Focal Point Ireland: national report for 2017 - Drug policy Ireland

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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Health Research Board

European Monitoring Centre for Drugs and Drug Addiction

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0. Summary

A new national drug strategy titled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* was launched in July 2017 (Department of Health 2017). While the strategy is structured around cross-cutting goals rather than the pillars of the previous strategy, its content largely follows on from that of the previous strategy with an increased emphasis on a health-led approach to addressing the drug situation in Ireland (Department of Community 2009). It reflects the commitment made by Government in May 2016 'to pursue a health-led rather than a criminal justice approach to drug use' (Government of Ireland 2016). It is also the first integrated drug and alcohol strategy in Ireland. The new strategy defines substance misuse as 'the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines' (p. 7 (Department of Health 2017)).

The strategy covers an eight-year period (2017–2025), and is accompanied by a shorter-term action plan (2017–2020). The strategy's vision is for: *'A healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life.'* The five strategic goals are:

1. To promote and protect health and well-being
2. To minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery
3. To address the harms of drug markets and reduce access to drugs for harmful use
4. To support participation of individuals, families and communities
5. To develop sound and comprehensive evidence-informed policies and actions.

A final substantive chapter focuses on what is termed 'strengthening the performance of the strategy'. There are two key elements to this: measuring performance, and the structures supporting the implementation of the strategy.

Government Departments with responsibility for implementing various actions in the strategy include: Health (overall responsibility); Education and Skills; Children and Youth Affairs; Social Protection; Housing, Planning, Community and Local Government; Justice and Equality; and, Transport, Tourism and Sport.

Summary of drug strategy evaluation

Unlike in previous years, there has been no progress report on the National Drug Strategy published for 2016. A Rapid Expert Review of Ireland's National Drugs Strategy was carried out as part of the development of the new drug strategy (Griffiths*, et al.* 2016). While this was mentioned in the 2016 National Report its findings were not published until late 2016. This was not an evaluation of the strategy, but it does provide some valuable insights and its findings are summarised in section 4.1 of this workbook.

Summary of drug policy coordination mechanisms

- The Minister for Health continues to have overall ministerial responsibility for the national drug strategy. As previously, the Department of Health also has a Minister of State with responsibility for Health Promotion and the National Drug Strategy.

- The National Oversight Committee is a senior official level committee comprising senior members of the statutory, community and voluntary sectors, and encompassing the expertise of both a clinical and academic representative.

- A Standing Subcommittee will support the implementation of the strategy and promote coordination between national, local and regional levels. It will be chaired by a senior official

in the Department of Health. Membership will include representatives from the statutory, community and voluntary sectors.

- The National Oversight Committee will be able to establish subcommittees to address specific issues and draw on any expertise necessary to support it on delivering its functions.
- The Drugs Policy Unit, Department of Health will support the Ministers, National Oversight Committee and subcommittees, analyse the implications of research findings for policy and design of initiatives to tackle the drug problem, and advise on the commissioning of new research and development of new data sources.
- The Health Research Board will continue to be the EMCDDA's national focal point. It will manage the commissioning of any research.
- The Early Warning and Emerging Trends Committee will receive, share and monitor information from national and EU sources.
- Local and Regional Drug and Alcohol Task Forces will continue to focus on assessing the extent and nature of the drug and alcohol problem in their areas, and on coordinating action at local level so that there is a targeted response to the drug problem in local communities. They will continue to be represented on the national committees.

Source: Structures supporting implementation of Reducing Harm, Supporting Recovery (Figure 11, p. 79) (Department of Health 2017).

Summary of 1.4 Expenditure

Data are available on labelled drug-related public expenditure, in line with the COFOG classification system (see Table IV). The total labelled public expenditure for 2016 was €249.08 million. No data is available on unlabelled drug-related public expenditure in Ireland.

Summary of 3.1 new developments

Key new developments other than the publication of the new national drug strategy *Reducing Harm',* (Department of Health 2017) described above are:

- **The Public Health (Alcohol) Bill** was launched on 8 December 2015, but the planned legislation continues to face delays. However, as part of the new national drug strategy, there has been renewed commitment by Government to enact the Bill before the end of2017.
- **Supervised Injecting Facilities:** The Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was signed into Irish law on 16 May 2017. The process of introducing the first pilot facility has begun and it is expected that it will open in early 2018.
- **Medicinal cannabis** has received a lot of attention in Ireland since publication of the 2016 National Report. The key activities have been as follows: progression of a Private Members' Bill on cannabis for medicinal use; publication of a Government-commissioned review of the evidence; and the access programme being established by Government in response to the review's findings.
- **Decriminalisation** of limited amounts of drugs for personal use continues to be discussed by stakeholders in the context of Irish drug policy. While there is no commitment in the new national drug strategy *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*' (Department of Health 2017) to legislate for decriminalisation, there is a commitment to 'consider the approaches taken in other jurisdictions to the possession of small quantities of drugs for personal use with a view to making recommendations on policy options to the relevant Minister within 12 months' (Department of Health 2017).

1. National profile

1.1 National drugs strategies

1.1.1 Current national drugs strategy

A new national drug strategy titled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* was launched in July 2017 (Department of Health 2017). While the strategy is structured around cross-cutting goals rather than the pillars of the previous national drug strategy (2009–2016), its content largely follows on from that of the previous strategy (Department of Community 2009). It reflects the commitment made by Government in May 2016 'to pursue a health-led rather than a criminal justice approach to drug use' (Government of Ireland 2016). The strategy covers an eight-year period (2017–2025), and is accompanied by a shorterterm action plan (2017–2020). The implementation structure is detailed in section 1.3, but an overview is as follows:

- Overall responsibility for the national drug strategy continues to rest with the Minister for Health and the Minister of State, Department of Health. With responsibility for Health Promotion and the National Drugs Strategy.
- Government Departments with responsibility for implementing various actions in the national drug strategy include: Health; Education and Skills; Children and Youth Affairs; Social Protection; Housing, Planning, Community and Local Government; Justice and Equality; and Transport, Tourism and Sport.
- Statutory bodies responsible for implementing actions in the national drug strategy include: Health Service Executive, Health Research Board, Child and Adolescent Mental Health Services (CAMHS), Tusla, Irish Prison Service, local authorities, An Garda Síochána, the Revenue Commissioners, Customs and Excise, State Laboratory, Medical Bureau of Road Safety, and the Probation Service.
- The community and voluntary sector, including Drug and Alcohol Task Forces, Union for Improved Services Communication and Education (UISCE, a service users' forum), and the National Family Support Network are also responsible for implementing actions.

Substance coverage

This is the first strategy to move towards an integrated approach to illicit drug and alcohol use. There has been a long-standing debate in Ireland on the question of whether alcohol *and* illicit drug use should and could be addressed in the same strategy. In 2009, the Government made a commitment to produce 'a combined National Substance Misuse Strategy to cover both alcohol and drugs' (p.5) (Department of Community 2009) but in practice alcohol policy has been largely implemented separately. The new strategy defines substance misuse as 'the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines' (p.7 (Department of Health 2017)). There is an explicit commitment to ensuring that 'an integrated public health approach to drugs and alcohol is delivered as a key priority' (p. 22) (Department of Health 2017). The strategy complements the Public Health (Alcohol) Bill and reinforces some of the key elements of the alcohol-focused 2012 *National Substance Misuse Strategy* (Department of Health 2012). While there is much more of a focus on alcohol when compared to previous drug strategies, illicit drug use continues to be the primary focus of many of the actions of the new strategy for 2017–2020.

Overview of strategy: vision, values and goals

The strategy is underpinned by a set of core values and is structured around a vision and five goals. Each goal has a set of objectives, accompanying actions and performance indicators. While not explicitly structured around pillars, as was the previous national drug strategy, the themes of the previous strategy are covered in the new strategy: supply reduction, prevention, treatment, rehabilitation and research. However, there is an additional focus on the role of users, their families and communities and taking a more health-led approach.

Vision

The strategy's vision is for: *'A healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life'*.

Values

To deliver on this vision, the strategy is underpinned by six values:

- *Compassion:* A humane, compassionate approach focused on harm reduction which recognises that substance misuse is a health care issue
- *Respect*: Respect for the right of each individual to receive person-centred care based on his or her specific needs and to be involved in the development of their care plan
- *Equity:* A commitment to ensuring that people have access to high-quality services and support regardless of where they live or who they are
- *Inclusion:* Diversity is valued, the needs of particular groups are accommodated and wideranging participation is promoted
- *Partnership:* Support for maintaining a partnership approach between statutory, community and voluntary bodies and wider society to address drug and alcohol issues
- *Evidence informed:* Support for the use of high-quality evidence to inform effective policies and actions to address drug and alcohol problems.

The five strategic goals and their accompanying objectives are:

1. To promote and protect health and well-being:
   - 1.1 Promote healthier lifestyles within society
   - 1.2 Prevent use of drugs and alcohol at a young age
   - 1.3 Develop harm reduction interventions targeting at-risk groups
2. To minimise the harms caused by the use and misuse of substances, and promote rehabilitation and recovery:
   - 2.1 To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs.
   - 2.2 Reduce harm among high-risk users
3. To address the harms of drug markets and reduce access to drugs for harmful use:
   - 3.1 Provide a comprehensive and responsive misuse of drugs control framework which ensures the proper control, management and regulation of the supply of drugs 3.2 Implement effective law enforcement and supply reduction strategies and actions to prevent, disrupt or otherwise reduce the availability of illicit drugs

3.3 Develop effective monitoring and responses to evolving trends, public health threats and the emergence of new drug markets

4. To support participation of individuals, families and communities:
    4.1 Strengthen the resilience of communities and build their capacity to respond.
    4.2 Enable participation of both users of services and their families
5. To develop sound and comprehensive evidence-informed policies and actions

A final substantive chapter focuses on what is termed 'strengthening the performance of the strategy'. There are two key elements to this: measuring performance, and the structures supporting the implementation of the strategy. The 'Strategic action plan 2017–2020' is embedded in the main strategy document and contains 50 actions, with a list of statutory, community and voluntary 'partners' with responsibility for their delivery. Throughout the strategy there is a focus on synergising with other relevant strategies. A list of 21 'relevant inter-connected strategies and policies' (p.99, (Department of Health 2017)) is cited in the document, with a number of the actions linked directly to those of other Government strategies.

1.2 Evaluation of national drugs strategies

1.2.1 Evaluations of national drugs strategies and supporting action plans

Unlike in previous years, no progress report on the national drug strategy has been published for 2016. However, a Rapid Expert Review of Ireland's National Drugs Strategy was carried out as part of the development of the new drug strategy (Griffiths*, et al.* 2016). This was not an evaluation of the strategy, but it does provide some valuable insights. It is summarised in section 4.1 below.

1.3 Drug policy coordination

1.3.1 Coordination bodies involved in drug policy

The new national drug strategy has meant changes to the coordination of the implementation of the strategy. Among the aims of the restructuring are that: the previous structure would be streamlined to better deliver on the key functions of the strategy; and that participation in the strategy would be optimised in a way that avoids 'duplication and overlap' (p.76, (Department of Health 2017)).

Ministerial responsibility: The Minister for Health continues to have overall responsibility for the national drugs strategy In addition, the Department of Health has a Minister of State with responsibility for Health Promotion and the National Drugs Strategy.

National Oversight Committee: This will be a senior official level committee 'sponsored' (p. 76) by the Minister of State with responsibility for the National Drugs Strategy. Membership will include representatives from: the statutory, community and voluntary sectors and expertise from both a clinical and academic representative. Membership from the statutory sector will be at the level of Assistant Secretary. The committee is to meet on a quarterly basis and has five main functions, as outlined in its terms of reference:

- To give leadership, direction, prioritisation and mobilisation of resources to support the implementation of the strategy
- To measure performance in order to strengthen the delivery of drug initiatives and to improve the impact on the drug problem

- To monitor the drug situation and oversee the implementation of a prioritised programme of research to address gaps in knowledge
- To ensure that the lessons drawn from evidence and good practice inform the development of policy and initiatives to address the drug problem
- To convene subcommittees, as required, to support implementation of the strategy (Department of Health 2017) (p.77).

Standing Subcommittee: A Standing Subcommittee will be established to support the implementation of the national drugs strategy and promote coordination between national, local and regional levels. It will meet on a monthly basis and will be chaired by a senior official in the Department of Health. Membership will include representatives from the statutory, community and voluntary sectors. Its terms of reference are:

- To drive implementation of the national drugs strategy at national, local and regional level
- To develop, implement and monitor responses to drug-related intimidation as a matter of priority
- To support and monitor the role of Drug and Alcohol Task Forces in coordinating local and regional implementation of the national drugs strategy with a view to strengthening the Task Force interagency model
- To improve performance, promote good practice and build capacity to respond to the drug problem in line with the evidence base
- To ensure good governance and accountability by all partners involved in the delivery of the strategy
- To report to the National Oversight Committee on progress in the implementation of its work programme.

The strategy specifically requires drug-related intimidation to be on the agenda for the committee's first meeting. Members are expected to develop what is called a 'liaison relationship' (p. 78 (Department of Health 2017) with Task Forces to support effective coordination and communication between delivery bodies and stakeholders at all levels.

Subcommittees: The National Oversight Committee will be able to establish subcommittees to address specific issues and draw on any expertise necessary to support it on delivering its functions.

Drugs Policy Unit, Department of Health: The Unit will be responsible for:

- Analysing the implications of research findings for policy and design of initiatives to tackle the drug problem
- Providing the National Oversight Committee with advice on the commissioning of new research and the development of new data sources, having regard to current information and research deficits and advice and changing patterns of drug use and emerging trends Providing a secretariat to the committee and the Standing Subcommittee.

Health Research Board: The HRB will continue to be the EMCDDA's national focal point. It will manage the commissioning of any research that the National Oversight Committee decides needs to be undertaken to address the gaps in their knowledge.

Early Warning and Emerging Trends Committee: This committee will receive, share and monitor information from national and EU sources on New Psychoactive Substances of concern and any emerging trends and patterns in drug use and the associated risks.

Drug and Alcohol Task Forces: The current terms of reference of the Drug and Alcohol Task Forces (DATFs) are referred to in the strategy. Based on these terms of reference, the role of the DATFs will continue to focus on assessing the extent and nature of the drug and alcohol problem in their areas, and on coordinating action at local level so that there is a targeted response to the drug problem in local communities. They will continue to implement the National Drug Strategy in the

context of the needs of their region or local area through action plans. They will also provide an annual report on their activities to the Minister of State with responsibility for Health Promotion and the National Drugs Strategy. It is envisaged that the new performance measurement framework will provide the DATFS with information that will support them in the delivery of their role.

Source: Structures supporting implementation of Reducing Harm, Supporting Recovery (Figure 11, p. 79) (Department of Health 2017).

1.4 Drug related public expenditure

1.4.1 Data on drug-related expenditure

Data are available on labelled drug-related public expenditure, in line with the COFOG classification system (see Table IV). No data is available on unlabelled drug-related public expenditure in Ireland. The total labelled public expenditure for 2016 was €249.08 million. A summary of labelled expenditure for the period 2013-2016 is in Table 1.4.1.1 below. This is a summary of data presented in previous national reports, since the more detailed breakdown (including COFOG classification) of data was first reported on in 2013.

Table 1.4.1.1 Labelled drug-related public expenditure 2013-2016

Department/Agency	2013 (€m)	2014 (€m)	2015 (€m)	2016 (€m)
Health Research Board	€0.957	€0.908	€1.013	€1.247
HSE Addiction Services	€90.392	€86.122	€91.523	€93.43
HSE Drugs and Alcohol Task Force Projects	n/a	€21.570	€22.064	€22.78
An Garda Síochána *	€44.00	€43.000	€43.000	€46.00
D/Children & Youth Affairs	€20.310	€19.548	€19.548	€20.05
D/Justice	€18.553	€18.762	€19.363	€20.56
Revenue Customs Service	€14.624	€16.235	€17.445	€17.36
D/Social Protection (former FÁS area)	€13.434	€14.063	€13.900	€16.41
D/Health**	€29.567	€7.266	€7.323	€6.08

Irish Prison Service	€4.500	€4.200	€4.235	€4.40
D/Education & Skills	€0.810	€0.748	€0.748	€0.77
Total	**€237.147**	**€232.422**	**€240.162**	**€249.087**

1.4.2 Breakdown of estimates of drug related public expenditure

The breakdown of labelled public expenditure in 2016 by COFOG classification is provided in Table IV below. The total labelled public expenditure for 2016 was €249.087 million.

IV Breakdown of drug-related public expenditure 2016

Expenditure	Year	COFOG classification	National accounting classification	Trace (Labelled, Unlabelled)	Comments
0.956	2016	gf07	s1311	Health	Research and reports in relation to drug services and drug-related deaths
0.291	2016	gf07	s1311	Health	HRB National Drugs Library
1.247					
0.33	2016	gf07	s1311	Health	Research and advisory function of the NACDA
4.14	2016	gf07	s1311	Health	Treatment and rehabilitation services provided to drug users- LDATF
1.07	2016	gf07	s1311	Health	Treatment and rehabilitation services provided to drug users – RDATF
0.21	2016	gf07	s1311	Health	National network of community activists and community organisations
0.17	2016	gf07	s1311	Health	Supports the development of family support groups throughout the country
0.00	2016	gf07	s1311	Health	Freephone service to report drug dealing and drug related crime
0.17	2016	gf07	s1311	Health	Other miscellaneous activities
6.08					
5.83	2016	gf08	s1311	Children & Youth Affairs	Youth programmes with Drug specific initiatives (round 1)
13.04	2016	gf08	s1311	Children & Youth Affairs	Youth programmes with Drug specific initiatives (round 2)
1.18	2016	gf08	s1311	Children & Youth Affairs	Mainstreamed drug projects (LDATF)
20.05					
0.40	2016	gfo9	s1311	Education and Skills	Drug education and prevention projects LDATF

0.37	2016	gf09	s1311	Education and Skills	Drug Court - Education support
0.77					
65.14	2016	gf07	s1311	Health Service Executive	Drug related health services
14.74	2016	gf07	s1311	Health Service Executive	Treatment and rehabilitation services provided to drug users –LDATF
7.51	2016	gf07	s1311	Health Service Executive	Treatment and rehabilitation services provided to drug users -RDATF
0.53	2015	gf07	s1311	Health Service Executive	Cross Task Force Funding
7.18	2016	gf07	s1311	Health Service Executive	Drug related health services - NDTS
21.11	2016	gf07	s1311	Health Service Executive	Drug related health services -PCRS
116.21					
15.81	2016	gf10	s1311	Social Protection	Training and

Expenditure	Year	COFOG classification	National accounting classification	Trace (Labelled, Unlabelled)	Comments
					rehabilitation places for drugs referred clients on Community Employment
0.600	2016	gf10	s1311	Social Protection	Support for community based drugs projects
16.41					
0.04	2016	?	s1311	Justice and Equality	Funding contribution to Maritime Operational and Analysis Centre Lisbon
0.12	2016	gf03	s1311	Justice & Equality	Drug Treatment Court
0.09	2016	gf07	s1311	Justice & Equality	Research on drug related deaths
1.6	2016	gf07	s1311	Justice & Equality	Community based rehabilitation services
18.71	2016	gf09	s1311	Justice & Equality	Youth crime diversion programmes
20.56					
4.4	2016	gf03	s1311	Irish Prison Service	Drug treatment services in Prisons
46.0	2016	gf03	s1311	An Garda Síochana	Policing/investigation costs
17.36	2016	gf03	s1311	Revenue's Customs Service	Border policing (anti-smuggling)
249.087					

Acronyms in Table IV
LDATF- Local Drug and Alcohol Task Force projects
RDATF- Regional Drug and Alcohol Task Force projects
NDTS - National Drug Treatment Service PCRS
- Primary Care Reimbursement Service

2. New developments

2.1 Developments in drug policy

New National Drug Strategy

A new national drugs strategy was launched in July 2017: Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025 (Department of Health 2017). This is described in detail in section1 above.

Public Health (Alcohol) Bill 2015

The Public Health (Alcohol) Bill was launched in Ireland on 8 December 2015 and its progress through the various stages of the legislative process continues to face delays. However, as part of the new national drug strategy, there has been renewed commitment by Government to enact the Bill before end 2017. The Bill addresses alcohol as a public health issue for the first time and it aims to reduce alcohol consumption in Ireland to 9.1 litres of pure alcohol per person per annum by 2020, and to reduce alcohol-related harm. As outlined in previous National Reports (2015 and 2016), the main provisions of the Bill include:

- Minimum unit pricing to tackle the sale of cheap alcohol particularly in the off-trade sector
- Compulsory health labelling of alcohol products, which would mean that alcohol containers would be required to carry information about the amount of alcohol measured in grammes, and the calorie count; health warnings, including one for pregnancy; and a link to a public health website. All alcohol imports would have to meet these requirements.
- The regulation of advertising and sponsorship of alcohol products. Advertisements would only be able to give specific information about the product, and advertising would be banned near schools, early years services, playgrounds, and around public transport. Alcohol-related advertisements would be restricted to films with an '18 and over' certificate and there would be a 9pm broadcasting watershed for alcohol advertisements. Advertising would be prohibited in sports grounds for events where the majority of competitors or participants are children, and merchandising of children's clothing would also be restricted.
- The structural separation of alcohol products in mixed trading outlets, where alcohol would have to be stored either in a separate area of the shop through which customers do not have to pass to buy 'ordinary' products, or in a closed storage unit(s) that contains alcohol products only. Alcohol products behind checkout points would have to be concealed.
- Promotions whereby alcohol products are sold at a reduced price or free of charge would be restricted or banned; these include promotions targeted at a particular category of persons, and 'happy hour' type promotions.

As outlined above, there continues to be Government support for the Public Health (Alcohol) Bill in Ireland. The Programme for Government launched in May 2016 (Government of Ireland 2016) made an explicit commitment to enact the Public Health (Alcohol) Bill, and the new Taoiseach appointed in June 2017 reiterated that getting the Bill passed was a priority for the current Government. However, the Bill has faced a number of delays. As reported on in the 2016 National Report, there have been challenges at a European level to its provisions on Labelling and Minimum Unit Pricing. On the domestic front, the Bill has also faced opposition and has been subject to lobbying by the drinks industry. This opposition to the Bill has been on a number of fronts, most significantly on the proposal to require traders to provide a structural separation for alcohol from other products. This opposition led to the debate on the Bill having been suspended since October 2016. As part of the launch of the new national drug strategy in July 2017, there was renewed commitment for it to be enacted by end 2017.

Supervised Injecting Facilities

The Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was signed into Irish law on 16 May 2017 (http://www.oireachtas.ie/documents/bills28/acts/2017/a0717.pdf). In the Introduction, the Act is summarised as: "An Act to provide for the establishment, licensing, operation and regulations of supervised injecting facilities for the purposes of reducing harm to people who inject drugs; to enhance the dignity, health and well-being of people who inject drugs in public places; to reduce the incidence of drug injection and drug-related litter in public places and thereby to enhance the public amenity for the wider community; and to provide for matters related thereto." The tendering process for the first pilot facility has begun and it is expected that it will open in late 2017/early 2018. A detailed description of the Act is provided in Section 3.1 of the Legal Framework workbook.

Medicinal cannabis

Medicinal cannabis has received a lot of attention in Ireland since the 2016 National Report. The key activities during the year in this area were:

- Progression of a Private Members' Bill on cannabis for medicinal use
- Publication of a government-commissioned review of the evidence, and;
- An access programme being established by Government in response to the review's findings.

The Cannabis for Medicinal Use Regulation Bill 2016 was reported on in the 2016 National Report. It is a Private Members' Bill, rather than one that has been proposed by Government. It was referred to a Select Committee in December 2016 and the final report was published in July 2017 (Joint Committee on Health 2017). The Committee recommended that the Bill should not proceed to the next stage. It found that 'the Bill has technical issues and implementation difficulties, that it may have unintended policy consequences (including leakage of supply of cannabis to recreational markets and a lack of safeguards against harmful use of cannabis by patients), that there are major legal issues (the numerous amendments which would be necessary to reconcile the Bill with existing law would be onerous), and that access to medicinal cannabis in Ireland would be better achieved through an access programme and secondary legislation, which the Committee has been informed is under preparation' (p. 10).

The access programme and secondary legislation described above stemmed from a Governmentcommissioned review of the evidence, Cannabis for medical use: a scientific review (Health Products Regulatory Authority 2017) which was published in early 2017. The review was carried out by the Health Products Regulatory Authority (HPRA) in response to a request from the Minister for Health in November 2016 for expert scientific advice on the use of cannabis for medical purposes (See section 4 for a summary of its findings). Following publication of the report, the Minister for

Health gave a commitment to establish a 'compassionate access programme for cannabis-based treatments'.2 His decision was based on the advice of the HPRA, and the programme will therefore only be accessible to people with one of the following three medical conditions:

- Spasticity associated with multiple sclerosis
- Intractable nausea and vomiting associated with chemotherapy
- Severe, refractory (treatment-resistant) epilepsy

Applicants will also be required to have the support of a medical consultant. The Department of Health has established an Expert Reference Group responsible for developing operational guidelines to facilitate the prescription and supply of medicinal cannabis to qualifying patients.

Decriminalisation

The decriminalisation of limited amounts of drugs for personal use continues to be discussed in the context of Irish drug policy. A survey on the topic found that the general population were divided in terms of their view on whether the law in this area should be changed (see section 4). There is no commitment in the new strategy to legislate for decriminalisation, but there is a commitment to explore it as an option for future policy. An action under Goal 3 of the new strategy is to:

‘Consider the approaches taken in other jurisdictions to the possession of small quantities of drugs for personal use with a view to making recommendations on policy options to the relevant Minister within 12 months’ (Department of Health 2017).

This objective will be delivered by establishing a Working Group to examine:

- The current legislative regime that applies to simple possession offences in this jurisdiction and the rationale underpinning this approach, and any evidence of its effectiveness
- The approaches and experiences in other jurisdictions to dealing with simple possession offences
- The advantages and disadvantages, and the potential impact and outcomes of any alternative approaches to the current system for the individual, the family and society as well as for the criminal justice system and the health system
- The identification of the scope of any legislative changes necessary to introduce alternative options to criminal sanctions for those offences
- A cost benefit analysis of alternative approaches to criminal sanctions for simple possession offences
- Make recommendations to the relevant Minister within 12 months.

Responsibility for delivering on this action is allocated jointly to the Department of Health and the Department of Justice and Equality.

Controlled Drugs and Harm Reduction Bill 2017
The Controlled Drugs and Harm Reduction Bill 2017 was introduced to the legislative process by Senator Lynn Ruane. The Bill proposes to amend the Misuse of Drugs Acts 1977–2016 to provide for the decriminalisation of the possession of controlled drugs for personal use. It would establish a ‘Drug Dissuasion Service’ to case manage people found in possession of small amounts of drugs, to divert people away from the courts by providing a system of harm reduction measures such as ‘drug awareness, drug rehabilitation and community engagement programmes’. The Bill does not define the thresholds for ‘personal use’. While the Bill reached the Second Stage in May 2017, it was not voted on and will be subject to scrutiny from the Committee on Justice and Equality in autumn 2017.

3. Additional information

3.1 Additional important sources of information

There were a number of publications since the 2016 National Report that provide information on drug policy in Ireland. Please note that the capital city, Dublin, does ***not*** have its own drug policy/strategy. It is covered by the national strategy. Other publications of interest are:

1. Rapid Expert Review of Ireland’s National Drugs Strategy
2. General public attitude to drug users and decriminalisation
3. Cannabis for medical use: a scientific review
4. Dublin Drug Policy Summit.

1. Rapid Expert Review of Ireland’s National Drugs Strategy

In late 2015, the then Minister of State with responsibility for the national drug strategy, Aodhán Ó Ríordáin, established a Steering Committee to provide him with guidance and advice on the development of the new national drug strategy. The work of the Steering Committee was informed by a number of inputs, including a report from a group of international experts who undertook a high-level review of the National Drug Strategy 2009–2016 (Department of Community 2009). The

Report of the Rapid Expert Review of the National Drugs Strategy 2009-2016 was completed in August 2016 (Griffiths*, et al.* 2016). It aimed 'to inform the development of the new NDS by providing a "helicopter view" and capturing some key learning points from the experience of the NDS 2009–2016' (p. 1). The review highlighted the complexities involved in developing a drugs strategy in a landscape that is always evolving and in which 'articulation between social, criminal and health policy areas is vital' (p. 31). The group's terms of reference were:

- To examine the progress and impact of the National Drug Strategy 2009–2016 in the context of the objectives, key performance indicators and actions set out in the strategy
- To identify deficits in the implementation of the strategy
- To summarise success factors or barriers to success
- To comment on Ireland's evolution in tackling the drug problem in the light of international trends
- To identify key learning points arising from the strategy and to highlight areas to consider for development in the new national drug strategy.

The review was based on documentary evidence, and meetings and site visits held during a weeklong visit to Ireland in January 2016. The review team met with a range of stakeholders, including Government officials, statutory and voluntary sector service providers, community members and service users. It is important to note that this was ***not*** an evaluation of the National Drug Strategy.

Some of the key findings from the review are presented here.

National Drug Strategy 2009–2016

The 2009–2016 National Drug Strategy was described by Griffiths *et al.* as a 'well-crafted and comprehensive version of a contemporary EU drugs strategy' of its time. Overall, those they consulted considered it to have been 'a valuable instrument, both in respect to the structures and coordination mechanisms it established, and in respect to its content which allowed priorities to be identified and targeted' (p. 6). It helped 'facilitate multiagency working, encouraged stakeholder buyin, and galvanised political support for drug issues' (p. 7). Over the course of the strategy progress had been made on many of the priority areas. In particular, it had been successful in targeting resources and developing services for opiate users.

However, the review also found that while delivery of the strategy got off to a good start, over time some of the positive changes delivered in the initial phases 'became less apparent' (p. 6) and the 'usefulness and appropriateness of the instrument declined' (p. 7). Areas that became problematic included: '[meeting] changing needs, stakeholder participation, sustaining appropriate coordination mechanisms, and follow-up and continuing relevance of actions' (p. 6). Griffiths *et al.* argued that it was inevitable that changes would occur over the period of a drugs strategy and it was therefore important that the strategy would adapt to meet these changes. The review discussed a number of areas in which the National Drug Strategy had lost its momentum over time, including:

- The 'strong role of community organisations' in both strategy development and delivery was identified as one of the key features of the Irish context (p. 9). In the course of the review they found that in some areas of the National Drug Strategy the **coordination between local, regional and national level** became less effective over time. Roles and responsibilities became less clear and lines of communications blurred. This impacted on progress in a number of ways. One of these impacts was that it meant opportunities to identify and adopt effective interventions were sometimes missed. 'The need for effective engagement with local communities, needs-based service provision, and mechanisms to ensure the quality of services delivered across locations, came up repeatedly during discussion on the current strategy' (p. 10).
- The impact of the strategy appeared to vary across **geographical areas** – in particular, the impact on local structures, services and practice. This was influenced by: 'changes in the location of needs since the drafting of the NDS; the difficulty in reconfiguring delivery structures in response to these changes; and practical and resource issues related to

developing service models suitable for areas where the target population is more geographically dispersed' (p. 9).

- The **policy and operational landscape** changed a lot over the course of the strategy. New strategies and structures had been developed across related fields. This had brought about 'some corresponding lack of clarity on the purpose and/or role of different structures or actors working in the area' (p. 6).
- The commitment to **research, monitoring and evidence-based interventions** in the National Drug Strategy was seen as one of its strengths. However, momentum in this area had faded over time. It was seen as having faced some 'problematic coordination and structural issues' (p. 11), including inadequate resourcing, a lack of standardisation for data collection, and a lack of capacity to analyse data collected and use it to inform strategic decisions.

Structure of the National Drug Strategy

To take learning from the experience of the National Drug Strategy, the review discussed the effects of three elements of the strategy structure:

- The topic areas of **the five pillars** were described as 'well chosen' as they contained all the main elements of a 'modern balanced drug strategy'. There were pros and cons to structuring the National Drug Strategy around the pillars. By keeping similar areas together this gives clarity to the main tenets of the strategy. Having a 'joint point of focus' (p. 7) encouraged joined-up working in some areas. However, it also impeded cross-pillar coordination at times, in particular when resources were limited or reduced. Where issues cut across more than one pillar they sometimes lacked ownership and failed to be addressed. However, the overall view was that the benefits of the pillar approach outweighed the costs. Griffiths *et al.* suggest that the new strategy could be designed in a way that would maintain the clarity that comes from keeping similar areas together but also facilitates better cross-area working.
- **Actions were embedded** in the seven-year strategy. Doing so was found to have particular limitations. The actions could not be reactive to change in the drug situation over time, and this contributed to an overall perception of a decline in the National Drug Strategy's 'relevance and momentum' (p. 6) over its timeframe.
- The National Drug Strategy included a set of **key performance indicators** (KPIs). These were to be used to measure progress over time. Their appropriateness as measures for both changes over time and the strategic goals they were linked to was not always clear. Furthermore, the data required in order to measure them were not always available and investment in monitoring the KPIs 'appeared to decline' (p. 6) over the course of the strategy. They therefore did not fulfil their intended role. The authors suggested that the objectives, actions and KPIs need to be more clearly linked together, be better sequenced, and to ensure that they are achievable.

New national drug strategy

Based on their findings, the authors made a number of suggestions for the development of the new national drug strategy. These included:

- **Separate the actions from the strategy:** Given the relatively long period of time covered by Ireland's current and forthcoming strategies, Griffiths *et al.* argued strongly for separating the strategy from the actions. The strategy document could lay out the vision, objectives and structure for the seven years; and a separate time bound (for example, three years) action plan could support the strategy. This approach would allow for an opportunity to reflect on progress and changes in the landscape at a mid-point in the strategy's timeframe and to make appropriate changes to the action plan.
- **Synergise with other strategies:** To minimise duplication and the waste of scarce resources, and to maximise the impact of strategies, the authors emphasised the importance of having clear 'synergy and complementarity' (p. 31) between the new national drugs strategy and other related strategies. This would include strategies dealing with other

substances (alcohol in particular), strategies dealing with the needs of specific populations, and strategies dealing with areas or social issues where drug use is an issue.

- **Ensure equality of access to provision according to need:** They argued that this is a concept that should cut across the strategy. High-quality interventions of proven effectiveness need to be universally available irrespective of the types of drugs being used, where the user lives, or which community the user belongs to.
- **Identify and roll-out good practice:** In the course of the review the authors were presented with numerous examples of good practice, but it appeared that there were barriers to them being implemented nationally. They argued for 'a clear mechanism for identifying good practice supporting programme evaluation, and encouraging wider implementation where this is appropriate' (p. 10). They suggested drawing on national and international practice and programmes to develop a suite of approved interventions which have been proven to work, and which partners would be able to draw from.
- **Monitor, research and evaluate:** These are considered 'an essential element of any strategic response in this area' (p.31). This would help ensure that the strategy is responsive to changing needs and will deliver on the goals. Following on from this, there must be mechanisms in place to facilitate the analysis of what is found, and the provision of advice based on this evidence to relevant stakeholders. Stakeholders would be able to spread good practice and identify problem areas.
- **Clarity of structural functions for implementation and delivery:** The strategy should have a clear focus on how it is to be implemented and delivered, including the organisational structure and roles and responsibilities of the various stakeholders. To facilitate the delivery of the strategy they highlight the importance of leadership (ideally at a ministerial level with the support of a committee) to provide drive, direction/prioritisation and to ensure that resources are made available.
- **Alcohol**: The authors gave special mention to alcohol as a theme that recurred throughout the review – the high prevalence of problems associated with it, the 'interactions' (p. 6) between alcohol and other drug problems, and its place in the forthcoming strategy. While Griffiths *et al.* do not identify a specific model to follow, they note that what is important is that in areas such as prevention and treatment where a 'cross-substance approach is essential' (p. 12), that these are adequately supported.

Specific issues for new national drug strategy

Section 4 of the review identified a long list of specific issues that the team considered important for inclusion in the new strategy. Replicating the full list is beyond the scope of this workbook. However, current issues in Ireland that reflect those in other EU Member States were: meeting the needs of an ageing cohort of opiate users; new psychoactive substances; concern about cannabis in its various forms, in particular its high-potency products; and the negative impact of criminalising users, especially young cannabis users. Issues that appeared to be of particular relevance to Ireland were: problematic prescription drug use, the spread of opiate use to rural areas, drug-related intimidation, and homelessness and housing insecurity.

As outlined earlier, the review is ***not*** an evaluation of the National Drug Strategy. Rather, its purpose was to take lessons from its delivery to inform the new national drug strategy.

2. General public attitude to drug users and decriminalisation – CityWide survey

The findings of a survey on attitudes to drugs and drug users by the general population in Ireland were published in November 2016. The survey was carried out by Red C for the CityWide Drug Crisis Campaign. It was an online national omnibus survey with a nationally representative sample of 1,035 adults. The topics covered included respondents' own drug use, various attitudes and beliefs about drugs and drug users, their place in society, and the decriminalisation of drug use. Some key findings are presented below.

Respondents' drug use

- One-third (31%) of respondents reported that they had ever used an illegal drug.

- One per cent of respondents described themselves as ‘regular users’ and 17% described themselves as having used them either ‘once or twice’.

Attitudes and beliefs about drugs and their use

- There were high levels of agreement that drugs are a problem in Irish society: 88% of respondents agreed that drug-related crime is a major problem in Ireland, and 87% agreed that the availability of illegal drugs poses a great threat to young people nowadays.
- Two-thirds (66%) agreed that alcohol abuse causes more problems in society than drug abuse.
- Two-thirds (66%) agreed that all illegal drugs are highly addictive and should be avoided.
  Those aged 18–34 years were more likely than the overall population to regard using cannabis once a month or less as ‘not really dangerous to your health’ (47% vs 34%), and that it was normal that young people will try some drugs ‘at least once’ (e.g. cannabis/ecstasy) (59% vs 53%).

Attitudes and beliefs about drug users

- It was a commonly held belief (91%) that drug users come from all backgrounds and classes.
- Negative views of drug users were found: one-half (51%) of respondents agreed that drug users really scare them and just under two-thirds (64%) reported that it would bother them to live near somebody who is addicted to drugs.
- However, there were also some sympathetic views expressed about users. Four out of five people (81%) agreed that all drug users should have access to the treatment they require.
- More respondents disagreed (44%) than agreed (31%) that they saw people addicted to drugs more as criminals than victims.

Decriminalisation

The public’s view on the decriminalisation of drug use was captured by first providing a brief description of what it would mean, and then presenting two options:

> Possession of illegal drugs, no matter how small the amount, is currently a criminal offence in Ireland. A conviction can stop a person being allowed to travel, get a visa, gain employment or access training. Many countries (including some in Europe) have decriminalised possession of small quantities of illegal drugs for personal use – which means that instead of a conviction, people can be fined or mandated to attend a drug treatment programme. Production, trafficking/supply and possession of larger amounts would remain a serious criminal offence.
>
> With this in mind, which of the following comes closest to your view on the issue of decriminalisation?
>
> a. The law in Ireland should stay as it currently is, so that possession of illegal drugs remains a criminal offence.
> b. The law in Ireland should be changed, so that the possession of small quantities of illegal drugs is ‘decriminalised’ as described.

Respondents were divided almost equally in their response. Forty-nine per cent were in favour of changing the law, whereas 51% were not. Men (56%) and younger people aged between 18 and 34 years (58%) were more supportive of a move towards decriminalisation.

3. Medicinal cannabis review

Cannabis for medical use: a *scientific review*[1] was published in February 2017 (Health Products Regulatory Authority 2017). The review was carried out by the Health Products Regulatory Authority (HPRA), which defined the medical use of cannabis as ‘a situation where a doctor prescribes or recommends the use of cannabis for treatment of a medical condition in a patient under his/her care’ (p. 9). The HPRA convened a group of clinical experts and patient representatives to assist it in carrying out the work. They did not undertake a systematic review of the data on cannabis for

medical use. Rather, they reviewed a selection of what they considered to be the 'main scientific reviews and relevant publications' (p. 2). They also carried out a survey of the HPRA's global regulatory counterparts to explore the situation in other jurisdictions and their policies on access to cannabis for medical use.

The review covered four main themes:

- The cannabis products available
- The regulatory regimes in countries where cannabis is allowed for medical purposes
- The research on new indications and evidence of efficacy of cannabis for various medical conditions
- The current legal situation in Ireland and legislative changes required for cannabis to be made available for medical purposes here.

Elements of the last two themes are considered below.

Evidence of effectiveness

Overall, the team found an absence of scientific data demonstrating the effectiveness and safety of cannabis products (p. 1). They also found that most cannabis products available through international access programmes did not meet 'pharmaceutical quality requirements' (p. 1). As the regulator of medicines and other health products in Ireland, the HPRA's role is to ensure that any medicines available on the Irish market are 'safe, effective and of an appropriate quality based on clinical and scientific data' (p. 7). The authors found insufficient evidence to allow for cannabis products to be authorised as medicinal products (medicines) under this regulatory requirement. There were a number of complexities involved when examining the evidence base. For example, 'a major limitation' (p. 13) was the variation in the formulations of cannabis that had been studied, particularly in relation to the tetrahydrocannabinol (THC) and cannabidiol (CBD) ratio.[6] Another limitation was the variety of medical conditions under examination. The potential benefits and risks of cannabis products depend on the product, dose and duration of use, and the patient population. Given the variation in what was explored in the studies, the team found it challenging to draw conclusions regarding the effectiveness of treatment.

Despite these limitations, the team found three medical conditions for which there was 'some scientific evidence to support the use of cannabis or cannabinoids as a medical treatment in patients who have failed available treatments' (p. 16). These were:

Spasticity associated with multiple sclerosis
Intractable nausea and vomiting associated with chemotherapy
Severe, refractory (treatment-resistant) epilepsy.

However, there was insufficient evidence to support their use for other conditions, including chronic pain.

At the core of the review's findings is the HPRA's acknowledgement that the Government may decide to make cannabis more readily available on a medicinal basis: 'The decision to permit access to cannabis for medical use is a societal and policy decision due to the paucity of scientific research, the recreational use of the product and the strong public and patient demand' (p. 1). Any products or preparations extracted from the cannabis plant that are psychotogenic are currently controlled under the Misuse of Drugs legislation and their medical use is therefore not permitted. However, if the Minister for Health considers it to be in the public interest, a specific licence can be granted which allows a doctor to prescribe products containing THC. Any application for a licence must be accompanied by an endorsement from a medical consultant who is responsible for the care of the individual applicant.

The authors argued that if cannabis were to be made more readily available for medical use in Ireland, then it should only be permitted under a controlled access programme for the treatment of

patients with a selection of medical conditions. Any programme should be part of a 'structured process of formal ongoing clinical evaluation in a limited number of clearly defined medical conditions' (p. 6). They advised that the programme be run for an initial period of five years and be limited to the medical conditions outlined above. The programme should have the following features:

- Patients treated with cannabis should be under the care of a medical consultant who has expertise in the condition being treated. He/she would be responsible for the ongoing monitoring of the patient.
- There should be a central register for patients, doctors and pharmacists involved in the programme, with data collected on the use of cannabis by these patients.
- Authorised cannabis-based medicines should be the products considered first. If unsuitable, then cannabis products from other countries that have been subject to quality control requirements could be used.
- Patients should be educated about the correct use of any cannabis product provided, the benefits and risks involved, how to report any side effects, and the care and safe disposal of cannabis products.
- Doctors and pharmacists should be supported in their prescribing and dispensing of the products (p. 6).

The Ministerial response to the review is outlined in section 3.1 of this workbook.

Dublin Drug Policy Summit

The Dublin Drug Policy Summit was held on 20 January 2017. It was organised by the Ana Liffey Drug Project and was attended by national and international experts on drug policy, including policymakers, practitioners, and academics. Among the delegates were Minister of State for Communities and the National Drugs Strategy Catherine Byrne TD and Ruth Dreifuss, Chair of the Global Commission on Drug Policy (GCDP). The summit focused on two issues: supervised injecting facilities and the decriminalisation of possession of drugs for personal use. This summary is based on the published proceedings of the event, which present a thematic analysis of the issues discussed (Ana Liffey Drug Project 2017).
As reported in section 3.1, it is Irish Government policy to introduce a supervised injecting facility. The summit focused on discussing how best to operationalise the facility. The key points discussed were grouped under the broad themes of people, place, and policing.

People

Access criteria: There was general agreement among participants that any access criteria should be as broad as possible and that any related legislation should not extend to defining which groups could access the service. The two groups noted in particular were pregnant women and those aged under 18. However, it was agreed that access should only be given to people who are already injecting drug users. Specialised protocols could be put in place for particular groups, and practitioners would have the flexibility to make decisions on a case-by-case basis to best meet the service user's needs.

An appealing service for potential service users: Having a service that appeals to users was considered critical. A number of themes were raised on this issue. First, there was both curiosity and apprehension among potential service users about what the service would be like and how it would work. Second, a good atmosphere and a person-centred approach that builds positive relationships between staff and service users is what would truly make the service appealing. Third, the service needs to be accessible and the importance of its proximity to where people buy their drugs was noted. While NIMBYISM – Not in My Back Yard – may present challenges, evidence from other jurisdictions did not show a 'honeypot effect' for supervised injecting facilities, i.e. they have not drawn in more dealers and users to an area. Finally, there were issues relating to the staffing of the facility. The attitude of staff members is key; they need to be able to deal with the paradox of being healthcare professionals (in some cases), while also supervising injecting, which is an 'inherently dangerous activity' (p. 14), as well as always treating service users humanely.

Place
The building: It was suggested that the building should not be overly clinical. Instead, it should be a safe place for people suited to the development of therapeutic relationships. For accessibility, it should be in the city centre. A mobile facility could be considered, as it could follow the flow of the target population.

Engaging the community: The location of the facility has attracted a lot of interest in the broader community and it was expected that NIMBYISM would be an issue. First, it was suggested that the supervised injecting facility would need to follow the practice of existing drug services in Dublin of engaging proactively with the community. Based on international experience, this would be an important element of the ongoing management of the facility. Second, communities elsewhere were reported to have been ultimately welcoming of these facilities despite initial opposition. They had a positive effect on an area, and the need to collect good baseline data to be able to evidence any such changes was noted.

Integration with other services: Supervised injecting facilities need to be embedded in the wider service landscape. First, there is a need to offer users access to other related services. This would require providers to identify and define pathways through the service and on to other services. Second, the provision of suitable ancillary services at the facility can be important, for example, access to food and showers.

Policing
Impact on drug markets and crime levels: As these facilities are not a criminal justice intervention, it was noted that they should not be expected to impact significantly on crime, either positively or negatively. The impacts will be in terms of the service user's health and the public amenity. However, international examples show that these facilities are not associated with increases in crime. Similarly, they do not affect any change in the drug market.

Role of policing: There was much discussion about the complexities involved in the policing of the centre, and a number of key points were identified. First was that the role of law enforcement agencies should not be underestimated in the successful delivery of the service. Establishing a positive and transparent relationship between police and the facility's management was identified as crucial. Second were the complexities involved in the approach taken to the policing of service users. Experiences in other jurisdictions highlighted these in terms of decision-making on whether to stop and search people in the vicinity of these facilities, for example. Overall, it was noted that Gardaí are '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' (p. 19). While there was no clear answer as to what was the best approach, there was a clear call for discretion on the part of the Gardaí and for it to be applied consistently. This would be facilitated by legislative clarity.

Decriminalisation
The decriminalisation of the possession of small amounts of drugs for personal use is not Government policy but is an issue of growing debate. At the summit, discussion about this fell into three broad categories: general discussion, responses, and threshold limits.

General discussion
A number of key points were made during the general discussion on decriminalisation. First, it was important not to overstate its benefits – it was not a panacea and it alone would have little or no impact on levels of drug use. Where changes in the law have led to better outcomes for users (e.g. in Portugal), this was likely related to a broader shift in policy and investment in services rather than a change in the law as such. Second, criminalisation causes harms. For example, it might mean users are less likely to access services, and labelling someone as a criminal can have a sustained negative effect on their life and opportunities. Third, the language used around the debate requires consideration; 'decriminalisation needs to be framed as a health and social issue rather than a

criminal one' (p. 21). Fourth, while some stakeholders were convinced about decriminalisation, others were not and concerns remained. These included concerns about the message it might send to (particularly young) people about drug use, and the new challenges it might present for law enforcement agencies. Finally, the importance of balance in drug policy generally was noted – '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' (p. 21).

Responses
Some of the discussion focused on what would be the most appropriate responses if someone were found in possession of drugs where this had been decriminalised. First, it was noted that decriminalisation does not mean the absence of any consequences for being found in possession of a controlled substance. Instead, these could take the form of a civil rather than a criminal sanction. Portugal's experience was highlighted, with a focus on the benefits of having sanctions for possession that do not come with a criminal record, stigma or the expending of a large amount of resources. There was also a call for research on what would be the most appropriate responses in the Irish context.

Threshold limits
Threshold limits were also discussed, i.e. the amount of drugs that a person could possess before they were considered to be in possession for supply. While it was recognised that there was a need for thresholds to be established, it was also suggested that they should be carefully selected and should not be rigid. Instead, there should be flexibility to allow for the needs of the individual to be considered. By doing so, the courts could refer to the health authorities and vice versa.

3.2 Estimate of the contribution of the illicit drug market to the National accounts

There are national estimates of the contribution of illicit drug market activity to National Accounts. To comply with the EUROSTAT requirements, the revised and additional estimates for illegal activities, including illicit drugs, for Ireland were first included in the Central Statistics Office (CSO) Quarterly National Accounts (QNA) for Q1 2014, (and in subsequent quarters), and in the annual National Income and Expenditure (NIE) accounts, the most recent being NIE 2016, published in July 2017. Ireland estimates the production and trafficking of illegal drugs from the supply side based on data on annual drug seizures by individual drug type (volumes and street value) provided by An Garda Síochána. Due to the volatile nature of seized quantities, the estimate is based on the average of a longer time series.

To derive import/wholesale prices, Ireland bases its estimates on information from the UNODC (United Nations Office on Drugs and Crime) *World Drug Report*. The CSO does not separately disclose the estimates for illegal activities in the National Accounts and Balance of Payments (personal communication, Michael Brennan, CSO).

4. Sources, methodology and references

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

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