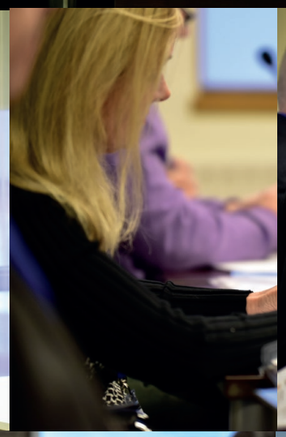
ana liffey drug project

ACTION • PREVENTION • SUPPORT

DUBLIN DRUG POLICY SUMMIT

20TH JANUARY 2017









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CHAIR-PERSON'S FOREWORD

The Dublin Drug Policy Summit brought together leading figures from Europe, North America and Australia to discuss two topical issues in drug policy – supervised injecting facilities and decriminalisation. These are both concepts which potentially challenge the *status quo*, and as such they can raise fears for many people. They are, however, also topics which are not specific to an Irish context. Indeed, many countries have implemented, or are actively considering implementing, policy in these areas. At the summit, we had the benefit of the expertise and insight of international academics and practitioners in both areas. The purpose of the session was to help Ireland, as a country learn from their experiences as we consider the practicalities of policy change.

As Chair, I'd like to extend my thanks to a few groups and individuals. First, to all the delegates who attended and participated – there was great energy in the room and this always makes the role of Chair significantly easier, for which I am grateful. There was much discussion and insight shared on both topics, which I believe has been well captured in this short report. Second, to the Ana Liffey Drug Project, Open Society Foundations, the London School of Economics and the Irish Management Institute who respectively organised and supported the event.

Third, I would also like to extend my personal thanks to the keynote speakers on the day. Madame Ruth Dreifuss attended and contributed in her capacity as Chair of the Global Commission on Drug Policy. It was wonderful to benefit from her experience as our guest of honour and I greatly enjoyed sharing the day with her. The same is true of Minister Catherine Byrne, who attended in her capacity as Minister of State with responsibility for the National Drugs Strategy.

Finally, I am pleased to say that since the completion of the summit I have been able to follow Minister Byrne's work in introducing the Misuse of Drugs (Supervised Injecting Centres) Bill 2017 to the Oireachtas. I wish the Minister well for its passage and subsequent implementation.

I have no doubt that the conversation on supervised injecting and decriminalisation in Ireland will continue among policy-makers, civil society and the communities they serve. I hope and trust that this short report will be of value in informing those conversations.

Eva Maguire
Chairperson
March 2017

'AT THE SUMMIT, WE HAD THE BENEFIT OF THE EXPERTISE AND INSIGHT OF BOTH ACADEMICS AND PRACTITIONERS IN BOTH AREAS.'

INTRO-DUCTION

This is the report of proceedings from the Dublin Drug Policy Summit, which was held in Dublin on 20th January 2017. The summit was hosted and organised by the Ana Liffey Drug Project, and brought together national and international experts in drug policy to talk about two key issues in current Irish drug policy – supervised injecting facilities and the decriminalisation of possession of drugs for personal use. The summit was held under the Chatham House Rule, and this report is consistent with that rule – what is reported on are the themes of the discussions, but no individual or organisation is identified as having made any particular statement. The report was prepared from the substantial notes of two observers from the Irish Management Institute who were in attendance on the day, with feedback on a first draft being provided by the Ana Liffey Drug Project prior to completion. Points reported are not presented in strict chronological order, but are rather grouped as general themes.

CONTEXT

A group gathered in Dublin to discuss two significant developments in the Irish policy approach towards drugs and drug use, those being:

1 The Programme for a Partnership Government notes that the government *"will support a health-led rather than criminal justice approach to drugs use including legislating for injection rooms"* [1]. Legislation which will create the legal framework within which supervised injecting facilities can lawfully operate is expected to be introduced to the Dáil in February 2017[2], and monies have been allocated in the national budget for expenditure on this project in 2017. The establishment of a pilot centre appears in the Health Service Executive's workplan for 2017[3].

2 In November 2015, and in line with a health-led position on drug use, the Joint Committee on Justice, Defence and Equality *"strongly recommend[ed] the introduction of a harm reducing and rehabilitative approach, whereby the possession of a small amount of illegal drugs for personal use, could be dealt with by way of a civil/ administrative response and rather than via the criminal justice route."*[4]

Ana Liffey has taken an active role in the public debate around these issues, and in providing civil society input into their development and progression as policy approaches. Ana Liffey is explicitly supportive of both supervised injecting and of decriminalisation of possession for personal use, but recognises that not all countries are the same and that it is important that the correct path forward is identified for the Irish context. The aim of the summit was to share learning from around the world on these important topics. Delegates included domestic and international experts from statutory and non-statutory agencies. A delegate list is provided at Appendix A.

1 See http://www.merrionstreet.ie/MerrionStreet/en/ImageLibrary/Programme_for_Partnership_Government.pdf , p56

2 The Bill was, in fact, presented on 08/02/2017

3 https://www.hse.ie/eng/services/publications/serviceplans/Service-Plan-2017/2017-National-Service-Plan.pdf

4 See http://www.oireachtas.ie/parliament/media/committees/justice/Final-Report---For-Publication.pdf

STRUCTURE OF THE SUMMIT

The agenda for the day is provided at Appendix B. In essence, the event was broken into four main areas:

1 A brief introductory session which included:

- **a)** A brief statement from the CEO of Ana Liffey, Mr. Tony Duffin
- **b)** A *tour de table*
- **c)** An Opening Address from Catherine Byrne TD, Minister for State for Communities and the National Drugs Strategy
- **d)** A Keynote Address from Madame Ruth Dreifuss, Chairperson of the Global Commission on Drug Policy and former President of Switzerland.

2 A module on key issues in supervised injecting in Ireland which included a presentation from the CEO of Ana Liffey, Mr. Tony Duffin followed by a roundtable discussion for all delegates facilitated by the summit Chairperson, Ms. Eva Maguire

3 A module on key issues in decriminalisation in Ireland which included a presentation from Ana Liffey's Head of Policy, Mr. Marcus Keane followed by a roundtable discussion for all delegates facilitated by the summit Chairperson, Ms. Eva Maguire

4 A closing session

EXECUTIVE SUMMARY

The establishment of a supervised injecting centre is government policy and policy makers are working towards an implementation date within the coming months. As they do so, the following are the broad considerations which emerged from the day.

1 People who inject drugs and other stakeholders should be consulted regarding service design and implementation. The service must be appealing to people who inject drugs in the public domain; it must be a discreet service that they trust; and it must be a sanctuary where they feel safe.

2 Access criteria to the facility should not be specifically legislated for. There is a need to maintain flexibility, such that people are not needlessly excluded. It may be the case that there are different operational protocols which apply to different groups, but as a general rule whether or not any individual can access the centre should be on the basis of an informed decision by the person seeking to access the centre and the responsible person running the centre at the time.

3 It is important to be clear on the benefits of Supervised Injection Facilities, and on their limitations. They will improve amenity by reducing consumption of drugs on the street and will lead to positive health outcomes for drug users. They will not solve the drug problem or decrease drug consumption.

4 There are challenges in operating drug consumption rooms. As a new service, staffing, policing and engaging the community will all require focus, but are all issues which have been addressed successfully in other jurisdictions.

The decriminalisation of possession of small amounts of drugs for personal use is not current government policy, but it has been the focus of attention in recent times from legislative structures such as the Joint Oireachtas Committee. There is an ongoing conversation in Ireland about decriminalisation as a policy choice. As this conversation continues, the following are the broad considerations which emerged from the day.

1 Decriminalisation is consistent with a health led approach to dealing with drug use. However, a mere change in the law is unlikely to have a significant effect either way on levels of use.

2 Decriminalisation does not imply a lack of consequences. However, it does permit a health based, person centred approach to be taken, and avoids the person having the stigma of being criminalised.

3 It is important to be clear in communicating precisely what is meant by 'decriminalisation' as this often isn't clear.

4 Threshold limits are likely to be a necessary part of any decriminalisation model. These must be carefully selected and the approach taken to enforcement must be flexible.

5 Whilst there was significant support for decriminalisation as a policy for Ireland at the summit, it was not unanimous, and not all delegates agreed that decriminalisation was the correct drug policy choice for Ireland.

INTRO-DUCTORY SESSION

WELCOME AND THANKS

The delegates were welcomed. It was noted that they were a diverse group, all with specific expertise in drug policy and / or healthcare service delivery. Delegates included a person who has injected drugs, clinicians, researchers, academic experts, community workers, policy experts and representatives from relevant statutory bodies.

It was noted that 2017 is an important year for the Ana Liffey, which celebrates 35 years in existence, having been established in 1982. Thanks were extended to the Irish state and to statutory bodies such as the Health Service Executive, which provide the vast majority of the funding for Ana Liffey's services. Gratitude was expressed to partners of the Ana Liffey for their support for the event, and in particular to the London School of Economics, the Open Society Foundations and the Irish Management Institute

INTRODUCTION TO THE DAY

The scope and purpose of the day was discussed. It was noted that there were a wide range of factors that will require consideration from the various stakeholder groups in progressing the issues of supervised injecting and decriminalisation, and that learning from the day's forum should be taken forward. It was recognised that not all stakeholders were in attendance on the day.

THE POLICY CONTEXT

It was noted that there will be a new National Drug Strategy in 2017, focused on reducing the harm caused by drug use and continuing to build on the foundations laid by previous policies and previous administrations. The process to create the new policy included submissions from a wide variety of stakeholders. The lessons from, and experience gathered in the forum can help inform the strategic choices around drug policy in Ireland. The importance of including the views of people who use drugs themselves was noted.

The Government's commitment to a health-led approach to drug use was underlined by its support for supervised injecting facilities. Street based injecting poses a significant health risk to users and to the community and a pilot project for safe injection facilities is planned in 2017. Learning outcomes from the pilot project should in turn be applied to inform wider, future policy development. The importance of designing the pilot with robust and appropriate data collection methodologies at the outset was stressed. It was also acknowledged that policy makers, expert advisors and field workers must work to ensure a high level of public awareness of the facts around safe injection facilities is available.

A growing level of interest in relation to decriminalisation as a policy choice in Ireland was noted, with increasing attention paid to models in places like Portugal. A parliamentary visit to Portugal had highlighted the long term stigma that can affect prospects for employment and social cohesion caused by criminal convictions for the possession of relatively small amounts of drugs for personal use.

'AN OBLIGATION EXISTS TO MINIMISE HARM AND TREAT ADDICTION NO MATTER THE METHOD OF DRUG CONSUMPTION.'

Ireland has already taken important and pragmatic steps in drug policy with its commitment to safer injecting spaces and openness to discussions on decriminalisation. In this regard, Ireland must be viewed in the context of a broader picture, that dealing with drug issues is a work in progress all over the world which, while not exactly the same everywhere, is nonetheless a different combination of the same core elements, including:

1. A public health emergency with social consequences
2. Prejudice against drug consumers - especially the poorest and most at risk, including ethnic minorities
3. Lack of access to services and housing for the most vulnerable drug consumers
4. A growing global black market, whether repression is strong or not
5. An increase in organised crime with a large influence on society
6. Higher level of violent crime
7. A loss of credibility of states and their laws

In this context, the need for an animated public debate and genuine participative collaboration in policy implementation between all stakeholders is understood as compulsory. There was consensus in the room that not every model will work for Ireland, but by undertaking this type of collaborative approach and applying the best of what works elsewhere and contextualising it to Ireland's specific needs, a well informed and culturally suited approach can be identified and adopted.

ON SUPERVISED INJECTING FACILITIES

Such facilities should and could be much more than just monitoring injections. They provide an opportunity for relief from the dangers that face many drug users and also opportunities to have conversations with peers, and to access other medical and social services.

Such facilities should be adaptable to new problems, new drugs and new trends in drug use.

In the Irish context, a drug checking service might also be considered – ensuring consumers know what is in what they have bought, how pure/impure and the strength of the substance. Such services are already in place in some countries at music festivals and night clubs where drug samples can be tested at fixed points and in mobile labs. This can help give up to date information on drug trends.

There was a semantic difference highlighted between supervised consumption and supervised injecting and that the pragmatic consequences of focussing on one particular method of drug use at the exclusion of all others needed to be acknowledged. An obligation exists to minimise harm and treat addiction no matter the method of drug consumption. Further, if there are other means of use that are less harmful than injecting then facilities should encourage this. The semantic distinction was also noted between 'safer' and 'supervised' in the context of drug consumption spaces.

'SOCIETY AT LARGE NEEDS A SUPPORTIVE ARCHITECTURE OF COMPASSION TO ENABLE PERCEPTIONS TO CHANGE.'

ON DECRIMINALISATION

It is important to be clear about what decriminalisation means, and to what it applies. In general, the issue is in changing the criminal law to decriminalise possession for personal use (and, in some cases, petty, non-violent drug crime), reducing harm and allowing the police and legal system to focus their resources on drug dealers and organised crime.

Criminalisation itself is in large part responsible for problems like stigmatisation. In moving to a health-led approach it is hoped that in time people will accept that to support people who use drugs problematically, it can be recognised that proper care is required rather than criminalisation. Society at large needs a supportive architecture of compassion to enable perceptions to change.

There are many ways to decriminalise, or at least reduce criminalisation that have been implemented in other countries. There is no "one-size-fits all", prescriptive solution. As a nation, Ireland must attempt to find a lower level of repression, one that abandons the stance on removing the rights of people to choose which drugs are acceptable. Alcohol and cigarettes were raised as examples of dangerous, addictive substances with huge personal and social costs attached, yet society does not seek to control simple possession or use via the criminal law.

It was noted that the markets for cigarettes and alcohol are legal and regulated. Though important to distinguish decriminalisation from regulation, it was noted that regulating markets can remove them from the criminal sphere. If done properly, regulation can help States minimise harm by moderating the production and sales environment in the same way that exists for chemicals, medicines and food.

MODULE 1: SUPERVISED INJECTION FACILITIES

The following summarises the key points discussed during the session on Module 1: Supervised Injecting Facilities, grouped under the broad headings of people, place and policing.

PEOPLE

ACCESS CRITERIA

There was a discussion about access and about who should be permitted to use the facility:

Access should be broad

There was a general agreement that access should be as broad as possible and that the introduced legislation should steer away from excluding certain groups from accessing the service (e.g. under 18s, pregnant women, etc.).

This was backed up by the experience in Sydney where a number of exclusionary criteria are in place (e.g. must be an already established user, no pregnant women, no under 18s, must not be significantly intoxicated). It was argued that if someone is already an injecting drug user, they should be welcomed even if they don't meet the other criteria above as it is in their best interest to access the services and support that they require as they need it.

It was, however, stated that access should be given only if the person presenting is an injecting drug user so as not to assist someone in becoming an injecting drug user.

There can be tailored protocols for certain groups

It was noted that specialised protocols can be put in place for particular groups and clinicians on the front line can make decisions on a case-by-case basis which are in the service users' best interests. In the case of younger injecting drug users, it is important that we become aware that they are using as early as possible so that interventions can be planned. There is nothing to be achieved by using the law to blanket block access to a particular group.

It would be better to have less specific direction in law such that it could be left to the clinician and the service user on the front line to make access decisions based on the specific situation at the time of access.

AN APPEALING SERVICE FOR POTENTIAL SERVICE USERS

The Supervised Injecting Facility needs to be a facility that is appealing to service users. It is therefore important that potential service users are consulted to understand what kind of facility they would use, and it was stated that there is some work underway to this end. The following was noted in this regard:

There is both curiosity and apprehension
Apprehension about such services does exist and there was a concern that there may be reluctance amongst some potential service users to attend the Supervised Injection Facility. However, there is also a curiosity amongst the target user group and they are anxious to understand what it will be like and how it will work.

A smiling welcome is important
From the experience of existing services, it was noted that although the locale, facilities and aesthetics of the service are all important what really makes the facility appealing is the atmosphere and the approach of staff. The smile and welcome you receive when walking through the door is key, and this will spread by word-of-mouth. A person centred approach, focused on building relationships is useful in this regard.

The service needs to be accessible
It was noted that people engaged in injecting in the public domain do not typically travel before they use, but tend to use close to where they purchase their drugs. It was suggested that 'NIMBYISM' may be an issue and people may be concerned about a honeypot effect, although it was noted that the evidence did not show that supervised injecting facilities had any sort of honeypot effect.

The service should seek to include, not exclude people. The service should be very flexible in terms of sanctions, only denying access in very narrow circumstances such as significant violent incidents.

There is facility in the Sydney centre for two people to use drugs together in a booth if they present together at the centre. In these cases, there may be some sharing of substances. However, drugs in Australia are expensive so the substances may have been jointly procured. Sharing and selling of drugs is not permitted outside of these circumstances. There is a legal basis for injection, but not for sale or purchase. In Ireland, it was noted that the law would be applied differently and that it would not be possible for sharing to take place.

Staffing
The staffing needs and implications of supervised injecting facilities were discussed. The following points were noted:

Attitude is key
There is a paradox in having healthcare staff supervise injecting, an inherently dangerous activity, particularly where the substance to be injected may be unknown. In the Sydney case, a medical approach to staffing the centre was taken and there is a part time Medical Director, a part time Operations Director and floor staff including Nurses and Health Education Officers. In practice, Health Education Officers can manage most situations but nurses are required to carry out certain interventions. What is key is that staff members need to be able to deal very humanely with the service users.

Consider practicalities
Medical involvement helps identify the facility as a health service and it also reinforced the strategy of approaching this with a health lens rather than a criminal justice one. However, it was noted that there can be a considerable burden on a Clinical Lead who is regularly on call and that this should be considered early in the planning for the facility.

It was noted that although staff will not always know what substances may have been consumed before someone presents at the facility, this can be assessed in real time and if there is an adverse reaction, the person is in a place where they can receive appropriate treatment. Overdoses can be assessed according to clinical criteria and can be managed proactively through monitoring and intervention when appropriate.

PLACE

THE BUILDING

There is a need to consider the best environment for this facility. It should be clean - but should it be clinical or should it be more hospitable? A discussion was held on this and the following points were noted:

Not overly clinical
Some facilities are located in medical and clinical buildings. This could be off-putting for potential users as it may be too administrative and too medical and not appealing as a place to approach. This was contrasted with facilities such as that in Copenhagen, where the set-up is not overly clinical in nature. A Supervised Injecting Facility should be a sanctuary for people, where trust increases and therapeutic relationships can develop.

Currently, drug use occurs in parks, public toilets and anywhere people can readily access but remain secluded. Drug use is not permitted on private or business premises including drop-in centres and homeless hostels, but the reality is that it does happen in all these locations. Many services have clinical waste bins in the toilets.

‘A SUPERVISED INJECTING FACILITY SHOULD BE A SANCTUARY FOR PEOPLE, WHERE TRUST INCREASES AND THERAPEUTIC RELATIONSHIPS CAN DEVELOP.’

In the city centre
In the context of Dublin, it was noted that a city centre location made sense. It was also noted that Dublin was not the only location where stakeholders had called for implementation of supervised injecting facilities. In particular, stakeholders in Cork have identified a need for a Supervised Injecting Facility and have identified a suitable building.

Potentially mobile
A Supervised Injecting Facility is a local solution to a local problem. However, one possible variable is to have mobile facilities which can follow the flow of the population. This would allow authorities to move the facility if the location of drug use changed and they could also service events where drug use is common such as festivals. However, mobile units have limitations with regards to capacity due to their size.

ENGAGING THE COMMUNITY

There is great interest in the community about where the facility will be located. There are a lot of stakeholders and ‘NIMBYISM’ will undoubtedly be an issue. This issue was discussed and the following noted:

The need to engage proactively
Existing services in Dublin spend a significant amount of time engaging with the local community and issues around anti-social behaviour and congregation are often cited as objections to services. In other locations input regarding supervised injecting centres is garnered from the community at regular meetings. This on-going consultation has emerged as an important element of the ongoing management of Supervised Injecting Facilities. Fears can be allayed by street visibility. In other locations, there are security staff on duty to manage and prevent congregation and congestion inside and outside the building.

The need for good data
Communities had, after initial opposition, generally been welcoming to Supervised Injecting Facilities where they had been introduced as they had had a positive effect on the area. In this regard, there is a need for good baseline data on key indicators such that the effectiveness of the facility can be measured and in order to capture any changes in opinion in society around the introduction of the Supervised Injecting Facility.

INTEGRATION WITH OTHER SERVICES

Supervised Injecting Facilities need to be embedded within the service landscape and it was noted that there was a need to integrate the Supervised Injecting Facility with existing services, including higher threshold treatment options. A discussion was held on this, with the following noted:

The need for pathways
With most Supervised Injecting Facilities, there is a three stage approach; reception, injecting room and an area to relax and interact. In the third stage, access to other related services can also be offered. The importance of identifying and defining pathways for people through the service and to other services was emphasised.

Provide what people want and need
In general, other services can also be provided to people at the facility such as basic food, showers, or laundry services. Having access to such services is important and can help change the perception people have of themselves. In considering what services to include, the needs of potential service users must be taken into account.

POLICING

IMPACT ON DRUG MARKETS AND CRIME LEVELS

Members of the public may be concerned about the impact Supervised Injecting Facilities have on crime levels and drug markets. These matters were discussed and the following was noted:

No increase in crime
International examples show us that there is no increase in crime associated with the introduction of Supervised Injecting Facilities. There has been some evidence of a reduction in certain types of crime and this should be explored further. Nonetheless, it was noted that supervised injecting is not a criminal justice intervention and should not be expected to impact significantly on crime, either positively or negatively. The key benefits will be in terms of service user health and public amenity.

No market influence
Similarly, it was noted that supervised injection facilities do not affect the drug market with sale, purchase and use continuing in the same areas. The presence of a Supervised Injecting Facility doesn’t influence the market, and is instead a response to an existing problem. However, Supervised Injecting Facilities can give real time drug trend updates and can respond more rapidly to emerging needs which has benefits.

ROLE OF POLICING

With the intense focus expected on the Supervised Injecting Facility in the early days many questions arose around the policing of the centre. The following points were noted on policing and supervised injecting:

The importance of law enforcement
The role of law enforcement agencies cannot be underestimated and the success of the project will depend on all stakeholders working together. In general, a relationship of trust between police and management of the facility is very important and a transparent relationship must be built from day one. Police must not target the centre and users but also must not avoid it. All police in the area should be educated on how to police the centre. This could form part of induction for all new police as well as a tour of the centre to see it first hand and dispel any myths.

Different solutions for different jurisdictions
Different jurisdictions operate different approaches in relation to policing. In Switzerland, police do not generally enter the centre unless they have been called for assistance in a violent case.

‘THE POSSIBILITY OF CRIMINAL SANCTION IS NOT A DETERRENT TO DRUG POSSESSION AND USE FOR SOMEONE WHO IS DEPENDENT – NECESSITY KNOWS NO LAW AND WHAT MUST BE DONE, MUST BE DONE.’

In Sydney, there is no ‘free zone’ around the centre. There is support from local police, and people coming to use the service are not actively targeted on the sole basis of a belief that they are heading towards the Supervised Injecting Facility and could be in possession of drugs. Where people are stopped, police in Sydney often use their discretion not to charge for possession, but they do still confiscate.

It was noted that people working in addiction services can feel like they are working in a ‘gray area’, given that they are working with people who by the nature of their addiction will often be in possession of drugs, thereby creating a potential criminal liability for staff and clients unless addressed appropriately. It was also noted that the possibility of criminal sanction is not a deterrent to drug possession and use for someone who is dependent – necessity knows no law and what must be done, must be done.

In the Irish context, it was noted that police are very aware of the complexities of policing in the context of social and health issues and take a very pragmatic approach to dealing with people on the street every day.

The importance of discretion

Discretion is important in policing supervised injecting facilities, and it was acknowledged that this presents challenges. Discretion is something which needs be applied consistently, and legislative clarity assists with this. If things are unclear, a very nuanced approach to complex issues is required, and it can be difficult to get a consistent approach. It is important that the facility is properly policed but not targeted. It was noted that policing is about all aspects of community safety and support, including health, and that police forces understand the role of consumption facilities in communities where they are needed. In terms of people using the centre, common sense dictates that if someone is merely walking towards the centre, there is no need to intervene absent any other reason. It was noted that issues of public injecting in Dublin city centre are currently policed in a conscientious way, and there is a lot of good collaborative work on the ground between the Gardaí and other statutory services and NGOs.

MODULE 2: DECRIMI-NALISATION

The following summarises the key points discussed during the session on Module 2: Decriminalisation, grouped under the broad headings of general discussion, responses and threshold limits.

GENERAL DISCUSSION

There was a discussion about decriminalisation generally as a policy approach. The following were the key points noted:

Decriminalisation is not a panacea
It is important to not overstate the benefits or impacts of decriminalisation. The reality is that (de)criminalisation has little or no impact on levels of drug use in an open society. Drug use is a complex issue, and a binary choice between criminalisation and decriminalisation is unlikely to have a great effect either way.

It is true to say that there have been better outcomes for drug users in, e.g., Portugal since decriminalisation, but these benefits cannot simply be ascribed to the change in the law. Rather, they are more likely to reflect a broader policy shift which included the legal change, but also investment in services and the establishment and operation of the commissions of dissuasion.

Criminalisation is harmful
Nonetheless, criminalisation causes unnecessary harms. Prohibitionist policies don't demonstrably impede drug markets, but they do have other effects. For example, they affect the way professionals engage with drug users. If a service provider becomes aware that a person is in possession of drugs, they must take steps to address this to ensure they are not exposing staff to criminal liability. Under current laws, users are by definition criminals and criminalisation is stigmatising. It can contribute to drug users remaining cautious about accessing services. Thus, there is a fundamental contradiction in the current system, where drug use is recognised as a health issue, but in order to receive assistance for that issue it is necessary for the person to be labelled as a criminal.

Under a criminalisation policy, the basic idea is that if a state punishes people who do things which are at odds with what society considers acceptable, then people will be deterred from doing those things. However, punishing possession for personal use has not been shown to have any significant deterrent effect. In reality, the crime of simple possession is not respected by large amounts of people, which undermines its credibility and the rule of law.

Nor does a policy of criminalisation affect all groups in society equally - people from disadvantaged areas are more likely to be criminalised than other members of society. Similarly, a policy of criminalisation has a negative effect across other policies - if a state's policy is societal reintegration of people who use drugs, criminalisation goes in the other direction. Labelling someone as a criminal can have lasting negative consequences.

The importance of language
It was noted that language can be important. Many people are instinctively against decriminalisation, but agree with a health based approach to drug use. Decriminalisation needs to be framed as a health and social issue rather than a criminal one.

Some concerns remain
There were concerns that a decriminalisation policy could lead to an increase in drugs coming into Ireland and that this additional supply element could have consequences for law enforcement. There were also concerns that a decriminalisation policy could send the wrong message to people, particularly under 18s. However, it was also noted that the criminal justice system is not the best way to communicate health promotion messages to people - young or old.

Balance is important
It was noted that dealing with drugs in society is a complex matter and that balance was important in drug policy generally. Going too far either way on a restrictive / permissive spectrum is likely to result in significant harms and be unhelpful as a policy approach attempting to minimise harm, and there is a need to ensure that this is understood.

RESPONSES

A discussion about responses also took place, with the following points noted:

A need for appropriate responses
Decriminalisation does not mean an absence of consequences, and that needs to be clear. It doesn't mean that the activity is not prohibited or frowned upon. It just isn't dealt with through the criminal justice system.

The Joint Oireachtas Committee report recommended dealing with possession with a civil administration response. Research must be done to ensure the appropriate response in the Irish context. Factors identified by the Committee such as role and discretion of statutory services; application on a case-by-case basis; and investment in education and training must be addressed.

Should support a health based response
Different jurisdictions have used different responses. It's important not to adopt any approach that could be more punitive in practice than criminalisation, or one that can lead to criminalisation by other means. Fundamentally, decriminalisation is about supporting a health led rather than a criminal justice led approach to drug use. It is not about adopting alternative, but equally punitive approaches to the issue.

In this regard, it was noted that some international commentators have argued against punitive penalties for certain drug related offences. Interventions should be health based, tailored to the individual and voluntary. The assumption that if you punish someone, they won't do it again doesn't work for drug users. There is no reason to punish someone for something which may bring harm to themselves, but not to others. Further, the law courts are not the appropriate setting for engaging with a health issue like drug use.

An alternative perspective was that possession offences could involve a civil sanction rather than a criminal sanction but that the response should send a message that it is not acceptable for people in our society to take the risks associated with drug use.

Lessons from elsewhere
In terms of other jurisdictions, it was noted that in Portugal possession for personal use was decriminalised and responsibility was moved from the criminal justice system and placed under the Ministry for Health. The health administration authority has the power to apply sanctions. In practice, the substance is not the issue but the pattern of use of the individual. Each person needs to be dealt with on a case by case basis.

The current system in Portugal works better than what was there before. It is much more focused on the person, and because the function is under the Ministry of Health, people are more willing to take the guidance being offered. It is not perceived in the same way as a court of law, which is important. It also allows police to focus on and deal with supply rather than possession.

The focus in Portugal now is clearly on health issues and health problems. This can be contrasted with the previous situation. Under criminalisation, if a drug user comes for help, he is admitting that he's a serial criminal. Without this stigma, all other interventions are made easier and more accessible to those who need them.

In Portugal, decriminalisation was intended to make things be more fluid. It's important to note that when possession was considered a crime, the courts were generally applying the same sanctions which are now applied by the Ministry for Health. However, now the sanctions come without the criminal record, the stigma and the expending of large amounts of resources.

Drug courts are not decriminalisation
It was noted that drug courts are not an example of decriminalisation and the US courts were described as a cautionary tale in this regard. As the court is not a health setting the health of the person is not to the forefront. Also that there is a need to consider the incentive structures of law enforcement in relation to drug arrests in any decriminalisation policy. It was suggested that drug policing is used as a proxy in other countries for managing certain communities, although that this is not the case in Ireland.

It was noted that policing in Ireland is often focused on supply issues and that there is a significant level of compassion and practicality in the way drug use is addressed.

THRESHOLD LIMITS

Threshold limits – the amount of drugs one can possess before the focus shifts from personal use to possession for sale or supply – were also discussed. The following summarises the main points:

Thresholds are needed
It seems inevitable that some thresholds will need to be defined. With no threshold, the quantity of drugs considered within or beyond a personal use limit is open to inconsistent interpretation.

Thresholds should not be rigid
Threshold limits must be carefully selected and the approach taken must be flexible. It is important that the thresholds are realistic. Otherwise, there is the risk of the decriminalised system being harsher than that under the criminal law.

Focus on the needs of the individual
In Portugal, the initial goal was not to have a threshold chart, but this led to ambiguity and a chart was introduced. However, the system retains flexibility – it is always open to the court to refer a matter to the health authorities, or *vice versa*. This helps to ensure that there is not too much weight placed on the threshold amounts – the focus should be on the needs of the individual where personal use is the issue.

CLOSING REMARKS

A brief closing session provided an opportunity to reflect on the day's proceedings. The following key points were noted:

Implementation of a Supervised Injecting Facility
On the issue of creating a supervised injection facility, Ireland is close to seeing the Irish parliament pass legislation and then the real challenges of implementation will begin. In getting to this point, the work of previous governments was acknowledged, as were the many public and private advocates who have kept the issue in the spotlight.

Take the dialogue on decriminalisation forward
On the decriminalisation discussion, the discussion at the summit was a starting point, and it is now for individual politicians to find the best window to suit the political agenda and take this dialogue forward. It is true though, that it has been considered by legislators and perhaps that time is now.

Honour the evidence
In general, our choices around drug policy should reflect good practise approaches and there should be a focus on the ways to get further, validated, reliable evidence into the debate. Academic research will play a part in this, as should existing and historical records – real human experience and individual cases.

Focus on reducing harm
A catalogue of harm reduction measures are needed to be effective in addressing the harms caused by existing and new substances and changing circumstances. This is a global issue, not only a local issue. Speaking in one voice is important, but so is being modest and bold at the same time. It will not all be done tomorrow, but Ireland is on the right path.

Many thanks to Leonie Blyth, Lauren Crook, Paul Duff, Jacqueline Kenny and Dawn Russell - members of the Ana Liffey who worked tirelessly to ensure the Dublin Drug Policy Summit was successful.

APPENDIX A: LIST OF DELEGATES

NAOMI BURKE SHYNE	Open Society Foundations
CATHERINE BYRNE	Minister of State for Communities and the National Drug Strategy
NUNO CAPAZ	General Directorate for Intervention on Addictive Behaviours and Dependencies (Lisbon, Portugal)
JOHN COLLINS	London School of Economics
CATHERINE COMISKEY	Trinity College Dublin
JOANNE CSETE	Columbia University (New York, USA)
TOM CUNNINGHAM	Ana Liffey Drug Project
AOIFE DAVEY	Health Service Executive
PASCHAL DONOHOE	Minister for Public Expenditure and Reform
JOSEPH DOYLE	Health Service Executive
RUTH DREIFUSS	Global Commission on Drug Policy (Zurich, Swizerland)
TONY DUFFIN	Ana Liffey Drug Project
TONY GEOGHEGAN	Merchants Quay Ireland
JOÃO GOULÃO	General Directorate for Intervention on Addictive Behaviours and Dependencies (Lisbon, Portugal)
ANTHONY HOWARD	An Garda Síochána
MARIANNE JAUNCEY	Uniting Medically Supervised Injecting Centre (Sydney, Australia)
MARCUS KEANE	Ana Liffey Drug Project
EAMON KEENAN	Health Service Executive
ALAN KELLY	Department of Health
BRIAN KIRWAN	Health Service Executive
EUGENE LENNON	Department of Health
EVA MAGUIRE	Chairperson
EUGENE MCCANN	Simon Fraser University (Vancouver, Canada)
JACK NOLAN	An Garda Síochána
JOHN O'DRISCOLL	An Garda Síochána
PAT PAROZ	Independent Consultant, ex NSW Police (Sydney, Australia)
BRIGID PIKE	CityWide - Independent Researcher
ANNA QUIGLEY	CityWide
EAMONN QUINN	Department of Health
SUSAN SCALLY	Department of Health
MIKE SCULLY	Health Service Executive
MIKE SHINER	London School of Economics
BOBBY SMYTH	Health Service Executive
ALEXANDER SODERHOLM	London School of Economics
JOHN STRANG	Kings College London
LAURA VUILLEQUEZ	Global Commission on Drug Policy (Zurich, Swizerland)

APPENDIX B:

DUBLIN DRUG POLICY SUMMIT AGENDA

FRIDAY 20th January 2017

09.00	Coffee / Tea
09.20	Welcome - Chairperson • Format of the day • Tour de Table • Introduction of Minister Byrne
10.00	Opening address – Minister Byrne
10.10	Keynote address – Madame Dreifuss
10.40	Refreshment Break

11.00	**Module 1 – Supervised Injecting** • Intro to structure of module - Chairperson
11.10	Key themes in supervised injecting in Ireland – Tony Duffin, Ana Liffey Drug Project.
11.45	Chaired roundtable discussion on SIFs, focusing on key issues.
13.00	LUNCH

14.00	**Module 2 – Decriminalisation** • Intro to structure of module - Chairperson
14.10	Key themes in decriminalisation in Ireland – Marcus Keane, Ana Liffey Drug Project.
14.45	Chaired roundtable discussion on decriminalisation, focusing on key issues.
16.00	Refreshment Break

16.20	**Closing Session** • Review of day - Chairperson
16.50	Closing remarks by Madame Dreifuss
17.00	Close of Plenary Session
17.00	Side Meetings / Media
18.00	Close

ana liffey drug project

ACTION • PREVENTION • SUPPORT

Our vision is for a society where all people affected by problem substance use are treated with dignity and respect and have access to quality services.

Our mission is to work with people affected by problem substance use and the organisations that assist them. We do this to reduce harm to individuals and society, and to provide opportunities for development of those individuals and organisations.

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