24 age category displayed more approval as 78% responded that they would be happy while only 22% of older people would be happy about it. The research also found that the older age category were more in agreement that methadone should only be provided in dedicated clinics rather than doctor's practices.

Fig.6



There was also a gender divide in response to this question as 44% of men responded that they would be unhappy about it while no women stated that they would be unhappy (Fig.7).

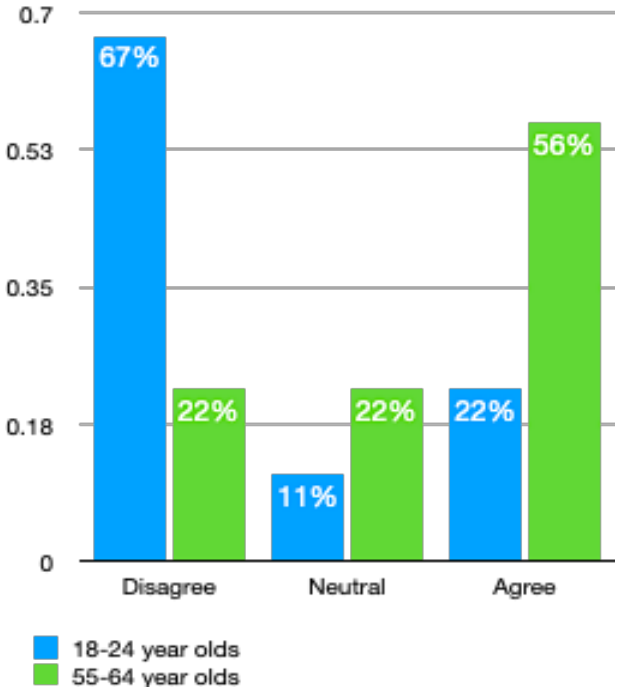
Fig.7



As 20% of men agreed with punishing drug users while no women agreed with it, it is evident that those who did not want to live near a methadone clinic had a less humanistic approach to drug use and were more likely to view drug users as delinquents or criminals.

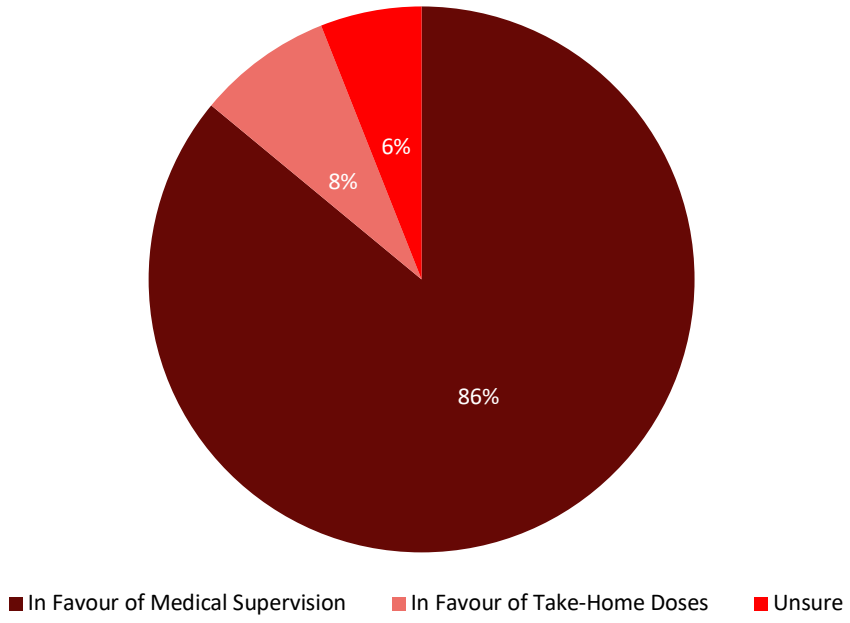
This indicates that these respondents want drug users to be contained in a certain space that does not enter their residential area. There is an apparent disapproval of encountering drug users and having to mix with them in society. This can be identified as cohesive containment that serves to control people and protect non-drug users from drug users.

Fig.8



Moreover, 56% of 55-64 year olds agreed that they didn't want 'junkies' hanging around their local doctor's practice in comparison to 22% of 18-24 year olds (Fig.8). This illustrates how older people would be less approving of methadone being provided in GP practices.

Fig.9



The research also found that the majority of participants were against methadone clients getting take-home doses (Fig.9). 86% were in favour of clients consuming their dose under medical supervision in the methadone facility, which further indicates that the non-drug using population wants drug-users to be contained within a methadone facility. This can be identified as an example of Foucault's biopolitics as it relates to the controlling and containment of bodies, the body of the drug-using individual in particular. Like Bennett (2011) argues, MMT is a biopolitical technology designed to control and contain drug users. His conclusion of MMT as 'liquid handcuffs' is evident in the consensus of the non-drug user population that methadone users should be contained within a methadone clinic, where they can be watched. While the majority were in favour of harm reduction, there is an obvious

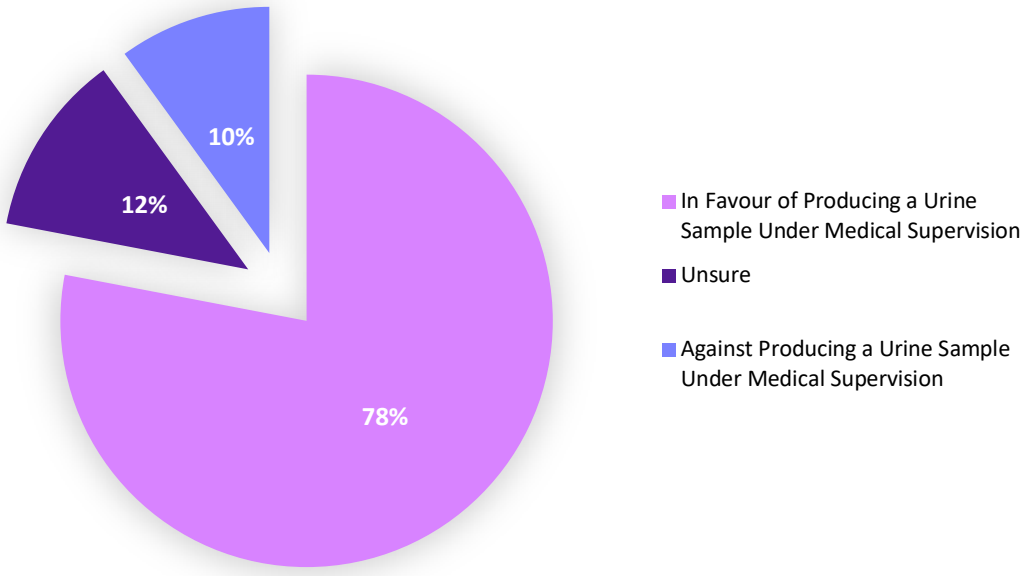
disconnection between it and methadone maintenance. The general societal perspectives on methadone are that it's good, but only when practiced a certain way: as a step towards abstinence, that's only supposed to be consumed under medical supervision and in a specific methadone facility.

Urinalysis as a Biopolitical Technology:

MMT clients are subjected to urinalysis as a way to monitor their compliance with the service rules. Urinalysis is "justified as a means to determine treatment compliance and to prevent overdose" (Harris and McElrath 2012), however this research argues that is a biopolitical technology used to regulate the methadone user. It is an intrusive form of surveillance that relates to what Harris and McElrath (2012) call the 'clean/dirty' dichotomy in methadone provision. This distinction is a means of social control that serves to "dichotomise recovery and reinforce spoiled identities" (2012:815) as users who produce 'clean' samples are rewarded with take home doses for example. Meanwhile, those who produce 'dirty' samples are sanctioned. This illustrates how urinalysis is a practice that serves to discipline the recipient as biopower is exerted in urinalysis through the possibility of reward. Power operates through the encouragement or constrain of certain actions that relate to the rules of MMT.

The survey included two questions on urinalysis. The first question asked participants if they think methadone users should be supervised by a member of medical staff when producing a urine sample. Overall, participants were more in favour of this than against it (Fig.10).

Fig.10



When those who were in favour were asked to expand on their answer, 80% explained it's to ensure users cannot provide a sample that's not actually theirs or something similar:

They could substitute someone else's urine

(Ciara*)

You can't trust an addict

(Shane*)

Because they are all sneaky and could provide another person's urine

(Ben*)

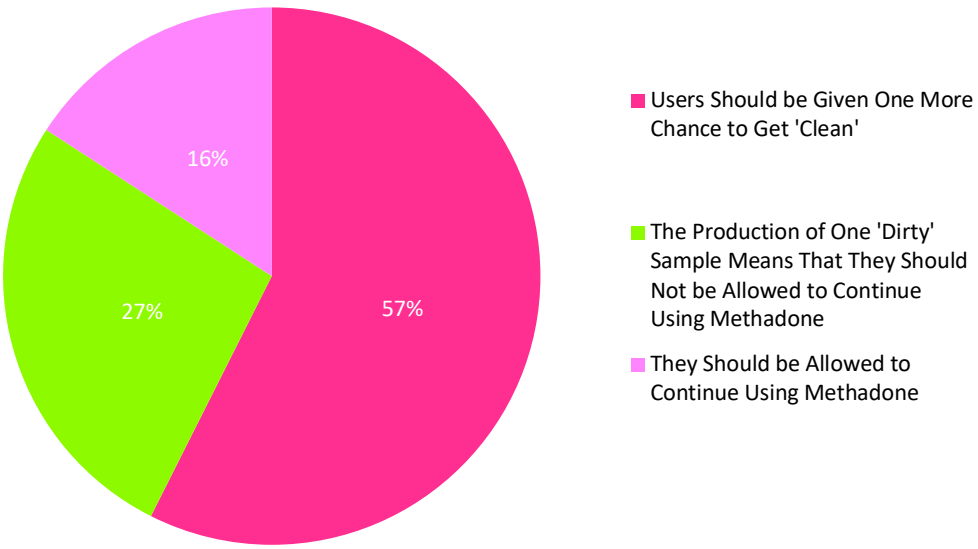
These responses indicate how methadone clients are seen as deviants and untrustworthy by the non-drug using population. This comparison of the methadone client to a criminal is not in keeping with a harm reduction ethos as it contributes to the punishment of the user rather than actually helping them.

Privacy is a privilege that is not awarded to the MMT client as they are seen as underserving of it. Drug users are a stigmatised population that do not have the same rights as

non-drug users and this is underpinned by the data. In terms of gender, men were more in favour of medically supervised urinalysis than women, with 84% of men agreeing with it, compared to 76% of women. A reason for this could possibly be that women are more aware and understanding of privacy in urine testing as they menstruate. Understandably, urinalysis can be more humiliating for a woman.

I then drew upon Harris and McElrath's (2012) hypothesis to understand if non-drug users believe that the production of a 'dirty' urine sample should be used as a means of discipline. This second urinalysis-related question essentially asked participants the extent to which they would 'forgive' a methadone user who produces a negative urine sample. When asked if they think methadone users who test positive for heroin should be allowed to continue using methadone, over half were in favour of the idea of giving the user one more chance to get 'clean' after the first instance (Fig.11).

Fig.11



Men displayed less forgiveness as 72% of women were in favour of giving the user 'one more chance' while only 36% of men agreed. 36% of men believed in no second chances when a methadone user tests positive for heroin once while 12% of women also believed this.

These societal perspectives demonstrate how a system of power is maintained over the drug user as even before a methadone client produces a sample, they are identified as sneaky or untrustworthy while those who present a sample that is 'dirty' are seen as unworthy of redemption or forgiveness. This demonstrates the "moral gaze" (Bennett 2011:142) that relates to urinalysis.

Urinalysis can be compared to the theory behind Bentham's 'panopticon', which makes the inmate visible to allow for the automatic functioning of power (Foucault 2012). The staff of the methadone facility are all-seeing while the methadone client is not. There is no escaping the medical gaze of MMT and as the data indicates, there is no escaping the moral gaze of wider society. As the 'Farrell report' recommends, it seems necessary to take a "fresh approach" to urinalysis (2011:29) or to cease the practice entirely. Furthermore, methadone service providers should place less reliance on urinalysis. The basic bodily function of urination should not be part of a wider strategy of power within MMT services, as this is perhaps causing further harm to the methadone user. This solidifies the point that MMT, although it is supposed to be based on a harm reduction ideology, is not. Instead, it operates in a biopolitical way that causes more harm to the user than help.

Disciplinary Power Within the Irish MMT model:

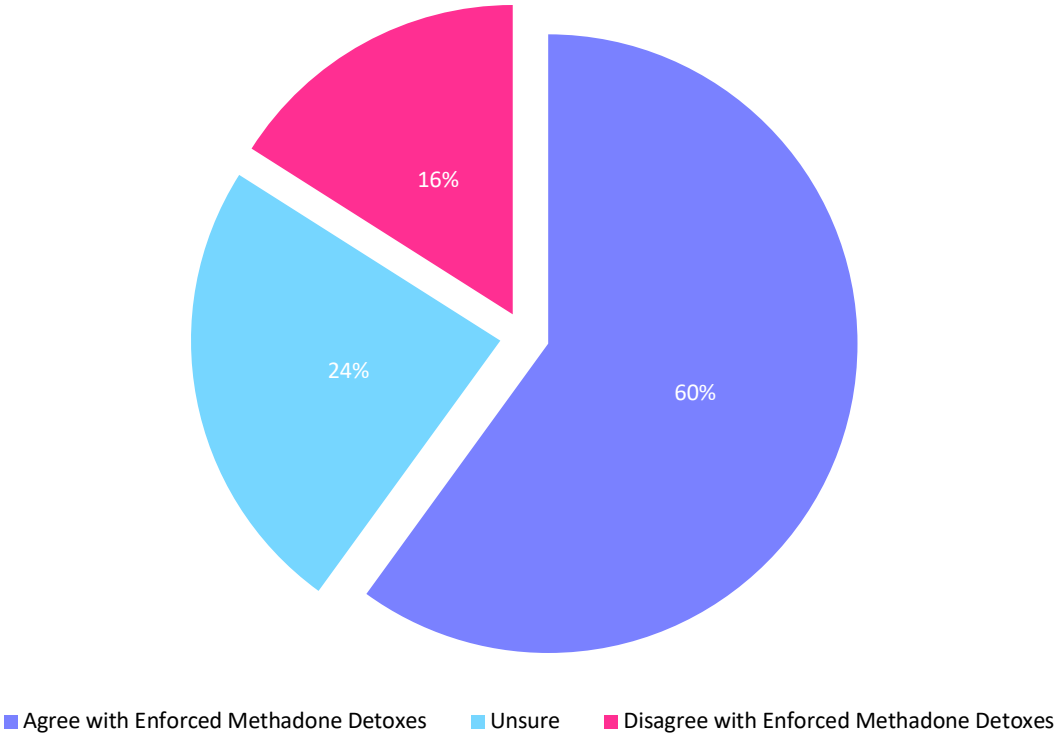
Power no longer relates to dealing with legal subjects and death but is rather about living beings (Foucault 1978). Biopower, which is present in the operation of MMT, is an element in the development of capitalism and refers to the ways "institutionalised forms of social control discipline bodies" (Bourgois 2000:167). The methadone user can be identified as the criminal delinquent, who is governed by discipline and required to conform or be corrected (Garland 1997). Surveillance is an underlying mechanism of disciplinary power and like a

prisoner, the MMT user is confined within the strict rules and regulations of the treatment programme. As Bourgois (2000) argues, methadone maintenance is the state's attempt to morally discipline "deviants who reject sobriety and economic productivity" (167). The concept of biopower can be used to interpret public attitudes towards MMT to understand why it operates in that way.

Governmentality is based on making the population more productive (McKee 2009) to continue capitalist production. According to Foucault, "the adjustment of the accumulation of men to that of capital" was "made possible in part by the exercise of bio-power in its many forms and modes of application" (1978:141). Capitalism operates on the controlling of bodies so they can be used in production (Foucault 1978). It relies on a particular type of worker and therefore, a particular type of society that is based on production and consumption. The drug user can be depicted as existing outside of this ideal as they are seen as unable to benefit the state firstly as workers and secondly as consumers. They are subjected to regulation and surveillance as they fail to benefit neoliberal capitalist society. Furthermore, the drug using population is regulated for the benefit of the non-drug using population, who are seen as "a deviant and to some extent dangerous class" (Harris and McElrath 2012:820). Ireland's market-based society means that people who are of no use to the market, such as drug users, are excluded. Thus, discipline and security are exercised over them as a population.

The findings illustrate how 60% of respondents believed that there should be a time limit on how long someone can be taking methadone before they are forced to detox (Fig.12). Men were more in favour of enforced detoxes as 76% agreed with them in comparison to 44% of women. This data demonstrates how society wants methadone users to eventually be drug-free. The fact that the majority were in favour of enforced detoxes could also be due to the 'scrounger' mentality surrounding methadone as methadone essentially is welfare.

Fig.12



In fact, 28% of participants, including everyone who viewed drug users as criminals, agreed with the statement 'drug users are scroungers living off the taxpayer's money'. Moreover, 34% of participants believed that methadone users should have to pay for methadone (Fig.13):

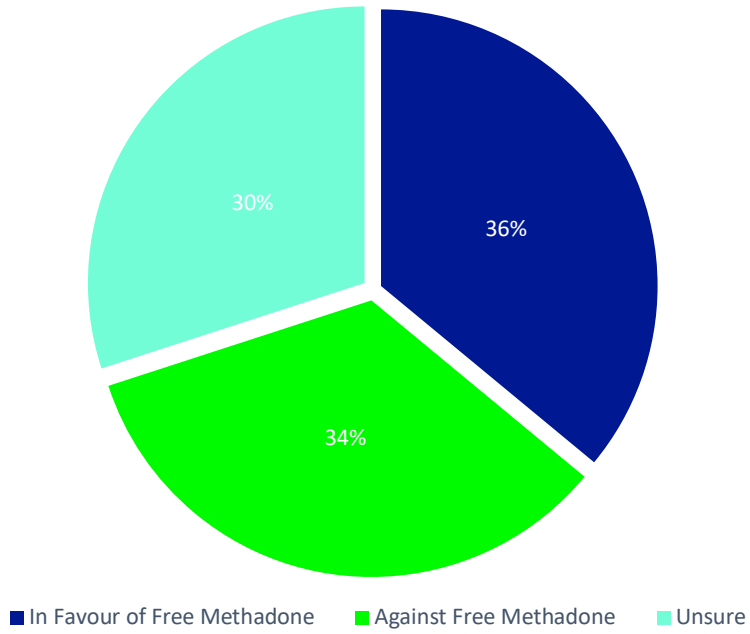
Methadone is costing our taxpayers money and this should not be the case as junkies don't deserve the hard working people's money

(Evan*)

I disagree with state sponsored drug use

(Tommy*)

Fig. 13



Those who identified drug users as criminals were also more likely to believe that all heroin users are 'scumbags from low social class backgrounds' in comparison to those who view drug use as an illness. These attitudes highlight the social construction of drug users; that they are taking advantage of welfare and are undeserving of long-term help from the state, if any. The identity of the drug user as a 'criminal delinquent' is also reinforced by these attitudes. These findings reflect those of Harris and McElrath (2012) who contend that MMT is often a latent form of social control for a population who are considered not to conduct themselves in accordance with neoliberal ideals.

The opinions of the general public are in keeping with the systems of disciplinary power within MMT. The drugs service user is a subject over whom rule-based control is exercised and the majority of society agrees that this is the way MMT should operate. As the data has discovered, MMT clients have no way of escaping the stigmatising public gaze as well the gaze of the methadone facility.

Conclusion of Findings:

The data serves as evidence that the sociological view of individuals who use drugs prevents proper harm reduction being implemented and progressing fully in Ireland. There is an evident disconnection in society between harm reduction and methadone maintenance. There is also a need to contain the body of the drug user and discipline the methadone client through urinalysis. Furthermore, the research has highlighted the governmentalities within the Irish MMT model. The research has argued that methadone maintenance is not reaching its goals. It has demonstrated how this is connected to societal perspectives and how the attitudes of the non-drug using population influence the implementation and practice of the harm reduction strategy of methadone maintenance.

Conclusion

The research succeeded in collecting societal perspectives on methadone and combining it with a Foucauldian criticism of MMT as a harm reduction modality in Ireland. Completed over the course of the academic term, it was carried out in compliance with the ethical guidelines set out by the university. The research is important as the increasing prevalence of MMT and the way it operates in Ireland has called into question its operation as a biopolitical technology rather than a harm reduction initiative, which the research has analysed.

The literature review served in highlighting how methadone is not being practiced in keeping with a harm reduction philosophy and instead identified it as a form of social control. The findings demonstrate how the non-drug using population is in favour of harm reduction but also of the techniques of disciplinary power within MMT. This illustrates a confusion among the general population about what harm reduction is. Moreover, the findings conclude that societal perspectives on MMT influence its implementation as non-drug users want methadone clients to be segregated from them in society, physically contained within a methadone facility. This solidifies the idea of biopolitics within methadone services and how it is present within the opinions of wider society. The societal perspectives also reinforce the idea that drug users are criminal delinquents that cannot be trusted as the majority of participants were in favour of medical supervision in urinalysis, for example. The attitudes of the non-drug using population are in keeping with the concept that the methadone client is a subject over whom rule-based control must be exercised. The general population's opinions dictate how discipline should be exerted over the drug-using population as they require punishment and control. This depicts how the societal perspectives influence the implementation of harm reduction in Ireland. Through these findings, the research has illustrated why governmentalities exist within MMT by connecting it to societal perspectives.

The literature review demonstrated how methadone users cannot escape the medical gaze of the methadone facility. Moreover, methadone users are subjected to the stigmatising public gaze of the non-drug using population, which is underpinned by the data. They are also unable to escape this gaze and are mainly constructed as delinquents who require discipline and regulation.

Societal perspectives were the vehicle through which an understanding was achieved of why techniques in MMT construct methadone clients as a socially deviant group who must be controlled. The research has argued that drug users can be identified as existing outside of the neoliberal ideals of Irish society that are centred around the market and economic productivity. Because individuals who use drugs cannot benefit society through either production or consumption of goods and services, they are marginalised. They are also subjected to surveillance, biopolitics and governmentality through drug services in order to make them less dangerous for the benefit of the non-drug using population.

If I were to do the research project again, I would design the surveys slightly differently, by providing optional spaces for participants to expand on their answers for every question. This would have given the respondents a chance to expand on the reasoning behind every one of their answers if they wanted to. It would have also provided me with richer data as participants would have an outlet to say exactly what they think. Moreover, I would have perhaps taken a mixed methods approach by carrying out interviews with methadone maintenance providers as well as surveys with the general population. This would have added another perspective to my research by viewing MMT through the eyes of a service provider to understand how they feel about governmentality within the service. Their experience as a staff member within MMT would generate valuable data that could be interpreted to produce findings rich in sociological analysis.

This thesis has identified an area that has the opportunity for more research as it has formulated a new way to think about how MMT is practiced in Ireland. Through arguing that MMT is a form of biopolitics that is used to control the methadone client and linking this to societal perspectives on methadone provision, the research has reimagined the Irish MMT model. If it is in keeping with ethical boundaries, new research could be carried out with Irish methadone clients to understand MMT from their point of view. Their attitudes towards it and experiences could be investigated to further understand how a strategy of power is maintained within methadone services in Ireland. It could also use the voice of the MMT client to make recommendations to MMT programmes. As my research found that 30% of participants think pregnant women should be denied methadone, further research could also be carried out on the topic of pregnancy and heroin use in an Irish context to understand why a section of society doesn't want pregnant heroin users to have access to methadone. The theoretical framework of Jock Young's vindictiveness (2003) could be applied to carry out the research.

This paper advances a scholarly knowledge of the topics of harm reduction and methadone maintenance. It has achieved an understanding of harm reduction from the perspective of wider society through the attitudes of non-drug users towards methadone maintenance services and service users. It serves in providing a new perspective on Irish MMT by applying the theoretical framework of biopower to understand why the non-drug using population wants to control and contain the methadone client. Furthermore, it has created a sociological understanding of why governmentality operates within MMT, concluding that drug services discipline drug users as they fail to adhere to neoliberal norms by rejecting sobriety and economic productivity. The research has solidified Newman's argument that "methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists" (1976:186) in the context of modern Ireland. It has demonstrated how the Irish MMT model is not a harm reduction initiative and has

highlighted a need for Irish MMT delivery to be re-designed. Some suggestions that have become apparent as a result of my research would be to place less emphasis on users achieving abstinence and to rely less on urinalysis. Further, the operation of a sanctions and rewards system should be terminated and programmes should work towards a more human rights-based approach for service users.

Bibliography

Abdulai, Raymond Talinbe and Anthony Owusu-Ansah. 2014. “Essential Ingredients of a Good Research Proposal for Undergraduate and Postgraduate Students in the Social Sciences.” *SAGE Open.* 1-15.

Barry, Joe and Michael Farrell. 2011. *The Introduction of the Opioid Treatment Protocol.* Dublin: Health Service Executive.

Bennett, Cary. 2011. “Methadone Maintenance Treatment: Disciplining the ‘Addict’.” *Health and History.* 13(2):130-157.

Birmingham, Peter and David Wilkinson. 2003. *Using Research Instruments: A Guide for Researchers.* UK: RoutledgeFalmer.

Bourgois, Philippe. 2000. “Disciplining Addictions: The Bio-Politics of Methadone and Heroin in the United States.” *Culture, Medicine and Psychiatry.* 24:165-195.

Bryman, Alan. 2012. *Social Research Methods.* 4th Ed. UK: Oxford University Press.

Butler, Shane. 1991. “Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed.” *Administration.* 39(3):210-235.

Butler, Shane and Paula Mayock. 2005. “An Irish Solution to an Irish Problem: Harm Reduction and Ambiguity in the Drug Policy of the Republic of Ireland.” *International Journal of Drug Policy* 16(6):415-422.

Bryan, Audrey, Eimear Farrell, Rosalyn Moran and Mary O’Brien. 2000. *Drug-Related Knowledge, Attitudes and Beliefs in Ireland: Report of a Nation-Wide Survey.* Dublin: Health Research Board.

Carlin, Tony. 2005. “A Therapeutic Response or a ‘free fix’? The Irish Experience of Methadone Maintenance Treatment.” *Irish Probation Journal.* 2(1):87-94.

Central Statistics Office. 2016. (https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/assr/).

Chambliss, Daniel F. & Russell K. Schutt. 2016. *Making Sense of the Social World: Methods of Investigation*. 5th ed. Thousand Oaks, CA: Sage Publications.

Delargy, Ide, Des Crowley and Marie Claire Van Hout. 2019. “Twenty Years of the Methadone Treatment Protocol in Ireland: Reflections on the Role of General Practice.” *Harm Reduction Journal* 16(5):1-10.

Dole, Vincent P. And Marie E. Nyswander. 1980. “Methadone Maintenance: A Theoretical Perspective.” Pp. 256-261 in *Theories on Drug Abuse: Selected Contemporary Perspectives,* edited by Dan J. Lettieri, Mollie Sayers and Helen Wallenstein Pearson. USA: National Institute on Drug Abuse.

Duncan, D.F, Nicholson, T., Clifford, P., Hawkins, W and Petosa R. 1994. "Harm Reduction: An Emerging New Paradigm for Drug Education." *Journal of Drug Education* 24(4):281-290.

Egan, Elizabeth and Elizabeth Kiely. 2002. *Harm Reduction: An Information and Resource Booklet for Agencies Engaged in Drug Education.* Department of Applied Social Studies, National University of Ireland Cork.

European Monitoring Centre for Drugs and Drug Addiction (http://www.emcdda.europa.eu/countries/drug-reports/2019/ireland_en)

EMCDDA. 1999. "Annual Report of the State of the Drugs Problem in the European Union."

Flavin, Jeanne. 2002. "A Glass Half Full? Harm Reduction Among Pregnant Women Who Use Cocaine." *Journal of Drug Issues* 32(3):973-998.

Foucault, Michel. 1978. *The History of Sexuality.* New York: Pantheon Books.

Foucault, Michel. 2012. "Discipline and Punish." Pp. 211-218 in *Contemporary Sociological Theory,* edited by Craig Calhoun, Joseph Gerheis, James Moody, Steven Pfaff and Indermohan Virk. UK: Blackwell Publishing.

Garland, David. 1997. "'Governmentality' and the Problem of Crime: Foucault, Criminology, Sociology." *Theoretical Criminology* 1(2):173-214.

Harris, Julie and Karen McElrath. 2012. “Methadone as Social Control: Institutionalised Stigma and the Prospect of Recovery.” *Qualitative Health Research.* 22 (6):810-824.

Inglis, Tom. 1998. *Moral Monopoly: The Rise and Fall of the Catholic Church.* Dublin: University College Dublin.

Keane, Helen. 2002. “Critiques of Harm Reduction, Morality and the Promise of Human Rights.” *International Journal of Drug Policy* 14:227-232.

Li, Tania M. 2007. “Governmentality.” *Anthropologica.* 49(2):275-281.

Miller, Peter, 2011. “A Critical Review of the Harm Minimization Ideology in Australia.” *Critical Public Health.* 11(2): 167-178.

McKee, Kim. 2009. “Post-Foucauldian Governmentality: What Does it Offer Critical Social Policy Analysis?” *Critical Social Policy* 29(3): 465-486.

Murphy, Sheilga and Marsha Rosenbaum. 1991. *Pregnant Women on Drugs: Combatting Stereotypes and Stigma.* New Jersey: Rutgers University Press.

Newcombe, Russell. 1992. “The Reduction of Drug Related Harm, A Conceptual Framework for Theory, Practice and Research.” *Journal of Contemporary Criminal Justice* 8(3):268-270.

Newman, Robert G. 1976. “Methadone Maintenance: It ain’t what it used to be.” *Br. J. Addict.* 71: 183-186.

O'Gorman, Aileen. 1998. "Illicit Drug Use in Ireland: An Overview of the Problem and Policy Responses." *Journal of Drug Issues* 28(1):155-166.

O'Hare, Pat and Diane Riley. 2000. "Harm Reduction: History, Definition and Practice." Pp. 1-26 in *Harm Reduction: National and International Perspectives,* edited by Lana D. Harrison and James A. Inciardi. USA: Sage Publications.

Tober, Gillian and John Strang. 2003. *Methadone Matters, Evolving Community Methadone Treatment of Opiate Addiction.* London: Martin Dunitz.

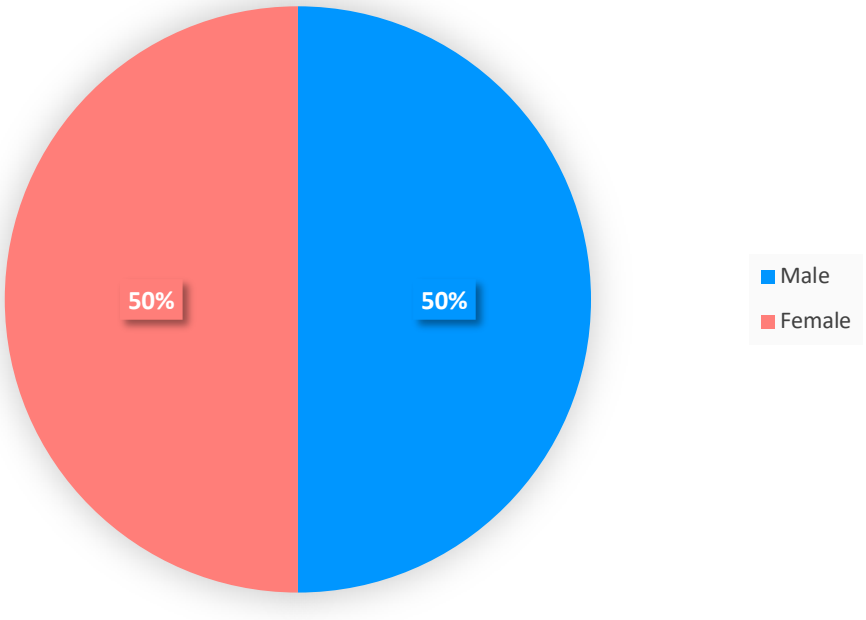
Walliman, Nicholas. 2011. *Research Methods: The Basics.* New York: Routledge.

Wisker, Gina. 2009. *The Undergraduate Research Handbook.* UK: Palgrave MacMillan.

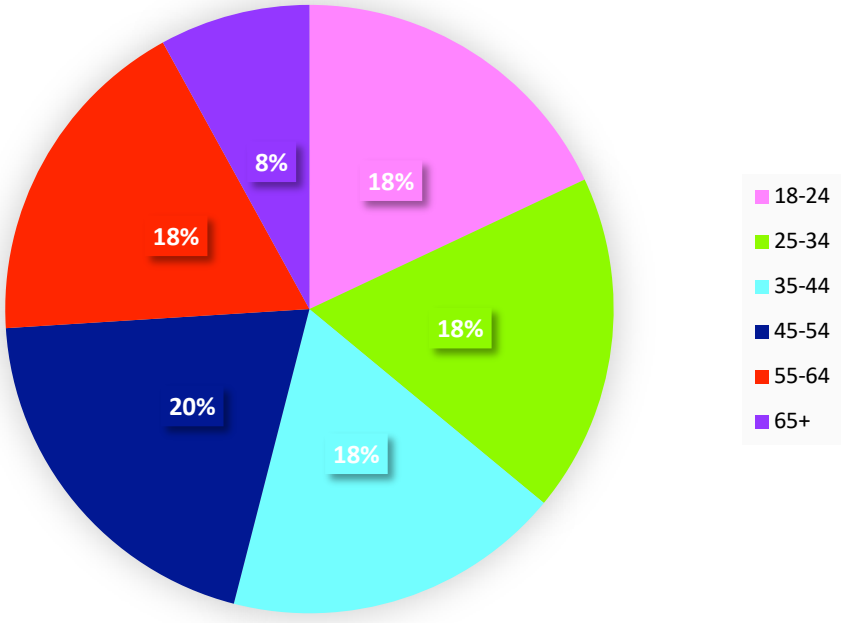
Young, Jock. 2003. "Merton with Energy, Katz with Structure: The Sociology of Vindictiveness and the Criminology of Transgression." *Theoretical Criminology* 7(3):389-414.

Appendices

Appendix 1: Gender of Sample



Appendix 2: Age of Sample



Blank Survey:

Please tick the appropriate box:

- **What age are you?**

18-24 ☐
25-34 ☐
35-44 ☐
45-54 ☐
55-64 ☐
65-74 ☐
75 or older ☐

- **What is your gender identity?**

Male ☐
Female ☐
Other ☐

PLEASE READ ⬇️

The following questions are related to the provision of methadone in Ireland. Methadone is used as a substitute medication for problematic heroin users. The heroin dependent individual takes a daily dose of methadone in the form of a liquid. This reduces their withdrawal symptoms and cravings for heroin while also reducing their risk of HIV from injecting. Research on methadone has also found that it reduces the death rate associated with heroin dependence and reduces criminal activity by heroin users

Please indicate the level to which you agree/disagree with the following statements:

'People are going to take drugs whether they are legal or not'

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

'Drug users are sick and they should be pitied'

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

'Drug users should be punished because they shouldn't have made the life choices they did to become a drug user'

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

'*Drug users are scroungers living off the taxpayer's money'*

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

'I don't want junkies hanging around my local doctor's practice. They should only give out methadone in clinics dedicated specifically to methadone'

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

'It is a better idea to try to reduce the harms caused by drug use rather than criminalising drug users'

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

Can you please expand on the reasoning behind your answer to this statement:

_____

_____

_____

'*People who use heroin are all scumbags from low social class backgrounds'*

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

Please indicate on the scale how you feel about heroin users being given methadone as a substitute:

○	○	○	○	○
Disagree	Somewhat Disagree	Neutral/ No opinion	Somewhat Agree	Agree

Please indicate on the scale how happy you would feel about a methadone clinic opening within a 5 mile radius of your home:

○	○	○	○	○
Extremely Unhappy	Somewhat Unhappy	Don't mind it/ No opinion	Somewhat Happy	Happy

Please answer the following questions by ticking the appropriate box:

- **Do you consider drug use a problem that needs to be addressed by public health services such as the HSE?**

Yes ☐
No ☐
Unsure ☐

- **From 2011-2014, providing methadone to heroin users cost taxpayers €55 million (The Irish Examiner) This is around €13.8 million a year.**

Do you think drug users should have to pay for methadone?

Yes ☐
No ☐
Unsure ☐

- **According to the European Monitoring Centre for Drugs and Drug Addiction, overdose deaths in Ireland rose from 174 in 2010 to 224 in 2015.**

If you had to pick ONE, what do you think is the most effective option for tackling drug-related deaths in Ireland?

- Increasing prison sentences for drug-related crimes ☐
- Improving treatment and rehabilitation services for drug users ☐
- Providing more facilities for the provision of methadone ☐
- Providing supervised injection facilities ☐
- Other (please specify)

_____

_____

- **According to the HSE, 10,316 people were officially listed as receiving methadone in 2018.**

Of this number 4,069 had been on the drug for ten years or more.
Do you think there should be a time limit on how long someone can be taking methadone before they are forced to detox?

Yes ☐
No ☐
Undecided ☐

Please provide reasoning for your answer:

_____

_____

- **Do you think heroin users should only be given methadone as a step towards abstinence (permanently giving up drugs) or as a life-long treatment?**

Step towards abstinence ☐

Life-long treatment ☐

Unsure/don't agree with methadone

- **Of the 10,000+ people currently on methadone treatment in Ireland, 40% of these are treated in GP practices.**

Do you think all GPs should be required to prescribe methadone?

Yes, it should be a requirement of every GP ☐

No, it should be an 'opt in' service for GPs ☐

Unsure ☐

- **Do you think methadone users should get take-home doses or should they have to take their dose under medical supervision at the methadone facility?**

Take home doses ☐

Medical supervision ☐

Unsure ☐

- **According to the Health Research Board, from 2004-2016 there were a total of 8,207 drug-related deaths in Ireland. Methadone was the most common prescription drug involved (although it could have been mixed with other drugs).**

Do you think methadone users should be supervised when taking it?

Yes ☐

No ☐

Unsure ☐

- **When being prescribed methadone, users are often required to produce urine samples to ensure they are not taking heroin. Do you think methadone users who test positive for heroin should continue to be prescribed methadone?**

Yes, they should be allowed to continue using methadone ☐

If they test positive for heroin once, they should be given **one more chance** to get 'clean' ☐

No. If they test positive for heroin once, they should **not** be allowed to continue receiving methadone ☐

Unsure ☐

- **Do you think methadone users should be supervised by a member of medical staff when producing a urine sample?**

Yes ☐

No ☐

Unsure ☐

If you answered 'yes' to the previous question, please provide an explanation for your answer:

_____

_____

_____

- **Around 130 babies in Ireland are born addicted to methadone or heroin every year and must go through withdrawal (RTÉ).**

Do you think pregnant women should be denied methadone?

Yes, pregnant women **should NOT** be given methadone ☐

No, pregnant women **should** be given methadone, but **only** if they are going to use it as a step towards abstinence ☐

No, all heroin dependent people should be allowed to take methadone, regardless of if they are pregnant or not ☐

PLEASE SIGN YOUR NAME
(it does not have to be your real name): _____

By signing this, you consent to your answers being used as data for my thesis project. All data will be encrypted and destroyed after 8 months.

Thank you very much for taking part in my research!