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Understanding and preventing drug-related interpersonal violence in Ireland through a public health approach

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ABSTRACT

There is an unresolved tension between the growing emphasis on public health approaches to illicit drug use and to interpersonal violence in some quarters, and the common refrain that drug-related violence is best resolved through law enforcement and criminalisation in others. It is timely, therefore, to analyse these concepts together and through an interdisciplinary lens, exploring how we conceptualise and prevent *illicit drug-related interpersonal violence* from a public health perspective. This essay explores public health approaches to preventing illicit drug-related interpersonal violence. We situate our analysis in Ireland, where our work is primarily based, and where we feel there is some potential to drive forward public health approaches. We start by outlining some key messages from the empirical literature on the dynamics of illicit drug-related interpersonal violence in Ireland. Next, we seek to map the typology of violence and the World Health Organisation (WHO) ecological model of violence onto evidence-informed approaches to prevention from public health. Finally, we identify some of the approaches which could help Ireland reimagine efforts to prevent at least some forms of drug-related interpersonal violence, while avoiding the harms of criminalisation.

Introduction

As applied scholars who have addressed questions of drug and violence prevention policy from different disciplines, we sense a growing bifurcation of these policy debates. On one hand, many increasingly recognise that illicit drugs and interpersonal violence are primarily health issues, with implications for how we prevent and respond to the harm they cause. At the same time, the continued rhetoric that both illicit drugs and violence are chiefly questions of morality, justice and crime seems as entrenched as ever, even making a resurgence, among many political, media and other societal actors across Europe. In this context, we believe it is important for people from different disciplinary backgrounds to speak collaboratively about the role of public health approaches in relation to both drugs and interpersonal violence, and specifically to the prevention of illicit drug-related interpersonal violence.

Much interpersonal violence is not drug-related, and violence is far from the primary health or social harm caused by illicit drugs. According to the Global Burden of Disease Study 2021 (Institute for Health Metrics and Evaluation, 2022), self-directed and interpersonal violence combined make up just 3% of the deaths globally attributable to drugs; cirrhosis and other chronic liver diseases make up the largest share of deaths at 38.3%. However, given the increasing global policy emphasis on preparedness and security (Council of the European Union, 2021), and the long-established assumption from political actors that illicit drug-related violence is best resolved through policing, law enforcement and criminalisation (Windle and Murphy, 2022), it is timely to explore how we conceptualise, and develop government policies that prevent and respond to, this form of violence from a public health perspective. Calls for scientifically-informed public health approaches to violence prevention in general have increased in recent years and the evidence on these approaches is emerging. For example, in their rapid review of this topic, Walsh et al. (2025) find that the prevention of violence requires a recognition that it often stems from broader physical and mental health issues, such as adverse childhood experiences, exposure to violence and poor mental health and addiction. This signifies a pressing need for a science-based approach underpinned by a coherent, multi-disciplinary framework such as public health.

We write this essay from our collective experience in criminology, addiction and violence research and scholarship. We seek to combine learning from these disciplines to understand illicit drug-related interpersonal violence in Ireland where we are based, and to map selected

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conceptualisations of violence and evidence-informed public health approaches onto the Irish context. Drug-related violence is a broad category of incidents, and we must operationalise the term for the purpose of this essay, clarifying the parameters around the phenomenon and the responses we explore. Our focus is on interpersonal violence which relates to the use and trade of illicit substances. Thus, we define illicit drug-related interpersonal violence as when a person physically harms another within an ecological framework associated with the use, marketing, trafficking and production of illicit drugs (Liem & Moeller, 2025). By focusing on Ireland, we explore a public health response to interpersonal violence which relates to both drug markets and drug consumption, in the context of a small, under-researched consumer country on the periphery of Europe, where drug-related violence has significantly shaped criminal justice policy and political debates (Marder & Hamilton, 2023). We situate public health approaches to violence in this setting, problematising the concept while illustrating how public health approaches to prevention may be applicable to violence that is framed or perceived to be drug-related in Ireland and similar contexts.

Understanding drug-related violence in Ireland

This section outlines three lessons from the empirical literature to help us understand drug-related violence in Ireland and its prevention. Firstly, while most people who consume illicit drugs are not consequently violent, a non-nominal proportion of public and family violence in consumer countries involves drug consumption in some way. However, this violence relates primarily to certain drugs and takes place in the context of mediating factors which drive that violence. Secondly, drug supply chain-related violence remains a major political issue in consumer countries like Ireland and can make up a significant proportion of the most serious or resonant public (i.e., non-intrafamilial) violence in some countries at certain moments. However, most people involved in drug supply chains seek to minimise the use of violence to avoid police attention, retaliation and other harmful consequences to their business. Thirdly, drug supply chain-related violence in Ireland often stems from interpersonal and interfamilial conflict, rather than from a desire to exert control over informal drug markets (Windle, 2023). These points are important for understanding how the public health approach to violence can be introduced to drug-related violence.

Consumption and interpersonal violence

'Drug-related violence' incorporates a diverse group of behaviours which differ greatly across time and place. Ireland, the focus of our analysis, is a consumer market, characterised by the importation and consumption of drugs, rather than by significant levels of manufacturing or cultivation. Consequently, certain forms of drug-related violence, such as that against coca farmers in Peru or Colombia (van Dun, 2014), or that which is used to exert control over logistics infrastructure in transit countries like Honduras (Ziosi, 2024), are mostly absent.

That said, within Europe it is estimated that either alcohol or drugs plays some role in a large proportion of interpersonal violence. This includes quite different forms of violence, from that involving consumers in the nighttime economy, to violence in the family setting, to violence between actors involved in different levels of the drug trade. For example, van Amsterdam et al. (2019) reviewed literature from the UK, Germany, Austria and the Netherlands. They found that alcohol consumption was linked to 26-50% of public violent incidents in those countries, with illicit drugs relating to a smaller 1.5-18%. They noted that the consumption of illicit drugs had varying associations with violence, with stimulants such as cocaine and methamphetamine more likely to contribute to violent behaviour than cannabis, heroin or ecstasy. However, as most people who use drugs and alcohol do not exhibit violent behaviour, personal and contextual variables must be considered in consumption-related violence. Likewise, although some studies find an association between drug consumption and intimate partner violence (e.g., Zhong et al., 2020) or sexual violence among students (Burke et al., 2025), the relationship is complex and often found to be mediated by other factors, not least adverse childhood experiences and mental health disorders (Kaufman-Parks et al., 2023). Thus, not all drugs are linked to consumption-related violence, and, for those that are, social and individual circumstances are relevant to our understanding and prevention efforts.

Supply chains and interpersonal violence

Violence in illicit supply chains is often a major political and media talking point in consumer countries, even though most such violence occurs in producer and transit countries. Drugs are not the only consumer good for which the supply chain is marred by violence (e.g., Moran et al., 2015; Rauthe & Kauzlarich, 2022). Yet, the criminalisation of certain substances has meant that their production, transit and supply exist primarily or exclusively in the informal economy, controlled by people who operate illegally and unregulated and involving organised and transnational criminal activity to varying degrees. Drug supply chain-related violence spills over more from producer countries to consumer countries than does violence relating to other consumer goods, contributing to its political and social salience in consumer countries.

In Ireland, few official statistics, victimisation surveys or other forms of research exist to inform conclusions about most crime types (Marder & Hamilton, 2023), including drug-related violence. In the absence of data, Connolly (2017: 415) writes, 'certain "taken for granted" assumptions or stereotypes' relating to the 'evil' of drug market players and the ubiquity of violence therein 'emerged to fill the gaps in knowledge'. Yet, Connolly (2017), following Coomber (2006), notes that most people involved in drug supply are never or not frequently involved in violence. In fact, many aim to avoid it: inviting police attention and encouraging retaliatory violence are 'bad for business'. Consequently, it is inaccurate to label people involved in drug supply as necessarily pathologically violent or always inclined to use violence to resolve commercial disputes. Indeed, Irish research by Connolly and Donovan (2014: 76) found that 'at the street-market level there was also a level of co-operation or co-existence between dealers', albeit conflicts still arose over prices, profits and turn-taking.

Whereas Ireland was previously considered a 'nation not obsessed with crime' (Adler, 1983), unlike its Anglo neighbours and cultural influences, drug-related violence has never been far from political discourse in recent decades. Moral panics followed the murder of journalist Veronica Guerin in 1996 (Connolly, 2017), a rise in the use of guns to commit public violence in the 2000s (Campbell, 2010) and feuds between family-based organised crime groups in the 2000s and 2010s (Windle, 2023). These events have been central to Irish public and political discourses regarding drug markets, drug policies, and crime, policing and community safety more broadly.

What research we do have on (ostensibly) drug-related violence suggests three conclusions. First, a spike in murders between members of organised crime groups involved in the drug trade in the mid-2010s has since declined. Yet, questions remain as to the extent to which this violence was always 'drug-related' – many incidents related not to control of drug markets, but to inter-familial conflicts, or 'gangland feuds' (Windle, 2019, 2023). This phenomenon, whereby spates of the most serious 'drug-related' violence in Ireland appear to be primarily driven by interpersonal conflicts, is an important factor in understanding its prevention.

Second, drug-related intimidation (Connolly & Buckley, 2016; Bowden, 2019), violence relating to drug debts, (Connolly & Donovan, 2014), and the recruitment of young people to undertake illicit activities, including drug supply and drug-related violence (Naughton et al., 2023), are drastically underreported. This means that many communities suffer significant harm from their proximity to the drug trade,

beyond direct experiences of physically violent acts.

Third, although illicit drug consumption is not more prevalent among lower socioeconomic classes, its harms are more concentrated, mapping broadly along lines of urban deprivation, and involving perpetrators and victims who overlap. For example, Connolly (2017) notes a concentration of homicides in or near Dublin's north inner city, creating significant, long-term harm to local communities. For individuals and communities as much and organised crime groups, violence which appears 'drug-related' may relate to drugs to a degree but takes place in the context of other factors that drive violence and social harm (Naughton et al., 2023). This is important because it illustrates the connection between the prevention of drug related violence and the prevention of other social harms, as well as the importance of addressing drug related violence effectively, based on evidence, given that it served to perpetuate harms to marginalised communities.

A typology of violence and the world health organisation (WHO) ecological model

In considering effective responses to a global public health issue, it is helpful to have a wider understanding of both the conceptual aspects and the evidence base underpinning drug-related violence. In conceptualising violence, the ecological model (Krug et al., 2002) is a helpful lens by which we can understand the inherent complexities of the phenomenon. Only when the full ecology of drug-related violence is understood can preventative efforts be effective.

The ecological model recognises that violence occurs at four different levels: individual, relationship, community and societal (World Health Organisation, 2002; see Fig. 1).

The World Health Organization (2002) typology categorises violence into self-directed, interpersonal and collective forms, each of which can involve physical, sexual, psychological, or deprivation-related harm (see Fig. 2).

Our primary concern is with drug-related violence at the interpersonal level. As Fig. 2. shows, interpersonal violence is multidimensional, causing harm to family members of different ages and relationships to the individual, and to people in the community more or less known to the person exhibiting or experiencing violent behaviour. The harms caused may be multifaceted and complex, intertwined with deep personal (sometimes, intimate) relationships and a home or familial context. The nature of the relationship (and the subsequent vulnerability and 'love' which may be intertwined if it is an intimate, sibling, child or parent) poses challenges for policymakers as the invisible human cost of drug-related violence remains almost impossible to capture. The dilemmas and pressures from partners and family members to minimise, collude and ignore drug-related violence further complicates the issue.

Community violence exists in neighbourhoods and public places, to and by people known or unknown to one another. In the drug context, this involves violence committed in the course of acquisitive crime, between people involved in supply chains, by people involved in supply chains against consumers, and to the families, friends and neighbours of both those involved in the supply chain and consumers. Intimidation and violence against those who end up in debt is encapsulated here (Connolly & Donovan, 2014). The impact can be felt much more widely than those with direct experience of violence, with others feeling unsafe by virtue of being in an environment where violence has occurred (Krug et al., 2002).

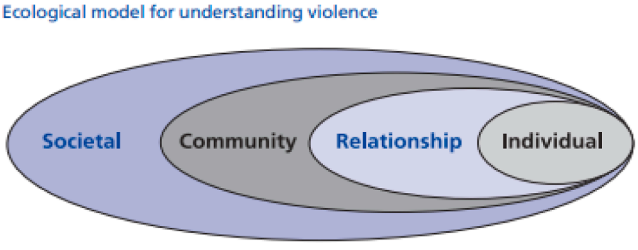

Fig. 1. The WHO ecological model of violence.
Note: Adapted from World report on violence and health (p.12), by World Health Organisation, 2002, World Health Organisation. Copyright 2002 by the World Health Organisation.

Although we are focusing on interpersonal violence, the importance of the ecological model is that no analysis of micro-level harms and behaviours is complete without contextualisation in terms of wider society and societal violence. Societal violence relates to cultural, social and economic discourses that have the capacity to enhance or inhibit violence. Policy and practice which maintain socioeconomic inequalities, and cultural norms such as patriarchy, parental dominance and retaliation, play a key part here. Research into societal violence highlights the impact of economic disparity. In their ecological study of 169 countries, Wolf et al. (2014) identified a high health burden of violence and abuse. Income inequality was related to violence and homicide in low- and middle-income countries. In the drugs context, societal violence also includes the violence of prohibition: through criminalisation, incarceration and, in some jurisdictions, execution, states, laws and institutions directly harm people who use drugs and marginalised communities. There is also the societal violence attributed to stigma-related harms, which are barriers to accessing health, care and other services and realising other human rights (Comiskey, 2020).

The inextricable and interrelated links between all aspects of the ecological model make it challenging but not impossible for policymakers to use. There are some important points to bear in mind when considering the model. Firstly, the WHO definition of violence highlights that violence is 'intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (Krug et al., 2002: 5). One might argue about whether or not 'intentionality' is always present amongst those who are under the influence of drugs, or under the duress caused by debt, threats and intimidation. Criminal law and criminal justice are yet to reconcile these drivers of human behaviour with the individualisation of 'guilt' in isolation of its social context.

The second consideration relates to the methodological challenges inherent in getting a true sense of the scale and impact of drug-related violence. Globally, the measurement of violence has been plagued with methodological variations relating to data collection, definition and national practices. Methodologically, measurement of violence has used mortality, morbidity, police statistics and victimisation surveys. Whilst some of these have value, each paint an incomplete picture. The 'dark figure' of crime (Fé, 2025) is acknowledged in criminology as the discrepancy between prevalence and detection. In essence, policymaking must recognise that it can only ever operate with partial information about the levels of different forms of violence, the trends therein, and the scale of its impact on society.

Public health approaches, prevention and the WHO ecological model

Public health was defined over 100 years ago (Winslow, 1920) as 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals. Within this definition the role of individuals, communities and societies are outlined and it is clearly reflected in the ecological model. Public health focuses on groups, rather than just an individual. At its core lies the principle of social justice, providing people with an equal right to be healthy and to live in conditions that support their health. This section outlines four key components of public health approaches and five stages of prevention, drawing parallels with the types of problems and interventions in our context.

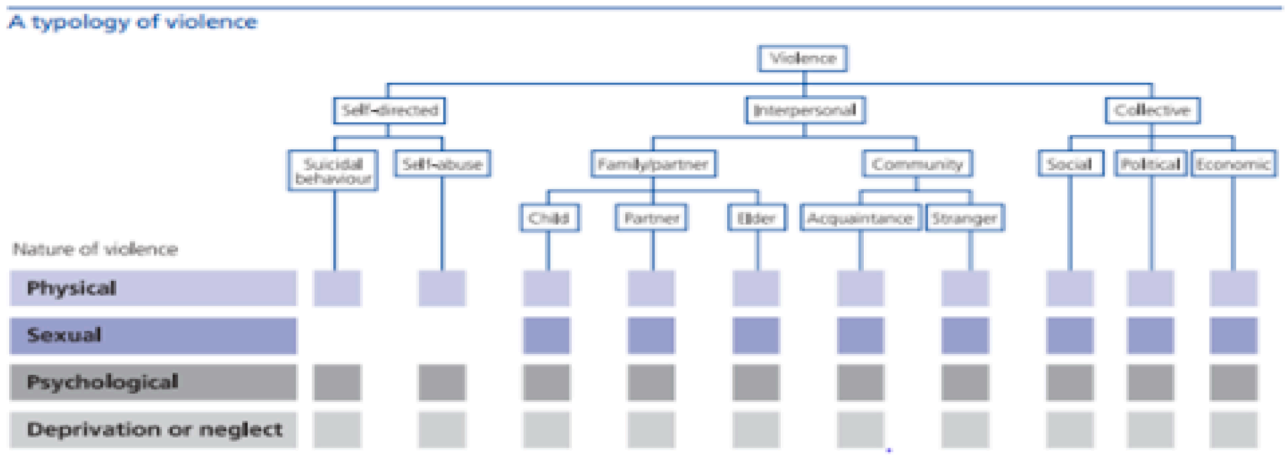

Fig. 2. Typology of violence.
Note: Adapted from World report on violence and health (p.6), by World Health Organisation, 2002, World Health Organisation. Copyright 2002 by the World Health Organisation.

The four key public components (Centers for Disease Control and Prevention, 2024) can be directly mapped to the ecological model:

- The first is to ensure control of disease and promotion of health through a healthy environment. This relates to the community aspects of the ecological model and the need to provide communities free from the underpinning social and health drivers of drug-related violence.
- The second is that of addressing wider disease and pandemics that affect populations. The analogy within the ecological model may be the need to address the unequal distribution and concentration of drug related violence.
- The third component of public health relates to preparedness and disaster responses. This could be likened to being prepared for spikes in drug-related violence when, for example, senior supply chain participants are arrested or killed and people commit violence to take their place. It could also relate to spikes in the dangerousness of substances where batches are unpredictably or unusually potent or contaminated, or when new psychoactive substances emerge, such as arose within the opioid epidemic (Comiskey, 2020).
- The final goal is that of prevention and policy. Public health works to protect and improve health, not just by responding to disease outbreaks or preparing for natural or human-made disasters, but also by implementing policies that support efforts at prevention and cultural change at the individual and societal levels.

Focusing on prevention – which, as the old adage states, is better than cure – we can outline five stages as discussed in a healthcare context: primordial, primary, secondary, tertiary and quaternary prevention. We can again identify ways in which prevention approaches for violence mirror disease prevention models. These are outlined below.

1. Primordial prevention targets a natural disease before it emerges by focusing on the underlying social conditions that promote disease onset. According to the EMCDDA and Europol (2023), environmental prevention, similar to primordial prevention, aims to change cultural, physical and economic environments within which people make behavioural choices. Such prevention strategies at this level may include bans on the sale of weapons, or universal nutrition programmes in schools (Thege, 2025).
2. Primary prevention is targeted at populations or individuals susceptible to contracting disease. This can involve interventions which address entire populations, usually in school, community or work settings. In our analogy, prevention at this stage within these settings aims to give people the social competence to delay or avoid using violence. For example, social skills training for young boys in schools is estimated to reduce violence significantly by teaching them to communicate and manage impulsiveness and aggression (Gaffney, Farrington et al., 2021).
3. Secondary prevention targets seemingly healthy individuals who have subclinical forms of the disease. In terms of drug-related violence, this could involve group violence interventions or the placement of caseworkers in hospitals to support victims of violence. These more targeted interventions have the potential to reduce retaliation, even among those who have not previously committed violence (Gaffney, Jolliffe et al., 2021).
4. Tertiary prevention targets people with symptoms and aims to reduce the severity of the disease. This could include interventions such as restorative justice, which engage with people who committed violence, and which have been found to reduce reoffending among those responsible for serious and persistent offences (Shapland et al., 2011). This could also include referrals to (mental) health services from the police and the courts where an unaddressed health issue is identified as having contributed to violence.
5. Finally, quaternary prevention according to Martins et al. (2018: 107), includes any 'action taken to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good'. In the context of drug-related violence, this could be envisaged as ensuring the de-implementation of policing approaches and criminal sentences that either have no or negative effects on the likelihood of recurrence, or that act as a barrier to implementing effective measures such as drug and mental health treatment (O'Donnell, 2024; del Pozo et al., 2025).

Discussion and conclusion: can a public health approach prevent future drug-related violence in Ireland?

Although the term 'public health approach' has been prepended to 'violence prevention' for years, processes of moving from theory to practice and policy transfer between jurisdictions have meant that it has referred to a range of approaches. Broadly, public health approaches to violence prevention involve non-justice bodies and non-law enforcement interventions which aim to address the drivers of violence at the community and individual levels, recognising the health and social determinants of violence (e.g., Centers for Disease Control, 2024, 2025).

Initially, this language was used to inform programmatic development in American cities such as Chicago, Boston, Cincinnati and others (Braga et al., 2019). Originating with Chicago's CeaseFire programme, these public health approaches to violence prevention were underpinned by drawing an analogy between violence and infectious disease:

direct exposure to violence was deemed to predict the commission of violence to such a degree that, as with infectious disease, an approach to tackling violence at the population level should include a) interrupting transmission between individuals in the short term and b) efforts at cultural change among populations in the medium-to-long term (Slutkin & Ransford, 2020).

In Chicago, 'violence interruption' took the form of conflict mediation, led by specialist outreach workers with lived experience of street violence: 'credible messengers' whose own involvement in drugs or violence gave them a unique ability to engage directly with people at risk of committing retaliatory, interpersonal, grievance-related violence (Whitehill et al., 2014). Cultural change was worked towards through school-based engagement with young people to discuss the experience and use of violence and community organising, such as public demonstrations against violence, speaking against violence at funerals, and other dialogic group or public-oriented activities. As such, the model recognises the ripple effect of violence as indicated in the ecological model, and the need to involve whole communities in public health-style approaches across the aforementioned range of prevention levels.

The perceived effectiveness of projects like these led to efforts at policy transfer, most notably to the establishment of the Violence Reduction Unit in Glasgow, Scotland, and a range of policy and (often, multi-agency) practice approaches. Initially, Scotland's approach focused on investing in early years and efforts to change youth culture (Fraser & Gillon, 2023). The Scottish approach, in line with many other places which developed 'public health approaches' in the years following Chicago's success, also involved identifying people who were prolifically or repeatedly involved in crime, creating and communicating opportunities for them to engage with varied supports and pathways away from crime, and coupling this with the direct threat of increased enforcement against people who continue to perpetrate violence – a combination of approaches known as 'pulling levers' or 'focused deterrence' (Braga et al., 2019) in policing contexts.

But how does this relate to *drug-related* violence? And how can it be implemented in Ireland and similar countries, given the fraught nature of efforts to transfer policies and approaches between countries in this and other areas of crime and justice (Graham, 2022)? Many such programmes and studies focused on street-based interpersonal violence, without necessarily distinguishing between that which does or does not relate to drugs. Below, we aim to explore the implications relating to drug consumption- and supply chain-related violence. Finally, we comment on the potential for research-policy-practice partnerships to support this work.

First, if we accept that drug consumption is a public health issue and violence is a public health issue, then we must accept that drug consumption-related violence is a public health issue. This justifies investing in multi-agency pathways, which allow for various evidence-based approaches to responding to drug consumption-related violence that do not require law enforcement and criminalisation. For example, England's Liaison and Diversion Scheme, run by the National Health Service, aims to 'identify and assess people with vulnerabilities as they pass through the criminal justice system, to ensure their health and other needs are known about and that they are referred to appropriate services for treatment or support' (Disley et al., 2021: iii). The evaluation showed that 30% of referrals to health interventions through the programme were for violent offences in 2017. The programme diverted people from prison without increasing offending and appeared to increase drug and alcohol treatment referral and attendance (Disley et al., 2021). Although the Irish government has long since approved a scheme that would allow first-time drug offenders to be diverted to a healthcare intervention, there is no equivalent scheme like Liaison and Diversion which would allow people who commit violence, whether drug related or not, to access healthcare, drug or alcohol interventions as a diversion from criminalisation. We also do not have a specific violence interruption and conflict mediation scheme, despite our highly developed, youth work-based diversionary scheme which has national coverage. All its staff are trained in restorative approaches to conflict resolution, many of whom likely to reflect the 'credible messenger' concept to a significant degree. Separate questions can be asked about how to expand public health approaches to drug consumption-related violence prevention beyond 'street violence' to include gender-based violence (Decker et al., 2018; Burke et al., 2025).

Second, if violence relating to the commercial aspects of drugs stems at least partly from the fact that such commerce exists in informal markets, then we might reconsider the legal and regulatory framework for those markets. In some cases, it is possible to create markets that provide legal, regulated access to drugs like cannabis in ways which displace informal drug markets (see, e.g., McDonald et al., 2025, who discuss the impact on informal market sales of cannabis legalisation in Canada). Substances which we might not wish to make commercially available to consumers, such as heroin, can still be provided safely. For example, research from countries like Switzerland and the UK suggest that heroin-assisted treatment, involving prescribing heroin to people who experience addiction, reduces participants' involvement in the illicit market, both as buyers and as suppliers (Pardo & Reuter, 2018; Smart, 2018). More research is needed to consider how participation in heroin-assisted treatment can penetrate the user base sufficiently to displace the informal market (Wakeman, 2015). Still, the potential for legal supply of different kinds to displace informal drug markets, and thus to reduce the associated violence, is worth considering as part of a public health approach.

Thirdly, if violence that appears to be drug related is primarily a matter of interpersonal conflict, we must offer wider conflict resolution strategies in communities. They must be delivered by people with the credibility (among communities and partner organisations, not least local authorities, youth work and police) and skills to intervene immediately following incidents of violence, and to intervene in conflicts that involve people at higher and lower levels in drug supply chains. Among the first recognitions of this in an official document in Ireland is a recent violence prevention strategy (Ruane, 2025). Commissioned by a drug service funding group in south inner-city Dublin, this emphasises violence intervention as a solution to drug-related violence. Meanwhile, there is scope to learn from evidence in other countries and develop school-based programmes which build emotional regulation and other social skills (e.g., Gaffney et al., 2021) and achieve long-term cultural change in relation to attitudes to, and uses of, (especially male) violence. The evaluation of a since-mainstreamed social empathy programme in Irish schools did not explore its impact on violence, but found that participating students showed significantly higher levels of empathy than a control group (Silke et al., 2021). The implications of this for drug-related violence should be explored and monitored.

Finally, we want to draw attention to the role of research partnerships. The Centers for Disease Control (2024) state that public health approaches are 'rooted in the scientific method' and characterised by scientific approaches to developing, testing and implementing programmes, as well as through the involvement of health and other non-justice actors in those programmes. Alongside the wealth of international evidence and research that can inform drug-related violence prevention strategies, this suggests that there should be some role for academic researchers and others with a background in conducting, designing and interpreting research in developing a public health approach. Here in Ireland, two of us are founding members of the CORD Partnership (2025), which brings research, policy and practice organisations together to embed a culture of interdisciplinary open research in criminal justice in Ireland. Given the flexibility of the public health approach (Snowdon et al., 2024), there is a need for deep local engagement across a range of professions, sectors and communities to identify local resources and ensure that the approach meets distinct local needs and problems and that the processes by which decisions are made (and thus the policy and practice outcomes and investments) are seen and experienced as legitimate. Research partnerships and universities can provide a neutral space for those affected to come together and

co-design a plan that works for all.

In conclusion, this essay calls for a reimaging of our approaches to drug-related violence. We invite the Irish government to collaborate widely to strengthen prevention, treatment and recovery, in line with the ecological model and typology of violence and its reflection of evidence-based public health approaches. Finally, we call for a new transdisciplinary and sustainable model for policy and practice development drawing together lived, living and professional expertise.

CRediT authorship contribution statement

Catherine M. Comiskey: Writing – review & editing, Writing – original draft, Conceptualization. **Ian D. Marder:** Writing – review & editing, Writing – original draft. **Melissa Corbally:** Writing – review & editing, Writing – original draft, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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