An Tionól Saoránach

The Citizens' Assembly

Report of the **Citizens' Assembly on Drugs Use**

Volume II

Record of Meetings, Results of Balloting, Appendices

January 2024

Table of Contents

Volume II: Record of Meetings, Results of Balloting, Appendices

1 Meeting #1

Meeting #1

Figure 1.1:
Group photo of Members of the Citizens' Assembly on Drugs Use

Figure 1.2:
Formal Opening - Paul Reid, Chairperson

Figure 1.3:
Welcoming Remarks - Cathal O'Regan, Secretary

Figure 1.4:
Message from Taoiseach Leo Varadkar TD

Figure 1.5: Induction for Members - Dan O'Dwyer, Ruth Ibeabuchi and Prof. John Garry

Figure 1.6: Session 1 - Prof. Mary Cannon, Joe O'Neill, Judge Ann Ryan, Paul Griffiths, Prof. Jo-Hanna Ivers

Figure 1.7: Session 2 - Brian Galvin, Dr. Eoghan Quigley, Anne Doyle, Deirdre Mongan

Figure 1.8: Session 3 - Derbhail McDonald, Andy O'Hara, Dr. Sharon Lambert, Pauline McKeown, Philly McMahon

Figure 1.9: Session 4 - Giovanna Campello, Dr. Eoghan Quigley

Figure 1.10: Session 4 - Dr. Eoghan Quigley

Figure 1.11: Session 4 - Thomas Kattau

Figure 1.12: Session 5 - Ben Ryan, Assistant Commissioner Justin Kelly, Prof. Eamon Keenan, Siobhan McArdle

Figure 1.13: Roundtable discussions

Figure 1.14: Roundtable discussions

Figure 1.15: Questions and Answers

Meeting #1

Figure 1.16:
Group photo

Figure 1.17:
Roundtable discussions

Figure 1.18:
Questions and Answers

Figure 1.19:
Questions and Answers

Figure 1.20:
Group photo

Figure 1.21:
Roundtable discussions

Figure 1.22:
Roundtable discussions

1.1 Overview

The inaugural meeting of the Citizens' Assembly on Drugs Use took place on 15-16 April May 2023 at The Grand Hotel, Malahide. The meeting provided members with an overview of how Citizens' Assemblies operate and the role of deliberative democracy in national policymaking. This was followed by introductory discussions on national drugs policy, current trends and patterns in drugs use, and international and European perspectives on drugs use and policies.

The following provides a necessarily incomplete account of the contributions of the speakers and panellists over the course of the weekend. Video recordings of each session are available online at **www.citizensassembly.ie**.

1.2 Session 1 – Formal Opening

The Citizens' Assembly on Drugs Use was formally opened by Chair Paul Reid, with a video message from Taoiseach Leo Varadkar T.D.

Welcoming members, the Chair remarked that he expected the Citizens' Assembly on Drugs Use would undertake the most extensive discussion on drug use in the history of the State. He outlined the role of the Advisory Support Group and Lived Experience Group, emphasising that members of these groups would not be giving advice or advocating. He assured members that there would be a wide and diverse range of viewpoints considered during the process, including from people with lived experience. The Chair also gave a commitment that he would ensure that the Assembly operates independently and without undue influence or pressure, including from the political system.

In his remarks, the Taoiseach explained that the Oireachtas had established the Citizens' Assembly because drugs use affects many individuals, families and communities right across Ireland, and there is a clear need to find more effective ways to tackle the problems arising from illicit drugs. He emphasised that, while a wider public debate about drugs use is important, the outcome of the Citizens' Assembly is entirely a matter for the members of the Assembly, which is designed to operate independently of the Government, Oireachtas and stakeholder groups. The Taoiseach thanked members for their civic service and wished them well in their deliberations.

1.3 Session 2 – Induction for members of the Citizens' Assembly

1.3.1 Prof. John Garry, Queen's University Belfast

Prof. John Garry, Professor of Political Behaviour and lead of The Democracy Unit at Queen's University Belfast, provided a background to, and explanation of, deliberative democracy. He introduced the concept of deliberative mini-publics, explaining that these are randomly selected groups of ordinary citizens, brought together to learn, discuss and consider in detail a particular issue. By weighing up the pros and cons of the current situation and considering the pros and cons of different approaches, these mini-publics arrive at recommendations that in turn feed back into the political system for consideration by government and parliament.

Prof. Garry explained that Ireland has become well known internationally for using the Citizens' Assembly model of mini-publics to examine important issues, which has generally resulted in significant and real change. The work of previous Citizens' Assemblies in Ireland has led to referendums and subsequent changes to the Constitution, but can also affect other areas including legislation and policy.

1.3.2 Questions and Answers session

The three-person discussion panel comprised Prof. John Garry, Ms. Ruth Ibeabuchi and Mr. Dan O'Dwyer. Ms. Ibeabuchi had been a member of the Dublin Citizens' Assembly, while Mr. O'Dwyer had been a member of the Citizens' Assembly on Biodiversity Loss, both of which ran in 2022.

Ms. Ibeabuchi and Mr. O'Dwyer recalled their experiences as Assembly members, recounting how they had learned a great deal about other peoples' experiences, views and perspectives; that deliberative democracy had been evident throughout the process; that every member had the opportunity to have their voice heard, and that it was an interactive, inclusive and very positive experience. Assembly members asked a range of questions concerning the

process of the Assembly, the nature of the inputs, the number of recommendations it might issue, and the prospects for those recommendations being accepted by the Oireachtas and Government.

1.3.3 Roundtable discussions

Note: the following is a summary of thematic issues discussed at three or more roundtable discussions. The summary does not necessarily indicate areas of consensus or agreement among members.

- Members are eager to learn more and to make a positive impact for society
- There is a desire to better understand addiction and needs of people affected by it, those with lived experience, in order to address the issue appropriately
- Terminology/jargon needs to be explained throughout the process
- Overview of Assembly procedures / processes helps all members and gives clarity

Members were asked to consider their hopes and fears regarding the work ahead.

Hopes

- To make informed recommendations that address the causes of societal issues related to drugs use and that make changes for the better
- To improve knowledge of the Assembly and of wider society of drugs use
- To improve service provision for people affected by drug use
- To achieve legislative change
- To see the implementation of the Assembly's recommendations
- To educate members and others on experience of Assembly
- To be comfortable with the recommendations made by the Assembly
- To see a diverse range of presentations that ensure impartiality and broaden viewpoints

Fears

- Recommendations will not be taken seriously or quickly implemented
- Presentations will be overly emotive, impartial, or biased
- Important aspects will not be addressed within the time of the sessions
- Overwhelm or overload due to the volume of information
- Personal beliefs / experiences get in the way of making informed recommendations
- Members are triggered by personal stories and traumatic experiences
- Recommendations have a negative impact on communities and society
- Issue is too divisive

1.4 Session 3 – Setting the Scene

1.4.1 Mr. Paul Griffiths. *An overview of drugs use and drugs policies from an EU perspective.*

Mr. Paul Griffiths, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), gave a brief background on the role of the EMCDDA and how its work has evolved since its establishment in 1993. The EU agency is policy neutral, providing independent scientific evidence and analysis on all aspects of illicit drugs in the European Union. Mr. Griffiths noted that the drug issue has always been complicated but is becoming increasingly complicated over time, and this is likely to continue. This has resulted in the focus of EMCDDA's work getting ever wider and the policy areas relevant to EMCDDA's work becoming ever broader.

> ***Drug-related issues appear almost everywhere, almost everything with psychoactive potential can be a drug and everyone can be affected, whether directly or indirectly.***

In the past, EMCDDA's primary focus was on heroin and drug injecting, particularly the associated risks of HIV and criminality. Reporting was mainly on plant-based drugs, primarily produced outside Europe, with reporting on other drugs based on estimates from surveys of the general population or school population. More complexity has been

added with the emergence of new drugs including ecstasy, New Psychoactive Substances (NPS), other drugs of concern, and greater regulatory complexity.

Mr. Griffith explained that drug use can't be understood in isolation. Polydrug use has always been very important but now it can be a driver of many of the problems we face, especially in respect to toxicity, increased risks through drug interactions and because people may unknowingly be consuming mixtures of drugs. Synthetic drugs have also become more important, creating new challenges for drug control and public health authorities. Synthetic drugs can be extremely potent, increasing the risks to health. As these can be produced near to consumer markets, it reduces the risk of detection by law enforcement. The world is changing rapidly, with globalisation and digitalisation transforming drugs markets.

Whilst national policy perspectives differ in Europe, there is far more consensus than there used to be. There is general support for a balanced approach that addresses both supply and demand holistically and recognises the role prevention, treatment and harm reduction can play. There is better evidence on what can work, and better understanding of things that don't work.

Overall, by global comparison, the situation in Europe looks in many ways more positive than it does for many other parts of the world. We have ample evidence that policy approaches make a difference – either positively or negatively - in respect of the societal costs associated with drug consumption. Mr. Griffiths concluded with the observation that complex multisectoral policy issues are likely to require complex multisectoral responses.

1.4.2 Prof. Jo-Hanna Ivers. *Diverse perspectives on harmful impacts of drugs use.*

Prof. Jo-Hanna Ivers, Associate Professor in Addictions and Associate Dean of Civic Engagement and Social Innovation, Trinity College Dublin, began by explaining that she brings both a professional and personal perspective to the issue, based on her experience growing up in Dublin's north inner city, where drug use and addiction is highly prevalent and had affected her own family members and friends.

Her presentation centred on why people use drugs, how they use drugs, what drugs they use, the benefits of drug use, the harms associated with drugs use, and the varying responses to different groups of drug users. She explained that people take drugs either to stop feeling something or to start feeling something, for example, to feel relaxed, or to stop feeling stressed, or to get away from pain. There are four ways to use a drug: orally, injecting, inhalation and absorption, with injection being the most direct and also the most dangerous method.

She suggested that a helpful way to understand drug use at a population level is to consider drug use on a spectrum from 'Beneficial Use' to 'Non-problematic use' to 'Chronic Dependence' and 'Addiction'. The same spectrum can apply to both legal and illegal drugs.

Posing the question 'Is all drug use problematic?', Prof. Ivers explained that, while up to 90% of drug users perceive their drug use as either beneficial or non-problematic, we need to remain aware of the other dimensions of risk that should be considered, including whether the person using drugs is otherwise healthy, whether they have a psychiatric illness, whether they are pregnant, where they are sourcing their drugs, and whether the drugs have been contaminated or altered.

A person's drug use can move along the spectrum, in either direction, at any time. She highlighted the mistaken belief that some drugs can result in an immediate dependency after just one use. Drug use, and whether it is problematic or not, can be very fluid. She explained that the science and evidence base regarding risk changes over time, contrasting previous health advice that a daily glass of wine is good for cardiovascular health with more recent data linking wine consumption to a higher risk of cancer.

Prof. Ivers outlined the immediate and enduring harms that might occur within various population groups, with different types of drugs, and different degrees of protective factors. Explaining that even though the issue of harm is a complex issue, it is important to classify the harms associated with drugs use, including those harms that are not always visible. We also need to stop stigmatising drugs and people that use them based on factors such as social class, and the types and ways that people use drugs.

The human body doesn't discriminate how it reacts to pain, whether that's social or physical pain, but society stigmatises people who use illicit drugs (e.g. heroin) versus those that use prescribed drugs (e.g. morphine) to deal with those pains. People who have experienced a pain or a trauma have a higher risk of going on to develop an addiction and if they 'find something to numb that pain, they will hold on to it for a while'. People who have co-occurring psychiatric illnesses, those experiencing pain, physical illnesses and people with limited opportunities

(work, education, meaningful relationships) are all more likely to be addicted.

1.4.3 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Stigma affects access to services and some terms should be avoided
- Individual non-problematic use may still be problematic for others
- Drug use is an individual issue, it is important to consider real-life experiences
- Social bias should not be attached to some drug users as drugs effect all classes
- Drugs are used for many reasons, which should be considered in recommendations
- Education can allow people to make informed decisions and to reach out for help
- High number of drugs monitored and present in EU, particularly synthetic drugs
- Large range of illegal and legal drugs, with increasing rates of dependency, supply and demand, ease of access, and complexity at a global level
- Difference between deaths in North America and Europe is significant
- Interest in understanding the benefits of drug use, particularly how one drug can be beneficial for one person but not another e.g. morphine versus heroin
- Irish drug culture has been altered by globalisation, with greater diversity and ease of access through transportation, social media, and the internet
- Removing access to drugs is difficult with ease of access and high demand, it does not address underlying problems that lead people to them, especially marginalised people
- Supports for people using drugs, such as a safety net and early intervention, should be expanded given issues with addiction services such as long waiting services
- Rising social pressure among children and young adults should be addressed
- There is a generational dimension to drug use
- Drugs use is still an issue despite high level of knowledge, the status quo is not working
- Lack of knowledge is overwhelming
- Drugs use is more open, widespread, and normalised across Ireland

1.4.4 Questions and Answers session

Mr. Griffiths and Prof. Ivers were joined by members of the Advisory Support Group (ASG) – Prof. Mary Cannon, Judge Ann Ryan and Mr. Joe O'Neill.

Members queried the appropriateness of the Misuse of Drugs Act 1977 in a modern context. In response, the Secretary noted that 1977 refers to the year the legislation was first enacted but that there have been numerous updates and changes to the Act since then.

Prof. Ivers was asked whether additional statistical data is available regarding the risks associated with different types of drug users. Prof. Ivers stressed that the risk depends on the person, the drug, and the context. With unregulated drugs, the person using the drug is not clear on the content of what they are using and is therefore taking a risk each time they use. In terms of the broader population, 90% of those who use drugs transition out of that drug use. When we look at risk of dependency, we are generally talking about 10% of the people who use drugs.

Mr. Griffiths provided further detail on EU monitoring of drugs, explaining that, as drug use is a hidden and stigmatised behaviour, it is difficult to measure directly, therefore proxy indicators are used. The EU Early Warning System involves the participation of all Member States. If a Member State discovers a new substance, the Early Warning System is notified and an alert is circulated to all Members States.

Mr. Griffiths then responded to a question about the greater ease in transporting illicit substances, the limitations authorities have in intercepting and stopping this flow and whether this will lead to inevitable legalisation of drugs in order to better control them. Mr. Griffiths described the logistical differences between producing and shipping heroin versus the laboratory-based production of fentanyl, acknowledging that this is a real challenge for the future. The emergence of synthetic drugs, with much stronger doses in smaller packages, has driven up the risk of fatal overdose and has a profound impact on public health. He warned that we cannot be complacent about the changes in drugs markets, and synthetic drugs are becoming a more significant class of drugs than they used to be.

The panel were asked their views on whether education would be more effective than prohibition. Prof. Cannon noted that young people are heavily influenced by what is going on in society, by their parents and by their peers.

Her view is that while education has a place, all the education in the world will not make much difference if society normalises the use of drugs.

Mr. O'Neill noted that education, prevention and early intervention will be considered in later meetings but these all play an important role. With regard to education on the safe use of drugs, Mr. O'Neill suggested this could be a tall order as there is always a degree of risk in drug taking. He suggested the larger question is not to talk about the drugs but to talk about the people i.e. why is it that certain people are more predisposed to using drugs than others. Prof. Ivers responded to a question on the benefits of drug use by referring to the individual and the importance of identifying what they see as the benefit of their own drug use. This is the crucial element of identifying a point of intervention for each individual. People use drugs to feel good, for self-medicating or trying to feel a different way. Judge Ryan noted that people who came in front of the Drug Court had reached an end point, their dignity and self-esteem were gone, and they were facing custody. Within the Dublin Drugs Court, the view was that custody is not going to help them, a different programme was needed, one that included education and filled a huge gap, giving the person back a sense of dignity and identity.

Mr. Griffiths was asked if, in the event that a substance was legalised, how would, or could, that drug be sourced and how could the sourcing be funded. Mr. Griffiths responded that it is a complicated issue. Some countries have taken the approach of providing drug testing facilities to provide clarity on what is contained in a substance. Another issue is the dosage - small amounts of a pure substance have a lower risk than taking a large amount of the substance, but the challenge is stopping people who take drugs progressing to ever bigger doses. Mr. Griffiths stated that contamination in the drugs market is clearly an issue, but that he didn't believe making pure substances available would solve all the problems associated with drug use.

Responding to a question on predisposition to addiction, Prof. Ivers noted that there have been studies carried out, but they are limited, and she would query whether, when comparing results, we are comparing like with like, if it is the same type of drug, in the same circumstances or with the same benefit to the person.

1.5 Session 4 - Drugs use patterns and trends

1.5.1 Ms. Anne Doyle and Dr Deirdre Mongan. *Research and evidence from Ireland*

Ms. Anne Doyle and **Dr Deirdre Mongan**, of the HRB Evidence Centre, presented latest data on drug use prevalence in Ireland.

Dr Mongan provided an overview how many people in Ireland use drugs, what drugs they use, how often they use them, how trends in drug use have changed over time and how Ireland compares to other European countries.

Prevalence – the proportion of the population who have used drugs in a particular timeframe.

Patterns of use – it's generally a person's pattern of drug use that determines them experiencing drug related harm.

She explained how drug use is measured, both in Ireland and across the EU, and the surveys used to collect data. She described two school surveys undertaken in Ireland as providing important data, given that this is a time that adolescents commence substance use and are particularly vulnerable to drug related harm due to their relative mental and physical maturity.

In 2021, Ireland participated for the first time in the European Web Survey on Drugs, which surveyed almost 6,000 people who had used drugs in the past year. Dr Mongan detailed findings from the survey. In 2019, 22% hadn't used any substance (including alcohol) in the last year, with 9% or 287,000 people (aged 15-64) reporting they had used an illegal drug in the previous year. Ireland is around the European average for cannabis use, however, we are near the top in terms of cocaine and ecstasy use. The 2019 survey indicated an increase in polydrug use, with 34% reporting using 3 or more types of drugs in the last year, an increase from 14% in 2002.

Dr Mongan detailed the pattern of drug use regarding cannabis, cocaine and ecstasy. In the 2021 web survey, over 4,000 people who used cannabis in the last year answered questions on their cannabis use and the different types they used. In 2019, 96% of people who have used cannabis in the last year reported they used cannabis herb, 47%

used cannabis edibles, 23% used cannabis oil/extract and 20% used cannabis resin. This signifies a shift over the past twenty years away from predominately cannabis resin use. Of the people who reported using cannabis herb, 35% reported frequent use (using a least once a week) and 24% reported intensive use (daily or almost daily). Those who reported intensive use also reported using a higher quantity of herb used than reported by infrequent users. This is important data, as international research indicates that both the quantity and frequency of cannabis use predicts the likelihood of experiencing cannabis-related health problems.

One of the adverse health effects of cannabis use is 'Cannabis Use Disorder' - a level of cannabis use that is causing psychological, physical and/or social functioning problems for the user. The HRB survey data shows that 1.4% of the Irish population aged 15 -64, which equates to about 45,000 people, meet the criteria for Cannabis Use Disorder. The HRB data also shows that this is most common among males aged 15-34 which is the group most likely to use cannabis. Of those who reported using cannabis in the last year 1 in 5, or 20%, met the criteria for Cannabis Use Disorder.

8% of survey respondents reported weekly use of cocaine. Weekly users of cocaine reported using double the amount of cocaine compared to those that reported using less than monthly. In contrast, users of ecstasy reported much less frequent use, with just 1% reporting using ecstasy weekly and 90% reporting using it monthly. Dr Mongan highlighted that the survey was conducted during 2021, at a time when Covid restrictions were still in place, which may impact on findings regarding the use of ecstasy, which is often associated with nightlife and festival settings, which were curtailed at the time.

Opioid use, including heroin, methadone, fentanyl and morphine, is a significant problem in Ireland. Problematic use refers to use that is harming people, or places them at a much higher risk of harm. People who use opioids in a problematic way are often a hidden population and it can be difficult to capture information. Therefore, the HRB takes a different approach, in line with international best practice guidelines, to estimate opioid use based on data from treatment providers, GPs, prison and Probation Services.

Figures for 2019 indicate that almost 20,000 people used opioids problematically in Ireland. This is an aging cohort, with almost three quarters of people with problem opioid use in the 35-64 age group. This contrasts with 2006 data, where 1 in 5 with problem opioid use were aged 15-24, compared to just 1 in 25 in 2019. This trend is very encouraging because it shows that far fewer young people today are using opioids in a problematic way.

Ms. Doyle described the demographic profile of people who use drugs in terms of their age, sex, region where they live and socioeconomic status. Overall, the statistics show that males are more than twice as likely than females to use drugs, though the gap is narrower in the 15-24 age group. Generally, 15-24-year-olds are most likely to use drugs, but when sex is considered, the highest drug users are males aged 25-34 years. The statistics show younger age groups start to use drugs in their late teens and continue into their early 20s, but for men they continue right through to their mid to late 20s or early 30s. For females, the numbers taper off as the women age into the 25-34 years age bracket.

Ms. Doyle compared figures from 2019 with historical figures from 2002, which show that young people are starting to delay initiating substance use. The age of initiation is important, as the earlier a person starts using substances the more likely they are to experience problems. For example, a person who starts drinking alcohol at 15 years of age or earlier is four times more likely to develop alcohol use disorder than someone who starts drinking at a later age. Similarly, early cannabis use is a predictor for Cannabis Use Disorder, while early cannabis use and early alcohol use are predictors of future use of cocaine.

Across the entire country, approximately 9% of the population use drugs. Drug use is more concentrated in the Dublin area, with 13% of the Dublin population using drugs, whereas it is more evenly spread throughout the rest of the country.

Compared to the rest of the population, drug use is higher among students, at 17%, and among unemployed people, at 14%. Data from the Census identifying the most and least deprived areas show that drug use is spread across society. Figures for cannabis use by school children show that social class does not determine whether a child uses cannabis or not.

While cannabis use is common across all socioeconomic groups, problem cannabis use, including Cannabis Use Disorder, is higher among individuals with lower education levels. Alongside this, the impact of drug use, i.e. problems with using or dealing drugs, is greater in areas of deprivation.

1.5.2 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Data presented is dated and potentially inaccurate given bias in survey answers, exclusion of 65+ year olds, and pandemic related restrictions
- National level data may miss nuances of localised drug use, e.g. greater accessibility to drugs and severity of its impact in Dublin and deprived areas
- Drugs use is an issue in all communities, however people from different backgrounds and in different areas experience different impacts from drug use
- Alcohol is key part of polydrug use and people who drink from an earlier age have a higher chance of using drugs later in their lives
- Surprise at high rate of drug use, particularly among young people
- More drugs are available today, reflected in increasing overall drug use
- Male use of drugs is disproportionately higher compared to other groups, and women may stop using drugs before men due to pregnancy or caring responsibilities

1.5.3 Questions and Answers session

Ms. Doyle and Dr Mongan were joined on the panel for Questions and Answers by Mr. Brian Galvin of the HRB and Dr. Eoghan Quigley of the EMCDDA.

Ms. Doyle and Dr Mongan responded to a series of questions on the timeliness, accuracy and granularity of HRB prevalence data, and socio-economic, gender and other differences in drug use in Ireland.

They explained that the Covid period has impacted on the data, and it will be very interesting to see what impact Covid has had on the prevalence of drug use. Two web surveys carried out by the HRB during Covid asked questions specifically on the impact that Covid had on people's drug use, and different results were seen in relation to different drugs. For cannabis, quite a high proportion increased their use, while some decreased. A lot of people who used ecstasy reported a reduction of their use.

Dr. Quigley explained that, from a European monitoring perspective, the Covid-19 pandemic has had a huge impact on monitoring systems, as it has affected how treatment centres operate and how they collect the data. Illegal drug use is a hidden, stigmatised behaviour that's very difficult to monitor and measure, particularly when comparing across Europe. The EMCCDA uses a multi-measure analysis, looking at as many different indicators as it can. Some of the indicators include analysis of drug residues in municipal wastewater, drug checking - which provides a targeted view of drug use at festivals and similar environments, and syringe residue analysis, which provides insight into what substances are being used in drug consumption rooms. These are all newer indicators which help give a more real time picture for specific groups, although is less representative of drug use across the whole population. Comparisons across countries have to be made with extreme caution. The European Drug Report examines hidden, stigmatised behaviour, and countries differ in terms of the tools used to monitor and look at drug use. For example, the latest data from Portugal dates from 2016, while the data from Ireland is from 2019, so it's quite difficult to compare. This is a very serious issue in Ireland where there's a large population of people who are injecting drugs and also a significant opioid problem, with other substances being used. Ireland features prominently in the top group of countries where drug-related deaths are an issue. Europe has many drugs problems, it's not one thing, and each country experiences a different configuration of drug problems.

Responding to a question about the socioeconomic profile of drug use, Mr. Galvin explained that the statistics show that drug use is more or less the same right across society. However, the impact of drug use, in terms of the numbers coming into treatment with problematic drug use, are far higher in more deprived areas. So, while drug use at a population level is the same across society, the harms and the more serious effects of drug use are felt more keenly in more deprived areas.

Members asked whether one reason why women stop using drugs at a younger age than men might be because of their new responsibilities as they start a family. The HRB explained that their surveys don't capture this information, but speculated that women perhaps mature a little earlier than men, and drug use among women tapers off in their late 20s and early 30s because they are getting to an age where they're focusing on their career and perhaps on having a family.

There is a high number of young males aged 25-34 using drugs. It could be surmised that young males in that age group may have more disposable income which can be spent on using drugs as part of their recreational activities.

Explaining why the data shows an increase in the age for initiation into drug use, the HRB representatives suggested there may be a range of reasons for this, including young people living at home for longer, becoming more involved in sports and extracurricular activities, and the whole social online presence impacting how young people socialise. Responding to a question about whether alcohol should be considered more of a gateway drug than cannabis, the HRB presenters agreed that alcohol is probably the main gateway drug, as generally people start drinking earlier, and usually the people who don't take drugs also don't drink alcohol. There isn't much research in Ireland as to what order people might start using alcohol and/or drugs, or if that order applies for everyone. In relation to cannabis, the research would suggest that people would generally use cannabis before moving on to other drugs.

The HRB presenters clarified that the data on opioid use includes people who are on methadone in treatment sessions in clinics, GP services, Probation and Prison services.

Responding to a question about what measures or initiatives had been introduced that drove down the level of opioid misuse among young people in the 15 to 24 year old age group during the period 2006 – 2019, Mr. Galvin suggested that the provision of community-based treatment services was a big factor, meaning that rather than people having to attend the major city centre-based treatment centres, they had easier access to treatment in their own communities. He added that the increase in the number of people in the older age cohort with problematic opioid use reflects the development of health services and the success of harm reduction measures such as needle exchange, and identification and treatment of Hepatitis C, meaning less people are dying from poisoning and blood-borne viruses, which is in fact a success story.

1.6 Session 5 - A person-centred perspective

This session featured a panel discussion, moderated by Ms. Dearbhail McDonald, with four panellists offering their perspectives on taking a person-centred approach to drugs use. The following account provides a summary of the discussion. A video recording of the full discussion is available on **www.citizensassembly.ie.**

1.6.1 Dr Sharon Lambert, UCC

Dr Sharon Lambert, University College Cork explored the factors underpinning drugs use. She noted that 90% of people who use drugs do so for their psychoactive properties, but there is also a group that experience very significant harm. She posed the question as to whether drugs are the problem or whether, in fact, we should be focused on dealing with underlying issues like poverty, stress and trauma. She also discussed the shame and stigma society places on someone who uses drugs, which makes seeking help more difficult, noting that drug policies feed into that stigma by criminalising the issue.

1.6.2 Ms. Pauline McKeown, Coolmine

Ms. Pauline McKeown, CEO of Coolmine, described the divergent paths for people who use drugs. The social capital that someone has around them can significantly influence the outcomes that person might experience. Coolmine Drug and Alcohol Treatment Centre works with people in homelessness who may have come directly from prison, homeless pregnant women, women with young children and members of the Travelling community, all members of Irish society who are coming from situations of deprivation and multiple adversities. Women, in particular, can face issues such as homelessness, poverty, transactional sex, and domestic abuse and violence. For people who are experiencing these adversities, and particularly multiple adversities, accessing treatment is not always easy.

1.6.3 Mr. Philly McMahon, advocate

Mr. Philly McMahon described his family's experience of dealing with the stigma associated with his brother's drug use before he was diagnosed with schizophrenia. He explained that, had they had that diagnosis when his brother was younger, they would have considered the drug issue as more of a health issue rather than dealing with the shame associated with what was considered criminal activity. He described the impact of having an addiction in the family and the way it impacts on all your day-to-day activities. He explained that there probably wasn't a moment when he wasn't thinking about his brother.

1.6.4 Mr. Andy O'Hara, UISCE

Mr. Andy O'Hara commented that his story isn't unique, that it has been told thousands of times. He suggested that we sometimes focus too much on people who have gotten to a better place, whereas the story should be about the people who didn't make it. UISCE is made up of people who have lived or living experience of drugs use.
He explained that sometimes there is a view that, if someone used to use drugs, they can have a voice, but if they are still using drugs, they can't.

'People tell us they tell us they want to live; they tell us they want to realise their full potential; they tell us they want to have a stake in society; they tell us they want to be involved.'

UISCE meets people where they are at, and people are brilliant, they have so much to offer, yet they are dehumanised, stigmatised, criminalised, and written off. These people are the ones with the experience and insights into the causes, consequences and the responses to drug use. While drug use happens across all demographics, there are certain groups of people that are stigmatised and criminalised more than most. These groups are then seen as just a problem, yet they are part of the solution.

1.6.5 Panel discussion

Discussing the stigma and shame associated with drug use, Ms. McKeown said that, depending on where a person lives and their background, they may not get offered or have access to the same services as someone else. It is a potential rite of passage for children growing up today to experiment with drug use, and if there isn't resilience built up around those children that experimentation has a greater risk of developing into further problems. When there is an intergenerational dimension to that spiral, there can be a deep distrust of Social Services and a fear for women, in particular, of having their children taken away from them. In contrast, if a person has recovery capital, where they have their physical health needs met, have a community around them that can support them, they are in a stronger position to maintain recovery. Ms. McKeown suggested that how State agencies respond and provide service delivery must be improved, and solutions need to take an holistic approach, including dealing with housing issues, providing mental health support and access to physical healthcare. In recognition of these broader issues, one of the services Coolmine offers is mother and child residential treatment services, meaning a mother doesn't have to put her children into care or into the care of her extended family in order to access the treatment she needs.

To illustrate what policies work and don't work, Mr. O'Hara gave the example of two men who had very similar experiences of drug use, but came from two very different backgrounds. One was from a council estate and the other was from a wealthy background. Both were using heroin intravenously, both had lost a partner, and both had issues with their children. However, the man from the council estate had his children taken off him, turned to crime and ended up in prison. On release from prison, he was homeless and is in and out of drug use and facing 18 months to access treatment. The other man had a system around him, his family took care of his children, he had resources to access treatment on four occasions when he needed it, when he came out of treatment he had a house, education and a job.

Dr Lambert recalled the stigma and shame that used to exist around mental health, and how euphemisms were used to talk about suicide. This has now completely changed, and if someone is feeling down, they can go to a GP and address the issue. While we still have some way to go regarding mental health supports, it is nothing like it was 20 or 30 years ago. In contrast, where we are now with regard to drug use is where we were then with regard to mental health. If someone's casual drink or drug use has developed into a more complicated relationship, it's very difficult for them to go and seek help, because of the stigma involved. We have made people feel it's their fault, thereby creating both external and internal stigma. Added to that are the drug policies that further stigmatise the person by telling them that they are a criminal.

'Nobody feels as bad about themselves as the person themselves.'

Mr. McMahon suggested that the 'War on Drugs' should more correctly be called a 'War on Class', given that the prison population is heavily populated with people from working class communities. Mr. McMahon questioned why that is the case, given drug use occurs across all communities.

Moving on to discuss society's response to drug use, Dr Lambert described how a significant number of people who have a drug dependency have experienced a psychological trauma. If these people have struggled to access services

to deal with this trauma at the time they needed it, and in the meantime, have found a substance that allows them to function and to cope and avoid suicide, how does society then turn around and traumatise them further with criminalisation? There are people who have come through recovery and rebuilt their lives, and yet, where they have a past criminal conviction, they are reliving that trauma every time they apply for a job that requires them to explain their conviction, even if it happened many years ago.

In response to comments that sometimes the strongest voice against a more liberal approach to drug use comes from families that have lost a loved one to substance abuse, Dr Lambert noted that the grief associated with such a loss is complex and carries its own shame and stigma. She said she would leave it to the words of the families affected by such loss, referencing an article published that week from Ms. Aileen Malone talking about the loss of her daughter Dara. Dr Lambert stressed that what we do know is the further you push people into the margins, the more dangerous the situation you create. She cited the example of two people taking heroin together where one starts to overdose, if the other person calls 999, they then have to leave the scene or risk being implicated, creating a level of fear. If the first person subsequently dies, what is the impact on the person who has left? The current situation is really complicated, emotive and polarised. She finished by saying we have to recognise what we as individuals don't know, and it can be very difficult to understand some else's life, particularly if we have lived with privilege.

The current policy, according to Mr. McMahon, works for certain people. It works for solicitors, the media world, and politicians, but doesn't work for the people it needs to actually work for. There are two aspects to going to prison, one is that your liberty is taken away because you've committed a crime, and the other is that you have to be rehabilitated before you can reintegrate into society. Mr. McMahon's brother, John, took drugs before he went to prison, he took drugs in prison, and he took drugs when he got out for prison. In many ways, going to prison makes you a better criminal. There are two and half thousand people in our prison serving sentences of less than 12 months. There is more intervention through the criminal justice system than through the health system.

Ms. McKeown expressed the view that, for possession of small amounts of drugs, we need to be looking at a public health response. The current system has become a revolving door for many people. It's important that the public health response is resourced properly, with treatment services and wrap around supports available both in rural and urban areas.

'It's a national issue, a national problem, it's not just confined to inner city areas.'

In response to concerns or fears around a relaxation in drugs policy, or how to distinguish between personal use and the larger problem of distribution and supply, Ms. McKeown highlighted a number of pilot projects around the country covering screening and brief intervention. This allows earlier intervention in someone's drug using, with a health response. Mr. O'Hara noted the same fears were expressed back in the 1980s regarding a liberal approach, yet 30 years later drugs are more available, they're cheaper, they're more potent and they're available in every parish in the country. He stressed that we need to be realistic about where we are at, and acknowledge that the criminalisation and stigmatisation of people hasn't worked.

'If we were able to get rid or banish drugs, it would have been done a long time ago.'

Mr. O'Hara asked why we take so long, because of our fears of radical change, to get to a place that will do something. He argued that a lot of the policies that should be rolled out are pragmatic fixes. He questioned how many more people need to die, how many more people need to be locked up and many more people will have their lives destroyed until we say 'Yes, let's do it!'.

Dr Lambert noted that often, when we talk about drug related harm, it relates to the medical effects of drug use, but there are other drug related harms. Having a criminal conviction is harmful for a person's future development. She pointed to the issue of cross-over between mental illness and drug use, noting that when someone comes in for drug treatment you cannot assume you know everything about them, often there is an underlying trauma that they may never disclose, or disclose many years later.

1.6.6 Questions and Answers session

The Questions and Answers session began with a question about the benefits of treating the mental health and socio-political or socio-cultural roots of the issue, rather than marginalising addicts with criminal legislation or concentrating on supply side polices, particularly given the apparent ease of access to drugs. In response, Mr. McMahon referenced his visit to Portugal to look at their health-led approach, and noted that the key element to the

success of their change was the multi-disciplinary approach that they wrapped around their decriminalisation model and the investment pushed into the public healthcare system. He stressed that we need to consider the elements of what other countries are doing and figure out what works best for our country. Ms. McKeown emphasised that we need to put in place services that are accessible. The current system results in too many wrong doors. Whether its mental health vs drug use, or the person is a pregnant lady, there are multiple barriers to treatment. There are good practices in Ireland that need to be better resourced.

Asked about effective legalisation approaches in other countries, Mr. O'Hara suggested that, as a society, we need to ask why there is a never-ending supply of young people, mostly men, who see selling drugs as a form of employment and why is it concentrated in certain communities? Any solution needs to include opportunities for people and address poverty in those communities. Dr Lambert pointed to problems in areas where they have legalised drugs, yet a black market has continued, noting that the people who had been involved in selling drugs prior to legalisation are not involved in the legal sale of the drugs following legalisation. You need to address the underlying issues, not just the legalisation question.

Members asked whether the country currently has the facilities to assist every person seeking treatment, and, if we were to take the holistic approach suggested by the panel, would the expertise and facilities be available to deliver on this? Ms. McKeown responded that investment will be needed and there will need to be an increase in targeted service provision. She stressed that the intersectionality element needs to be addressed: it's not just the drug policy response, it's also about the State's response to poverty and homelessness. There is a waiting list for residential treatment services today, and restrictions around access to detox. She advised that we need to look at the services we have, and we need to map how we increase those services.

Ms. McKeown raised concerns regarding pay disparities between Section 39 organisations in the community and voluntary sector and State agencies. Dr Lambert made the point that even if nothing changes and the status quo remains, we will still require those extra resources. If there is a change based on evidence-based policies, you will end up reducing costs in the future. The cost of imprisoning someone for a year is in the region of €83-85,000, while the cost for someone in an intensive Residential Treatment service could be somewhere in the region of €13,000 for a single person, and in the region of €24-25,000 for a mother and child. Over time, moving away from a criminal justice response will provide additional resources for a health-led approach. A study of Coolmine's services published in 2016 showed that 7 out of 10 people who came through the service were still drug free two years after treatment, 100% were back in contact with meaningful relationships, 98% were not engaged in criminal activity and just shy of 50% were engaged with education and training pathways.

The panel were asked their views on decriminalisation and whether it should be available for all types of use, or limited to specific uses such as recreational use or more serious drugs. Dr Lambert spoke about the behaviour of teenagers and explained that all generations of teenagers will do things that they grow out of. However, if a teenager is using drugs recreationally and they end up with a criminal record, that is a drug-related harm that will limit their opportunities in life. There has been suggestion of a 'three strikes and you're out' policy but that definitely won't work for somebody dependent on heroin, for example. Dr Lambert suggested that it's not always helpful to distinguish between the different types of use, and asked what it says about recreational, use particularly if it is not impacting on others. She suggested that all these myriad issues and circumstances need to be teased out.

Panel members were asked what their key message to the Assembly was. Mr. McMahon stressed that it's not often one gets a chance to make a big difference in society, and this is one of those times. He called on members to consider people they might know who could be facing the kind of pain and suffering his family has experienced, and consider whether they would like those people to be treated with a criminal justice approach or a health led approach. Mr. O'Hara remarked on the great sense of hope in the room, but called on members to be realistic and to remember it's a matter of life and death. He emphasised that there are a lot of people depending on the development of policies that are centred around people, and warned that if policies are created without the lived and living experience voices, they will not work and will create further marginalisation. Dr Lambert encouraged members to ask 'Why?' when considering research and to remember that there is no one expertise in the area, and often the people with the most expertise are not heard. Ms. McKeown commented that, if we are truly looking at a health led approach and reducing the harms associated with drug use in Irish Society, we need to ensure we have the services to support people when they need it.

1.6.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- There are not enough facilities / availability in addiction and treatment services
- A form of health-led approach that is person-centred should be prioritised
- Investment in public health system and services / supports for drug users should be put in place before any decriminalisation / legalisation
- The criminal system is not effective for drug users and has negative impacts
- The issue is wide in scope and there are no simple answers
- There is frustration at lack of change and empathy for people affected by drug use
- Criminalisation of drugs includes significant personal ramifications through conviction
- Avoid using 'addict', and instead use person who uses drugs, drugs users or someone that is drug dependent
- Use empathetic language in discussion and treat people with dignity and respect
- Avoid using the word 'junkie'
- Avoid words which stigmatise people
- Agree terminology so everyone knows what is being discussed e.g. illicit vs illegal, decriminalisation vs legalisation, dependence vs addiction, harmful vs non-harmful
- Avoid derogatory language and do not use terms which members themselves would not want to be called

1.7 Session 6 - International and European perspectives on drugs use

1.7.1 Ms. Giovanna Campello. *An International Perspective on Drugs Use*

Ms. Giovanna Campello, Section Chief, Prevention, Treatment and Rehabilitation Section, United Nations Office on Drugs and Crime (UNODC), provided an overview of the international drug control system. She explained that the term 'War on Drugs' is not used by the UNODC, and that the right to health has been at the centre of the drug control system from the very beginning. That there has been considerable evolution since the original conventions in the 1960s, with all changes made by agreement with the consensus of UN members, including Ireland.

Ms. Campello discussed the right to health of people who need access to controlled medicines, illustrating regional discrepancies by contrasting the ease of access to pain medication in North America and Central Africa. On a per capita basis, North America has 7,500 times more doses of pain medication.

Turning to the right to health of people who may be vulnerable to starting to use drugs, Ms. Campello explained that there is a wide range of vulnerability factors that are largely outside the control of the individual. Adverse childhood experiences and inequalities are key factors in the development of Substance Use Disorder later in life, particularly for marginalised communities. We know how to support healthy and safe development of children and youth through evidence-based preventions, and these are detailed in the International Standards on Drug Prevention published by the UNODC in conjunction with the WHO.

Prevention, done well, will address the vulnerabilities that are at the root of many different risky behaviours. If we promote the development of children and youth, we get less mental health problems, less substance use, less risky sexual behaviours, better school performance, less youth violence, less child maltreatment and less crime. The UN promotes prevention practices that are based on scientific evidence, which means using interventions that have been shown to be effective and safe according to the scientific evidence and therefore uphold the principle of 'do no harm'. The tools the UN promotes have been shown to be effective across poor communities and communities affected by violence. They have been found to be effective for both boys and girls, and also for populations in very difficult situations such as displaced people.

Discussing the right to health of people who use drugs and people with drug use disorders, Ms. Campello noted that, globally, only one in eight people who need access to drug treatment receive that treatment. While this is the global average, the situation in Europe is probably better than this. There are disparities regionally and within certain groups. She highlighted in particular women, citing that while almost one in two people who use amphetamines is female, less than one in five people in treatment for amphetamine use is female.

The final challenge highlighted by Ms. Campello was in relation to the poor quality of drug treatment and care, as well as the human rights violations associated with that treatment. She suggested, however, that it is possible to provide access to quality treatment and care services that are accessed voluntarily, based on scientific evidence and updated to the needs of the population. The 'International Standards for the Treatment of Drug Use Disorders'

covers the full continuum of care from first contact with a harm reduction service right through to recovery. Ms. Campello concluded by emphasising that evidence-based treatment doesn't just decrease drug use, thus shrinking the illicit market, but it also decreases overdoses, crime rates and incarceration. This is why the UNODC promotes the expanded use of alternatives to conviction and punishment, including for appropriate cases of a minor nature for trafficking. These alternatives can be implemented at each phase of the criminal justice system, including in prison settings.

1.7.2 Dr Eoghan Quigley. *European Drug Report 2022: Trends and Developments*

Dr Eoghan Quigley, EMCDDA, gave an overview of the European Drug Report, the EMCDDA's main analysis of drug use, related harms and drugs markets in Europe. The main headline message from the report is that both drug supply and use have begun to bounce back following disruptions during the Covid-19 pandemic, with indicators of supply and use already starting to return to pre-pandemic levels.

The report shows increased seizures of large shipments trafficking through Europe's seaports in intermodal containers, with new trafficking routes emerging along with new concealment routes and new production processes. The European Union remains a significant producer of some drugs both for domestic consumption and for global export.

Innovation is driving the high availability of a greater diversity and range of substances on the drug market, while these substances are increasingly more potent. It's also driving more complex patterns of drug consumption. Dr Quigley summarised this with the phrase '*everywhere*, *everything*, *everyone*', meaning that drug problems today are appearing almost everywhere. This is exacerbating issues such as homelessness, youth criminality, the management of psychiatric disorders, as well as violence and intimidation in communities related to the operation of drug markets. Dr Quigley noted that almost everything with a psychoactive potential can appear as a drug often mislabelled in mixtures or powders. He pointed out that in the area of new psychoactive substances (NPS), EMCDDA had about one new drug notified per week in 2021. The EU early warning system is currently monitoring 880 substances, 370 of which appeared on the market in 2020, illustrating the growing diversity of substances available. Dr Quigley highlighted the increase in synthetic opioids, cannabinoids and cathinones, which are linked to a range of concerning harms.

Cannabis remains Europe's most popular illicit drug, with an estimated 15.5% of 15–34-year-olds having used cannabis in the last year. Cannabis is responsible for about 80,000 people accessing drug treatment in Europe, with about 43,000 of those accessing treatment for the first time and is responsible for about 45% of all first-time treatment entries. Cannabis products, Dr Quigley noted, have become more complex, and are available on the market in extract and edible form, with a high THC content, but also CBD products with a low THC content. He noted the increasing complexity with regard to European cannabis policies, which now encompass a wider set of areas including control of illicit cannabis, regulation of cannabis for medical uses, and other emerging uses and forms including as ingredients in foodstuffs, cosmetics and other commercial products.

Some EU Member states are looking at adjusting their cannabis policies, including Germany, Malta, the Netherlands, Luxembourg and, most recently, Czechia. Medical use of cannabis is available in most EU member states, although the type of access and products available differs considerably between them.

Dr Quigley discussed concerns about the adulteration of cannabis with synthetic cannabinoids, stressing that people may be purchasing what they think is illicit natural cannabis but, instead, are receiving something adulterated with synthetic cannabinoids. This creates different kinds of risks, as these synthetic products provide more intense intoxication, mental, physical and behavioural effects than natural cannabinoids, and have also been associated with some fatal and non-fatal poisonings.

Dr Quigley described the increase in drug production in Europe and efforts by European police forces to dismantle some of these production networks, noting that a record 213 tonnes of cocaine was seized in 2020. However, EU wastewater analysis indicates that 32 out of 58 cities saw increased cocaine residue readings between 2020 and 2021. Alongside these results, the EU index trend shows that the purity of cocaine has risen 40% above the baseline year of 2010, while the price has remained relatively stable. All of these results indicate high availability of cocaine on the European market. There are also signs of increased crack cocaine usage among vulnerable groups, which is also driven by economic deprivation and the availability of small, cheap, crack cocaine dosages. This is particularly evident for people in vulnerable groups experiencing marginalisation, and includes people who have a primary opioid dependency. Crack cocaine use is linked to high frequency consumption of the drug, which can lead in some cases to rapid mental and physical deterioration and other social problems, including violence, gang-related violence and financial problems.

There are similar dynamics in play with methamphetamine, where there is greater global collaboration amongst organised crime gangs with greater production of the products in Europe. While this production is primarily aimed for export to lucrative non-European markets, and while usage in Europe has been low, there is a concern that some of this production could leak onto European markets in the countries where it is produced or that it transits through. Harms related to methamphetamine use include acute drug toxicity, psychotic episodes, polydrug use and bloodborne viruses from injecting, as well as death.

Dr Quigley spoke about the signs of decline seen in Darknet drug markets during the pandemic period as result of targeted policing activity, as well as delivery problems, with increased detection in postal and delivery services. This is reflected in survey data which indicates revenues dropping to €30,000 a day in 2021 down from €1,000,000 in 2020. However, he noted that there has been an escalation in the use of social media and instant messaging apps to address this drop in revenue.

While injection drug use is declining, it remains a significant concern, with 22% of first-time treatments of clients who use heroin reporting injecting as their main route of use in 2020, down from 35% in 2013. There is a greater diversity of substances being injected including opioids, heroin, amphetamines, cocaine and other medicines. Recent syringe analysis studies have shown two or more drug residues present in some syringes, indicating a polydrug use or the sharing of needles across different drug users.

In 2020, there were 563 new HIV diagnoses associated with injecting drug use, with half diagnosed late, raising concerns about interruption in access to testing and care during the Covid-19 pandemic. This comes at a time when there is a concern regarding access to harm reduction services generally. In 2020, only 4 countries reporting to the EMCDDA met the WHO targets to distribute 200 syringes per person who injects drugs, and have 40% of the population of high-risk opioid users in opioid agonist treatment. The EMCDDA estimates there were about 1 million high-risk opioid users in 2020, with considerable differences across European countries in terms of the access and coverage of treatment. There were an estimated 5,800 fatal overdoses in the EU in 2020, giving a mortality rate of 16.7 deaths per million. Opioids are present in approximately ¾ of overdose-related deaths.

Dr Quigley detailed the impact of developments in Afghanistan on European drugs markets, particularly an increase in methamphetamine imports from the region into Europe. The war in Ukraine has also increased the uncertainty of Europe's drug situation. Concluding, Dr Quigley summarised the headline information regarding the wider dimensions of the drugs problems experienced by European countries, noting that not all problems are experienced by the same extent everywhere. Some of these issues are present in Ireland, some are not.

1.7.3 Mr. Thomas Kattau. A Human Rights perspective

Mr. Thomas Kattau, Deputy Executive Secretary of the Pompidou Group at the Council of Europe, opened his presentation by reviewing how the international community has, since 1961, adopted international regulations dealing with the public health risks associated with narcotic drugs to ensure healthier, safer societies. These regulations took the drastic step of scheduling certain substances, making them illegal for production, distribution and use. Criminal law is a very strict measure to deal with risks, and since the 1960s, there have been many positive efforts to seize substances and raise awareness of the risks, but there have also been many unintended adverse effects. These effects often come in situations where you try to secure public safety and health by repressive measures that may impinge on human rights.

Mr. Kattau posed the question as to why human rights, which have always been at the heart of drugs policy when considering the tension between the rights of the individual versus the need for public health measures, have become more prominent in recent years. At the beginning, prohibition was at the core of the debate but for the past twenty years human rights have gained more prominence in the debate. However, it was not until the UN General Assembly on Drugs in 2016 that human rights became an issue of primary concern. Mr. Kattau suggested three reasons why this has happened.

The first is that there has been more awareness and understanding about drug-related harms not only in terms of public health risks but also, in terms of seeing the unintended consequences and harms different repressive policies have created. He stressed this by noting that if you make one product illegal, it gives rise to illegal markets, organised crime all the way down to the consequences of criminalising behaviour, with knock on consequences for societies and individuals alike.

Secondly, the debate around drugs has become wider, with a wider range of media, meaning Civil Society has engaged in the dialogue much more widely and intensively.

The third reason is the emergence of a greater focus on cost/benefit thinking. Over 40 years have been spent investing in methods to reduce supply, but it does not appear that the world's drug problem has decreased. The question therefore arises for many policy makers as to whether it is still worth the investment or do we have to rethink the cost, not only of investing in supply reduction but also the cost of the unintended consequences of this approach.

Mr. Kattau explained that human rights are entitlements to certain treatment or abstention from treatment, and as a concept can be either political, ethical or legal. Political declarations, such as the United Nations Declaration of Human Rights, are not legally binding; international conventions do create rights and bind governments; and national legislation may provide specific rights and procedures in a court of law.

While there are different ideas as to what constitutes human rights, there is some level of consensus evident in international legal instruments regarding certain rights, including the right to life, protection of human dignity etc.

Mr. Kattau highlighted the following rights relevant to drug policy:

- The right to equitable access to health care
- The right to information about one's health, including the right not to be informed
- The protection of personal data concerning health
- The prohibition of medical treatment without consent
- The prohibition of inhuman or degrading treatment
- The prohibition of compulsory labour

Mr. Kattau highlighted the prohibition of medical treatment without consent, noting that there is a trend to discuss whether there should be compulsory treatment imposed. Mr. Kattau noted that all these rights are enshrined in legal instruments of the Council of Europe and constitute legally enforceable rights for any individual residing in a Council of Europe member state, including Ireland. Human rights law is constantly evolving, with the European Court of Human Rights in Strasbourg continually developing case law in the area. A recent development Mr. Kattau highlighted is a right for civil society participation:

'All citizens have the right to make their opinions known and are allowed to form, support and join political parties and pressure movements to effectively enjoy to their rights to make their political thoughts known.'

Human rights do not create rights between one citizen and another, but rather rights and entitlements between governments and their citizens. Mr. Kattau proposed that the challenge for governments is that they need to ensure their drug policies are effective in guaranteeing the rights of individuals, while at the same time ensuring public health and safety. Meeting these aims sometimes entails the restriction of individual rights.

In practice it can be difficult to strike a fair balance between these two aims. The European Courts of Human Rights has established three key principles in terms of availability and access to treatment which particularly apply to people who use drugs or suffer from drug use related medical conditions. The first is that all policies must be proportionate. The second is that treatment must be available, accessible and of sufficient quality. The third is the care in prison should be equivalent to the care made available to society in general. The principle of equivalence means that detention is the punishment for the crime and not for the worsening of the person's health. This is a very important argument in terms of ensuring adequate healthcare in prisons, particularly for those who are suffering from drug use related pathologies.

Concluding his presentation, Mr. Kattau offered a number of key points:

- Human rights violations lead to discrimination, which in turn leads to social exclusion such as unemployment and marginalisation.
- A lack of harm reduction actually leads to increased public health risks and individual consequences.
- If treatment is inadequate, we have severe comorbidities and relapse and if we have disproportionate criminal justice responses, we're creating career criminals and social outcasts.
- If we don't listen to Civil Society, we will very often have inadequate responses that don't really meet the needs of the population and the target groups.
- Above all, if you don't observe human rights, you will suffer not only from increased human consequences but also increased social and financial costs.

1.7.4 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Health approach to drug use with an emphasis on harm reduction should be adopted over a criminal justice approach, particularly given cost-benefits.
- Health services require increased staffing and investment, particularly mental health services.
- Prison system requires reform and investment given need for rehabilitation and presence of drugs in prison.
- Drug use is getting worse despite investment and prohibition, and there has been increased proliferation through the internet and social media.
- Ireland is not alone at an international level in tackling drug use, and needs to catch up with international policy and research.
- Data today highlights a gap between HRB and international data.
- Tension between individual and collective rights as use may affect wider communities.
- Drug markets are reactive and adaptive, creating new substances frequently.
- High number of drugs monitored, even in countries with decriminalisation / legalisation.
- Surprise that synthetic drug use is rising, demonstrates scale of issue.

1.7.5 Questions and Answers session

Mr. Kattau was asked to describe the consequences where the State breaches human rights by not providing sufficient quality healthcare to someone struggling with drug use. He replied that the person is able to seek legal remedy. Ireland is obliged to implement the Convention on Human Rights and the case law of the European Court. You can challenge any decision not to provide treatment, or where you feel treatment has been insufficient, and this could result in civil damages to be paid and require the authorities to provide you treatment.

Mr. Kattau noted that, in the prison system, drugs are more readily available than outside the prison system. There are anecdotal stories of people being initiated into drug use by criminal networks within prisons. Some countries have pilot projects to not only provide drug-free wards in prisons but also to establish therapeutic communities inside prisons, separate from prison wards, where prisoners are offered access strategies to escape their addiction.

Dr Quigley provide further information on the Escape Project. This project operates at a local level, taking syringes that have been used to inject a drug and have been returned to a needle exchange programme and analysing the contents to identify what types of substances are being used. It might be the case that a person thinks they have taken an opioid but do not know exactly what is contained in what they have been sold. This provides information on what is actually available on the drug market at a local level. It provides a real time indicator of what people are gaining access to.

Dr Quigley provided an overview of how a number of EU member states are considering how they might adjust their approach to cannabis, specifically recreational cannabis use. The most recent proposal has been in Czechia, where they have launched their latest National Drug Strategy Action Plan to look into regulation of cannabis. Malta has allowed some home growing, with Luxembourg, Germany and Czechia considering evolving proposals. The Netherlands are running an experiment about potentially operating a closed supply for cannabis coffee shops. In the Netherlands cannabis is de facto legalised, but the production of the drug is referred to as the 'back door problem', as it still comes from the black market. The Dutch government is looking to address this issue with this experiment, which will run for the next few years and will be monitored and evaluated in terms of its effects.

With regard to the impact of drug seizures on reducing the supply of drugs in Europe, Dr Quigley noted that drug seizures reflect policing resources and priorities, and don't necessarily tell us the size of the market. If you focus intensely on the trafficking, then you'll seize a lot more. A key part of the response to drugs is intercepting drugs being trafficked and dismantling production facilities. Drugs seized are destroyed, usually incinerated.

1.8 Session 7 - National perspectives on drugs use

1.8.1 Ms. Siobhán McArdle, Department of Health

Ms. McArdle, Assistant Secretary, Department of Health, outlined the policy approach to drug use in Ireland and highlighted the new priorities for the National Drug Strategy. She explained that the Department of Health has an open and inclusive approach to drugs policy, with a strong tradition of involving people who use drugs, their families and communities and civil society organisations in the policy making process. She commended the powerful testimony on the lived experience of drug use heard during Saturday's session, and noted that those who shared their lived experience are actively participating in the development and implementation of drugs policy.

Ms. McArdle presented some statistics showing the societal impact of drug use. In 2020, 7% of the population had used drugs in the past year. For 2021, the most recent full year treatment figures show there were 4,206 new presentations for drugs treatment, up from 3,802 the previous year. There were 235 drug induced deaths among adults in 2017. Health expenditure in 2021 on drugs use was €145 million, which included funding spent by the Department of Health, HSE, community-based services and the Health Research Board. Additional funding in recent budgets amounts to an increase of €20 million. Ms. McArdle noted that there is an estimated societal cost of drug use of €650 million, including costs to hospitals, prisons, the criminal justice system. This reflects the costs of addressing the medical and legal consequences of drug use as well as the productivity losses associated with drug use.

Ms. McArdle outlined the policy response to drug use set out in the National Drug Strategy. This sets out a health-led approach to drug use with the statutory, community and voluntary sectors providing a cross-cutting and coordinated response to drug use. The strategy is overseen by a National Oversight Committee involving government departments, State agencies and civil society. The committee is chaired by the Minister for State with responsibility for Public Health, Well Being and the National Drugs Strategy. The strategy is also supported by international cooperation, including through the EU Drug Strategy and Action Plan and the British Irish Council work sector on Drugs and Alcohol.

One of the key principles underpinning the health-led approach to drug use is person-centred care and compassion – meeting people where they are. Ms. McArdle highlighted the need to develop integrated care pathways for high-risk drug users, including people who are homeless, offenders and people injecting drugs, in order to achieve better health outcomes. This requires integrated care pathways, connecting care between GPs, Primary and Community Care Providers, Community specialist teams and hospital-based specialists. Ms. McArdle highlighted the need to understand and incorporate the social determinants of drug use. That is, understanding that there are underlying social and economic determinants that increase the prevalence of problematic drug and alcohol use in certain communities, which require action across government to promote community development and community safety. Ms. McArdle stressed the importance of partnership, highlighting that there is a need for input and commitment from a wide variety of government departments, State agencies and members of civil society in order to achieve the goals of the Strategy.

The National Drugs Strategy covers the period 2017 to 2025, with a midterm review undertaken in 2021. The review found significant progress had been made on the majority of actions and identified six strategic priorities for the remaining period. One of these priorities is to focus on the prevention of drug use and harms among children and young people. The Department of Health has made a €1.5 million allocation for a three-year drug and alcohol prevention and education program, which will utilise evidence on best practice throughout Europe to help professionalise drug prevention practice in Ireland.

A further objective is to improve access to drugs services within communities. In 2022, the Department of Health and the HSE provided over €30 million of funding to 280 community-based drug and alcohol projects through the local and regional Drug and Alcohol Task Forces. Ms. McArdle noted that drugs do not impact on all people and communities in the same way, and the National Drugs Strategy recognises that the impact of drug use is greater in disadvantaged communities. The Strategy aims to address the strong overlap between homelessness and drug use. Another key element of the Strategy is to take a holistic approach to recovery. Recovery is an essential part of drugs policy and means recognizing the people affected by drugs use have complex health and social needs that require a sustained and comprehensive response.

Ms. McArdle referenced the Health Diversion model, which takes a health-led approach for people found in possession of drugs for personal use, noting that other contributors would discuss this more thoroughly. The Misuse of Drugs Act provides the public health legal framework for drug use and establishes a system of control on certain

drugs to protect the public from dangerous or potentially dangerous and harmful substances. The Act has been updated in recent years to address issues like the Medical Cannabis Access Programme and the supervised injection facility, which is being currently established.

1.8.2 Prof. Eamon Keenan, HSE Addiction Services

Prof. Keenan, National Clinical Lead, HSE Addiction Services explained how addiction services in Ireland have developed for the three main substances treated, namely heroin, cocaine and cannabis.

He described the response to the heroin crisis of the 1980s, noting that the first use of methadone as a replacement treatment for heroin occurred in 1971 but very few people presented for treatment through the 1970s. In 1981 we saw the emergence of the Dublin opioid epidemic, where there was a significant increase in the number of young people presenting for drug treatment, rising from 54 people with a heroin problem in 1979 to over a thousand by 1983. The State's immediate response at the time was to detox everyone.

The Dublin opioid epidemic had huge health consequences, with rising cases of Hepatitis C and, from 1985, the emergence of HIV as an issue. One in five people presenting with heroin-related problems were HIV positive. The earlier detoxification model did not appear to be impacting on the rates of HIV, so there was a move away from this approach to use methadone as a substitution therapy. At the time there was also a shift in community responses. Communities were being devastated by young people dying from drug use and there was a move towards a greater focus on harm reduction. By the mid-1990s, and with the publication of the Rabbitte Report, Task Forces were established in those communities with the most need, bringing the statutory, community and voluntary sector organisations agencies in the area together.

Prof. Keenan explained that harm reduction is a pragmatic response to drug use, which focuses on the harmful consequences of drug use and accepts that not everyone will be successful at abstaining from use. Harm reduction measures include needle exchange, methadone maintenance programs and supervised injecting. Prof. Keenan then referenced the introduction of the Methadone Protocol in 1998 to regulate the prescribing and dispensing of methadone. Anyone in receipt of methadone is recorded on a central register, they have a treatment card and a special prescription. Only designated, trained GPs and pharmacists are allowed to provide the treatment.

Ireland has just under 20,000 problematic opioid users, with almost 11,500 of those on replacement therapy of either methadone or buprenorphine, delivered via HSE clinics, community GPs and community pharmacies. At the end of March 2023, there were 94 HSE Clinics, 278 Level 1 GPs, 89 Level 2 GPs and 748 Community Pharmacists across the country providing methadone. These services are developed in conjunction with local and regional Drug and Alcohol Task Forces. HIV rates have significantly reduced, particularly amongst young people, so much so that it is rare to see somebody presenting with HIV.

While there has also been a reduction in problem opioid use associated with young people, what is now being seen is that 42% of young people under the age of 25 seeking treatment are presenting for cannabis-related problems, and 22% for cocaine-related problems. Prof. Keenan highlighted that cocaine use is increasing across all age groups, with a significant increase in use by females aged between 15 and 24. In addition, crack cocaine has emerged as a problem in disadvantaged communities. There has been a tripling of people presenting for treatment for cocaine use in the last six years, with 34% of this group indicating they are employed.

With regards to cannabis, Prof. Keenan stressed that cannabis today is not the same as it was 10 or 20 years ago, with potency significantly increased. He explained that the psychoactive component – tetrahydrocannabinol (THC) has increased while the balancing component - Cannabidiol (CBD), which would relieve anxiety or counter the potential psychotic features of THC, has reduced. As a result, people are taking cannabis more for the psychoactive effect, but the HSE is seeing more side effects associated with its use – particularly mental health problems. There has been the emergence of new cannabis products such as cannabis edibles, vapes and syrups. The HSE, earlier this year, issued a risk communication in relation to cannabis edibles whereby people are taking jellies which are infused with either cannabis or synthetic cannabinoids, which have caused hospitalisations in Ireland, often with the resulting mental health problem being the reason for that hospital attendance.

Prof. Keenan displayed a graph showing a steady increase in hospital admissions for cannabis and cocaine-related problems over the last twenty years. He noted that the HSE is commencing a dual diagnosis clinical program, starting with pilot sites in Limerick, Cork and North Dublin which will look at some of the issues associated with drug use and mental health problems. There have been 41 new psychoactive substances with ones of particular concern being cathinones and cannabinoids.

The Health Diversion programme, recommended by a working group in 2019, relates to people who are caught in possession of any drug for personal use. While possession will remain a criminal offence, the response will change to, in the first instance, the individual being referred by a member of An Garda Síochána (AGS) to the health services for a screening and brief intervention, and there will be no conviction. If they are caught again there will be an Adult Caution applied, and - again - no conviction. Only on a third occasion would someone enter the criminal justice system. This scheme is currently being progressed with the Departments of Health, Justice, and AGS. Prof. Keenan explained that while the HSE have structures in place and are ready to roll out the Health Diversion programme, with is a SAOR practitioner in each area, legislative change is required to allow this process to happen.

He also explained the drug testing initiative at Electric Picnic in 2022, which was a back of house drug monitoring pilot that allowed the HSE to analyse substances at the event. The testing identified a very high potency MDMA (ecstasy) tablet, and as a result, warnings were shared on screens either side of the main stage. This had a real impact on the safety of people attending the event.

Concluding, Prof. Keenan summarised some key points from his presentation:

- Ireland's opioid problem is stabilising but the population receiving treatment is growing older, potentially increasing associated medical complications, meaning they still need a lot of care and support.
- Cocaine and cannabis presentations for treatment are increasing, which could be associated with the increasing potency of both substances. The mental health impacts and the problem drug use amongst young people is a concern.
- The emphasis is now on a health led approach, with drug monitoring - including back of house testing at more festivals this year, wastewater and syringe analysis – being a key element to inform harm reduction responses and service development.
- Prevention needs to be prioritised, with the Department of Health recently putting out a call for a number of prevention initiatives.
- Recovery approaches should be at the core of strategies, implemented across all government departments and integrated into a whole of society response to drug use.
- The importance of sustained investment in health services including community-based services as well as residential services.

1.8.3 Mr. Ben Ryan, Department of Justice

Mr. Ryan, Assistant Secretary, Department of Justice, highlighted that government policy is not a fixed issue but rather it continuously evolves based on expertise built up from listening to people's individual experiences. The Department of Justice works very closely with the Department of Health on the National Drugs Strategy and connected policy and legislation. With regard to the Misuse of Drugs Act, while it is Health legislation, the Department of Justice also has a significant role. The Department is a member of the National Oversight Committee, the Strategic Implementation Group that operates below the Oversight Committee; and the Drug Related Intimidation and Violence (DRIVE) Task Force.

The Department determines policy and legislation to enable AGS to tackle organised crime groups. It also works with the Office of the Director of Public Prosecutions (ODPP), Forensic Science Ireland – who have a key role in terms of drug testing - and the Courts Service. The Department's role is to identify effective mechanisms to combat harm and ensure safety.

Mr. Ryan provided an overview of the Sheehan Working Group, set up in 2019 and chaired by retired Judge Garrett Sheehan. The group examined possible approaches to personal possession of small amounts of drugs. It included the Departments of Justice and Health, the HSE, AGS, the ODPP, academics and people with lived experience. It considered approaches taken in other jurisdictions, health led approaches and alternatives to prosecution. It considered depenalisation, decriminalisation and legalisation. The Department of Justice's current approach would be very much in the depenalisation area.

Mr. Ryan explained the recommendations arising from the Sheehan Working Group, firstly referencing the Adult Caution scheme. While this scheme has currently only been rolled out for cannabis, it is potentially available for all drugs, and the Department is working with AGS and the ODPP on this. Mr. Ryan then referenced the Health Diversion approach. While the initial plan had been to amend the Misuse of Drugs Act to facilitate the rollout of this approach, this proved much too complex. The Department is now considering criminal justice legislation to progress Health Diversion.

Other recommendations from the Sheehan Report included setting clear referral pathways for people seeking help with drug problems, rolling out national level harm awareness campaigns, and improving data collection and

evaluation. Mr. Ryan indicated that all of those have been implemented to some degree. Some recommendations were not universally agreed by the working group and these included removing prison entirely as a punishment option and reducing the spent convictions period to three years. This is the amount of time you have to declare a conviction for employment or travel, and stands at seven years currently. These didn't receive universal agreement as there was a concern for some members of the group regarding unintended consequences.

Mr. Ryan describe current and ongoing initiatives being pursued by his department. The Adult Caution scheme has been expanded to include cannabis possession for personal use, and further expansion is being considered. Anyone arrested under 18 will have to be considered for Youth Diversion before any other criminal justice activity. The Department is currently working on a similar scheme for 18–24 year olds, and hope to have it ready by the end of the year. Work is being undertaken on a Rehabilitative Periods Bill, brought forward by Senator Lynn Ruane, which aims to expand the approach to spent convictions.

The Sheehan Working Group also considered other international approaches, in particular the Portuguese model. The Group recognised a lot of positives with this model but ultimately found it would not be possible to operate the same way in Ireland, given the significant differences in our legal systems. Other unintended consequences also became apparent to the Group, having consulted with a number of US States who have lightened their legal approach. This included an increase in drug tourism, increase in drug driving and other crimes, and the fact there is still a large illicit market driven by criminal gangs.

In recent days, Germany has indicated a move towards a more liberal approach, and Irish officials will be in contact with their counterparts in Germany to leverage any insights or learnings from their experiences. There are difficulties with not having a unified EU position on this issue. However, even if there was a clear EU position, we would still have a border with a non-EU country and potential issues to consider regarding cross border smuggling and differing approaches.

The Department continues to consider all possible options and recognises that there are clearly benefits both to the individual and in terms of the criminal justice system with a decriminalisation model. However, it must also be acknowledged that organised crime gangs will adapt to any changes in legal approach, potentially exploiting people to carry and deal within any new restrictions. There has been previous evidence of policy changes to mandatory minimum sentences leading to changes in gang behaviour. Previously, senior gang members brought drugs into the country, but now vulnerable people are exploited to do this and run the risk of detection and subsequent sentencing. Mr. Ryan noted that the power to search individuals would also be diminished.

With regard to legalisation, he noted that the main benefit suggested would be the State receiving the revenue rather than the criminal gangs, but he noted that this is not the reality from what has been seen in other jurisdictions, where gangs still remain involved in supply.

1.8.4 Assistant Commissioner Justin Kelly, Organised and Serious Crime (OSC), An Garda Síochána

Assistant Commissioner Kelly explained that An Garda Síochána (AGS) is a community-based police force whose mission is to keep people safe and to protect the vulnerable. The function of AGS, as set out in Section 7 of the Garda Síochána Act 2005, is to provide policing and security services to the State. AGS is committed to upholding the law, one of the key bases for democracy. However, AGS must prudently apply the law in a manner that is ethical and fair for all.

AGS fully supports the National Drugs Strategy and work closely with health partners and other criminal justice partners to reduce harm and ensure safety. AGS's law enforcement focus is not on the prosecution of those addicted to controlled drugs, but rather on disrupting drug trafficking supply lines and dismantling the organised criminal groups behind these lines. At the forefront of this work is the National Drugs and Organised Crime Bureau (NDOCB), which undertakes intelligence-led operations leading to seizures of substantial amounts of drugs firearms and cash. In the last eight years, AGS has seized more than €365 million worth of drugs, 147 firearms and deprived criminal organisations of over €28 million. Another element is mounting 'threat to life' operations, which prevent criminal gangs from committing murders. Since 2016, over 80 people have been convicted for feud-related activity. An additional aim is to deny people access to assets that they have accrued from criminal activity, which is achieved through the work of the Criminal Assets Bureau (CAB). The work of AGS with regard to drugs is supported by a network of local drugs units in every part of the country, which focus on localised and street level supply. This work is coordinated under Operation Tara.

AC Kelly examined drug supply across four levels. The first level is global, or international, and concerns the actual production of the drug and its international movement. The criminal gangs operating at this level are powerful, with substantial resources and influence. The second level is national, or middle market, and involves the importation and wholesale distribution of controlled substances. The third level is local, or street level, supply. People supplying at this level are actually putting drugs into the hands of the final customer. The final level is that of the individual user of drugs. AC Kelly commented that there is a direct link between those that use drugs and the criminal gangs that use violence to enforce their business models.

Drug trafficking is a priority at European and international level, with 40% of criminal networks in Europe involved in drug trafficking and 60% of criminal networks using violence. International partnership is vital to disrupt transnational groups. AGS has a network of officers around the world from Bogota, Colombia to Dubai to further drug enforcement activities.

'It takes a network to defeat a network'

Many problematic drug users commit crime to support and fuel their addictions. AGS deals with a range of such offences on a daily basis, ranging from simple theft to murder, and are often at the forefront of supporting families affected by drug abuse. Drugs related intimidation, where drug debts are levied against family members, is a particular challenging area for AGS. The force supports and engages in a number of initiatives designed to prevent drug harm, including the Early Warning Trends Committee, the Adult Caution scheme, the back of house testing initiative at festivals, and the proposed safe injection facilities.

AC Kelly reiterated that AGS are supportive of the current health-led approach, noting that it is extremely rare for anyone to be imprisoned for simple possession of drugs alone. He outlined that AGS have a long history of diverting people away from the criminal justice system, such as the Adult Caution and youth diversion programmes mentioned earlier.

Ireland is today 3rd in the global index for the safest places to live, whereas in 2016 we were ranked 13th. AGS has made huge strides in recent years in tackling organised crime groups behind Ireland's drug supply, with gangland murders at an all-time low. However, AGS have concerns around the potential legalisation of controlled drugs and its impact on wider society. Ireland represents 0.67% of the EU population and an obvious risk of legalisation would be drug tourism into the country, and all that that would entail. AC Kelly also referenced the impact of having a substantial different regime to that of our land border neighbour. Learnings from police colleagues in other jurisdictions indicate that decriminalisation of cannabis can have negative effects on policing, with increases in crime and a normalisation of drug use generally. AGS have also been told of increased open use of drugs in public parks and transport and an increase in drug driving. Last year in Ireland, nearly 2,700 people were arrested for drug driving. In Canada when they legalised cannabis, they saw almost a doubling of drug driving incidents.

In countries where cannabis has been legalised, organised criminal groups have not been eliminated and in many cases have undercut the legal market or continued to supply to less advantaged areas. AC Kelly recognised that there has been a call for the State to fully regulate and control the market. However, flaws emerge in this proposal in relation to some drugs, such as cocaine, where production is fully controlled by the cartels, or heroin, where the majority of supply comes from Taliban-controlled Afghanistan. It would obviously be unconscionable for the State to source drugs from such areas.

1.8.5 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Legalisation could entail negative or unintended consequences e.g. drug tourism
- Notable lack of convictions for possession alone or instances of drug use
- Historical issue with lack of implementation of policies
- Data is outdated
- Lack of services which are needed to address drug use issues
- Drug dealers and drug users should be treated differently by the criminal justice system

2 Meeting #2

Meeting #2

Figure 2.1: Session 1 - Shannon Connors, Fionn Sexton Connolly, Gillian O'Donnell, Karl Ducque, Dearbhail McDonald

Figure 2.2: Session 2 - Tom McLoughlin, Elaine Kehoe, Maria O'Hara, Dr. Chris Luke

Figure 2.3:
Session 3 - Cathy Kelleher

Figure 2.4: Session 3 - Paul Reid, Gearaidh Matthews, Maureen Penrose, Annemarie Sweeney, Aileen Malone, Caitriona Kirwan, Dearbhail McDonald

Figure 2.5:
The Printworks - Dublin Castle

Figure 2.6: Session 4 - Cathal O'Regan, Philip Jennings, Jennifer Clancy, Dearbhail McDonald, Amy Carey, John Paul Collins, Paul Reid

Figure 2.7:
Roundtable discussions

Figure 2.8: Pauline McKeown, CEO of Coolmine, briefs members on the site visit to Coolmine

Figure 2.9:
Paul Reid, Chairperson, on the site visit to Coolmine

Figure 2.10:
Site visit to Coolmine

Figure 2.11: Site visit to planned supervised injection facility at Merchant's Quay Ireland

Figure 2.12:
Questions and Answers

Figure 2.13:
Questions and Answers

Figure 2.14:
Questions and Answers

Figure 2.15:
Questions and Answers

2.1 Overview

The second meeting of the Citizens' Assembly on Drugs Use took place on 13-14 May 2023 at Dublin Castle, incorporating site visits to Merchants Quay Ireland and Coolmine Therapeutic Community. The theme of the meeting was 'the lived experience of people who use drugs, families, communities and service providers.

The following provides a necessarily incomplete account of the contributions made by speakers and panellists. Video recordings of each session are available online at **www.citizensassembly.ie.**

2.2 Session 1 - Lived Experiences of Individuals

The first session, featuring a discussion panel moderated by Ms. Dearbhail McDonald, explored the lived experiences of people who use drugs. The four panellists, three of whom were members of the Assembly's Lived Experience Group, discussed their experiences of, and insights into, illicit drug use.

2.2.1 Ms. Gillian O'Donnell

Ms. O'Donnell spoke about being born into a family where her parents suffered from addiction, where her father was one of the first people in the country to die of a heroin overdose, where she herself was born with substance use disorder and how she had developed a heroin addiction by age 11. She explained her experience growing up in a disadvantaged community where the heroin epidemic was deeply ingrained, drug use normalised and addiction widespread. She painted a picture of her experiences trying to live with the impact of poverty, childhood trauma and addiction. Alongside this complex interplay of challenges, Ms. O'Donnell highlighted the negative impact that criminal convictions and prison have on people dealing with drug addiction, particularly mothers grappling to retain custody of their children in the midst of personal turmoil. Ms. O'Donnell outlined the trauma she experienced at becoming homeless following a prison sentence drove her to develop a crack cocaine addiction. Now in recovery and working with UISCE as a peer support worker, Ms. O'Donnell's key message for the members was that services and health-led policies need to be implemented with the people most impacted at the centre of decision making.

2.2.2 Mr. Karl Ducque

Mr. Ducque spoke of growing up in inner-city Dublin, describing how his experience of drug use and eventual addiction started in the context of traumatic family and community experiences. Mr. Ducque outlined how he began using drugs experimentally, discovering that it gave him a sense of belonging and a means of escape. Escape from the harsh reality of poverty, the effects of marginalisation and the resulting sense of internalised shame and stigma. Over the space of a few years, his drug use progressed from experimental to problematic, developing into full dependency. He recounted the failure of the education system to intervene at an early stage, as well as the failure of the health system – recalling his 16-year-old self sitting in front of a GP being prescribed a 6-week course of methadone, without being offered any more holistic or therapeutic supports. Mr. Ducque recounted how, following that initial GP visit he remained on methadone treatment for 18 years, during the course of which he caused what he described as 'carnage' to himself, his family and his community. Having lost friends and family to drug use, spending time in prison and in hospital, Mr. Ducque eventually got into sustained recovery which he maintains with the help of a 12-step Fellowship programme. Having attended university, Mr. Ducque now works as a Team Leader and Intensive Outreach worker with marginalised young people in Dublin's south inner-city, explaining to the Assembly that 'I don't shy away from my story, I don't feel sad for my story, I feel like my story is who I am and that's what I do and how I help people'.

2.2.3 Ms. Shannon Connors

Ms. Connors shared her experience of drug use and addiction in the context of childhood trauma and experience of stigmatisation as a traveller woman and a mother. She spoke about the particular challenges facing traveller women in prison, many of whom are grappling with addiction but not able to access the help they need. She described the compounding impact of being separated from, and sometimes losing custody of children, referring to it as 'that perfect storm of troubles that engulf you'. Ms. Connors called for greater levels of service provision for addiction treatment and recovery and reiterated the importance of peer education and mentorship in the journey to recovery.

2.2.4 Mr. Fionn Sexton Connolly

Mr. Sexton Connolly shared his perspective on drug use within the student population, highlighting the wide acceptability and availability of drugs. Mr. Sexton Connolly spoke of the range of pressures, including financial, that many students are grappling with. He noted the role that drug use, particularly stimulants, play among people forced to work long shifts to support themselves through college. He also spoke from a personal and family perspective about drugs use in the context of people dealing with mental health issues, emotional or physical pain, describing how difficult it can be to articulate the need for psychological and emotional support. He noted the attraction that drugs might have for someone who wants to self-medicate their pain.

Concluding the session, the panellists called for additional services and a lower threshold for people to access services, as well as calling for greater societal compassion. In particular the panellists urged people grappling with addiction to reach out and seek support. Drawing the session to a close, Dearbhail thanked the panellists for their courage to share their stories.

2.2.5 Questions and Answer session

Panellists were asked what outcomes they would like from the Citizens' Assembly on Drugs Use and what one intervention would have made a difference in their own case.

Responding, several panellists referred to early-stage interventions with young people, and the need for targeted interventions for young people, travellers, women, and mothers, to break the cycle. Speaking from his experience of working with young people, Mr. Ducque suggested that society should not be criminalising young people for using drugs, it should be looking for ways to help them.

Mr. Sexton Connolly called for a framework with a health-led approach that is focused on, and tailored for the individual, and capable of responding flexibly to the needs of individuals including vulnerable and marginalised people. He stressed that while the criminal justice system still has a role, a criminal justice response alone is not sufficient.

Other suggestions from the panel included specific additional government/monetary supports for mothers in addiction treatment; prioritising further supports to travellers in order to break the cycle of drugs use; the need to integrate systems, i.e., courts services, addiction services and housing.

Several felt that the systems are negative by design towards people who use drugs (PWUD). Speakers voiced the difficultly of recovery in the current system, with delays in the judicial system causing harm to individual's recovery journey.

Speaking of his personal recovery, Mr. Ducque referred to the importance of being backed by someone who believes in you, and also taking responsibility for ones' own actions and addiction as a key step to making changes.
Two speakers noted the importance of intervention, with Ms. O'Donnell speaking about the need to meet people where they are at and Mr. Sexton Connolly calling for interventions such as teaching young people how to articulate their needs, the importance of being listened to and recognition of personal value.

Finally, panellists called for better access to holistic programmes that are tailored to individual needs, integrated services which invest in cross cutting support plans, namely improved access to mental health services. The importance of addressing stigma in language across society, both in relation to drug addiction and mental health, was also stressed.

2.2.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- People with addictions experience a lot of stigma.
- Stigmatisation exacerbates the problem. Drug users are stigmatised by society in a cruel way and made feel like failures, but it is the system that failed them.
- People shouldn't have to reach the point of crisis before they are treated. Early intervention is crucial.
- Trauma is a source of addiction.

- Services provided to people experiencing drug addiction need to be improved. The system we currently have is not working.
- Peer pressure contributes to drug-use in children and young people.
- There should be a greater focus on prevention.
- Drugs numb a set of circumstances in which people find themselves.
- Addiction is not a choice.
- Socio-economic status can reduce or increase the likelihood of a criminal conviction.
- A health-led approach is necessary to address the drug crisis.
- Criminal records prevent individuals from progressing in their lives.
- Members felt shocked and overwhelmed by the individuals' lived experience stories.

2.3 Session 2 – the experiences of front-line workers

The second session, again moderated by Dearbhail McDonald, featured four front-line workers, from different parts of the health and criminal justice sectors, speaking about their experiences and perspectives on drugs use.

2.3.1 Dr. Chris Luke, Emergency Physician

Dr. Luke opened the discussion, describing the added burden that problematic drug users place on already overcrowded emergency departments (EDs) around Ireland. Presentation in EDs related to problematic drug use span as range of issues from overdose poisonings to medical complaints such as stroke, heart-attack and seizures to psychiatric and psychological problems including psychosis, delirium, agitation and violence.

2.3.2 Mr. Tom McLoughlin, Advanced Paramedic, Swords Fire Station

Mr. McLoughlin spoke about his work as an Advanced Paramedic, describing the types of drug-related incidents attended to by Emergency Services, and the work of Advanced Paramedics in administering naloxone to reverse the life-threatening effects of opioid overdoses. He described the levels of violence and aggression that can often feature in drug-related incidents, and the risk posed to emergency crews. He provided an overview of the most common drugs used, and the increasing level of poly drug use, observing that drugs use is now prevalent across Irish society.

2.3.3 Detective Garda Maria O'Hara, Garda National Drugs and Organised Crime Bureau

Detective Garda O'Hara explained she had previously worked for many years in Pearse Street Garda Station, covering Dublin city centre. She outlined the duty of care An Garda Síochána has for public safety and the welfare and preservation of life above all. She explained how draining it can be on Garda resources to deal with certain drugs-related issues and highlighted the range of offences and problems that Gardaí have to respond to, from assault and violent disorder to public order offences to theft, burglaries and attempted suicides.

2.3.4 Ms. Elaine Kehoe, Merchant's Quay Ireland (MQI)

Ms. Kehoe, MQI Clinical Nurse Manager based in St. Francis' Farm, a medically-supervised residential detox unit in Carlow, explained the range of low-threshold harm reduction, treatment and therapeutic interventions offered by MQI. Ms. Kehoe spoke about the complex needs of service users with dual diagnoses and the frequency of undiagnosed mental health problems.

2.3.5 Panel discussion

Dr. Luke responded to a question about the potential impact of cannabis legalisation. He suggested that following the legalisation of cannabis in parts of North America, cannabis use amongst young people and adults in general had increased by about six-fold, and that once usage goes up within a population it tends to stay elevated. He made the point that increased usage of cannabis leads to additional numbers attending hospital emergency departments. He noted that it also increases the level of harm to children, particularly where parents using drugs are not adequately vigilant, citing examples of increased poisonings by children accidentally ingesting cannabis edibles. Highlighting the risk of intensive cannabis use, he said that having one episode of cannabis-induced psychosis increases the risk of

developing schizophrenia, bipolar or other psychoses by 50%. He explained that between 10% and 20% of heavy cannabis users go on to develop Cannabis Use Disorder, in which people can withdraw from family relationships and from society generally. Another consequence of intensive cannabis use for some people can be Cannabinoid Hyperemesis Syndrome (CHS) in which people experience repeated and severe bouts of vomiting. He also remarked on the risk to victims of random violence on the street, with people who are withdrawing from cannabis becoming angry and sometimes violent.

Detective Garda O'Hara outlined the direct connection between people who use drugs and organised crime, whereby those involved in drug sale and supply demonstrate elaborate signs of wealth, funded by those using drugs and people grappling with drug addiction, which is wreaking destruction on them and their families.

The panel discussed the challenges of working in front-line roles dealing with drug-related issues, which was variously portrayed as sometimes dangerous, frustrating, stressful, exhausting and dispiriting. They spoke about the risks and challenges of burnout and the need for self-care and support systems.

2.3.6 Questions and Answers session

The panellists fielded a question about what policy changes and recommendations they would make from the point of view of frontline workers in the health and emergency services. Mr. McLoughlin called for more definitive pathways and improved referral systems for frontline workers to use to safeguard people from falling between the health and criminal justice systems, including guidelines for paramedics to support individuals that refuse treatment. Dr. Luke called for urgent investment in childhood and adolescent psychiatric and mental health services, and for a trauma informed approach to prevention and treatment, including training to raise awareness of ACEs (adverse childhood experiences). Ms. O'Hara called for more dual diagnosis programmes, and voiced her support for decriminalising possession of drugs for personal use. As a point of reflection, she commented that if Ireland wants a health led approach to drugs use and addiction, we need adequately funded addiction treatment services that are available when and where people need them, with joined-up care pathways for people with dual diagnosis. As a point of consensus, panellists urged the Assembly members to keep compassion to the forefront of any recommendations.

Resources for service providers were cited as an obstacle. Ms. Kehoe provided an example of St Francis Farm, a residential detox unit in Tullow Co. Carlow, operated by Merchant's Quay Ireland. She highlighted that both the location of the rehab facility and the marked oversubscription for places has implications for those seeking access.

2.3.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Concerns over whether cannabis is safe and whether it may induce psychosis;
- Healthcare services are strained and over-worked;
- People shouldn't have to be free from drugs to enter treatment centres;
- There is a lack of resources to treat the problem, and the few available resources are misallocated;
- Lack of services to treat people who suffer from addiction;
- Support services need to be adequately staffed with trained professionals;
- Criminalisation makes people afraid to go to A&E if they've overdosed or need help. Decriminalisation may mean people are more inclined to go to the hospital;
- Without social and historical context, it's difficult to justify criminalisation of certain drugs while alcohol remains entirely legal. Drugs are stigmatised but alcohol isn't;
- Frustration with the lack of government response.

2.4 Session 3 - Lived Experiences of family members affected by problem substance use by a relative

The third session of the day focused on the experience of family members of people who have been affected by drug use. The session began with a presentation from the Health Research Board, followed by a panel discussion with five individuals sharing their personal experiences of drugs use impacting family members.

2.4.1 Ms. Cathy Kelleher, HRB: *The experience of affected family members*

Ms. Kelleher, Health Research Board (HRB), presented an overview of the experience of Affected Family Members (AFMs), based on relevant HRB data from drug and alcohol treatment providers and Family Support Services. There are an estimated 100 million AFMs. worldwide, defined as family members, friends, and colleagues affected by another person's problem drug use. These are an often forgotten and largely hidden population, only a minority of whom come into contact with services. However, they have a key role in supporting people with problematic drug use and are also an important client group in their own right, often needing supports themselves.

Ms. Kelleher highlighted that AFMs. typically care for loved ones without recognition or reward, and often at great personal cost. They experience considerable stress and strain that can negatively impact their own mental and physical health and impair family relationships. International literature shows that AFMs. can benefit from formal and informal social support mechanisms that enhance coping skills/ability and reduce negative impacts on health and functioning. AFMs. deal with barriers to seeking help, such as stigma, fear and shame, and even loyalty to the person who is dealing with problematic drug use.

Between 2010 and 2020, the HRB recorded some 13,744 referrals for AFMs. (children and adults) seeking support and help from treatment services. Those seeking help are disproportionately female (3 in every 4), while one in 20 were children. The most common resulting interventions were counselling and brief interventions. Concluding, Ms. Kelleher emphasised that while the data shows considerable demand for treatment for AFMs, the true level of need is likely much greater than the data shows. In this sense, this is an important 'hidden harm' of drugs use.

2.4.2 Panel Discussion

The panel discussion, featured five individuals who shared how they personally, and their family members, were impacted when someone within their family developed a drug addiction. Panellists reflected on the challenges of caring for a loved one with an addiction; the impact on parents, siblings and children; the challenges of dealing with the health care system, Gardaí and prison systems; the emotional, physical and financial toll of caring for drug dependent family members; the shame and stigma that comes with having a family member in addiction; and the type of supports that made a difference.

2.4.3 Ms. Aileen Malone

Ms. Malone recounted how she has lived with drug dependency within her family for the past 20 years, describing it as 'absolutely exhausting .... affecting the family on so many levels, emotionally, physically, financially and socially, taking so much out of us'. Ms. Malone explained that her daughter Dara, who passed away six years ago, had begun using drugs recreationally, then began to smoke heroin to help her 'come down' following weekend raves. Ms. Malone recalled that at that stage, Dara, who had a good job and a nice boyfriend, quickly spiralled into dependency. Ms. Malone described the impact on the family unit when confronted with the spiral of events that began to unfold with the onset of Dara's problematic drug use. She described it as 'unrelenting', recalling how she and her husband got caught up in dealing with recurrent crises. She outlined how this all impacted on Dara's three siblings. One of Dara's sisters, who had also started using drugs, was badly affected by Dara's death and went on to herself develop a severe dependency on heroin and benzodiazepines. Meanwhile, as Ms. Malone explained, she and her husband didn't have enough time to give to her other two children.

2.4.4 Mr. Gearaidh Matthews

Mr. Matthews described the impact of his son's drug use on himself and his family. What began as experimentation with cannabis progressed onto using other drugs. His son developed a drug dependency, then experienced the onset of mental health issues. The dual diagnosis of drug dependency and mental health issues led his son into a downward spiral. Mr. Matthews explained how his son, whom he described as an intelligent, sporting and musically

talented person, became withdrawn, lost interest in life and frequently got into trouble, ending up hospitalised on several occasions. Mr. Matthews recalled how this impacted on him as a parent, describing how he, too, spiralled downwards, feeling he had little control over what was happening in his own household. He explained how the situation had consumed his life for over a decade, with everything focused on trying to protect his son from the harm that he was subjecting himself to and the danger he was putting himself into, until his son finally managed to break the cycle of dependency. He described the importance of support systems for parents and family members, crediting the Family Addiction Support Network for helping him get through this period in his life, where his own security, health and wellbeing were sidelined and neglected.

2.4.5 Ms. Maureen Penrose

Ms. Penrose described her experience of caring for the children of one of her daughters, who was grappling with a heroin addiction. When her daughter entered residential treatment, Ms. Penrose explained the choice facing the family, either put her daughter's children into foster care or look after them herself. Ms. Penrose took on the role of 'kinship carer' for her grandchildren, initially for a period of about six months, and at subsequent points when her daughter relapsed. Ms. Penrose described the impact on her grandchildren, who simply wanted to be with their mother and struggled with her absences. At one point, Ms. Penrose's grandchild expressed her protest and distress through elective mutism, whereby every morning as she approached school, she stopped speaking and didn't say a word until she got home that evening. Ms. Penrose described the financial burden on kinship carers, explaining that while foster carers received a weekly allowance, kinship carers, often grandparents surviving on their pensions, were not entitled to a comparable allowance and took on the financial burdens themselves. She also highlighted that children in kinship care were not eligible for emotional or psychological supports in the same way as children in foster care are. While Ms. Penrose explained that kinship carers like herself willingly provide this care, it would be good to be supported appropriately.

2.4.6 Ms. Annemarie Sweeney

Ms. Sweeney described her experience as a traveller woman dealing with her own addiction while also dealing with the challenges of being a parent. She recalled how being a traveller woman with addiction issues gave rise to what she described as a 'double stigma', coming both from within her own community and from wider society. Ms. Sweeney described how, as her addiction progressed, she went to prison a couple of times, lost custody of her children and lost her relationship with her family. She explained that her parents simply didn't know how to deal with the situation, the shame they felt, and the worry they had about their daughter. The worry and stress about whether Ms. Sweeney was going to be alive the next day impacted her mother's mental health for a considerable time. Describing herself as 'one of the lucky ones', Ms. Sweeney explained that she is now in recovery, has regained custody of her children, has restored her family relationships and now works as a peer support worker helping other members of the travelling community dealing with addiction issues.

2.4.7 Ms. Caitriona Kirwan

Ms. Kirwan described her experience as a parent whose son spent time in prison because of drug-related issues. In Ms. Kirwan's own words, to have a family member in prison 'takes you on a journey that never in your wildest dreams you imagined you would have to travel'. She explained the disruption to the rest of the family, the stress and anxiety of making prison visits that could sometimes be cancelled at the last minute without any explanation. While in prison, Ms. Kirwan's son was given medical support and structure and stopped using drugs, but that support was not continued on his release, which led him to relapse and reoffend. Ms. Kirwan, who is part of the Southeast Family Support Network, spoke about the importance of having support structures for families. She called for practical measures to help families of people in prison, including a Step-by-Step Guide for a successful prison visit and contact information for Prison Chaplains.

2.4.8 Questions and Answer Session

Members asked panellists about the challenges they faced in supporting family members dealing with dual diagnosis (concurrent addiction and mental health issues). Panellists spoke about the lack of awareness of dual diagnosis among health care professionals, barriers to accessing services, disjointed service provision and lack of integrated care pathways, as well as lengthy waiting lists for accessing supports including mental health and methadone services. They called for more full-time psychiatrists to be attached to methadone services.

Ms. Malone noted the challenge she faced in 2022 trying to get her second daughter onto methadone treatment. Because she had a dual diagnosis, mental health services insisted that she go to the National Drug Treatment Centre

on Pearse Street, which she didn't want to attend because of personal security concerns, so she instead tried five different Clinics, each of which refused her because of her pre-existing mental illness. Ms. Malone explained how she ended up having to buy methadone from street dealers for her daughter. Her daughter had to wait 11 months to access treatment. Mr. Matthews spoke about the difficulty in distinguishing the effects of drug use from the effects of mental illness, which, he explained, 'both feed into each other and compound one another.'

Members sought further updates and clarifications regarding the closure of the National Family Support Network. Ms. Penrose explained that there wasn't clarity on the reasons for the closure, but there is now a Steering Group seeking to re-establish the network.

A member asked panellists whether addiction is regarded as an illness, and what supports are made available. Ms. Kirwan explained that while she personally believes it is an illness, she recognised that there are some that disagree with this. Ms. Kirwan spoke about the intergenerational nature of addiction, and the importance of providing supports to families to break that intergenerational cycle. Ms. Sweeney made the point that there is a long way to go in terms of building public awareness of addiction.

A member asked the panellists about the financial implications and the scale of drug debts incurred by families. Ms. Malone spoke of seeing her daughters being beaten up over drug debts, saying 'it's so painful, it kills you to see your daughter with bruises and black eyes'. While she did have to pay off drug debts for her own daughters on several occasions, these were relatively manageable debts in the range of €500 - €1,000. She did, however, know several families that had to deal with far more significant debts in excess of €30,000.

Concluding the discussion, several panellists emphasised that stigma and shame are an impediment to helping people with addiction, and that society needs to recognise that people with addiction are real people, with feelings, hopes and aspirations, who have become submerged in addiction.

2.4.9 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Lack of funding and resources allocated to services that support people and families experiencing drug addiction;
- It is unfair that no financial support is given to kinship carers;
- Current system is not working and is full of systems errors;
- The public and private sectors are siloed and lack communication with each other. Agencies and semi-state bodies need to coordinate with each other;
- The voices of effected families should be reflected in the policymaking process
- Charities contribute significantly to the public sector work, and voluntary work is not adequately incentivised;
- Disappointment at the lack of services and accessibility for support. There's a gap between what we need to do and what is being done;
- There is a lack of compassion for drug users. Service providers must be compassionate and understanding;
- Stigma is a significant issue that drug users and their families face;
- Families dealing with drug addiction do not where to turn for help;
- The fact that those with dual diagnosis cannot be admitted to some centres needs to be changed.

2.5 Session 4 - Experiences of Communities

2.5.1 Panel Discussion

The final session involved four panellists with experience of living or working in communities impacted by drugs use.

2.5.2 Ms. Jennifer Clancy

Ms. Clancy outlined her experience of working and living in Clondalkin, which she described as a community disproportionately affected by drugs. Jennifer, who had previously worked as Coordinator of the Clondalkin Drug and Alcohol Task Force, explained that in developing responses to drugs issues, it's important to understand the underlying socio-economic factors and the relationship between poverty, inequality and drug use. She observed that

disadvantaged communities with high levels of poverty have become breeding grounds for the drug market, where young people get caught up in the drugs economy from a very young age. In such communities, drugs are readily available, while open drug use and drug dealing has become normalised. Drug-related intimidation and violence in these community means families can be forced to leave their home or experience violent incidents. In these circumstances, communities can live in fear, people are afraid to speak with the Gardaí, and too often communities that need to pull together don't, because people are too afraid to get involved. Close neighbours can be involved in the drug economy, making it very difficult for people to speak out.

2.5.3 Mr. Philip Jennings

Mr. Jennings, a Community Development worker with the Safer Blanchardstown Initiative, described his role as looking after people in the community who are living in fear because of drug-related intimidation and violence. He referenced research by the National Advisory Committee on Drugs and Alcohol (NACDA) into the illicit drugs market in Ireland, which outlines the push and pull factors for people getting involved in drug-related criminality. He described how drug-related violence had evolved from the 1970s, when the heroin market was controlled by the Dunne family. At that time, an unpaid drug debt might mean that the person would simply no longer be supplied with drugs. From there, it escalated to beatings, severe beatings and now murder. Mr. Jennings stated that, in the period since Martin Cahill died (in 1994), 312 people have died in Ireland from drug-related violence. Given that the motivating factor for violence is control of the lucrative drug market, and given the scale of the recreational drugs market, he described recreational drug users as 'the real driving force and powerhouse for the violence'.

2.5.4 Ms. Amy Carey

Ms. Carey, a youth worker and CEO of the Solas Project based in the Liberties area of Dublin, described how young people from disadvantaged areas can get drawn into a life of criminality. The apparent wealth, flashy cars and nice clothes commonly associated with drug dealing was a 'pull factor' for some. She recalled coming across one six-year-old boy who, when asked what he wanted to be when he grew up, said he wanted to be like 'those boys on the Block'. For Ms. Carey, the idea that a six-year old's dream for his future was to become a drug dealer epitomises the depth of the problem. The normalisation of open drug dealing has a clear impact on communities. Young people start dabbling in drug use, developing their own addiction. To feed that addiction, they take on roles as 'runners' and find themselves in a cycle that they can't get themselves out of. Other young people get involved in shoplifting and theft to fund their drug use. Youth work services operate to interrupt this cycle, but at that point it's a very difficult situation for young people to escape from.

2.5.5 Mr. John Paul Collins

Mr. Collins, a Community Development Worker with Pavee Point Drug and Alcohol Programme, described the problems and challenges facing the Traveller community. He described the levels of trauma and adverse life experiences within the traveller community, explaining that suicide levels are at least seven times higher than within the general population. Drug use within the community is at pandemic levels. Travellers face stigmatisation generally, but traveller women dealing with drug addiction face compounded stigma. He explained that drug-related intimidation and violence is also a factor within the travelling community, where drug dealing now takes place on sites, which wouldn't have been the case 10 or 15 years ago. Dealers are aligned with very significant gangs, which is very worrying and intimidating for the community.

2.5.6 Panel Discussion

Ms. Clancy explained the impact of drug-related debt on individuals and families in disadvantaged communities. When drug-related debt is accumulated, many families simply can't afford to pay off those debts, so the person owing the money ends up being subsumed into criminality, only to discover that the debt can never be paid off. The numbers of people who have been prosecuted for drug-related intimidation and violence are still very low, so official statistics don't show a true picture of what is happening in communities. Drug dealers are grooming vulnerable young people into their gangs to enforce and intimidate. At face value these young people are just wreaking havoc within their communities. Ms. Clancy asked at what point does society start to understand these 13-, 14- or 15-year-olds not as criminals, but as victims who haven't had the systemic family support they've needed, and have been failed by statutory agencies, by the education system, by housing and social welfare policy, child protection services and the criminal justice system. She argued that the problems have now become intergenerational within families.

Mr. Jennings explained that 13- and 14-year-olds are often used by drug dealing gangs as the first point of enforcement of drug debt because, as juveniles, they are outside the scope of the criminal justice system. They

learn the art of intimidation and progress from there. He again emphasised that money is the underlying motive, and that drugs use is right across society, from disadvantaged communities to the middle classes to rural Ireland. He described how cannabis potency has changed significantly in recent decades, arguing that it is not a safe drug and is the first drug taken by most people who end up with problematic drug use.

Ms. Carey explained that while drug use is prevalent across all parts of society, the impact is felt disproportionately in disadvantaged communities, where intergenerational trauma is evident in terms of poverty, unemployment and addiction. Ms. Clancy spoke about the challenges facing families in terms of accessing services and supports, referencing her own lived experience as a kinship carer for her niece and nephew for the past 13 years. She described having to fight 'tooth and nail' through the courts system to get any sort of service for her nephew, who has foetal alcohol spectrum disorder. She described also having to fight constantly for addiction services for her own brother, saying that these are services that they are entitled to, and shouldn't have to fight for.

Mr. Collins described the challenges that members of the travelling community have in accessing services. Even when services are available, the sense of shame and stigma often acts as a barrier to people connecting with those services. The role of peer led support is vital in terms of increasing engagement with services.

Concluding the discussion, panellists offered their thoughts on what the Citizens' Assembly might bear in mind in forming their recommendations. Mr. Jennings called for a recognition that the issues are complex and argued for a public information campaign to raise public awareness of the dangers of drugs, including cannabis. Ms. Clancy argued for a joined-up policy approach, including gender proofing and poverty proofing of policies in relation to drugs. Ms. Carey argued that what we're doing is not working, and our education system, housing policy and criminal justice approach to drugs use is failing our young people and impacting disproportionately on disadvantaged communities. Mr. Collins reiterated the need for a holistic approach to policy and the need to bring the voice of people directly affected by substance misuse into the conversation.

2.5.7 Question and Answers session

Panellists were asked several questions about what changes they might recommend. Ms. Clancy responded that housing policy plays a crucial role in dealing with drugs issues. For example, how social and affordable housing is built and allocated at the moment tends to exacerbate the concentration of issues, and called for more integrated wrap-around supports for people dealing with drug misuse. The phenomenon of 'Cuckooing', where drug dealers move in to take over the accommodation of vulnerable people, could be dealt with by giving Gardaí powers to intervene. Ms. Carey responded that it's necessary to tackle the underlying issues of poverty and inequality, support people at a young age to remain in education, provide early intervention through adequately funded youth services, childcare and youth work supports, and recognise the importance of positive male role models.

Mr. Collins called for effective early intervention and clear pathways into recovery, removing the barriers to accessing services. Mr. Jennings called for targeted supports and responsive services for young children from birth to 10 years of age, particularly for children from disadvantaged backgrounds.

Members posed several questions regarding potential legislative approaches. One member asked whether a regulated market for recreational drugs, which controlled the source, quality, distribution and price, would work to counter the flow of revenues from the drug economy into organised criminal gangs, and generate tax revenues to be redirected back into communities and services. Mr. Jennings responded by citing some emerging research from the US about the experience in Oregon following legalisation, whereby cannabis misuse had increased by 245%, the illegal supply of cannabis had grown exponentially, and that increase was driving the mental health issues and other safety issues in the State. Mr. Collins indicated that he would favour decriminalising the individual.

Ms. Carey explained that the amount of services and investment involved in prosecuting young people for minor possession offences is very significant, and those resources could be reinvested in tackling supply and improving services and community resources.

Another member asked whether legalisation of drugs would limit the draw for young people to become involved in drug dealing. Ms. Clancy cited the example of Urugay, which has a State supply model whereby cannabis is sold for $1 per gramme, a price level that removes an element of the black market. This contrasts with the US, where legalised cannabis is still sold at market value, giving the black market a continued foothold.

A final question asked what can be done to ensure the recommendations of the Assembly are implemented. Panellists agreed that implementation needs proper resources to be allocated, political will and accountability at the

highest level, a recognition that the issues are complex and require a cross-governmental approach, rather than being left to one or two departments.

2.5.8 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- It is concerning that young people are beginning to glamourise drug dealing and romanticise it as a way to acquire luxurious goods and make money
- Legalising drugs may generate less money for the black markets and reduce illegal drug dealing
- Legalising drugs would make them less dangerous since they would become more controlled and monitored for harmful substances
- Decriminalisation should be done in a way that removes money and power from gangs
- Educational programmes are key in preventing kids and young adults from dealing and using drugs

2.6 Engaging with Service Users and Service Providers

On Sunday 15th May, members of the Citizens' Assembly had a series of engagements with service users and service providers, both in Dublin Castle and via site visits.

Dublin Castle Exhibition space

- Family Support Networks
- Family Resource Centres
- Citywide
- UISCE
- SAOL
- Coolmine Therapeutic Community
- Merchant's Quay Ireland
- Pavee Point
- DRIVE
- Izzy Tiernan
- Tallaght-based services (TDATF and JADD)

Videos

A series of videos were also shown to members:

- Lived & Living Experience of Drugs – UISCE
- USICE 'Now You See Me' campaign videos x 5: 'I am'; 'My voice matters'; 'You don't see me'; 'I've a pain in me hoop'; and 'The next chapter'
- CityWide
- Michael Ward, Patrick McCann and Anne Marie Sweeney – lived experiences of travellers, in conjunction with Pavee Point and UISCE
- 'Hunger' – Izzy Tiernan's story
- Karen's Story - Tallaght Drug and Alcohol Task Force
- Fiona's Story - Tallaght Drug and Alcohol Task Force
- Marianne's Story - Merchants Quay Ireland
- Coolmine Services: Coolmine Lodge and Ashleigh House, Coolmine Mid-West, Cork, and Dublin 15 Community Service.

2.7 Closing Plenary Session

The closing plenary session offered members an opportunity to reflect on what had been a busy, and, at times, an emotionally intense weekend. Members shared their impressions of, and reactions to, site visits to Merchants' Quay Ireland and Coolmine Therapeutic Community, and to the service providers and service users they had met at the Dublin Castle exhibit space.

Several members commented on how the weekend's proceedings had highlighted how destructive drug misuse is not just on the individual drug user, but on children, siblings, parents and the wider family system.

Members expressed appreciation for the courage and honesty shown by speakers who shared their lived experience. Similarly, there was widespread appreciation for the 'inspirational' service providers whom members had met over the weekend. To quote one member, these services are 'run by heroes'. Multiple speakers complimented the work being done by service providers such as Coolmine and Merchant's Quay, noting that while they have a high success rate, they cannot respond sufficiently to the level of demand for their services.

One member described the complex nature of drug use as both a consequence of, and result of mental health problems, both a result of, and a cause of trauma. Drug use causes loss of relationships and isolation, leading to poverty for the individual and possibly the family. It is both driven by crime, and crime is a consequence. The Assembly applauded a call for a societal transformation to a respectful and listening society, and for a whole of society approach from childhood to adulthood.

Members supported the argument that society needs to respond more effectively, with one member describing drugs use as 'a crisis for society', requiring massive long-term funding of integrated services. There was considerable support for the suggestion that a health-led approach is needed, underpinned by funding and regulation of addiction services, better practice models, and an implementation committee to ensure that Citizens' Assembly recommendations are followed up on by Government.

Several contributors made the point that dealing with drug addiction doesn't require a new solution to be invented, it just needs sufficient resources to be invested, combined with effective coordination across statutory, community and voluntary service providers, and a joined-up approach. Others highlighted the importance of ensuring there is political will and accountability.

The experience of Merchant's Quay's efforts to open a supervised injecting facility was used to illustrate the frustratingly slow pace of progress. A plan first submitted in 2017 was only now getting clearance, following lengthy delays in the planning process. Meanwhile, MQI has a six-month waiting list. One member described as 'staggering' the lack of services and lack of communication between statutory bodies.

Several contributors made the point that a health-led approach is essential, and that putting people with problematic drug use in prison achieves nothing, often exacerbates the problems and is extremely costly. Taxpayer money could be better spent on improving resources for services.

Key themes emerging from roundtable discussions

- Members found it very beneficial to see the drug treatment services and rehabilitation centres in person
- Centres need more funding and support to continue providing valuable services
- Safe injection sites are a good initiative and reduce risks associated with drug use
- Merchants Quay Ireland (MQI) treats service users like humans, there are sanitary facilities on site and staff are friendly and compassionate
- Shocked that MQI has waited 5 years to open (a medically supervised injecting facility) and is only an 18-month pilot scheme
- There are over 90 people on the waiting list for Coolmine Therapeutic Community. We need more places like it
- It is very disappointing that some of these facilities are privately funded, rather than government funded
- There appears to be a lack of political will to fund services
- Coolmine's peer-led structure inspires hope and promotes honesty
- The workers at these centres are paid less than people employed by HSE, leading to problems with staff retention
- The Coolmine Women and Children's Centre (Ashleigh House) has great supports and programmes
- Smaller treatment facilities and cohorts are preferable so people can feel more comfortable and integrate more easily

- MQI is placed behind an elementary school, this seems problematic
- Coolmine is a great centre, and should be used as a model
- Coolmine Women and Children's Centre showed the importance of allowing children to stay with their mothers while they recover
- Need more places to detox
- Safe injection sites are great for harm reduction but only a temporary solution to a much larger problem

3 Meeting #3

3 Meeting #3

Meeting #3

Figure 3.1:
Paul Reid, Chairperson and Cathal O'Regan, Secretary

Figure 3.2:
Paul Reid, Chairperson

Figure 3.3:
Session 1 - Dr. Alfred Uhl, Nuno Capez, Jim Walsh, Dr. Suzi Lyons

Figure 3.4: Session 2 - Joe Kirby, Tommy Gilson, Dermot King, John Bennett, Bríd Walsh, Prof. Eamon Keenan

Figure 3.5:
Session 3 - Nicki Kileen, Catherine Kenny, Gary Broderick, Tony Duffin

Figure 3.6: Session 4 - Dr. Íde Delargy, Dr. Gerry McCarney, Dr. Sean Foy, Dr. Anne Marie Carew

Figure 3.7:
SAOL Sisters perform for Members

Figure 3.8:
Members join the SAOL Sisters on stage

Figure 3.9: Session 5 - Noel Murhpy, Dearbhail McDonald, Nicola Smith, Mick Devine, Daniel Jones, Prof. Jo-Hanna Ivers

Figure 3.10: Session 6 - Breda Fell, Dearbhail McDonald, Anna Quigley, Joe Slattery, Dr. Austin O'Carroll, Paul Reid

Figure 3.11: 'The VanaLiffey' – Ana Liffey Drug Project's mobile harm reduction unit

Figure 3.12:
Tony Duffin briefs members aboard the 'VanaLiffey'

Figure 3.13:
Professor Jo-Hanna Ivers

Figure 3.14:
Dr. Alfred Uhl, Mr. Nuno Capaz and Mr. Jim Walsh

Figure 3.15:
Roundtable discussions

Figure 3.16:
Roundtable discussions

Meeting #3

Figure 3.17:
Roundtable discussions

Figure 3.18:
Roundtable discussions

Figure 3.19:
Questions and Answers

Figure 3.20:
Questions and Answers

Figure 3.21:
Questions and Answers

Figure 3.22:
Questions and Answers

Figure 3.23:
Questions and Answers

Figure 3.24:
Questions and Answers

3.1 Programme Overview

The focus of the third meeting, held on 24-25 June 2023 at the Grand Hotel Malahide, was on the role of policy and service delivery providers in the health, community and voluntary sectors. Policy and service delivery (operational issues) were two of the three key areas outlined by the Terms of Reference, which asked members to 'consider the legislative, policy and operational changes the State could make to significantly reduce the harmful impacts of illicit drugs on individuals, families, communities and wider society'.

3.2 Session 1 - Health-led approaches

3.2.1 Dr Suzi Lyons. *Latest data on drug-induced and drug-related harms*

Dr Lyons, Senior Researcher with the Health Research Board (HRB), presented new data from the National Drugs-Related Deaths Index (NDRI). The data detailed the level of poisoning (drug-induced) and non-poisoning (drug-related) deaths over the period 2011 - 2020. This was the first time that the still-provisional data for 2020 had been made public, underscoring the valuable support the HRB provided the Citizens' Assembly throughout the process. The data showed a significant increase in drug-induced deaths in 2020, and an elevated level of drug-related deaths in the same period. Dr Lyons described the trend as a clear and sustained increase in drug deaths over the four-year period to 2020.

The NDRI draws on four data sources, including closed Coronial files, HSE Hospital In-Patient Data (HIPE), the Central Treatment List register of Opioid Substitution Treatment, and the CSO General Mortality Registry. Despite the time lags associated with closed Coronial files, Dr Lyons explained the files ensure highly accurate records of drug-related deaths, offering significantly detailed insight into the burden of drug-induced and drug-related premature fatalities.

Poisoning deaths are defined as premature deaths caused by the toxic effects on the body of one or more substances. The data for 2020 showed 409 poisoning deaths, a significant increase of 38 compared to 2019, and the highest number of deaths per annum reported over the decade. These 409 deaths equate to nearly 12,000 potential life years lost in a single year. The profile of those who died from poisoning in 2020 showed that 5 in 10 had a history of mental health issues, one in 8 were homeless, and 4 in 10 deaths occurred when the person was alone. In terms of the drugs involved, 8 in 10 involved more than one drug (poly drug use), 7 in 10 involved opioids, while 3 in 10 involved cocaine. Poisoning deaths involving cocaine had increased from 24 in 2011 to 130 in 2020, representing a more than four-fold increase in the period, which is driven by the greater prevalence of cocaine use in the general population. Almost 6 in 10 poisoning deaths involved benzodiazepines such as Xanax or Valium, while 6 in 10 involved other prescription drugs, most commonly anti-depressants or anti-epileptics such as Lyrica (pregabalin).

In addition to deaths by poisoning, there were also 397 drug-related non-poisoning deaths in 2020, equating to more than 10,000 potential life years lost in just one year. Non-poisoning deaths are defined as premature deaths of people who use drugs, which are not due to poisonings. Non-poisoning deaths in 2020 were primarily the result of hanging or cardiac events. A quarter (108) of non-poisoning deaths in 2022 were as a result of hanging, with cannabis, followed by cocaine, being the most common drugs used by people who died of hanging. Three out of four were men, half were aged 35 or younger, and two thirds had a history of mental health issues.

Describing the data as 'grim and stark', Chair of the Assembly Paul Reid thanked Dr Lyons, remarking that Ireland was already a significant outlier in terms of drug-related deaths compared to any country in the EU, and that the latest data puts us further behind, describing it as 'a wake-up call' for society, policymakers and legislators, as well as a reminder of the importance and urgency of the Citizens' Assembly.

3.2.2 Mr. Jim Walsh. *A Strategic Perspective: Ireland's National Drugs Strategy*

Mr. Walsh, Principal Officer in the Drugs Policy and Social Inclusion Unit at the Department of Health, set the strategic context for the work of the Citizens' Assembly. Explaining that the current National Drugs Strategy *Reducing Harm, Supporting Recovery* is due to expire by end of 2025, Mr. Walsh suggested that the Citizens' Assembly was very timely in that its recommendations should shape the next iteration of the National Drugs Strategy. Drawing from international policy developments at EU level, at the British Irish Council and the Council of Europe, Mr. Walsh offered suggestions for a more effective and health-focussed upcoming National Strategy. He also

highlighted policy developments at a national level that sought to have a more health focused drugs policy that was better integrated and aligned with overall health policy.

Suggestions for the next drugs strategy included: incorporating a rights-based approach obligating a health-led drug strategy to prioritize those with the greatest needs, including people with problematic drug use, children and young people, ensuring that nobody is left outside or left behind and no discrimination takes place for reasons of stigma or otherwise; ensuring the involvement of people with lived experience a core component of the next strategy, both in terms of policy development and service design; prioritising prevention policy and supporting prevention objectives with adequate funding; better integrating drugs services with the healthcare system, with integrated care pathways for people with problematic drug use, in the context of the roll-out of the new HSE Health Regions and the Health Communities Initiative; taking a gendered perspective on drugs policy and services, with an emphasis on services for women; commencing the Health Diversion Programme for people found with the possession of drugs, with Mr. Walsh commenting that this programme had been agreed by Government in 2019 yet still hadn't been legislated for; and finally, addressing premature drug-related deaths as an urgent public health priority.

3.2.3 Mr. Nuno Capaz. *Portugal's health-led approach*

Note: Portugal was selected as a case study to illustrate a health-led approach with de-jure decriminalisation[1].

Mr. Capaz, from the General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD) in Portugal provided a case study of the Portuguese approach to drugs use. Setting out the historical context for drug policy reform in Portugal, Mr. Capaz outlined that the country's democratic revolution in the 1970s led to the exposure of the country to external influences. Problematic cannabis use emerged in the late 1970s, quickly followed by a heroin epidemic in the 1980s. With an estimated 1% of the adult population using heroin, and widespread open drug use highly visible, drug abuse became the primary issue of concern for Portuguese society. It also became a major public health problem, given the associated rise in blood-borne transmission of diseases such as TB, HIV and Hepatitis.

In the late 1990s, a cross-party political consensus emerged in support of establishing an expert scientific forum to develop proposals to respond to drug-related problems as a health-care issue. This cross-party political consensus for an expert-led response ensured that policy formulation was informed by science and evidence, rather than the typical political debate characterised by strong opinions and moral perspectives. The political consensus acted as a cornerstone for significant policy changes which could be introduced simultaneously. These changes were focussed on a wide range of objectives, not just treatment, but prevention, harm reduction and reintegration.

One of the changes introduced was to decriminalise possession of drugs for personal consumption, which Mr. Capaz described as Portugal's version of Health Diversion. In Portugal, possession offences are dealt with on an administrative basis. With referrals to the Dissuasion Committees based on law and applicable to everyone (mandatory), there is no discretion. Noting that decriminalisation was not the most important feature of the policy changes introduced in 2000, Mr. Capaz emphasized the significance of the creation of a specific structure under the Ministry of Health to coordinate all aspects of drug policy. These structures, equivalent to a Secretary of State, coordinates prevention, harm reduction, reinsertion programmes under a single structure, the Dissuasion Committees, which combat a patchwork of services fighting for the same resources whilst ensuring horizontal communications between structures.

3.2.4 Dr Alfred Uhl. *Austria's health-led approach*

Note: Austria was selected as a case study to illustrate a health-led approach with de-facto decriminalisation[2].

Dr Uhl, of Austria's National Public Health Institute and the Sigmund Freud Private University in Vienna provided a case study of Austria's health-led approach to drugs. Describing the historic context, Dr Uhl explained that

1 In Portugal, Law 30/2000, art.10-14 treats possession of drugs for personal use as a health issue and drug dependence as a multi-factorial health disorder, which primarily needs to be treated. People found in possession of drugs for personal consumption are required to attend a meeting with a Dissuasion Commission, and may be referred to treatment or counselling.

2 While Austria has not formally decriminalised drug use on a de jure basis, it has a comprehensive health-led approach and de facto decriminalisation for personal possession charges, with flexibility to divert problematic drug users to health led interventions. According to the EMCDDA, Austria's drug laws (the SMG/Narcotic Substances Acts. 35-38) allows for temporary withdrawal of the charge or criminal proceedings for personal possession with a probationary period of 1-2 years, and where necessary these may include an agreement to go to treatment. If successful, the proceedings will be permanently closed.

Austria's first addiction clinic, established in 1956, included a founding board comprised of Federal ministries and State administrations, health insurance providers, trade unions and the Catholic Social Foundation. Essentially, this reflected a whole of society response to drug addiction.

Today, Austria's addiction services are entirely funded by a Federal regulated health insurance model, ensuring that everybody is covered with insurance costs proportionate to an individual's income.

In 1971, Austria adopted a strategy of 'treatment instead of punishment' in relation to drug use, reflected in the 1971 Narcotics Act. The approach has evolved over time. Dr Uhl gave the example of how a drug user convicted of burglary and sentenced to one year or less can have their sentence deferred and instead be admitted into drug treatment. Then, subject to completing treatment, that person can have their sentence quashed.

Dr Uhl also referenced ongoing challenges in Austria including the lack of supervised injection facilities and heroin treatment facilities. Dr Uhl stressed the importance of good cooperation between police and health services to ensure the success of harm reduction initiatives.

Dr Uhl concluded by highlighting the trend in Austria towards integrated addiction treatment, explaining the importance of integrated social work, housing first and employment initiatives. Historically, drug use in Austria has been recognised as a health issue and therefore sufficiently resourced. The provision of necessary supports, universal access to healthcare and health insurance were also reflected upon.

3.2.5 Questions and Answers session

Members posed a series of questions to Mr. Capaz about the Portuguese approach to drugs use. The following summarises Mr. Capaz's responses.

Regarding public buy-in to the new policies, Mr. Capaz remarked that today, certain cohorts of the public are unaware of, or misunderstand, Portugal's drug policy. While possession for personal usage has been downgraded from a criminal offence to an administrative offence, the law remains largely unfamiliar till an individual is found in possession of drugs for the first time and sent to a Dissuasion Commission rather than to court.

A key feature of the Portuguese model was the major increase in investment in addition services and treatment facilities. Mr. Capaz estimated that, when the Expert Group made 86 recommendations to Government about changing the approach to drugs use, the vast majority of the recommendations – 80 or so – related to increasing accessibility to treatment.

Mr. Capaz explained that Dissuasion Commission is an administrative authority under the Ministry of Health, with the legal power vested to refer individuals to treatment and to apply dissuasive sanctions. Through interviews and risk assessments, The Commission decides whether to refer an individual found in possession for treatment and/or education or job-seeking services, impose sanctions such as a fine, community service order or regular presentation at the Dissuasion Commission. The Commission can also decide to suspend the dissuasion procedure, or effectively close it if the person accepts a recommended referral for treatment.

Portugal's approach to prevention evolved from a costly model that focused on large-scale and public awareness campaigns, with little impact, to campaigns targeted at specific groups (e.g. immigrants, university students, sex workers, etc.).

Responding to a question about Portugal's approach to substances such as ayahuasca, mescaline & psilocybin, and their therapeutic role in dealing with addiction, trauma and mental illnesses, Mr. Capaz explained that trials have been initiated to establish the therapeutic value of these substances, but that all drugs were considered illegal substances and therefore all fall under the decriminalised model.

Several questions related to the findings presented by Dr Lyons on drug-induced and drug-related deaths were posed.

A member asked whether, given that 50% of people who died from overdosing with benzodiazepines present had a history of mental health issues, was there a need for more oversight of the prescribing of antidepressants by physicians, especially for people with mental health issues. Dr Lyons explained that benzodiazepines have clear therapeutic value when taken correctly under medical supervision, but when misused, including when combined inappropriately with other drugs, can lead to overdose and death by poisoning. Dr Lyons explained that there is

currently no electronic prescribing system that would allow for risk analysis and the reduction of 'GP shopping'. She also highlighted that there is no connectivity between NDRDI data and the national prescribing system, which limits the HRB's capacity to determine the extent to which poisoning deaths are connected with correctly prescribed drugs, as opposed to illicitly-sourced drugs.

Responding to a question regarding poisoning deaths involving methadone, Dr Lyons informed members that methadone is the main drug in Ireland's opioid substitution programmes and was implicated in 1 of 3 poisoning deaths in 2020.

Responding to a question regarding whether cannabis had been involved in any poisoning deaths, Dr Lyons explained that cannabis is rarely, if ever, implicated in poisoning deaths, but is frequently present in non-poisoning deaths among people who use drugs. For those drug users (n=108) who died in 2020 due to hanging, cannabis was the drug most commonly used and international research shows that people who use drugs are much higher risk of suicide than general population.

3.2.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Create a non-partisan, overarching agency which is responsible for addressing drug use and overseeing addiction services across Ireland
- Increase communication & coordination between government agencies and treatment services
- Drug use needs to be de-politicised so that the government's approach goes beyond partisan politics
- Include people directly affected by drug use within policymaking processes
- Prioritise a health-led approach over a criminal justice approach
- Prioritise addressing mental health issues early on to prevent addiction from occurring later in life
- Implement a comprehensive drug education programme in schools that emphasizes prevention and harm reduction approaches
- Create a special task force to coordinate different statutory services and agencies involved in responding to drug use
- Lower the threshold to access drug treatment so more people can receive help
- Adopt a health-led, evidence-based approach to drug policy
- Create an independent oversight body with non-political actors (e.g. experts, scientists, people with lived experience)

3.3 Session 2 – Strategic Service Delivery Partnerships

3.3.1 Prof. Eamon Keenan. *Health service provision*

Prof. Keenan, National Clinical Lead of HSE Addiction Services provided an overview of drug services in Ireland today, explaining how the focus of services has evolved over time.

Latest treatment data, for 2021, shows over 23,000 cases received treatment, two thirds (66%) of which involved opioids as the main problem drug, followed by cocaine (16%), and cannabis (11%).

Overall, treatment numbers are up 10% since 2014. The profile of cases today is very different compared to previous decades. While treatment services continue to focus on heroin, new treatment cases for opioid dependence are reducing, whilst there has been a big increase in service demand for cannabis and cocaine-related problems. Cannabis is the main drug requiring treatment in under-19-year-olds.. The high potency of both cocaine and cannabis is contributing to increased demand on addiction services.

The challenge in treating cocaine and cannabis addiction is very different to that of heroin, which uses medications such as methadone for treating addiction. There is no equivalent medication-based response for either cannabis or cocaine addiction. Treatment for dependence on these drugs requires much greater emphasis on psycho-social interventions, counselling and other supports.

Effective responses to drug-related problems depend on strategic partnerships between statutory, community and voluntary organisations, and engaging with and listening to people and communities. This was key to dealing with the opioid epidemic, and is vital today in responding to new and evolving challenges. Jobstown Assisting Drug Dependency (JADD) was cited as an example of an effective strategic partnership.

The Assembly learned of the HSE Dual Diagnosis Clinical Programme, which was recently launched on a pilot basis, with three pilot sites. Prof. Keenan called for the National rollout of this clinical programme as a priority.

In terms of residential facilities, the HSE funds over 50 services with a total of 1,028 beds for detox, treatment, rehabilitation and recovery, with dedicated services for women and mother and child. He emphasised that a residential bed is only part of the solution; people also need housing, education, employment and other opportunities.

The HSE is involved in a range of harm-reduction initiatives, including expanding access to Naloxone, drug checking, supervised injecting and drug analysis (syringe, hair and wastewater). The HSE Naloxone programme has been very successful in saving lives. To date in 2023, over 500 people have been trained in administering Naloxone, with 89 reported administrations. Prof. Keenan called for legislative change to remove Naloxone from prescription to ensure pharmacists and members of An Garda Síochána can dispense it. The HSE also works closely with Tusla to respond to the hidden harms affecting family members of people who use drugs.

Prof. Keenan highlighted the detrimental impact of lengthy legislative delays, citing that despite the fact that it was four years in the making, the Government's planned Health Diversion model still hadn't been legislated.

Summarising the current situation, Prof. Keenan noted drug problems have become more complex, drugs are everywhere, almost everything can be a drug, and anyone can be affected, directly or indirectly. He called for enhanced prevention and treatment as well as sustained investment in rehabilitation and recovery. Prevention, including education, employment, housing, needs to be prioritised, to reduce the number of people in society who are suffering harms due to drugs. The Citizens' Assembly has unique opportunity to shape the national response over the next decade. Concluding, Prof. Keenan called for a Cabinet Committee with the Taoiseach at the head of the table.

3.3.2 Ms. Bríd Walsh. *Regional Drug and Alcohol Task Forces (DATFs)*

Ms. Walsh of the Regional DATF Network provided an overview of the background to the establishment of the 14 Local and 10 Regional Drug and Alcohol Task Forces in response to the drugs crisis.

The Task Forces, which receive funding from the Department of Health, operate on the basis of authentic partnerships at local level between statutory partners (including the HSE, Gardaí and County Councils), community and voluntary service providers, community representatives, youth services, people with lived experience and their families. Ms. Walsh described it as a 'powerful structure to respond to drugs issues', involving all the relevant partners, where each has an equal voice, and 'everybody who knows what's happening in the area' is involved.

Ms. Walsh identified a number of challenges facing Task Forces. One is the allocation of resources in accordance with identified needs and ensuring equity of access for the whole population. She highlighted the lack of consistency in service provision across and within different regions. While some areas have a proliferation of services, other areas, often rural, can have significant service provision deficits. There can also be deficits for specific parts of the population, for example new communities. She proposed that funding the Regional and Local Task Forces and resourcing appropriately will end the 'postcode lottery' access to services. She also highlighted the challenge of staff retention in the community and voluntary sectors, calling for the State to value community drug workers and peer workers.

3.3.3 Mr. John Bennett. *Local Drug and Alcohol Task Forces (DATFs)*

Mr. Bennett, Chair of the Local DATF Network recollected growing up in the 1970s in a block of flats in Dublin when the heroin problem first started. Initially, people didn't fully realise or appreciate the serious nature of the drugs problem. It was only as diseases like Hepatitis and HIV began to spread, as overdoses began to take people's lives, and as serious organised crime began to emerge that the gravity of the problem became evident.

He recalled the effectiveness of Ireland's response at the time with the 1977 report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, known as 'the Rabbitte Report', leading to the creation of a Cabinet

Committee on Social Inclusion and Drugs, chaired by the Taoiseach. The Taoiseach also oversaw the establishment of Local Area Partnerships to tackle social deprivation and unemployment. According to Mr. Bennett, Ireland had grasped the idea that a whole of society response was needed.

Despite the success of the approach, Ireland subsequently wandered off track and a sense emerged that a partnership approach 'gets in the way' of getting things done. Mr. Bennett welcomed the remarks from Prof. Eamon Keenan of the HSE calling for a Cabinet Committee to deal with drugs. A similar message was coming from the ground up, via the Drug and Alcohol Task Forces.

Mr. Bennett suggested that Ireland has accumulated massive amounts of expertise, skills, and knowledge in how to deal with drugs, with universities and colleges providing excellent training for professionals working in the area. However, many communities served by the local DATFs face resourcing challenges given the intensity of the problem.

'We have a medicine that works, but we don't have enough to give all the patients equally.'

3.3.4 Mr. Dermot King. *Voluntary and Community service providers*

Mr. King, speaking on behalf of NVDAS (the National Voluntary Drug and Alcohol Sector), explained the role of voluntary and community service providers.

NVDAS is a national representative body for over 60 voluntary and community sector organisations working in the area of drugs and alcohol. Member organisations deliver drug and alcohol services throughout Ireland, catering for individuals at different points across the spectrum of drug use, and for the full continuum of needs, from prevention and education to harm reduction and stabilisation to treatment, abstinence and recovery supports.

Typically, voluntary and community service providers are established in response to a localised need within a community, or within a particular cohort of the population. Mr. King explained these are local services developed by people on the ground who are close to the problem and in a position to develop pragmatic responses. There is collaboration with a wide range of partners including statutory agencies and service providers as well as the Drug and Alcohol Task Forces.

The sector offers avenues for people who have previously availed of services to bring their skills and insights into the further development and delivery of drug and alcohol services.

The sector faces a number of challenges. Funding is typically provided on an annual basis, causing instability which hampers the sector's capacity to engage in long-term planning and consistent service delivery. Recruitment and retention of staff into the sector, which is funded under Section 39 of the Health Act, is significantly impacted by the disparity in pay and conditions with the statutory sector. Many staff are moving out of the sector into more secure and better paid jobs in the statutory sector.

Summarising the written submission that NVDAS had made to the Citizens' Assembly, Mr. King concluded with a series of observations from NVDAS:

- The impact of substance use on families is hugely evident, but the experience of NVDAS member organisations is that support for families is not being prioritised;
- Collaborative working, supported by integrated care plans and case management, needs to be promoted more widely among all services;
- The criminalisation of drug use continues to create obstacles to an effective response to drug use;
- NVDAS members support the development of a health diversion programme, moving beyond the one chance model. If drug use is a health issue the first time, it's a health issue the 100th time;
- NVDAS cautions against the proposition of commissioning services, which has been used in other jurisdictions. This approach fundamentally undermines the ethos in the voluntary sector, pitching organisations into competing against each other and hampering the collaboration that is a hallmark of the sector;
- There's a need to move beyond 'a one size fits all' response to drug and alcohol use. Mr.

3.3.5 Tommy Gilson. *Case Study of integrated community-based service provision*

Mr. Gilson, manager of JADD (Jobstown Assisting Drug Dependency), provided a case study a community-based service provider that is effectively integrated with statutory service providers.

He explained that JADD was established in the late 1990s in response to a serious heroin problem in the Jobstown area of south-west Dublin. At that time, heroin was having a devastating impact on individuals, families and the wider community, with people as young as 15 years of age overdosing. Members of the community, GPs and the then Eastern Health Board formed JADD in response.

Twenty-five years on, JADD continues to operate in the Jobstown area as an integrated service provider offering a full spectrum of services to individuals and families affected by drugs use. Services available include a crack cocaine response including assertive outreach, low-threshold drop-in, harm reduction (needle exchange, naloxone), Opioid Substitution treatment, childcare facilities and family supports, addiction treatment and counselling, with pharmacy and GP services available onsite 7 days per week. The case study demonstrates how HSE and community-based providers, working in strategic partnerships, can achieve an integrated community-based, low-threshold model for responding comprehensively to drug issues within a community.

Concluding his presentation, Mr. Gilson reiterated the importance of community-statutory partnerships, particularly in responding rapidly to new and emerging drug risks. He called for members to consider accessible and equitable healthcare for all in their recommendations.

3.3.6 Mr. Joe Kirby. *Case Study of Integrated Service Delivery in Cork and Kerry*

Mr. Kirby, HSE Social Inclusion Manager for Cork and Kerry, outlined the integrated service delivery model that had been established in the Cork-Kerry region in recent years. He characterised the previous model of care as an overly fragmented and complicated 'patchwork quilt' involving two Drug and Alcohol Task Forces, 12 different employers, 31 services and several lone workers operating in isolation. This approach meant inconsistent service provision, with different areas within the region receiving different types of service.

Following a review by an independent consultant, a series of recommendations were made, including the co-location of workers, the targeting of services to areas of high deprivation, the development of a hub and spoke model, and consideration of one single employer. The new model introduced appointed a single lead service provider, Coolmine, to provide drug and alcohol services in the Cork-Kerry region. The new structure has streamlined and integrated service provision, with 6 distinct service hubs across the region, each with a dedicated phone number offering a single point of entry for service users and family members, as well as referring partners.

Describing the new model as a 'significant partnership' between statutory, community and voluntary sector organisations and Drug and Alcohol Task Forces, Mr. Kirby outlined the success of the approach, which took four years to design and implement. To date, there have been 995 referrals to the service, with the primary source of referrals being self-referral (40% of referrals), indicating that the service is accessible to people and families in crisis. To illustrate how the new model has supported integration of care, Mr. Kirby explained that 26% of referrals have come from mental health services, compared with less than 3% in the former model. The new model has allowed the HSE and its partners to map drug and alcohol services onto the broader healthcare system, ensuring integrated care pathways involving hospital discharges, community healthcare networks, liaison psychiatry, primary care, community mental health teams, homeless services and so on. Concluding his presentation, Mr. Kirby emphasized that integrated care can be achieved with meaningful partnerships between the statutory, community and voluntary services providers, with the voice and interests of the service user at the centre.

3.3.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Adopt an integrated services model
- The Government should increase funding for service providers and voluntary organisation
- Address the pay gap between the voluntary sector and statutory services (e.g. pay parity, single employer for both healthcare and service providers)
- Establish one centralised institution responsible for organising and coordinating drug services nationwide
- Drug use and solutions should be depoliticised
- Things that are working locally should be scaled-up nationally and be used as a template for what's working
- Funding for regional areas should be means-based and regional metrics should be established to monitor the effectiveness of this funding

3.3.8 Questions and Answers session

Responding to a question about whether there was merit in providing a single dedicated national point of contact for all drug services, Prof. Keenan clarified that there is already a national helpline number for drugs and alcohol, with trained counsellors available to assist callers from Monday to Friday, with out of hours contact. There is also a national directory of services on drugs.ie, though it is not as widely known as it should be. Mr. Bennett suggested there is a need to communicate with the public on an ongoing basis about available services.

Members sought further clarification on governance and implementation, with one member asking why previous structures failed to succeed, and whether new implementation mechanisms could similarly fail. Prof Keenan explained that, paradoxically, the structures introduced following the Rabbitte report in the late 1990s eventually failed because they had worked so well. They were introduced to address the heroin crisis by getting people onto opioid substitution treatment. By succeeding in this objective, drugs gradually became less of a political priority and, with that, the efficacy of implementation mechanisms diminished. Prof. Keenan argued that, with the emergence of new drug-related problems and risks, there is a need to reinvigorate the approach to implementation and governance.

Mr. King added that structural changes made an impact, arguing that the governance and implementation mechanisms need to be responsive to new and emerging risks. He mentioned that the timely response to emerging risks and recent problems such as headshop drugs, or crack cocaine, hadn't necessarily been agile enough, remarking that, 'sometimes, when we get the answer, we forget that the question keeps changing'.

Mr. Gilson suggested that, following the establishment of new structures in the late 1990s (e.g. Drug and Alcohol Task Forces) and increased investment into services, people assumed that everything was now working well. He urged members to ensure that there continues to be a Minister for Drugs at the Cabinet table.

Ms. Walsh echoed the view that the system hasn't been responsive as the drug landscape has changed, that drugs policy has become less visible as a political priority, and that some of the statutory partners need to be mandated to return to the table.

Members asked whether the case study of integrated care delivery introduced in Cork-Kerry could be replicated nationally. Mr. Kirby agreed that such a model was scalable, but requires significant partnerships between statutory, community and voluntary sectors.

Asked whether the rise of cocaine and cannabis use was a mental health problem, Prof. Keenan was clear that cannabis and cocaine contribute to mental health issues and that can be seen from hospital admissions data. In terms of responding to dual diagnosis, Prof. Keenan explained that prior to the 2021 strategy, Sharing the Vision, there was no recognition of the significant connection between addiction problems and mental health. The 2006 health strategy, Vision for Change, separated addiction and mental health policy. Prof. Keenan clarified that for the past two decades, he had been calling for a model akin to the HSE's new Dual Diagnosis model of care, only recently launched on a pilot basis. Prof. Keenan called for the Dual Diagnosis model to be adequately resourced and expanded on a national basis.

One member asked whether a Health Diversion approach that referred the 90% of recreational drugs users without problems would further strain an already overburdened health system. Prof. Keenan explained that anyone found in possession for personal use would be sent to the health service for a brief intervention, similar to the Dissuasion Commission in Portugal. However, the majority would not require onward referral to specialist addiction services. Prof. Keenan stressed that not everybody will need onward referral for treatment, but everyone will benefit from a brief intervention with a trained practitioner to discuss their drug use, the risks and harms associated with the substance and how to access services if needed. For the 10% or 15% of people who need treatment, referral pathways will facilitate access into treatment services.

3.4 Session 3 - Targeted Harm Reduction

3.4.1 Performance from SAOL Sisters Choir

The SAOL Sisters Choir is part of the SAOL Project, a community project focused on improving the lives of women affected by addiction and poverty. SAOL works to promote the needs of female drug users and their children, and

their CEO presented to the Assembly later in the session. The Choir were joined by members of the Assembly in a lively sing-song during coffee break.

3.4.2 Mr. Tony Duffin. *Low-threshold services for people with complex needs*

Mr. Duffin, CEO of the Ana Liffey Drug Project, described how low-threshold services support people with complex needs and addiction issues, which are often heightened by challenges such as street homelessness and/or mental health problems.

The Ana Liffey Drug Project, established in 1982, provides low threshold services in Dublin and the mid-West region. Remarking that 'there are no hard-to-reach people, only hard-to-reach services', Mr. Duffin explained that low-threshold services keep the barriers to accessing services as low as possible, enabling vulnerable people, often in difficult situations, to engage with the service. Staff work with clients on a non-judgemental basis to establish trust, build relationships and offer supports. Ana Liffey provides a range of support services including street outreach, drop-in facilities, accommodation supports and a spectrum of interventions and supports for people with drug dependency.

Mr. Duffin described how Ana Liffey and An Garda Síochána work in partnership to deliver the LEAR (Law Engagement and Assisted Recovery) programme, whereby Gardaí refer individuals with problematic drug use directly to Ana Liffey for appropriate interventions. He described LEAR as working very well, with Gardaí and Ana Liffey staff work effectively together on a case management basis, with shared confidentiality around clients.

He invited members to visit the 'Vana Liffey', a mobile outreach unit that he had brought onsite to showcase some of the low-threshold harm reduction services offered by Ana Liffey. The unit enables staff to go out onto the streets, into parks, into people's homes, squats or wherever people using drugs are found, and offer help such as needle exchange and syringe programmes, Hepatitis C advice and testing, nursing services and linking people into treatment services.

Staff take a case management approach, with key workers offering brief interventions to help clients identify and define their own personal goals, whether stabilisation, recovery from drug use, securing housing, or overcoming issues that form barriers to progression and ultimately lead a healthier life. Low-threshold services don't seek to push people down particular paths and respect the fact that some people are not ready to start addressing every issue they face.

3.4.3 Mr. Gary Broderick. *Targeted supports for women*

Mr. Broderick, CEO of SAOL (Women's Recovery and Education Project), based in Dublin's north inner-city, described the work of SAOL in providing both harm reduction and recovery supports for women with addiction issues.

Women experience addiction differently to men, and have different biological, psychological and social needs. Consequently, services including harm reduction and recovery supports need to be adapted accordingly.

Women experience vastly greater levels of trauma than men do, particularly as a result of domestic violence. High percentages of women in addiction services have experienced domestic violence either as a child or as an adult, or both, and use drugs to cope with such experiences. Yet, harm reduction services for domestic violence are rarely accessible for women in addiction. Mr. Broderick stressed the impossibility for women in addiction to gain stability when they are experiencing repeated trauma and domestic violence. He called for dedicated supports including refuges for women who experience the dual issue of domestic violence and addiction, with targeted harm reduction interventions and tailored programs like SAOL's '*Seeking Safety*' programme that 'teaches harm reduction to women who have never had a day of safety in their lives'.

Tailored services for women in addiction need also to address other challenges including poverty and childcare, particularly when a mother requires addiction treatment. Mr. Broderick suggested that women, and mothers in particular, are subject to greater levels of shame and stigmatisation for using drugs than men, given societies expectations of women.

Mr. Broderick called for the provision of childcare across addiction services, arguing that mothers must be enabled to avail of detoxification or stabilisation programmes without the continual fear of never having access to their children again, regardless of how successful treatment is. Marking relapse as part of the process of recovering, Mr. Broderick advocated for supporting mothers and their children when she is in early recovery and when she relapses.

Concluding his presentation, Mr. Broderick commented that 'Breaking up families because of addiction should be the rare exception, not the norm. We must do better for our women who use drugs and for their children than we are currently doing, if we do no, we will repeat the same patterns that led to the industrial schools and the Magdalene laundries of the recent past'.

3.4.4 Ms. Catherine Kenny. *Targeted supports for people who experience homelessness*

Ms. Kenny, CEO of Dublin Simon Community, outlined how Dublin Simon supports people dealing with addiction and homelessness, describing the current homelessness levels in excess of 12,000 as a crisis. She explained that drug use was the second most commonly cited original cause of homelessness amongst its clients.

People experiencing homelessness face particular barriers to services generally, including access to drug services. In 2003, Dublin Simon began offering homeless-specific addiction treatment services as a response to the endless waiting lists experienced by clients. Last year (2022), 934 clients accessed its clinical and therapeutic services. Clients frequently present with complex multi-morbidities, including physical health, mental health and addiction challenges. Poly drug use is very common. Women in addiction who have childminding or other family responsibilities face distinct barriers to access addiction treatment, often deterring women seeking support until they reach crisis point.

Ms. Kenny explained that addiction recovery is different for every client. Dublin Simon takes a health-led approach, offering a range of harm reduction and abstinence-based programs, along with motivational interviewing, CBT, and education. Its work is underpinned by a non-judgmental approach and emphasises client autonomy, building trusting relationships, providing a safe space and meeting the immediate needs of the individual so they can then shift focus onto their health and well-being.

The evidence suggests the approach works. Research data shows that, at the early stages of accessing Dublin Simon's Treatment and Recovery Services, clients scored an average of 41.9 on a post-traumatic stress disorder (PTSD) diagnostic checklist. With a score in the range of 31-33 indicating a PTSD diagnosis, this suggests the typical client accessing Dublin Simon's addiction treatment services comes in with considerable experience of past trauma. In fact, less than 10% of clients reported no childhood trauma. Demonstrating that the services can and do make a difference, those clients who then went through the recovery services had a mean score of 30.5, bringing them under the threshold for a PTSD diagnosis.

In 2024, Dublin Simon Community will open a new 100-bed health and addiction treatment facility on Usher's Island. With support from the departments of Housing and Health, this project is finally coming to fruition some ten years after it was first conceived. It will offer a detox unit for alcohol and benzodiazepine, along with rapid access stabilisation, and residential treatment and recovery with counselling, health and well-being.

Offering recommendations from the frontline, Ms. Kenny called for an increased focus on prevention and early intervention to tackle trauma, poverty and deprivation. Finally, Dublin Simon called for increased funding of tailored services for vulnerable sub-populations and people with more complex multi-morbidities, and the creation of opportunities for stability. When it comes to addiction and homelessness, Ms. Kenny stated 'prevention is definitely better than the cure', concluding that 'support must be as easily accessible as drugs.'

3.4.5 Ms. Nicki Killeen. *Harm reduction initiatives for the night-time economy*

Ms. Killeen, HSE Social Inclusion Office, outlined the HSE's Emerging Trends project and harm reduction initiatives for the night-time economy.

Ms. Killeen explained that drug services in Ireland have historically been configured to deal with dependency issues, particularly opiate dependency. As a result, the people typically accessing drugs services are the most marginalized and most impacted by drug harms.

However, there is also a large cohort of people who use drugs, often in nightlife settings such as bars, pubs, nightclubs, festivals and parties, who do not have dependency issues and are therefore much less likely to engage with drugs services. While this cohort may not experience harm in terms of dependency, they are nevertheless exposed to other risks. For example, during the period 2012-2017 there were 40 deaths linked with PMA and PMMA[3], substances similar to, but more toxic than, MDMA/Ecstasy.

3 PMA (Paramethoxyamphetamine) and PMMA (Paramethoxymethamphetamine) are stimulants with hallucinogenic effects similar to MDMA, but are toxic at lower doses.

The fact that a large number of people using drugs do not come into contact with drug services gives rise to potential gaps in knowledge about the emergence of new drugs, and the risks that this cohort are exposed to. The HSE's strategy for engaging with people who use drugs in nightlife settings enables enhanced monitoring of emerging trends and offers harm reduction supports to a difficult to reach cohort.

Ms. Killeen described the HSE Safer Nightlife project, initially piloted in 2022 in two festival settings, and now being rolled out more extensively. This is a multi-component harm reduction campaign, with a particular focus on social media information, as well as 'back of house' drug checking. Typically, a HSE team supported by volunteers will attend a festival and set up a tent checking substances for high potency or altered components. Under an agreement with the Department of Justice, An Garda Síochána and the Department of Health, surrender bins are operated which allow festival goers to provide a sample of their drugs for analysis. In the event that any concerning risks are identified, warnings can be broadcast to festivalgoers across event screens and social media channels.

The initiative is supported by a large number of volunteers from different backgrounds, who are appropriately trained to engage with people who use drugs in the nighttime economy, to provide brief interventions and information, and to identify potential drug emergencies. The programme for training volunteers looks at the basic pharmacology of drugs, socio-cultural influences and really intricate harm reduction interventions.

The success of the initiative is thanks to a partnership between the HSE, Department of Health, Justice and An Garda Síochána, including both the National Drugs and Organised Crime Bureau and local Gardaí.

In her closing comments, Ms. Killeen highlighted the need for a dedicated laboratory for emerging drug trends and the further expansion into other nightlife settings, working with the Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media.

3.4.6 Questions and Answers session

Responding to a question about whether pubs, clubs and concert venues could deal more effectively with the presence of drug users and dealers on their premises, Ms. Killeen said that festivals at which the HSE operates its drug tent are policed in a way that facilitates people receiving support and harm reduction interventions. She added that it requires a partnership approach between the Departments of Justice and Health, the Gardaí and HSE to ensure safe spaces where people can get health interventions.

Asked about the data and evidence in relation to long term recovery, Ms. Kenny explained that Simon Community's long-term accommodation and independent housing services show a 98% sustainment rate. The repeat rate for detox services is 31%, as it can take multiple times for people to move through the service and occasionally, they have a relapse and need to begin over, but the stats show that 69% are moving through the services and into other services.

Responding to a question about domestic violence, Mr. Broderick said that laws and responses have improved alongside Garda training. However, there is a shortage of refuges to house women who are using drugs given the reluctance to accept women with addiction issues, as they're not confident in the capacity to support the women. Whilst some victims of domestic violence will have very good social capital and supportive family members, other scenarios will see women return to a dangerous situation.

In answering about a child's prospect when its mother willingly undergoes voluntary-treatment, Mr. Broderick explained that it depends on the extent of support that the woman has. Often the decision surrounding treatment can be risky given the high probability of relapse, and attention on addiction can result in children being taken into care.

Mr. Duffin spoke about the regional disparities in accessing assessment services, detailing that his staff based in the mid-west often drive the round journey from Limerick to Beaumont hospital to simply attend a detox unit assessment. Mr. Duffin argued that such services are need across Ireland.

Asked about demand for Ana Liffey and other similar services Dublin, Mr. Duffin responded that their service is busy, with approx. 80 staff supporting thousands of people annually. Nurses in particular are 'absolutely flat out'. Mr. Duffin responded to a question about the level of pushback outreach teams experience from potential clients or from communities who might not want drugs services operating in the area. He explained that, while people tend to like what Ana Liffey does in terms of harm reduction and engaging with and helping people, Ana Liffey does encounter the twin phenomena of NIMBY-ism ('Not in my back yard') and NOTE-ism ('Not over there, either!'). He

suggested that it's incumbent upon service providers to do their best by the community as well as by their clients, so they have a good neighbourhood policy for their clients and have a very positive engagement with the business community in their areas of operation. Ms. Kenny added that communities can also be a great asset to the work being done to support people.

Responding to a question about the number and cost of services, Mr. Jim Walsh from the Department of Health explained that the total annual investment in services is approximately €140 - €145 million, funding 280 drug and alcohol services. This is comprised of approximately €31 million to community and voluntary sector services through the Drug and Alcohol Task Forces, another €24 million via the HSE for voluntary services (including 50 residential services), and another €82 million to the HSE directly.

A member asked whether, if wider societal problems such as cost of living pressures, housing and the difficulty getting planning permission for building homes, limited public transport, high rates of loneliness, lack of institutional transparency and so on were addressed, would this stop people from using drugs as a form of escapism. Mr. Broderick commented that drug use is part of how people respond to challenges such as loneliness. While addiction services play an important role in helping people deal with addiction and trauma, those services on their own can't make all the difference. It's important also to deal with other challenges that the person, and their family members, are facing.

A member asked the panel how they ensure service users feel safe using services without the risk of intervention of other agencies such as Tusla or An Garda Síochána. Ms. Killeen explained that, in setting up the HSE drugs tent at festivals, detailed inter-agency meetings are held in advance to ensure the health setting is a safe space for people to go to. This is a good example of agencies with different core objectives working together on a health-led response.

Mr. Duffin explained how, under the LEAR initiative, Gardaí refer people who need assistance directly to the Ana Liffey project. There are regular case conference meetings between the Gardaí and Ana Liffey staff, with shared confidentiality and a mutual commitment to finding effective solutions for people.

3.4.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Increase the amount of treatment centres for women to address their complex needs (e.g. trauma from domestic violence and childcare options);
- Drugs treatment services should receive more funding. The current budget is far too low;
- More harm reduction facilities at festivals and pubs (e.g. making these facilities a licensing requirement for large public events and nighttime economy);
- More mobile harm reduction services/units should be established and made available to people in rural areas;
- Education on drug use and mental health should be established at an early age;
- Expand harm reduction practices within the nighttime economy sector (e.g. drug testing and information).

3.5 Session 4 – Treatment

3.5.1 Dr Anne Marie Carew. *Latest drug treatment data*

Dr Marie Carew, Health Research Board, presented the latest data on drug treatment demand, based on the National Drug Treatment Reporting System (NDTRS)[4] . Treatment demand is an important measure that shows both the numbers and the profiles of those entering treatment every year. Data can indicate drug use in the general population and provide an evidence-based approach to policy development and service planning.

The data over the 7-year period 2016-2022 shows some encouraging trends. There has been an overall increase in the number of cases entering treatment, a sign that more people are coming forward on their own initiative to seek treatment. There has been an overall decrease in the number of cases reporting injecting.

4 The National Drug Treatment Reporting System collects data from all publicly-funded addiction services on individual cases, new and returning. Data collected includes information on age, gender, living arrangements, employment status, drug types used, treatment type and where treatment is provided. Data is provided by some 350 services, representing approx. 90% of all day and residential services in the country.

Latest treatment data shows that just over 12,000 cases entered treatment during 2022, almost four in ten of which were new cases that had never previously been in treatment. The main problem drugs were cocaine (34% of cases), opioids (33% of cases), cannabis (19% of cases) and benzodiazepines (19% of cases). 57% of treatment cases involved poly drug use, with the most frequent combination of drugs being cocaine and alcohol, followed by cocaine and cannabis.

The demographic data shows clear differences in drug use among different age groups, and different socioeconomic groups.

Age profile: Cannabis is the main problem drug for young people aged under 19 years, cocaine is the main problem drug for those aged 20-34, while opioids are the main problem drug for those aged 35 or older.

Cocaine treatment: 4,048 cases were treated for cocaine-related problems, 78% of which were for powder cocaine, and 22% for crack cocaine. Over half of cocaine-related cases had never previously been treated. The average age of cases was 30 years, 79% of cases were male and 21% female. 41% of cases were people in employment. 5% were people experiencing homelessness, while 59% of cases involved poly drug use, most commonly cocaine used with alcohol or cannabis.

Crack Cocaine: There were approx. 850 treatment cases for crack cocaine in 2022, 12% of which had never been treated previously. The average age for crack cocaine cases was 39 years. 58% of cases were male, and 42% female. Just 6% of cases were people in employment. 25% of cases were people experiencing homelessness. 62% of cases were polydrug use, with crack cocaine most commonly used with opioids, benzodiazepines and cannabis. 30%, or one in three, had ever injected and many were still injecting at the time of receiving treatment.

Heroin: The average age of people seeking treatment for heroin was 38 years. Seven in ten cases were male. 79% of cases had previously been in treatment, while 15% were new cases. 70% of cases were unemployed people, 22% were people experiencing homelessness, 45% had ever injected, while 60% of cases involved polydrug use, most commonly involving problematic use of cocaine, benzodiazepines and cannabis.

Cannabis: Of the cases presenting for treatment for cannabis-related problems, 65% were first-time cases, while 32% had previously received treatment. The average age of cases, at 23 years, was much younger than for other drugs. 76% of cases were males, with 24% female. One in five cases were students, while just 6% were people experiencing homelessness. 39% of cases involved polydrug use. The drugs most commonly used in conjunction with Cannabis were cocaine and alcohol, followed by benzodiazepines.

Benzodiazepines: data on treatment for benzodiazepine-related issues showed that 29% of cases had never been treated before. The average age of cases was 33 years, with 70% male and 30% female. 13% of cases were people in employment, while 72% were unemployed. 15% of cases were people experiencing homelessness. 65% of cases involved polydrug use, with benzodiazepines most commonly used in conjunction with cannabis, opioids and alcohol.

First drug ever used: the treatment data showed that, for all drugs (powder cocaine, crack cocaine, opioids, cannabis and benzodiazepines), the first drug ever used by the individuals tended to be cannabis, and the average age of first use of this drug ranged from 14-16 years, depending on the treatment category.

Parental status: 47% of treatment cases were parents, with four in ten cases having at least one child living at home with them at the time they accessed treatment, with females more likely than males to be living with children at the time that they enter treatment. Dr Carew recalled contributions earlier in the day about the impact of problematic drug use on children, and the barriers that mothers face in accessing treatment, including the fear of losing their children, the stigma associated with being a parent who has an addiction, and the practicalities of who's going to mind the kids while the parent attends for treatment.

Ethnicity/Travellers: Nearly 400 treatment cases self-identified as being a member of the Irish traveller community, there is a greater need for drug treatment among this group compared to the wider population. Female Travellers presented for treatment for opioids and benzodiazepines, conversely to females in the wider population who commonly present for opioids and cocaine. There was a similar profile for Traveller men where the primary drugs are cocaine and opioids. Male and female Travellers were slightly older when they entered treatment than their male and female counterparts in the wider population.

3.5.2 Dr Sean Foy. *Addiction and the Bio-Psycho-Social treatment model*

Dr Foy, a clinical psychologist with 30 years' experience working in addiction and mental health, described the Biopsychosocial model of addiction as an holistic approach to understanding what is going on in someone, taking into account physical, psychological and social factors. People can sometimes have a ready-made one-dimensional explanation of addiction, putting its root causes down to either genetic and biological factors, or to the pharmacological properties and addictive potency of a particular drug, or to the environment that a person has grown up in and the trauma they have experienced.

Dr Foy said that, in his experience, both recreational drug use and dependency are underpinned by complex factors, and that 'if we don't consider the multifaceted nature of drug use and dependency, we're not doing justice to the people that we work with.' While contributory factors such as genetics, mental health issues, trauma and social norms all affect a person's risk of developing dependency, it does not mean that if a person has one risk factor, they will develop an addiction. Rather than a singular cause, the interplay between numerous biological, psychological and social factors increases or decreases the risk of addiction becoming problematic for individuals.

Elaborating on the social dimension of the biopsychosocial model, Dr Foy explained that a person's social capital, or their network of family, friends, colleagues and wider community that they are part of, has an important impact on their ability to deal with addiction. He described research by Dr Bruce Alexander that demonstrated the importance of social contact, intimacy, and enhanced living conditions in moderating opioid addiction in laboratory rats. He also described a seminal study by Dr Lee Robins that looked at readdiction rates for opioid addiction among US Vietnam veterans. The research found that 20% of the US armed forces were using heroin during their service in Vietnam. This fell by 95% among veterans who had returned to the US. Robbins ascribed this to the enhanced living conditions, connections with loved ones, the opportunities and hope. Removing the environmental conditions of a war zone meant there was no longer a functional role for ongoing heroin use.

On the challenges facing patients with dual diagnosis (the co-occurrence of addiction and mental health issues), Sean recalled that in his 20-year professional career in Ireland, he was unsuccessful in getting any client of his with dual diagnosis into mental health services. He called for a much more extensive roll-out of the dual diagnosis clinical care model.

3.5.3 Dr Gerry McCarney. *Addiction treatment & supports for young people*

Dr McCarney, consultant addiction psychiatrist with the HSE's youth addiction service in North Dublin, known as SASSY (Substance Abuse Service Specific to Youth), presented on the impact of drug use on adolescents.

Dr McCarney illustrated how those parts of the human brain essential to critical judgement and decision-making are still developing even into early adulthood. Evidence suggests that young people begin experimenting with drug use, while still developing physically, emotionally and socially. Their peer group has become a bigger influence in their decision making than their family, and it's also the first time for many that they may begin to have mental health difficulties.

Dr McCarney showed a continuum of motives for why young people use drugs. Most drug use begins with experimentation and continues initially where the person uses drugs to experience fun. Some people continue to use drugs as part of a peer group activity, even if they themselves are beginning to have second thoughts. For some, drug use can become a compensatory behaviour, in an attempt to cope with mental health difficulties or simply where a person thinks they don't 'fit in'. Continued usage can become habitual and ultimately, for some, a dependency. At that stage it's a more significant issue and much more difficult to manage. While youth addiction services see clients involved at all points on the continuum of usage, the main focus is on harm reduction, trying to help young people move away from the more serious implications of drug use.

Young people referred to SASSY tend to present with problems in relation to school attendance, impaired academic attainment and relationships at home. Cannabis, the drug most frequently used among this age cohort, significantly impacts on how they function and progress in their lives. Within SASSY, multidisciplinary care is provided by addiction psychiatrists, addiction counsellors and family therapists. A wide range of stakeholders and partners can be involved, including the young person's family, school, Child and Adolescent Addiction Services and Child and Adult Mental Health Services, as well as Gardaí, Probation, Juvenile Liaison and the Courts.

The profile of clients shows that the majority of young people referred to addiction services are aged between 15-17 years, with some aged 13-14, and some younger than that. Age of first use ranges between 12-15 years, with some

outliers at a younger age, with access and attitudes being very important.

Of 118 clients in 2022, 99 had cannabis use as a significant problem at presentation, followed by alcohol, cocaine, ecstasy, nitrous oxide, and ecstasy. Nitrous oxide has been a growing problem in recent years, causing significant neurological difficulties for some.

An analysis of exit outcomes shows that 40 out of 76 users who finished treatment in 2022 had reduced their drug use; another 18 had completely ceased to use drugs. 38 service users reengaged with school, family and social pastimes or sporting activities.

In terms of service expansion, the hub and spoke model under the HSE national clinical programme envisages 4 regional hubs for adolescent addiction services, two in Dublin, one in Cork and another in Galway. This would enable supports to be offered across the country, including to rural communities, with technology supporting greater use of telehealth.

3.5.4 Dr Íde Delargy. *The role and experience of the Family GP*

Dr Delargy shared her perspective as a general practitioner with 30 years of clinical experience working in substance misuse, as well as National GP Co-ordinator for the HSE Addiction Services, and, formerly, Director of the Addiction Management in Primary Care Programme at the Irish College of General Practitioners.

Dr Delargy's presentation focused on how the role of the family GP could be enhanced as part of the effort to respond to drug misuse in society. For someone dealing with substance misuse problems, the family GP is generally their first point of contact with the health services. Given their proximity to the patient, the family GP can often be ahead of the research in terms of understanding trends and recognising emerging risks in relation to substance misuse.

Dr Delargy explained that significant progress has been made in equipping GPs to manage drug misuse cases, with addiction awareness training now embedded into GP training. However, she acknowledged that a lot more could be done, describing it as a 'never-ending challenge to try and get more doctors on board.'

All psychoactive substances, both legal and illegal, have the potential to be abused and to ruin people's lives. Not only can they damage the health of the individual, but can also have a tragic impact on children and families. Wider economic and health burdens include the impact on a person's career as well as the increased burden on health services, such as hospital admissions, and subsequent demand on psychiatric services, and GPs.

Describing substance misuse as a 'pan-societal problem', Dr Delargy emphasised that the issue is not confined to deprived areas and GPs see drug misuse in all sections of society. While people living in deprived areas are disproportionately impacted because they have less access to resources, no particular group in society escapes the impact of substance misuse.

Cautioning about the normalisation of drugs use, particularly in the younger population where cannabis use, and cocaine use, is increasingly commonplace and perceived as being 'somewhat harmless', Dr Delargy described this as a dangerous message to convey.

Describing the legal substances that GPs see giving rise to dependency problems, alcohol is the most familiar. Medications such as benzodiazepines (Valium, Xanax, sleeping tablets), which are regularly prescribed by GPS for a variety of reasons, contribute to dependency issues and lead to increased health and social harms, such as increased falls, driving offences and admissions to hospital. Pregabalin (Lyrica), marketed to GPs as a solution for people who needed tranquillisers or anti-anxiety medication, is now proving problematic and features quite prominently on HRB statistics around drug-induced harm. GPs have seen an increase in people presenting with problems associated with Codeine products, over-the-counter Solpadine, Nurofen Plus.

Dr Delargy explained how, in the United States, prescription opioid medications were marketed to medical practitioners as safe and highly effective painkillers. The risk of dependency has become abundantly clear, with a huge number of poisoning deaths and people on the streets using heroin and synthetic opioids. Though Ireland is not at that stage with opioid analgesics, she cautioned that it's important to not go there. She urged caution when big business and big Pharma are involved, giving messages about how useful their particular products are.

In terms of illicit drug use, GPs are seeing the rise in cocaine use and cannabis use. Poly-substance use, whether

with prescribable medications or illicit drugs, is the area of concern. One of the key factors in drug-induced deaths is the misuse of other substances in conjunction with alcohol. As prescribers, doctors must be aware of a given medication's interaction with illicit substances, which may result in polysubstance dependency. Dr Delargy urged that we learn from experience and not sleepwalk into another crisis.

From a public health perspective, prevention is better than cure, and education and early intervention is critical. It is important to remove the stigma associated with addiction and encourage GPs to get involved. Lessons can be taken from the successful messaging to promote mental health and destigmatise mental illness, supported by high-profile public figures. Substance misuse is a complex problem, with no quick fixes. She concluded by stating that, based on current evidence, she is not convinced that legalising drugs is one of the solutions.

3.5.5 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Mandatory training on drug misuse for healthcare providers (e.g. doctors, nurses, social, workers, and undergraduates studying for any of these professions)
- Holistic approach tailored to the individual service user
- Make the general public aware of drug services and available treatments (e.g. public service announcements on radio)
- Mandatory training for GPs on how to treat drug users and addiction
- Provide the necessary infrastructure and resources to adopt a bio-psychosocial model
- Reduce widespread dependence on medication and consider alternative treatments instead (e.g. yoga, mindfulness, meditation, plant medicine)

3.5.6 Questions and Answers session

Responding to questions about expanding the use of the biopsychosocial model of addiction care, Dr Foy responded that the model is already well-established and widely practiced but could be further strengthened and underpinned with the provision of additional services and greater coordination between services. Further training and investment would support this. Dr Foy referenced the need for empathy and compassion. A cultural shift in thinking is needed to address addiction. Addiction services have more recently embraced trauma-informed care.

Members put a series of questions to the panel about prescription medications, including their role in deaths by poisoning, whether people who experience trauma are prescribed medication too easily, and what could be learned from those people who have experienced trauma but don't use drugs.

Dr Delargy explained the role of anti-depressant medication for helping people with trauma, noting how drug users self-medicate to deal with trauma. Whilst others have resources to access psychological supports, there are other supports that should be enhanced.

Dr Carew explained that deaths involving codeine would be counted as part of the deaths by opioid poisoning. Opioids are second most common treatment in Ireland. Eight out of ten poisonings are due to heroin, meaning that two in ten poisonings are associated within other opioids.

Responding to a question about whether the progression rates from cannabis to cocaine use within the under-20-year-old population is monitored, Dr Carew explained that the HRB does not capture transition data, and suggested that rolling out an individual health identifier would be of significant help in facilitating advanced research.

Responding to a question about whether substance misuse training is mandatory for all GPs, Dr Delargy explained that it is optional. Though training is embedded in undergraduate training programmes, ensuring existing GPs voluntarily update is a challenge. She described substance misuse as a 'Cinderella' issue for GPs.

Responding to a question about the research into alternative medicines for addiction of heroin for instance like ibogaine, Dr Foy said this was not something he had worked with, but as a science practitioner would be open to looking at any intervention that had an evidence base behind it. Dr McCarney responded that ibogaine had been examined a number of years ago but the evidence base was not as strong as that for the medications already in use, so there was no apparent reason to use it.

Dr Delargy described the pathways for GP referrals to specialist drug treatment services as variable, dependent on the location of referral. Dr Foy added that while there are a range of services available in rural areas, including through the Drug and Alcohol Task Forces, ongoing effort is required to ensure the public is aware of local addiction services.

Panellists broadly agreed on the need for a public health information campaign aimed at reducing stigma about drug use and promoting help-seeking behaviour and access to services, learning from some of the successes of recent public health messaging around mental health.

Dr McCarney explained that a lot of progress has been made in developing a prevention module within the SPHE programme in secondary schools. However, teachers are often too busy to attend the necessary training, which gives rise to difficulties in rolling out and implementing prevention models aimed at reducing harm for young people.

3.6 Session 5 – Supporting recovery from addiction

3.6.1 Prof. Jo-Hanna Ivers. *A systemic approach to recovery*

Prof. Ivers, Associate Professor in Addiction, Trinity College Dublin, and member of the Citizens' Assembly Advisory Support Group, delivered a presentation titled 'Building Systemic Capital to Advance Addiction Recovery in Ireland.'

Setting out the context for her presentation, Prof. Ivers explained that the current National Drugs Strategy, *Reducing Harm, Supporting Recovery* (2017-2025) might appear to have a dual focus on Harm Reduction and Recovery. In fact, most of its 50 actions are focused on Harm Reduction, with very limited focus on Recovery. While the strategy is a prime example of how to promote and support Harm Reduction, Prof. Ivers argued that much more needs to be done in terms of Recovery.

Ireland's lack of strategic focus on Recovery might be traced back to the first response to drug use in the 1980s during Dublin's heroin epidemic. The focus of that strategic response was predominantly on reducing the harmful impact of heroin use, containing the associated spread of HIV and hepatitis, and reducing crime rates. In this respect, the strategy proved very successful for a period of time. However, Ireland's strategic response to drugs misuse in subsequent decades has continued to focus predominantly on Harm Reduction. In contrast, other jurisdictions including the US and UK, which have had strategic responses to drugs since the 1960s and 70s, have also developed a more strategic perspective on, and approach to, Recovery.

Explaining Recovery as 'life after drug use, the stuff that happens a person after treatment', Prof. Ivers described Recovery as a 'self-defined' term. When a person resolves their drug use, whether that's to stabilize, reduce or abstain from drugs, they define for themselves what Recovery means for their life. 'Recovery Capital' means the factors people have in their lives that help them sustain Recovery. Amongst other things, Recovery Capital can include quantifiable things like having access to education, training, housing, employment, somewhere nice to live and engagement with your community.

While sustained recovery is important to the individual and their family, it is also important from an economic perspective. Prof. Ivers cited research from Dr John Kelly of Harvard which found that five years is an important threshold in terms of sustained recovery outcome. An individual who does not relapse within five years is at the same low risk of relapse as an individual who has never been in recovery.

Research shows that individuals who are unable to sustain recovery are more likely to be parents, have experienced childhood traumas, have co-occurring mental health issues, are experiencing homelessness at the point of treatment, be early school leavers and/or experienced high rates of unemployment.

Taking a systemic response to building Recovery Capital means going beyond the immediate health response to recognising the social determinants of health, including the importance of where we work, live and play.

In the absence of a truly systemic approach to Recovery Capital, Prof. Ivers described the pressure on frontline workers and individuals in Recovery who must fight for recovery capital. She explained how frontline workers might find themselves, in the middle of a housing crisis, trying to find somebody a house while they might be in detox, or helping someone get their physical and mental health issues sorted out while they're in treatment, or trying to get someone into a Higher Education institution when numbers have never been higher, or negotiating an employment

market when there's never been such a demand for more skilled workers, or trying to resolve what could be a lifetime of Social Services issues and a very complex relationship with the justice system.

She described as 'unsustainable' the pressure on frontline workers to deliver a health-led approach when, in fact, it requires a systemic, cross-sectoral response. To build Recovery Capital at a systemic level requires a strategic partnership between key actors across housing, health, education, employment, social services and Justice, and indeed beyond into policy areas like planning.

From a policy perspective, adopting a 'Health in All Policies' approach would improve policy coherence and population health outcomes.

Concluding, Prof. Ivers called for mandated support from other sectors for Recovery, stakeholder engagement from people in Recovery, and effective evaluation frameworks.

3.6.2 Moderated Panel Discussion and Q&A: Supporting Recovery from addiction

A panel discussion, moderated by Dearbhail McDonald, featured five people with diverse expertise and experience in Recovery.

3.6.3 Mr. Noel Murphy

Mr. Murphy, manager of Soilse, HSE Social Inclusion and Addiction Services, explained that Soilse provides Recovery supports as one component within a full continuum of care model. This includes a 3-month pre-Detox day-care programme that prepares people to enter treatment. Once ready, people can progress into residential detox or treatment for 6-8 weeks, followed by Soilse's Recovery Education and Relapse Prevention day-care programme, with individualised recovery care plans. In a partnership between the HSE and City of Dublin ETB, clients can avail of recovery and rehabilitation supports including counselling, coaching, NA supports, life skills training, and education and employment supports.

Many people enter the service with very little Recovery capital, often with challenges such as a family history of substance misuse, low literacy levels, street use, a criminal history. Explaining the lengthy journey to enter recovery, Mr. Murphy explained that many people will relapse as part of the process, some simply never recover, and some people, unfortunately, will die as a result of their substance misuse. Those who do have recovery capital fare much better. Soilse's most recent graduates included 10 people who were drug-free, 3 of whom had earned degrees at university, one of whom had earned a master's and one going forward for a PhD. Fellowship programmes like NA, AA and CA are an important part of the Recovery system.

3.6.4 Ms. Nicola Smith, Expert by Experience

Ms. Smith shared her personal experience of Recovery, explaining that she had attended a methadone treatment clinic for 12 years, during which time she received very little support or guidance other than the prescription of medication. She never had a care plan, nor a conversation about how long she wanted to remain on methadone. While she recognised that methadone was helping her, she didn't have a deeper understanding of her addiction, nor that she suffered from post-traumatic stress disorder. She experienced particular stigma as a mother suffering from addiction. Her situation began to change when a new Social Worker at the methadone treatment centre listened to Ms. Smith and supported her to being a journey to come off methadone. It took another two years before Ms. Smith entered Soilse's stabilisation programme. Seeing other people getting stabilised and detoxing was an important encouragement.

3.6.5 Mr. Daniel Jones

Mr. Jones, an Addiction Recovery Coach, shared his experience of addiction and recovery, describing how he began using drugs at an early age, and was put on a methadone programme, at age 16, for what was meant to be a couple of weeks. Twenty years later, he was still taking methadone. Over that time, he was in and out of prison, methadone clinics and hospitals. He explained how, he was living the only way he knew how to live. Nobody ever offered him an alternative such as a recovery programme, or a vision of how his life could change. Mr. Jones lost three family members to addiction, his own mental health deteriorated, and he developed paranoia and depression. He described how he had planned many times to come off methadone, but was never given the necessary supports. Learning to live without it, learning to be a brother and a dad on a daily basis without relying on some substance or other was the difficult part.

For Mr. Jones, the key was finding people who believed in him and offered him hope that things could change. He found this when he went to Soilse. He explained that he did not have the skills to live a normal life and needed to learn how to live again. Having never previously attended school or sat exams, Mr. Jones began his education in Soilse. He discovered that he was dyslexic, and received supports to develop his literacy. He took up sports and fitness coaching, which was an important part of his own recovery, and eventually got the opportunity to become a Recovery coach, studying in DCU part-time for a year. He now works supporting other people in recovery, explaining that, if he can do it, he can definitely encourage and help others to Recovery.

3.6.6 Mr. Mick Devine

Mr. Devine, Clinical Director of the Tabor Group and representing the Addiction Treatment Centres of Ireland (ACTI), explained how residential treatment services play an important part in tackling substance misuse and supporting Recovery. People undergoing addiction treatment in residential centres experience safe, drug-free environments where they learn about addiction from both a theoretical and experiential perspective, developing personal insights into how addiction works, and learning how to cope with cravings and sustain recovery. As well as addiction treatment, clients can learn important life skills through psycho-educational workshops that, for example, teach people how to deal with a crowded room, which is often very challenging for people in addiction. Working in group settings within a residential treatment centre gives people the skills and confidence to participate in recovery groups like NA and AA.

3.6.7 Panel Discussion

Prof. Ivers explained that Ireland is generally good at providing treatment, and treatment services when properly resourced, but we do not yet have a systemic approach to Recovery.

The panellists each responded to a question about potential 'game-changing' ideas. Mr. Jones called for more peer supports for people attending methadone clinics, and for recovery to be more visible and promoted. He explained that people with lived experience can be a powerful influence in encouraging and helping other people, saying 'we've been in the hole, and we know the way out.'

Mr. Murphy described Soilse's ongoing project to develop a Recovery Campus, supported by statutory agencies like the HSE and the ETB. The campus currently has a Recovery Café, with groups like NA, AA, CA, and Recovery Academy Ireland on-site. Currently, there are 29 people in recovery training to become Recovery Coaches. They will then go out to work in places like treatment centres, community centres and so on. Outlining the wider social impact of Recovery, Mr. Murphy explained that many people in active addiction are also involved in crime. Recovery is not just about stopping drug misuse, it also means someone stops committing crime and becomes a productive contributor to their community. People who were previously known within their communities as drug users, who get into Recovery, reemerge as influential role models.

'Recovery is contagious: the more people you get into recover, the more will follow.'

Ms. Smith called for a greater community-based focus to the drug response, including community-based pre-stabilisation programmes, as well as treatment services and 12 or 18-month day-care recovery programmes. She explained how people in Recovery need ongoing support to deal with life challenges like learning to become a parent again and having to face your children's teachers in school. Particularly when people in recovery hit a bad place, which is part of the process, they need to have the support of a key worker, and need safe places to go within their local communities. She remarked that doctors do not even recommend local community-based services.

Mr. Devine explained that the biopsychosocial model means that dealing with addiction is not just about the treatment intervention but the follow-through supports to help people reintegrate into society. This means giving people stable accommodation, access to training, education, employability, and supports to learn, or re-learn, life skills. He explained that a trauma-informed approach to care is very important and that addiction interventions need to address both developmental trauma and PTSD.

Prof. Ivers described the broader societal benefits of Recovery. While the most immediately obvious benefit is the reduced burden on the health and criminal justice system, benefits can also be seen across communities and society. Economic studies show that investing in Recovery makes financial sense. The US has invested in Recovery for over two decades, with every dollar spent yielding a return of 2, 3 or 4 dollars. The panel responded to questions from members about why Recovery is not happening on a more extensive scale, and what are the particular challenges for someone who is homeless with no recovery capital

Mr. Murphy explained the 'equifinality phenomenon', whereby if you put someone in the right environment, with the right care and conditions, they will respond and grow. He described how Recovery is a slow process, where a person needs step-by-step support, setting small goals and moving forward gradually. It can take six months just to be ready for Detox. Following Detox, when a person is drug-free they begin to experience all the emotions and underlying issues that need to be dealt with in therapeutic treatment. Following treatment a person requires extensive day-care, followed by after-care. It is a tried and tested process, but it takes time and things can happen at any stage along the way.

Prof. Jo-Hanna Ivers explained that it is difficult to sustain recovery, but particularly so for people experiencing homelessness, who have more complex needs, are more likely to have co-occurring mental illness and to have left school early. This is why it is important to think about building systemic recovery capital, and that a 'patchwork quilt' approach will not suffice, saying 'if we keep on going where we're headed, we'll still be here in two decades facing the same challenges.'

Mr. Devine concurred that sustaining recovery requires a multidisciplinary response including a joined-up approach by services offering housing, training and employment. Stigmatised individuals and communities are easy to push down the priority list.

Mr. Jones commented that services need to communicate better with each other. In his experience, he has often seen people ready for treatment but new barriers cropped up, sometimes resulting in people going back out using drugs.

Ms. Smith commented that services need to examine what is not working, and understand that for some people, perhaps recovery starts the day they walk into a clinic to access methadone treatment.

Mr. Murphy explained that Soilse works with partners like the McVerry Trust to ensure homeless clients exiting detox go into stable housing rather than back into hostels where drugs are readily available.

Panellists then responded to a further series of questions from members, including why people on methadone programmes can spend so long without being offered a pathway to recovery; whether prisons are a lost opportunity to support a cohort of the population with significant levels of addiction and mental health issues; and what are the barriers, including stigma and bias, in reintegrating people in recovery back into society.

Prof. Ivers expressed the view that prisons could play a very significant role in supporting Recovery, and that it would be very helpful if the Department of Justice made Recovery a policy priority. While there are some people who do not need to be in prison, we also need to recognise that there are many people who will be in prison for a long time, who deserve access to treatment and recovery services. There are several evidence-based programmes internationally that are demonstrably effective in getting people in prison onto recovery journeys. In terms of the therapeutic model of peer-driven support, prisons can be a microsystem for Recovery, where people are part of a community with access to peers that can bring them along.

Mr. Murphy explained that having worked in methadone clinics for many years, he has seen the complex variety of reasons why people do not come off drugs. Not everyone wants to come off drugs, others are not ready to come off, and others want to but struggle with their doctor or nurse who doesn't seem to hear them. While some clinics have now introduced case management, this is not the case in every clinic. Many clinics still do not use care plans, which makes a huge difference and means a person using drugs has a meeting every 4-6 weeks to discuss their goals and objectives.

Ms. Smith echoed a point made earlier by Mr. Jones, which is that the challenge for people in recovery programmes is to realise that it is not just a question of coming off drugs, it is about learning to deal with the challenges that life throws at you. For her, it is important to implement the 12-step programme on a daily basis. It is also important to find a purpose in life: 'If you're going to take something as big as drug use out of your life you've got to replace it with something else. Giving back is important.' For Ms. Smith, this includes running a home group.

Mr. Devine concluded his remarks by saying that just because the problem is complex does not mean it cannot be tackled effectively. Drugs services are the Cinderella of services, and a higher priority needs to be put on tackling problems related to drugs misuse. People are in place and doing very good work, but it is not sufficiently prioritised as a health problem. How many people in prison with drug-related challenges really need to be in there in the first place? There needs to be a shift in our approach.

Concluding, Prof. Ivers reiterated her point that we need to promote cross-sectoral responses and invest up front in objectives that will pay a rich dividend in the medium to long-term.

3.6.8 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- The importance of education.
- The positive impact of recovery capital on recovery.
- The additional stigma for women and mothers taking drugs.
- Recovery has wider impacts and is for life- not simply related to drugs, but diverting crime, prison etc.
- The need for a shift in understanding in drug and alcohol services.
- The need for drugs to be a high priority for Government

3.7 Session 6 – Innovative supports for families and communities

3.7.1 Moderated Panel Discussion with Questions and Answers

The final panel discussion of the weekend, moderated by Dearbhail McDonald, featured four people with diverse experience in supporting families and communities dealing with drug-related challenges.

3.7.2 Dr. Austin O'Carroll, GP

Commenting on why some patients remain on methadone for lengthy periods of time, sometimes many years, Dr O'Carroll explained that a key principle for doctors is to 'first, do no harm', and that a medical practitioner's ultimate aim is not necessarily always to get someone off methadone. Some clients will want to get off methadone. Other clients feel safer remaining on methadone, while still getting their lives back on track, resuming contact with their family, taking up training or finding employment. The question of whether someone remains on methadone is secondary to them succeeding in getting their lives back on track.

Continuing, Dr O'Carroll explained the ethos of the services he has established. His clients are the most vulnerable and marginalised in society, many of whom are homeless and in addiction. Many also present with health issues related to drug use such as HIV, Hepatitis C and injecting wounds. While some may never go into Recovery, they still need to be cared for by health professionals. His services offer clients access to a full range of primary care and GP services, as well as addiction services including opiate substitution treatment and detox services for benzodiazepine and alcohol dependency. In contrast to what they might have experienced in other parts of the health system, clients can expect a warm welcome and low-threshold access. Describing his clients as the 'most marginalised and behaviourally challenged people in society, the ones most likely to die young', Dr O'Carroll explained that his ethos is rooted in a recognition that it is society which has created poverty in the first place, then society proceeds to blame people living in poverty for being poor, and, even though all the evidence shows that addiction is caused by poverty, we blame and criminalise people for being addicted.

3.7.3 Ms. Anna Quigley, Citywide

Commenting on the relationship between statutory and community drug services, Ms. Quigley outlined the evolution of the community and State responses to drug problems dating back to the heroin crisis of the 1980s. She suggested the reason the State and society are continuing to fail to resolve the issue of drugs misuse is because we are not addressing the underlying issue, namely poverty. Since its establishment in 1985, Citywide has supported grassroots community-based drug services. Many of these services were set up by local people acting on their own initiative, without financial support from the State, in response to the fact that people were dying from drugs misuse. The Drug and Alcohol Task Forces evolved from this community-based response, with community reps approaching the State agencies and proposing a joined-up partnership response to the issues.

3.7.4 Mr. Joe Slattery, Northstar Family Support Project, Limerick

Mr. Slattery described the harmful impact of drug misuse on families. While attention tends to focus on the person misusing substances, for every substance user there is a mother, a father, a brother, a sister, children, extended family and even neighbours who can be seriously impacted. Family members of a person with an addiction are dealing with the issues on a 24/7 basis, with no respite. The emotional trauma that family members go through is relentless. Compounding this is the significant stigma and shame associated with problematic drug use. Family members often struggle to access supports even when they are readily available, as they do not feel emotionally ready to start facing the issues. The family member's initial perspective is often that, if the substance user is ok, they'll be ok. The trauma, stress, pain and grief that they themselves have lived with for many years can remain hidden and unresolved. Northstar helps families affected by drug misuse to learn how to mind themselves and cope effectively with the trauma and stress that is part of their lives.

3.7.5 Ms. Breda Fell, Family Support Networks

Ms. Fell explained the role of the Family Support Network, which started organically in the community about 25 years ago. Initially, it was driven by families coming together during times of crisis to try and help their loved ones who were impacted by drug use. Initially, their focus was on the substance user and not their own needs, but soon came to realise that, if they look after themselves, they will be better able to support their loved ones. The Family Support Network is based on Community Development principles, with family members coming together to share their experiences of addiction, diagnosis, kinship care, bereavement and so on. They learn about coping with these situations, but also about looking after themselves in the process. They also support family members dealing with the challenge of navigating systems and dealing with barriers. Over recent years the focus has been on helping people reclaim their families back from drug use, and focusing on Recovery for the whole family.

3.7.6 Panel discussion

Dr. O'Carroll shared his views on what is not working at present, and potential solutions. The first priority, he suggested, is to recognise that the root cause of addiction is inequality, and that addiction will always be an issue while there is inequality. Second is the need to make all services trauma-informed, to ensure that clients are treated with dignity and understanding. Third is the need to ensure that health professionals take responsibility locally so that people in addiction don't have to leave their local area to get Services.

He offered a harrowing example whereby one of his clients, a mother with a four-year old daughter, was forced to travel from her hometown in the midlands to Dublin to access methadone treatment, as not one of the 20 or so GPs in her local area would offer OST. To attend the Dublin-based methadone clinic, the woman had to stay overnight in a hostel, and following a traumatic sexual assault one night, died shortly afterwards of an overdose. Describing it as 'disgraceful', Dr O'Carroll said that, had a GP in her hometown taken her on for treatment, she would be alive today and her daughter would have a mother.

His fourth suggestion is to provide a one-stop-shop approach for supporting drug users, rather than the current approach where addiction services are detached from other health services, which in turn are detached from housing, education and employment services. Fifthly, he called for a campaign to destigmatise drug addiction and help society understand drug users as human beings who have suffered trauma and are self-healing by using drugs. Finally, he called for a better way to help and support mothers in addiction so that they do not lose access to their children. He described the trauma experienced by mothers losing access to their children as 'one of the most inhumane things I've ever witnessed in my life.'

Ms. Quigley offered her views on how the relationship between the State and grassroots community organisations might evolve. She emphasised the importance of the State including people with lived experience and local expertise in decision-making. While the 1996 Rabbit Report led to the establishment of a partnership between the State and communities, with communities involved in the decision-making process, Ms. Quigley argued that this no longer exists and needs to be restored. She stated that just because drug use is now prevalent across wider society doesn't mean that there shouldn't be a continued targeted focus on disadvantaged areas and a continued focus on tackling the socio-economic determinants of drug use. While stigma is a huge issue for people who use drugs and their families, it is also a huge issue for communities already stigmatised because of poverty. There is a strong sense within disadvantaged communities that the level of harm they are experiencing would not be tolerated were it happening in more affluent communities. Concluding her remarks, she made the point that there is nothing more stigmatising to a human than being declared a criminal.

Mr. Slattery called for more joined up thinking between different parts of the health system in relation to funding and service delivery. He explained how difficult it can be for a person in addiction, or their families to get the right supports when addiction services and mental health services are so disjointed, and when there is a general lack of understanding across the system about the central role of trauma in drugs misuse. He argued that if the drugs issue can be dealt with as a health-led response with compassion and curiosity as opposed to judgment and shame, more people will come forward for support and will not stay in secrecy for so long. He called for more equitable approaches to funding services to reduce the disparities between relatively well-resourced urban areas and poorly-resourced rural areas.

Ms. Fell commented that the existing National Drug Strategy envisages that drug users' families and communities will be involved in the decision-making process. However, the Family Support Network does not see that happening, and rural populations in particular have been overlooked. The Southeast Network covers a big population spanning five counties with a wide geographical area, but the level of supports needed is not available, and the supports that are present are not consistent across all areas.

Dr. O'Carroll highlighted the importance of political will, explaining that the urgency shown during the COVID-19 pandemic meant Ireland had one of the best international responses in terms of protecting homeless people. The homeless population had a lower rate of COVID-19 infection than the general population, and the system 'moved Heaven and Earth' to achieve that, securing own-door accommodation, providing harm-reduction services and slashing waiting times for addiction treatment overnight from 12 weeks to three days.

Ms. Quigley made the argument that Ireland has a long history of basing social policy on moral judgment, and that has always proven to be disastrous, with more of an impact on people who are poor than others in society. Policies based on moral judgement tend to lend themselves towards ineffective punitive responses, which in the case of drugs use includes shame, blame, criminalisation and punishment.

Ms. Fell emphasised that, in tackling stigma, the choice of language that we use is important. We can dehumanise and humiliate people by the terms we use. Stigmatisation creates huge barriers for people who would benefit from reaching out for help. We can tackle stigmatisation through a national campaign that educates society about drug use. A whole family approach to recovery would have a sustainable impact on breaking the generational aspect of drug misuse.

Mr. Slattery added that society is influenced by the language used in media, and on social media, where derogatory terms are still widely used. Emphasising that people with addiction are people's loved ones, he called for society to have a bit of humanity and curiosity about the issue and enquire as to why someone might have ended up using drugs in the first place. Now that Ireland has a big cocaine epidemic, a lot of people from all sorts of backgrounds are experiencing the impact of addiction in their own families. This is creating the conditions for more compassionate and empathetic attitudes to substance abuse. People with loved ones in addiction are already judging themselves and beating themselves up with a stick, asking themselves 'what did I do wrong, where did I go wrong…'. They do not need society beating them up as well.

Dr. O'Carroll argued that the GP profession needs to change its approach to drug use and drug users. It only takes a half-day training course online for a GP to be able to offer methadone treatment. He recalled being invited to give a talk on drug treatment to over 40 GPs in a midland's town. Not one GP turned up for the talk. Dr. O'Carroll expressed the view that GPs in some areas don't want their practices to be seen as the 'practice for drug users'. A practical solution could be brought about by the Irish College of General Practitioners and the Medical Council ensuring that drug misuse is treated the same as any other health condition, that GPs get training on treating people who use drugs, and that drug treatment features as a core element of GP education.

Referencing the media frenzy and conflation of concepts that typically happens whenever there is a conversation about legislative change, Ms. Quigley called for a more nuanced use of language and distinction between decriminalisation of the person who uses drugs and decriminalising of drugs per se, which are two different things.

Mr. Slattery called for a national response to drugs issues, where people across all sections of society realise that no community is immune from drugs-related problems, everybody experiences the same pain and harm from drugs misuse, and we are realistically never going to get rid of drugs in society. Drug use is an effective way for someone to ease their pain in the short term, but it has devastating long-term consequences for the person using drugs and their loved ones.

3.7.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Educational programmes and information need to be easily accessible, especially to families of drug users
- Introduce formal and mandatory drug use and addiction education for GPs. There should be further work to ensure GPs take on Methadone patients
- Establish an independent statutory body to be responsible for matters related to drug use in Ireland with an oversight function over drug services (e.g. task force, steering committee)
- Policy and services need to become more trauma-informed
- Political will is essential. Recommendations must be implemented and not become just another report sitting on the shelf
- Create a national media campaign to de-stigmatise drug use (e.g. include real people with lived experience)

4 Meeting #4

4 Meeting #4

Meeting #4

Figure 4.1:
Opening Remarks - Paul Reid, Chairperson

Figure 4.2:
Submissions Overview - Cathal O'Regan, Secretary

Figure 4.3: Session 1 - Dr. Sean Redmond, Siobhán Maher, Seamus Boland, Michael O'Sullivan

Figure 4.4:
Session 2 - Andrew Cunningham

Figure 4.5: Session 2 - Anthony Lee, Paula Kearney, Fiona Carolan, Maeve Foley, Judge Ann Ryan

Figure 4.6: Session 4 - Tony Duffin, Mark Wilson, Assistant Commissioner Justin Kelly

Figure 4.7:
Session 3 - Ashling Golden, Gary O'Heaire, Brian O'Sullivan, Keith Purcell, Sheila Connolly, Fergal Black, Caron McCaffrey

Figure 4.8:
Contribution from Andy O'Hara

Figure 4.9:
Contribution from Fionn Sexton Connolly

Figure 4.10:
Contribution from Karl Ducque

Figure 4.11:
Contribution from Shannon Connors

Figure 4.12: Session 6 - Dr. James Windle, Prof. Tom O Malley, Prof. Deirdre Healy, Prof. Yvonne Daly, Brendan Hughes

Figure 4.13:
Session 6 - Prof. Andrew Percy

Figure 4.14:
Session 5 - Graham Temple, Prof. Bobby Smyth, Prof. Anne Doherty, Eddie D'Arcy

Meeting #4

Figure 4.15:
Roundtable discussions

Figure 4.16:
Roundtable discussions

Figure 4.17:
Roundtable discussions

Figure 4.18:
Roundtable discussions

Figure 4.19:
Roundtable discussions

Figure 4.20:
Roundtable discussions

Figure 4.21:
Workshop on legal options

Figure 4.22:
Questions and Answers

Figure 4.23:
Workshop on legal options

Figure 4.24:
Roundtable discussions

Figure 4.25:
Questions and Answers

Figure 4.26:
Questions and Answers

Figure 4.27:
Questions and Answers

Figure 4.28:
Professor John Garry, QUB

Figure 4.29:
Legal Workshop

Figure 4.30:
Legal Workshop

4.1 Programme Overview

The fourth meeting of the Citizens' Assembly, held on 02-03 September 2023, focused on the role of the criminal justice system and Ireland's legislative framework. The meeting featured contributions from a wide range of people with experience of, and expertise in, these issues.

The Chair opened the meeting by paying tribute to the recently deceased Mr. John Bennett, Coordinator of the Finglas-Cabra Local Drug & Alcohol Task Force, who had been an invited speaker at the previous meeting of the Assembly.

4.2 Session 1 – Supply-side issues

4.2.1 Mr. Michael O'Sullivan: *An international perspective*

Mr. O'Sullivan, former Executive Director of MAOC-N (Maritime Analysis and Operations Centre, Narcotics) and retired Assistant Commissioner with An Garda Síochána, offered a perspective on supply reduction challenges and the role of international organised crime.

MAOC-N is as a multi-national agency established in 2007 to combat transnational illicit drug trafficking. Based in Lisbon, MAOC0-N includes six EU Member States (France, Ireland, Italy, Spain, the Netherlands, and Portugal) and the United Kingdom, working in partnership with international drug and crime authorities and partners from various jurisdictions around the world. Its mission is to coordinate intelligence gathering and operations to intercept drug consignments being sent by air and sea from the Americas and Africa into Europe.

Mr. O'Sullivan described the international drugs trade as consumer-driven, with current demand in Europe driving the increasing level of cocaine trafficking from South America. With the European cocaine market conservatively estimated to be worth €9 billion, drug producers and traffickers are responding accordingly. Just before he left MACO-N, the agency had seized some 26 or 27 ships bound for Europe from South America, carrying a total value of about €4 billion of cocaine, all destined for organised crime gangs in Europe.

Describing cocaine as a very difficult drug to combat, Mr. O'Sullivan suggested that people use cocaine mainly because they see it as a social drug, driven in many cases by high disposable income. Heroin is a completely different issue from a policing perspective. Many, if not most, people using heroin want to come off it and are amenable to getting help. He regretted the lack of public health messaging or education nowadays, especially for young people, about the dangers of cocaine.

Describing the 'War on Drugs' phraseology as outdated and misleading, giving the mistaken impression that law enforcement is trying to solve the entire problem, Mr. O'Sullivan argued that law enforcement internationally is keenly aware that they cannot police the drug problem away. Effective response to drug use requires a combination of law enforcement, prevention, treatment and rehabilitation, and research. If any of those pillars are underfunded or undermined, the overall response will be ineffective.

He challenged the idea that drugs supply could be taken out of the hands of criminals, arguing that this simply can't be done, and that no country has ever managed to do so, saying that 'the criminals are here to stay.'

He suggested that different drug challenges require different responses, and that the criminal justice system has shown itself capable of responding with compassion to heroin users, of whom there are now around 21,000 right around the country. People addicted to heroin need to buy their drug on daily basis, they often want to get off the drug, but need help and require a humane response. A heroin addict, if caught, goes to court, is assigned a probation officer and is then directed by the court to seek treatment. The experience of appearing in front of a judge is a wake-up call and an incentive to engage with health-led services.

Mr. O'Sullivan offered the view that, having observed the Irish system for many years, he is convinced that it works. In contrast, he suggested that the Portuguese model is not a solution to Ireland's drug problems. Having lived for four years in Lisbon, he suggested there is a lot of misinformation about what happens in Portugal. Police divert people into the health system where they are dealt with by a Dissuasion Committee. He offered the view that this approach would not work here, because Irish criminals are 'completely different to Portuguese criminals', with a level of violence and viciousness that simply isn't seen in Portugal.

Concluding his presentation, Mr. O'Sullivan reiterated that he has seen many systems around the world and is convinced that Ireland's system is as good as any, and better than most. However, it needs greater resources, especially in respect of treatment services. Finally, he cautioned that if drug laws in this country are relaxed, Ireland will see a surge in the use of drugs.

4.2.2 Mr. Andrew Cunningham: *An EU perspective on Supply Reduction*

Mr. Cunningham, Head of Drug Markets, Crime and Supply Reduction at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), explained the agency's work in relation to supply reduction and the nature of organised crime.

The EMCDDA looks at the drug Market in its broadest sense, from production through trafficking and distribution, all the way through to consumption by users. They study production processes and trends, from the growing of crops like coca-bush for cocaine production in Latin America, or opium poppies for heroin production in Afghanistan, to the production of synthetic drugs by illicit laboratories in Europe, and the role of source countries like China for chemicals for drug production. They also study the role of organised crime in the drugs trade.

While the drugs issue is both complicated and politicised, with a diverse range of viewpoints, what is clear is the huge cost to society related to drugs. In some respects, drug markets are like other commodity markets, governed by rules of supply and demand. However, drug markets don't work in the same way as normal markets. The profits involved are huge, as are the risks for people involved. The dynamics of drug markets are difficult to monitor because it's largely a hidden phenomenon and a hugely complex industry.

The EMCDDA collects data on the prevalence of drug use, the price and purity of drugs at wholesale and consumer level, consumer-level data about drugs seized and drug law offences. It synthesises and analyses these multiple sources to estimate the size of the drug market.

According to the most recent estimate, Europeans spend at a minimum €30 billion each year on illicit drugs. Cannabis has the largest share of the illicit drug market in the EU, with about 40% of the market.

Mr. Cunningham outlined how, with the liberalisation of laws on cannabis consumption in parts of North America, a misleading impression can be conveyed by the media that everybody is now consuming cannabis, especially young people. He explained that the average prevalence of cannabis use across the EU is around 8%, meaning that 92% of the adult population is not using cannabis. Even in high prevalence countries like the Czech Republic and the Netherlands, prevalence stands at 20%, meaning 80% of the adult population in those countries is not using cannabis. This goes against the narrative from news outlets, which contributes toward the normalisation of cannabis use, which in turn influences attitudes about drug use and can in fact stimulate additional demand.

Describing Europe as a significant market for global cocaine production, Mr. Cunningham explained that the UNODC estimates there was a total global production of 1,400 tons of cocaine in 2021. Of that, 160 tons were consumed in Europe, while another 300 tons were seized by law enforcement, meaning almost 500 tons of the global cocaine production output, or more than one-third of global cocaine production, was destined for the European drug market. Explaining the involvement of organised crime in the international drug trade, Mr. Cunningham pointed to Europol's Serious and Organised Crime Threat Assessment (SOCTA), which describes the corrupting influence of organised crime on Europe's economy and society. The drugs trade dominates organised crime in the EU in terms of the number of criminals and criminal networks involved as well as the vast criminal profits generated. Much of the violence committed by serious organised crime across Europe is related to the trade in drugs.

People choose to get involved in the drug trade because they see it as a way to earn a living, and don't tend to be concerned about the negative impacts of their activity on the health of users, the extreme violence and intimidation of communities, the impoverishment of farmers and communities in countries like Bolivia or Afghanistan, or the devastating environmental impact of Coca production in Colombia. Like all people involved in any supply chain, drug dealers are in it to make as much money as possible.

Supply reduction is not a simple matter. There are big stakes for those involved, and no easy solutions. The example of what's currently happening in Afghanistan is illustrative of the complexities. The Taliban have banned the cultivation of opium poppies, so its farmers are facing a humanitarian crisis because their income has been cut off, which is leading to forced migration.

Concluding his presentation, Mr. Cunningham argued that, if drugs were made legal, the criminals involved in the drug trade wouldn't just say 'oh well, that was good while it lasted, I think I'll go off and train as a plumber or an electrician or run away to join the circus'. The flow of illicit cannabis has not stopped in the U.S or Canada. One of the stated aims of proponents of cannabis legalisation, the idea that regulating the market will take the money out of the hands of organised crime, is not such an easy task, and to think it could be described either as disingenuous, or naïve.

4.2.3 DCS Seamus Boland: *A national perspective on supply reduction*

DCS Boland, Detective Chief Superintendent with the Garda National Drugs and Organised Crime Bureau (NDOCB), provided a national-level perspective on supply reduction and the role of Irish and international drug trafficking gangs.

The NDOCB mission is to disrupt, dismantle and prosecute organised crime networks involved in serious criminal activity at national level, focusing on drug trafficking, firearms offences, violence and intimidation, including murder, and associated money laundering. NDOCB's approach focuses on disrupting drug trafficking networks, with intelligence-led operations targeted towards high-value members of criminal organisations, including decision makers, facilitators, supply routes, wholesalers, enforcers and money launderers.

Organised crime groups in Ireland are well-established, structured and linked to the global drug trade network. At present, the NDOCB is involved in 20 national priority operations targeting identified criminal networks, all of which have a nexus with significant international drug trafficking. Irish criminals are involved in the drugs trade all across Europe, Central and South America, Asia and the Middle East, and have been responsible for the supply of cocaine as far away as Australia and New Zealand.

Ireland is not only a destination country but also a strategic transit country for illicit drugs destined for the UK and EU markets. Vast sums of money are involved. The NDOCB estimates the annual turnovers for certain Irish organised crime groups to be between €10 million and €24 million. This cash flows to money laundering operations and also pays for the enforcers who commit the violent acts on behalf of the networks. Criminal networks create underground economies, cause economic dependency, undermine local communities and perpetuate the presence of criminal structures.

The UNODC World Drug Reports show the evolving nature of drug trafficking, in particular how synthetic drugs are reshaping drug markets, with lethal results. The report identifies that public health prevention and access to treatment services must be prioritized worldwide, and underscores the need for law enforcement responses to keep pace with agile criminal business models and the proliferation of cheap synthetic drugs that are easy to bring to market.

DCS Boland explained that drug traffickers and cartels are well prepared for all eventualities. Criminal organisations have no intention of allowing their profits decrease and are continuously making and adjusting plans to increase consumption and ensure profit increase. The business model ensures that new products are continuously being introduced to the market, such as cannabis edibles, vapes and nitrous oxide, all of which target younger people with the intention of creating the next generation of consumers.

The GNDOCB is satisfied that Irish criminal networks have been considering the supply of fentanyl into the Irish Market, a very concerning development as fentanyl poses a significant risk not just to opioid users but to all drugs consumers. Synthetic opioids such as fentanyl can be mixed with other drugs to increase addiction levels, thereby increasing the customer base leading to greater profits and bigger drug debts.

Irish criminal groups have also discussed the opportunities flowing from the legislation of cannabis in certain jurisdictions. They had discussed plans to invest 30 million euro into the global legal cannabis industry, which would facilitate money laundering and ensure they continue to generate vast incomes even in situations where cannabis would become legal. They have formulated plans to ensure the illegal drugs industry will be maintained irrespective of any moves towards legalisation and market regulation by the State. The strategy of criminal organisations is all about increasing profit by increasing the customer base and consumption, whether the consumption involves legal or illegal supply. The legalisation of cannabis in Canada and parts of the US has now become an issue for law enforcement in Europe, where product legally purchased in those jurisdictions is illegally imported into Ireland and other jurisdictions for sale by criminal organisations.

4.2.4 Dr Sean Redmond: *A criminological perspective on youth crime and interventions*

Dr Redmond, Adjunct Professor in Youth Justice at University of Limerick School of Law, presented a criminological perspective on children's involvement in crime networks in Ireland, and the efficacy of alternative policy responses. There are roughly 500,000 young people aged between 12 and 18 in the State, an estimated 12,000 to 20,000 of whom are detected for crime every year. There is very strong data showing that, without any intervention, the majority of these young people will grow out of crime by the time they reach their late teens or early twenties. Researchers are not entirely sure how and why young people grow out of crime, but reasons could include neurological and personal maturation. The policy implication is that the State should take a light touch with these young people, which doesn't mean that we don't hold young people accountable for their behaviour.

Of more significant concern from a policy perspective is the fact that there are about 1,000 young people in the State involved in much more serious crime. This small cohort is estimated to be responsible for about 50% of all juvenile crime. These young people are likely to commit crimes in conjunction with adults as part of neighbourhood-based criminal networks and will often be involved at the retail end of illicit drug sales in local neighbourhoods. Research conducted by Dr Redmond and colleagues in 'Whitetown' and 'Yellowtown', two anonymised urban locations in Ireland, maps children's involvement in criminal networks to help build a better understanding of what entices children into these criminal networks, and what keeps them there. The criminal networks are often built on complex kinship relationships between family members and associates. The networks are very often exploitative, with young people enticed, groomed, and in many cases coerced into, committing crime.

One example showed how the leader of a criminal network in Greentown operated a money lending operation which generated obligation relationships, with middle ranking members of the network carrying out debt enforcement, while the wider community held an almost reverential view of the leader of the criminal gang.

A second example showed an associate member of the gang, who had very chaotic family circumstances, poor relationships with the authorities and was involved in crime from an early age. He grooms children from the neighbourhood into the criminal network, helping sustain network activity at the local level.

Examining the composition and dynamics of these networks helps to build a picture of the multiple layers of adversity bearing down on the children who are captured into this toxicity. Recognising that the young person's involvement in this type of organised crime is hardly a choice, punishing them on the assumption that they have a free reign to act pro-socially or anti-socially is both unfair and ineffective. There are arguments that prevention in the early years and anti-poverty measures can be much more impactful in reducing the chances of these situations happening.

The Department of Justice is funding a trial programme with four distinct interventions delivered simultaneously into Whitetown and Yellowtown. The first intervention is an intensive family programme which identifies and engages the 20 to 30 young people most embedded in a crime network in the local area. The second is a pro-social opportunities programme which identifies individual pathways for each young person away from crime. The third is a community efficacy pillar which cultivates activity in the community to reclaim power, and the fourth is a network disruption pillar which identifies the groomers and disrupts their grooming behaviour. The programme is still in development, but even at this early stage is yielding promising results.

4.2.5 Ms. Siobhán Maher: *A perspective on community issues and responses*

Ms. Maher, Coordinator of the DRIVE (Drug Related Intimidation & Violence Engagement) initiative with the North Dublin Regional Drug and Alcohol Task Force, explained how drug related intimidation is manifesting itself across the country and the different ways that family members are being impacted.

Ms. Maher gave a few topical examples, including a young mother living in the midlands whose family has been intimidated because her daughter has built up a €20,000 drug debt and dealers are coming to her home threatening to cut her throat; or the case of a young father whose teenage son has a €15,000 drug debt, who has been told that if he doesn't pay the drug debt that he has to leave the country for Spain. She described how young people in towns and villages across the country are being coerced and lured into minding drugs and storing firearms.

The DRIVE project is a national inter agency project to counter for drug related intimidation and violence. It is built on the premise that stakeholders and agencies need to work in collaboration to respond effectively to drug-related intimidation and violence throughout the country. There are six pillars to DRIVE, including capacity building and

awareness; data collection and analysis; information sharing; community involvement in law enforcement; legislation; and systemic change.

Ms. Maher outlined the governance and implementation structures for DRIVE, and how it engages with the Drug and Alcohol Task Forces around the country through Liaison officers, who form a network that supports roll-out and shared learning. Each area also has a DRIVE interagency group consisting of all relevant stakeholders in the local area. Training is provided to all participating Drug and Alcohol Task Forces and delivery partners, including on the Drug Related Intimidation Reporting Programme, Trauma-informed care, risk management and referral options. Training is aimed at any service that comes into contact with people who may be experiencing drug-related intimidation and violence, from Gardaí to sports clubs to credit unions.

Concluding her presentation, Ms. Maher explained that DRIVE is being funded on a one-year basis, and called for long-term funding on a national basis.

4.2.6 Questions & Answers session

Responding to a follow-up question about the Portuguese approach, Mr. O'Sullivan offered the view that the Irish have a tendency to 'knock everything about ourselves.' However, we have been responding well to drug issues for decades, since the introduction of the 1977 Misuse of Drugs Act. We have long recognised that the way to deal with heroin addicts is to get them treatment. Like it or not, the Courts have a key role in diverting people with chaotic lives into drug treatment. He knows many drug counsellors today who would admit they would never have come off drugs except for the intervention of the court. He contrasted the Portuguese situation with Ireland, describing criminals in Portugal as being 'in the ha'penny place compared to Irish criminals … we're dealing here with criminal lunatics, at times…' While the Portuguese model has brought down the number of heroin addicts, so too has the Irish model. The Irish system works but needs more funding for treatment and rehabilitation services.

The system can only be as good as the funding that's put into it.

DCS Boland added that it was important to bear in mind that, under the Portuguese model, drugs are still illegal, and that he's not aware of any other jurisdiction that has introduced the Portuguese model. Even though cigarettes are sold legally in regulated markets, there is still a booming multi-billion Euro illegal cigarette industry that impacts Ireland, and that he is of the opinion that criminality will still exist even if drugs were legalised.

Mr. O' Sullivan recalled how Ireland had a serious problem between 2007 and 2010 with new psychoactive substances being sold by Head Shops. Young people getting 'legal highs' were having serious effects such as nervous breakdowns and various other life-changing effects. Initially, the State placed people outside Headshops to persuade them not to consume these substances. However, the young people had the attitude that 'because it's legal, it can't be that harmful.' After two and a half years, the law was changed, new psychoactive substances were made illegal, and people stopped using them.

The panel responded to a question about what, above and beyond extra funding, was needed to improve the State's response to drugs.

Ms. Maher emphasised the importance of agencies and communities working in partnership and collaboration together.

Dr Redmond described the Citizens' Assembly as a valuable way to deal with a 'wicked problem', or a complex and regressive problem where it's difficult to separate science from values. For example, scientists can be as conflicted as anyone else on a question like decriminalisation, and one can find studies supporting every position in relation to this question. Forums like a Citizens' Assembly are important in allowing finding a balance between value-based and science-based perspectives.

DCS Boland emphasised that supply reduction is not simply a law enforcement problem, and that the drug problem is fundamentally driven by consumption. It's a global issue, and Ireland cannot deal with it in isolation. At international, national and local level, it requires partnerships and working together.

Mr. Cunningham agreed drug use is a 'wicked problem' that has no silver bullets or easy solutions. Drug policies are geared both towards reducing supply and reducing demand, and Europe doesn't have a 'War on Drugs'. Law enforcement is there to try and stem supply, but supply is always going to be there as long as demand is there. The real gain is to be found in reducing demand by investing in good prevention programs.

The panel responded to a question about whether there are too many community and voluntary organisations and whether one over-arching body could enhance governance and implementation. Ms. Maher explained that the 24 Drug and Alcohol Task Forces each serve to coordinate statutory and community services within their catchment areas and work together through their networks. Dr Redmond highlighted the risk that, when things are brought together under one roof that sometimes things can get overlooked, and that requires compensatory responses. While there can be many commonalities across a country, each community can have idiosyncratic, distinctive features of their own, so you need both an overarching mission but also the capacity to respond flexibly at local level.

Responding to a question about the merits of civil versus criminal approaches to sanctions, Mr. O'Sullivan explained that Ireland's criminal justice system isn't ruthless, it's humane and compassionate and has a number of checks and balances before anybody ends up in court, such as the Adult Caution Scheme and the Juvenile Diversion Scheme. He argued that the existence of criminal sanctions is an important deterrence and helps explain why the vast majority of the public does not use drugs. Drugs were made illegal in the first place because they are dangerous, and they haven't become any less dangerous over time. Criminal sanctions, or the threat of them, has worked well in countless cases.

Dr Redmond reiterated that it is the 1,000 or so young people engaged in serious criminality that he is concerned about. Punishing these young people is neither fair nor effective. The best way to deal with the issue is to engage young people, get them involved in 'doing more good stuff than bad stuff', and protect them from malign influences. DCS Boland reiterated the viewpoint that Ireland's criminal justice response already has opportunities for diversion, including the Adult Caution for cannabis, which will be expanded to other drugs, as well as the Drugs Treatment Court and the planned Health Diversion programme. He argued that making drugs legal will only lead to a much larger consumer base that will, in turn, lead to greater problems.

Responding to a question about whether cash and assets seized by the Gardaí and CAB can be redirected back into addiction services, DCS Boland explained that the cash and assets seized are sent to the central Exchequer fund, but a portion of that funding is routed back into the Department of Justice. While the Garda NDOCB has seized significant amounts of cash, more is also seized by CAB, Revenue and Customs.

Ms. Maher explained that DRIVE has nominated inspectors in every Drug and Alcohol Task force area. Depending on the needs of the family, the Task Forces can offer family support, counselling and youth counselling.

Concluding the panel discussion, DCS Boland explained that the criminal justice and health sectors are broadly aligned with the same strategic response to drugs, and the challenge facing them is to tackle drug consumption, with public health messaging needing to be improved.

4.2.7 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Increased education and prevention efforts in schools. Provide role models and people with lived experience to spread awareness
- Legal approach is not working, a health-led approach is needed
- A health-led approach needs to be better resourced
- The biggest problem is the disjointed approach
- All presentations were very large scale and some said things were working well. If drug laws were working, we'd be in a different position
- Lack of funding for rehabilitation services
- Fear of courts doesn't always deter people from taking drugs

4.3 Session 2 – Courts

4.3.1 Judge Ann Ryan: *Therapeutic Jurisprudence.*

Judge Ryan outlined her experience as a judge in the Dublin Metropolitan District Court and the Special Criminal Court. Until her retirement in 2021, Judge Ryan had, for many years, been the lead judge in the Dublin Drug Treatment Court (DTC), which runs an innovative programme for people affected by substance misuse.

The DTC operates under the principles of Therapeutic Jurisprudence (TJ), whereby the court offers socially just and compassionate responses in order to motivate offenders to accept treatment and rehabilitation. It is a holistic approach based on a non-adversarial relationship between the Court and the offender.

The DTC was originally set up to provide an alternative to custodial sentences for convicted offenders with underlying problematic drug use. It has no statutory footing and has operated on a pilot basis for 22 years. The Court is led by Judge Patricia McNamara and is supported by a dedicated team involving personnel from the Courts Service, Probation Service, HSE and City of Dublin Education and Training Board. Participants are referred by the Criminal Courts within the Dublin Metropolitan District, having either already pleaded guilty, or having been found guilty at trial.

Most participants are dealing with complex challenges: they may be homeless, have very little education, come from disadvantaged backgrounds, have huge health and mental health problems, and perhaps have little or no family support. In the DTC they find a safe place to go, where they are treated with compassion and respect. The DTC's Education Centre offers participants a warm welcome and breakfast each morning, and during the course of the programme each individual's needs are dealt with. The Court monitors compliance and applies sanctions and rewards to incentivise progression. Every person is treated with dignity and respect, given a voice and an opportunity to be involved. The transformation is incredible, with participants regaining their self-worth, dignity and pride in themselves, and restoring their family relationships.

The DTC has been criticised by some, and in Judge Ryan's view rightly so. So, few people can avail of the programme, and many more could if it were properly resourced. While many politicians have visited the court and promised support, nothing has materialised.

Endorsing a call previously made by Prof. Ivers for the State to build systemic recovery capital, Judge Ryan likened the current approach to 'putting a sticking plaster on a broken leg'. She emphasised that addiction cannot be treated in isolation and called for health-led responses to be implemented in conjunction with responses to other needs, whether that be housing, education, employment or mental health issues. There needs to be a cross-sectoral response, with departments like Health, Justice, Finance, Education and Housing working with the Gardaí, Probation and the Courts to provide the recovery capital.

Judge Ryan explained that some of her colleagues in other District Courts around the country also have therapeutic jurisprudence initiatives for drug offenders and she referenced Judge Olann Kelleher in the Cork District Court (Judge Kelleher presented to the Assembly in Meeting #5). There are several other judges around the country trying to do something on their own, but this ad-hoc approach is not sustainable, and successful innovations need to be extended around the country on a national basis. Judges have no training in relation to addiction and therapeutic jurisprudence, which should be part of every judge's training.

Concluding her remarks, Judge Ryan said that therapeutic jurisprudence has a huge value to society but is only one part of a wider response to a complex issue that needs a multi-disciplinary approach.

4.3.2 Ms. Maeve Foley and Ms. Fiona Carolan: *The Drugs Treatment Court.*

Ms. Foley, Courts Service and Ms. Carolan, City of Dublin Education and Training Board presented a case study of the Dublin Drugs Treatment Court (DTC).

Ms. Foley explained the role and operation of the DTC from the perspective of the Courts Service. The DTC supports a cohort of offenders who find themselves within the criminal justice system dealing with charges other than simple drug possession charges. The DTC is an example of how the existing legal framework can effectively provide for people who are in front of the courts and presenting with an obvious underlying drug-related problem.

The DTC offers a supervised treatment programme as an alternative to custodial sentences. The DTC involves a unique multi-disciplinary team made up of staff from various agencies including the HSE, An Garda Síochána, Probation Service, City of Dublin Education Training Board, the Courts Service and the judiciary. This multi-disciplinary team meets on a weekly basis to discuss the case management of each participant and to review how participants are progressing.

Before being admitted, candidates for the DTC programme must show that they are prepared to become drug-free, other than medically-prescribed drugs, and to make positive changes to their lives. Once the participant is assessed as suitable, they sign up to a treatment plan and enter the first of a three-phase programme. The aim is for each participant to reduce or eliminate their drug use, improve their overall health, attend counselling, participate in education and/or training, perhaps resolve their housing situation, and engage with community-based support services.

The first phase, Bronze, aims to stop the use of the most harmful drugs and to begin to take part in agreed training or education programme. The second phase, Silver, focuses on continuing to reduce the use of those non-prescribed habits and with the aim of stopping drug use and continuing with education and training. The aim of phase three, Gold, is to remain free of all illegal drugs and start to create a postgraduate Life Plan.

The programme is supportive and compassionate, and takes account of participants' complex personal circumstances. A point system operates throughout, whereby participants receive plus or minus points across all aspects of engagement. Those who earn sufficient points receive gift vouchers, while those who reach a certain lower threshold face the prospect of bail revocation or being discharged from the programme.

Participants learn to trust the Court and take responsibility for their actions. The judge plays a big role in empower participants to use their own voice and to be heard in Court. Participants can derive significant benefits from finding themselves within a supportive, trauma-informed criminal justice system that's willing to understand where the person is coming from and not just see the person as an offender. The DTC could not succeed were it not for the partnership between the agencies and services. No single entity can solve the complex needs of a person's problematic drug use, it requires a partnership of multiple parties working together to ensure people with problematic drug use get meaningful opportunities to stay out of prison and receive the interventions they need, and to remain living in their communities and with their families, rather than being separated and going to prison.

The programme is of direct benefit also to families and wider communities. When participants engage with the DTC they're committing fewer criminal offences, which has a knock-on effect for victims of crime and for the burden on the prison system, thereby creating substantial savings to the State.

Ms. Carolan continued the case study of the DTC by describing the educational component of the Drug Treatment Court programme. The education component is provided by the City of Dublin ETB's Adult Education service. The education elements of the programme are wrapped around the individual's recovery pathway and personal progression plan.

Each participant receives an assessment of their educational and training needs that empowers them to devise their own pathway through recovery, moving from the extrinsic motivation of the court system to intrinsic motivation. All subjects are accredited to QQI level two, three and four. The Education Centre also provides participants with addiction awareness, guidance counselling, peer support and self-care. Many students require additional supports to help them develop basic literacy and numeracy skills. Students discover a drive and self-belief in their capacity to learn, some discover a talent for art, others may discover a commitment to self-care, health and fitness, many have progressed on to college, further education or apprenticeships, and have ended up working back in the community.

None of this could happen without a safe learning environment with a consistent relationship with the teaching staff, based on genuine respect, regard and empathy. Many addictions develop from maladaptive responses to trauma or pain, and that many students are experiencing life traumas, homelessness, poverty and adverse childhood experiences. All teachers are trauma aware and informed and continually upscale in their understanding of addiction. Teachers meet weekly to prepare a progress report for the judge in respect of each participant. The relationship between the students and the judge is very therapeutic and powerful and is often the first-time students may have had somebody held in very high regard witness the progress they make in their lives.

4.3.3 Ms. Paula Kearney: A lived experience perspective

Ms. Paula Kearney and Mr. Anthony Lee shared their experiences of the Dublin Drug Treatment Court (DTC).

Ms. Kearney explained that she had entered the DTC programme three times before finally graduating. She suggested that addiction doesn't belong in the criminal justice system, but that, in the absence of decriminalisation or legalisation, the DTC provides that alternative option that stops people from going into prison.

Having been to prison many times herself, Ms. Kearney expressed the view that prison doesn't support people to come out of addiction. The ready availability of drugs, and the fact that people in prison are dealing with trauma means that, if anything, prison just helps push people further and further into addiction.

As part of the DTC programme, Ms. Kearney attended the SAOL women's project, which provided her a safe space to deal with the trauma in her life. If she hadn't attended the Drug Courts at that time in her life, she wouldn't have been able to progress in life the way she has. Now, she is proud to call herself a master's graduate.

She offered the view that you 'cannot police addiction out of people.' If you work with people from a compassionate lens, it gives a different outreach approach and will have a different impact.

Recalling her experience in the DTC, she described how different it was to any of the other courts she had been in front of. She described how unusual an experience it was to have a judge show compassion and ask how you are. She was used to being stigmatised, shamed and put down. The DTC is great at giving people their voice and allowing them to explain what's going on in their lives. In other courts 'you're just locked up, the solicitor speaks on your behalf, and the judge doesn't even try to get to know you.'

Ms. Kearney called for societal change in terms of how people who use drugs are viewed. The media portrays drug use and the issues that come along with that without listening to the people who have actually experienced it, or the people who live in the communities destroyed by drugs.

'While drugs do destroy communities, drug policy destroys communities even more.'

Drug use is more prevalent than it's ever been, and cocaine use is found in all walks of life, but the current policy is only affecting communities negatively. Certain communities are heavily policed with stop and search happening extensively. There has to be more alternatives to prison, it destroys families and impacts in particular on mothers, who experience the greatest level of stigma and shame.

Concluding her presentation, Ms. Kearney urged the Citizens' Assembly to keep an open mind, recognise that the Drug Court and other services that already exist to offer alternatives to prison are not fully resourced, and actually people with lived and living experience to be part of that whole process.

4.3.4 Mr. Anthony Lee: A lived experience perspective

Mr. Lee, who now works as a peer support worker in the Drug Treatment Court Education Centre, introduced himself as one of the first graduates of the DTC. He described his experience before entering the DTC 20 years ago, outlining how he had been 'in the system' since age 14, when he was sent to a home in St Michael's for not attending school for three weeks. His trauma began when he was in the care home, and he progressed from there to St Patrick's Institution, and then to Mountjoy. He described how thinly stretched prison services were at that time, with no interventions available for people dealing with drug addiction or mental health issues.

Mr. Lee described how he used to appear frequently in front of the Bridewell courts, where he would be routinely sent back to prison. On one particular occasion, the judge offered him the option of attending the new Drug Treatment Court, as an alternative to going back to prison. He decided to try out the DTC, where he met Judge Horan. He explained how the judge got out of his chair and came down from the bench to have a conversation with him in the dock. He described the impact of experiencing, for the first time in his life, a person in authority asking him how he was and showing genuine compassion and empathy. Mr. Lee explained that, 20 years later, he continues to feel grateful for the way the judge dealt with him and considers the judge to be a personal friend.

Mr. Lee explained that the DTC Education Centre deals with a lot of people living in homelessness, and some of the personal stories of participants, especially the women, are horrific.

Explaining that, while the DTC is 'not perfect', it works as best it can, with limited resources, to support people through addiction and into recovery. A lot of people that have come through the programme are now themselves working in Addiction Services and doing their best to help people and meet them where they are at in their lives.

4.3.5 Questions and Answers session

Judge Ryan explained the referral pathways into the Drug Treatment Court. The DTC deals only with District Court charges, so offences of a more violent nature and other cases dealt with by the higher courts are not currently referred to the DTC. This is something that could be considered in the future. She explained that a person appearing in the District Court, irrespective of the nature of the charge, will be eligible for referral to the DTC if the judge forms the view that the person has underlying drug problems. The DTC is currently only available to judges of the 12 criminal courts in the Dublin Metropolitan District, but Judge Ryan expressed the view that 90% of judges around the country would like to be able to do something similar. She reminded the Citizens' Assembly that the DTC is not an easy programme, and is not suitable for everyone, but it does work for some people.

Several panellists responded to a question about the relative cost of the DTC education programme versus sending someone to prison, and the success rate of the programme. Ms. Foley of the Courts Service explained that many of the costs are embedded within existing services and are not easily separated out. There has been a total of 98 graduates to date, but this figure does not adequately capture the full success of the programme. Many people who do not graduate still have so many accomplishments to show and are awarded certificates along the way to acknowledge their achievements. For many, this could be the first time in their lives that they've been acknowledged for the positive steps they've taken in their own life.

Ms. Kearney added that the people who've been through the programme have gone through it at a time in their lives when they would otherwise have been sent to prison, where they would have lost access to their children, where they would have faced an uphill battle after prison to regain their lives and get back their responsibilities. Alternatives to prison are not just about keeping people out of prison, but about keeping families together. Even if some people on the DTC programme don't make it all the way through to graduation, their participation is keeping them stable for that period of time, which in itself is a success. There can be too much emphasis on numbers graduating, but sometimes recovery and success means people making positive changes in their lives and doesn't always equate to getting drug-free.

Judge Ryan explained that judges don't receive any training in therapeutic jurisprudence or trauma-informed justice. Judges are effectively operating 'on a wing and a prayer' and expected to learn as they go along in the job. She felt that therapeutic jurisprudence should be part of every judge's training. The approach won't suit everyone, and some judges would never want to run the Drug Treatment Court as it isn't their way of doing things. As a judge in the DTC, you're operating as part of a team, working in a non-adversarial way with the participants, developing relationships and friendships.

It's not a 'them-and-us' scenario, everyone is working towards the same goal.

Many judges around the country would love to have a DTC referral option, and she suggested that one approach would be to encourage judges to innovate and experiment, discover what works, and replicate it more widely. Different geographic areas will have different drug-related problems and demographic profiles, meaning each judge and their teams will need to respond differently. Mr. Lee explained that there were 7 or 8 people working in the Dublin DTC Education Centre. He said he would like to see the model rolled out on a nationwide basis. The participants on the DTC programme are vulnerable and come from very disadvantaged backgrounds. Many are sleeping in tents, don't have access to medical or dental care. Even if some participants don't graduate, getting half-way through the DTC programme to the stage that they become stable on their methadone treatment and stop committing criminal acts is a success.

Judge Ryan described how, as a judge, she would respond to somebody with a drug habit who appeared in front of her on a burglary charge. She explained that there are multiple factors that need to be taken into consideration. Even when someone pleads guilty, she would tend to seek a report from the Probation Service to get more insight into the person before sentencing them. Every crime, whether it be against a person, a community or a business, has a victim, and that victim's voice must be taken into consideration. She explained that restorative justice is a huge part of how judges work, and it empowers victims and helps judges determine the most appropriate sentence. There are other ways and means of dealing with sentencing, but more than likely in the District Court the last resort is to send somebody to prison. The short maximum sentences for offences seen by the District Court, and the fact that offenders will only likely serve one third of a prison sentence handed down means that somebody is often just 'in and

out' of prison, and it does nothing. In a case where the victim has been badly traumatized, and where the offender shows no remorse or has lots of previous convictions, regardless of whether or not there's an underlying addiction, the right answer might be to send that person to prison, but that is the last resort.

The panel responded to a question about whether Ireland should decriminalise or legalise drugs. Ms. Kearney offered the view that people who use drugs should never be criminalised, that decriminalisation doesn't go far enough, and that as long as structural inequality and structural violence isn't dealt with, Ireland is always going to have a huge drugs issue. Ms. Kearney advocated for a regulated model that ensures people can use drugs in a safe manner, which saves lives. She referenced countries like Germany that have heroin assisted treatments that have great success rates, with higher retention levels higher than methadone clinics. She argued that, if you provide safe drugs, you're also taking young people away from the criminal activity that they are groomed into. While she personally thinks the only way to deal with the drugs issue is to introduce a regulation model, decriminalisation would be a first step. She argued that there's no point in regulating drugs without introducing a Spend Convictions bill for people who are being groomed into gangs in predominantly walking class, poor communities. There needs to be policies put in place because a lot of young people in these communities who use drugs already have convictions.

4.3.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Drug Treatment Courts should be implemented nationwide on a statutory footing
- The Drug Treatment Court shows that leading with compassion instead of authority works well
- Judges in all court systems should have continuous professional development and training around drug issues
- Need a holistic and compassionate approach to drug use

4.4 Session 3 – Prisons

4.4.1 Ms. Caron McCaffrey, *Irish Prison Service*

Ms. McCaffrey, Director General of the Irish Prison Service, described the significant challenges that drug use and addiction creates for the Prison Service. Over 70% of people in custody are experiencing addiction to some form of substance. The Prison Service understands addiction as part of a person's overall mental health status, and recognises that a person's addiction has been their survival mechanism and coping strategy. While society often views addiction as either a problem to be treated by medical professions or as a legal issue to be dealt with by the criminal justice system, these discussions often fail to the address the fundamental question of why a person turns to substances to cope with what has happened to them in life. Understanding the 'why' behind addiction requires services to be developed in a way that treats each person as an individual, considering their addiction within the context of their entire life experience.

Ms. McCaffrey explained that the Irish Prison Service has identified emotion dysregulation as a prevalent factor in the development of difficulties later in life, including addiction. The regulation of emotions is a skill we learn as children, but, for some, these skills were not taught or were hindered by adverse childhood experiences such as complex trauma or poly-victimisation. Almost all clinical risk assessments completed by its prison-based psychologists have identified emotion dysregulation as a fundamental part of a person's offending history, and it is particularly associated with violent crime early in life, when overwhelming and confusing emotions cannot be managed. For people struggling with emotion regulation, the use of substances becomes a powerful regulatory strategy, numbing intolerable feelings of fear, shame, anger, guilt or uncertainty. Understanding the role of emotional dysregulation is crucial in developing comprehensive and effective supports for people who are struggling with addiction.

People who experience four or more adverse childhood experiences (ACEs) are 15 times more likely to be a perpetrator of violence in the last 12 months, and 20 times more likely to have been incarcerated in their life. The average school-leaving age of those currently in custody today in Ireland is 14 years of age, highlighting the importance of early intervention. In many cases where children have suffered significant adverse childhood instances, or where their parents have their own addiction or mental health issues, children's ability to engage with the formal education system is impaired. Where a child falls out of the education system, they are much more vulnerable to offending behaviour.

Drug addiction reaches alarming proportions within the prison system, with at least 70% of people in prison having addiction issues. People's drug addictions do not stop at the prison gate, and they will use every method available to access illicit drugs. While the Prison Service is very committed to strengthening measures around drug treatment, drug-free prisons will only be achievable when we have a drug-free society.

Of the 4,162 sentences handed down by the courts in 2022, 78% were for sentences of 12 months or less, and the majority of those offenders were in the throes of active addiction. Research has shown that rehabilitation requires time, consistency and an holistic approach. Longer sentences allow for the implementation of evidence-based rehabilitation programmes that address the root causes of addiction, provide education and vocational training, and offer support for mental health issues. However, the fact that such a large proportion of the prison population is serving shorter sentences of less than 12 months hinders the ability of the Prison Service staff to implement effective rehabilitation.

The recently-published Review of Policy Options for Prison and Penal Reform 2022-2024 contains proposals to help strengthen the options available to judges when they are considering cases, to facilitate the effective and efficient use of community sanctions by the courts, and to ensure the courts have a wider range of appropriate options for dealing people who've committed minor offences.

Ms. McCaffrey quoted James Leonard, joint host of the 'Two Norries' podcast recently, who recently explained how a prison sentence assisted him in achieving recovery:

'When somebody in the throes of addiction is in custody, it is often the only time they will receive adequate health care. When someone is in addiction, they neglect their health, they avoid addressing issues out of shame. When someone is in custody they have access to free dental care, GP, psychology, nursing, and psychiatry, if needed. They would never get this integrated care in the community.'

Ms. McCaffrey cited a study done in UCC by Graham Cambridge, who argued that crime is a by-produced of addiction and found that desistance always followed recovery. Concluding her presentation, she emphasised that the best way to reduce crime is to address addiction in an holistic way. The issue of drugs cannot be solved by a single entity and certainly not by the Prison Service. Punishment for drug addiction does not make sense when we understand it as a coping strategy in the context of trauma. We need to find an holistic, community-based structure which can meet the individual needs of a person without them having to come into contact with the criminal justice system.

4.4.2 Mr. Fergal Black: *Irish Prison Service*

Mr. Black, Director of Care and Rehabilitation with the Irish Prison Service, described the addiction services available to people in prison. He opened his presentation by observing that the vast majority of prisoners return to their communities, and that a key objective of criminal justice agencies is to make communities safer and, ultimately, have less victims. The prison system has a key role in helping prisoners to change their lives for the better and help break the cycle of reoffending. There's a popular myth in some quarters that prison should be about breaking people down, but the view of the Irish Prison Service is that it should endeavour to empower people and build them up, giving people in custody the best possible opportunity to reintegrate themselves into society and putting them back on the road to being a good citizen.

At the same time, it also needs to help people in prison understand that their actions hurt people and trample on people's rights. The most effective intervention with someone in prison is the relationship they have with staff. Good relationships require that people are treated with dignity and respect. The relationship is an instrument to take an offender into a space where they begin to own some of their behaviours and take responsibility.

Prison provides a unique opportunity for someone to address their addiction, that is, if they are in prison long enough to access the services.

The Irish Prison Service is currently finalising its new drugs strategy, which seeks to reaffirm the work already underway and enhance other methods to tackle the problem of drug use and demand. The strategy sets out

ambitious goals under three pillars to address the issues of drugs in prison: inform and educate; detect and reduce; and support and treat.

The primary objective of the Irish Prison Service is to ensure the provision of healthcare to prisoners at a standard consistent with what applies in the general community. Addiction programmes in prisons seek to reduce the demand for drugs through education, treatment and rehabilitation services for prisoners suffering from addiction. Services include the provision of detoxification, methadone maintenance, education programmes, addiction counselling and drug therapy programs. Through-care, ensuring people receive continuity of care following release, is a really important element. The Prison Service, in collaboration with HSE addiction services, make every effort to ensure that prisoners engaged in treatment programmes within the prison system are linked back to community addiction services on their release. Prisoners face increased risks from overdose in the first weeks after release, with risk of death from overdose as much as 12 times higher than the general population. Plans to provide intranasal naloxone on release to people with a history of opioid use may prevent fatalities in the event of an overdose.

The Prison Service has reinvigorated and recommenced its Treatment and Recovery Programme, previously known as the Drug Treatment programme in Mountjoy, which had been suspended during the pandemic. The objective of this nine-week programme is to support individuals in recovery to live a fulfilling substance-free life and to facilitate a successful reintegration back into society. Merchants Quay Ireland is contracted to provide an essential addiction counselling service to prisoners, with funding support from HSE Social Inclusion.

Concluding his remarks, Mr. Black reiterated that prisons are a very important component of the State's overall response to drug problems in Irish society. There's often a lack of recognition of the scale of activity within prisons. To illustrate the point, there are currently 650 patients with active methadone prescriptions in custody today. Almost 50% of women incarcerated in Dóchas today are on methadone substitution therapy. Of the 11,600 people in receipt of methadone, one in six will end up in custody in any given year. These are particular challenges for the Irish Prison Service, which has recently commissioned, with the Department of Health, a health needs assessment. Finally, the Prison Service needs to improve the level of collaboration with HSE addiction services providing specialist services to prisons.

4.4.3 Ms. Sheila Connolly: The Cork Alliance Centre

Ms. Connolly, CEO, outlined the work of the Cork Alliance Centre. The Centre was established 21 years ago with the support of the Prison Service and Probation Service to tackle the issues of recidivism and the revolving door phenomenon, recognising that people being released from prison, particularly those in active addiction or in recovery, need post-release supports.

The Cork Alliance Centre supports people into recovery. It views its clients as more than the sum of their convictions and addictions. They are somebody's son, father, daughter, mother or sister. Unfortunately, addiction breaks those connections and relationships, and causes a disconnect from self, from family and from community. When a person doesn't feel wanted or loved, they can turn to drink or drugs for comfort. When someone from a socially disadvantaged area develops a drug dependency, and doesn't have resources or social capital, crime can become a means of supporting their addiction.

Prison is a huge interruption and disruption in people's lives, bringing multiple challenges to children and families. It can exacerbate housing and homelessness issues, and can exacerbate addiction. However, sometimes prison can also save lives. It can enable things to stop, because it's a safe space. However, to stop the revolving door phenomenon it requires that the person exiting prison has an adequate support system in place. Otherwise they face a heightened risk of relapse and recidivism, and ending back in prison.

The Cork Alliance Centre provides a community-based one-stop shop that offers continuity of care for people following their release from prison. It ensures people receive the links into addiction services, therapy and provides people with a consistent support and somebody walking with them shoulder to shoulder. When people get support in when you're doing this in a respectful and trusting space, change can happen.

In conjunction with the Probation Service and Prison Service, Cork Alliance has piloted a Community Sentence Support Scheme, where people who are given sentences of less than 18 months can serve that sentence in the community with the Cork Alliance. They put a personal plan together, which identifies what supports they need, what accommodation they need, and so on. People who finish their community sentences often stay on longer with the Cork Alliance and continue to receive therapy and treatment. The trauma that is in people's lives is not something that can be solved in a three-month treatment programme, it can take years of work to deal with the trauma and heartbreak and brokenness.

4.4.4 Mr. Keith Purcell: *A lived experience perspective*

Mr. Purcell, who today is in recovery and works in drugs services, described his experience of addiction and the criminal justice system. As a child, he kept getting into trouble both at school and at home. He left school at an early age, ran away from home, started using substances, and ended up in prison from the age of 16.

He described how prison was a safe place for him, and indeed saved his life. When he was in prison he was never in trouble, his life was manageable, and he always made the right choices. When he came out of prison, his life was unmanageable, he had no support or direction and quickly went back drinking.

Eventually, he was introduced to Cork Alliance. Usually on release he was homeless, living on the streets, and believed his family was better off without him, but this time, under the Community Support Scheme (CSS), the Cork Alliance helped him rebuild his relationship with himself, his children and family. It supported him going through college, and effectively saved his life.

4.4.5 Mr. Brian O'Sullivan: *A lived experience perspective*

Mr. O'Sullivan explained that he had developed an addiction to a range of substances including cannabis, benzos, alcohol, cocaine, heroin and crack cocaine. He described how he was constantly getting into trouble because of his addiction and was in and out of prison for small sentences trying to feed his drug habit. He explained that he just could not come off drugs, it was so hard in the circumstances. Every time he got released from prison, often with just an hour's notice, he never knew where to go and generally ended up going to the homeless services.

Eventually, he was introduced to Cork Alliance while in prison, and qualified for the Community Support Scheme. Cork Alliance became the first port of call when he was released from prison and provided him with a support system. It helped him access the MQI St. Frances' Farm treatment centre in Co. Carlow, and since going through that programme he has been in sustained recovery. He now works as a recovery support worker in Cork and does a lot of work with Cork Alliance.

4.4.6 Mr. Gary O'Heaire: *A lived experience perspective*

Gary O'Heaire described his experience of addiction and the criminal justice system. He introduced himself by explaining that he is now 16 years in recovery, drug and alcohol free, and works as the Chief Operating Officer for Tiglin, an organisation that supports people in recovery from addiction.

Mr. O'Heaire outlined how, at the age of 16 he started to drink and smoke cannabis, and before long started to take other drugs like LSD, ecstasy and speed. A lot of his friends were using heroin, so he never considered himself as having an addiction issue, but later, in his 20s, he developed a habit where he was using a minimum of €500 worth of cocaine per day. He went into a really bad place, his body started to shut down, and he was going for days on end without eating. He lost his job and started to turn to crime to feed his habit. He used to get large amounts of cocaine from drug dealers, and on one occasion got into serious debt for over €20,000. In 2007 he was charged for two criminal offences and his solicitor told him to expect a prison sentence. Looking back now, he realises facing a prison sentence was the catalyst for him to decide to do something. He went into residential treatment, got a loan from a family member and cleared his drug debts. By the time it came to be sentenced he was off all drugs for a year. The judge recognised that he had done a lot of work on himself, and instead of a nine-year prison sentence was given two years.

In prison, he was transferred to the Training Unit, which was a drug-free unit, and began to study social studies with the Open University. After serving 11 months he was released on a two- or three-year probationary period. The prison linked him to a service called Pathways, where he continued with his education. He received aftercare housing, which helped take him out of the environment that he'd been in before prison. A year later he completed a Diploma in Addiction Studies, then a degree, then a HDip in Social Care and, this year, will graduate from the Royal College of Surgeons with a Level 9 Diploma in Clinical Leadership.

Reflecting on what helped him, he explained that the catalyst for his recovery was the fact that he was facing a prison sentence. While the supports he received in prison were important, what was particularly important were the aftercare supports post-prison.

'If we come out of prison and there's nothing there for us, we go back into the community and we mix with the same people again and before you know it, you're either back in prison or you're dead.'

Today, he explained, he works for Tiglin, an organisation that provides a lot of those treatment and recovery supports. He described it as a privilege to be able to work with those services now and offer people something that he himself was given. He concluded by remarking that 'there's one question I have to ask myself: if I were not faced with a prison sentence would I ever have had the motivation to change? I'm not sure I would.'

4.4.7 Ms. Ashling Golden: *Solas and Compass Prison Programme*

Ms. Golden outlined the impact of drugs on young people from her perspective as CEO of Solas, which runs the Compass Prison Programme for young people in Wheatfield, Mountjoy Progression Unit and Oberstown.

Under Irish legislation, detention is the last resort for people aged under 18. However, from the day a young person turns 18 they don't enjoy those same protections. Even though 18- to 24-year-olds only make up 9% of the general Irish population, they make up 20% of the prison population.

Solas staff routinely meet young people in prisons who are crying out for support and help. They do not want to be in prison, and want to tackle their addiction, look for employment or whatever supports they need when they get outside. They're already saying they don't want to be part of the revolving door system and are 'absolutely jumping' to be involved in a programme like Compass. As good as it is though, the Compass programme does not reach anywhere near the number of young people who are within the prison setting. Young people are more open to change and rehabilitation than adult offenders. Their brains are still maturing and they're still in the space where they have that opportunity to really turn their lives around. If we can provide the right interventions for those young people within the prison system, we can have a much better chance of supporting to turn their lives around.

The drugs trade is the number one reason why young people are finding themselves in prison. Not all of them have necessarily gone in because they have a drugs conviction, but it can often be drug-related offences, like assault connected to warring drugs factions, or robbery due to drug debt. The statistics on people going to prison for drugs offences does not show the full extent of the impact that the drugs trade is having on young people in this country.

The drugs gangs have a huge grip on the most marginalized communities in society, and at the moment they are winning, and young people are losing out. Young people find themselves caught up in the drugs trade not because they want to be there, but poverty and trauma is leading them there. There's a whole section of society who are looking to exploit the situation, and groom vulnerable young children into criminality. The fear of a prison sentence is not enough to stop young people going down this path, unfortunately.

While the prisons have health services and drug counsellors, not all young people get to avail of these supports, particularly if they're serving short sentences of under one year. That all contributes to the revolving door problem within the prison system.

We need to start treating people who have become involved in the drugs trade, for whatever reason, differently than we currently do. We need to stop excluding them from society, and we need a system where we can talk openly about drugs-related issues, where we can educate and support people when they find themselves struggling with addiction or going down a path into criminality.

Anybody who finds themselves in prison needs the support of a service like Compass or Cork Alliance when they walk out of prison, somebody guiding them along that road and encouraging them that they are an important part of community life and there is still a place for them in society.

4.4.8 Questions & Answers session

Ms. McCaffrey responded to a question about why prisoners on shorter sentences don't get access to services to the same extent that people on longer sentences do. She explained that prisons in Ireland are overcrowded and at 103% capacity. Whilst there are very good services in prison, there are waiting lists to access those services.

For example, the Prison Service has 39 psychologists for a population of over 4,600 prisoners, the majority of whom need psychological interventions. There are 1,700 prisoners on the waiting list to access psychological services,

which means that prisoners who are only serving shorter sentences of a few months duration realistically won't get access to that service. Even when someone does get access, the interventions themselves take quite a lot of time.

She continued by explaining that motivation is also an important factor in determining whether people in prison seek out services. A lot of people serving shorter sentences are in the throes of addiction and are not mentally in the space to start engaging with services and begin the road to recovery, which, she argued, is why those services need to be accessed in a holistic way within the community.

Mr. Black added that the Prison Service can engage in a much more meaningful way with those people serving longer sentences. There are about 400 people in the prison system serving life sentences, and the reality is that there is a change in those people during their sentence.

The panel responded to a question about why there is a disproportionate and higher proportion of young people in prison, and what can be done in and out of prison to help this problem.

Ms. Golden responded that one of the reasons there's a higher number of young people imprisoned is to do with the fact that younger people are more socially active and out and about in their community. Offending behaviour across all types of offences tends to be higher for young people, but when drugs are introduced into the equation that gets quite significantly bigger. She explained that the lack of services for responding to this issue comes down to resource allocation. It costs approximately €300,000 to send one young person to Oberstown Detention Centre for a year. In contrast, it would cost approximately €100,000 for Compass to provide juvenile justice services for 12 young people. This, in her view, raises a serious question about why the State is putting so much money into imprisoning young people and not putting the same resources into engaging with young people in their communities.

Mr. O'Heaire explained that drug use among young people is very prevalent at the moment, and people make mistakes when they're young, they experiment with drugs and end up in all sorts of trouble.

Ms. Connolly spoke about the influence of role models, recalling the adage that 'you can't be what you can't see'. For young people living in deprived communities with poor social capital and lack of community resources, with older men role modelling drug use then the reality is that they can very quickly find themselves on a fast track into prison.

Highlighting the important role of education and employment as protective factors against criminality, Ms. McCaffrey reflected on the fact that the average school leaving age of people in prison today is 14. She explained that people who disengage from mainstream education at an early age become vulnerable to involvement in criminality, often associated with drug addiction. It is important to look at how we support vulnerable children to remain in education, particularly where they are in families that are living with trauma, mental health or addiction issues.

Mr. Purcell described that when young people come into prison they don't get assessed for issues like ADHD or dyslexia. He described himself as one of the lucky ones, who eventually discovered that he had ADHD and dyslexia.

Mr. Black explained that a young person is still developing cognitively up until their mid-20s, so there are a lot of people in the prison population who are still immature young adults. The Prison Service engages these young people in things like psychological programmes and the Gaisce Award, which work well but not everyone is involved.

Responding to a question concerning the supports he received in prison, and whether he considered his to be an exceptional case, Mr. O'Heaire explained that he was 12 months drug and alcohol free when he began his prison sentence, so had already started to deal with his addiction. The services he needed were available in prison, especially within the Training Unit. He was offered educational opportunities and decided to go forward for third level education. He explained how important both the Medical Unit and the Progression Unit are for prisoners – one without the other won't work. The opportunity to detox in the Medical Unit, followed by opportunities for training or education in the Progression Unit were both essential for anyone trying to find a drug-free lifestyle.

Mr. O'Sullivan explained that prison saved his life on many occasions. Each time he went to prison he would get well, put on some weight with three square meals a day, and his physical health was looked after. However, he was in the throes of addiction, and wasn't in a position to seek help. He was doing shorter sentences and was trying to find drugs in prison, which he had no issue in getting. He wasn't looking at that stage to get off drugs, and didn't want to be helped. He agreed that there is a lot more support available to prisoners who are serving longer sentences.

Ms. McCaffrey responded to a question about whether or not people with a drug problem can be helped in prison. She explained that the prison system provides excellent services for people who have an addiction, including a healthcare team with doctors, nurses and addiction counsellors. However, people need to be in the right place to

begin their journey of recovery. Last year, 78% of prison sentences handed down by the Courts were short sentences of less than 12 months duration, for crimes like public order offences, drug-related offences, theft and burglary. If one accepts that it's very often addiction that leads a person into committing these type of offences, then there's a compelling argument for focussing on preventative strategies to stop people coming into the criminal justice system. She described it as 'a shame' that people need to come into the criminal justice system to access addiction services and argued that what is needed is appropriate and accessible community-based addiction services that can provide alternatives to custodial sentences for more minor offences.

The Prison Service finds that peer-led recovery programmes work well and are working with the Recovery Academy and the Recovery Institute to develop a peer-led programmes within prisons. There are already some successful models within our prisons including the Red Cross and the Samaritans listener schemes.

Ms. Golden highlighted the issue of recreational and choice-based drug use. She gave a case study of one of the young people currently engaged with the Solas project. 'Conor', a 21-year-old male, is a daily cannabis user who might be considered as being in addiction. However, he has no intention of giving up cannabis and is still functioning well. He has already faced 12 charges for simple possession, and one for sale and supply, has paid fines and has served five months in prison. He has briefly attended drug rehab but continues to use cannabis on a daily basis. Because of his criminal record he struggles to build a career, feels excluded from the community and feels hounded by the Gardaí. He purchases his cannabis from local criminals, unintentionally funding organised crime. Ms. Golden described this as a common scenario in modern Irish society, and one that policy needs to respond to. Not all drug addiction is coming from trauma or is a full-on addiction, some of it is recreational use and some of it is choice-based. She argued that society cannot criminalise young people because they choose to engage in recreational drug use and have a joint after work or on a Saturday night. Recreational drug use is a problem that we can't ignore, and affects young people from all walks of life, including from disadvantaged communities and more privileged backgrounds.

Ms. Connolly added, while there are not adequate community-based and residential services, judges can feel like the only sentencing option available to them is prison. Very often it takes six or nine months to get somebody into residential treatment, and even getting someone onto a methadone programme takes time. When a person in the throes of addiction is living in the community without the right supports, they are in chaos and picking up more charges as they try to feed their addiction.

Mr. Black highlighted that the Prison Service has started to engage people with lived experience to work with prisoners, and now pays former prisoners to come in and work with its psychologists, nurses and educational teams. One example is the Two Norries, who are now contracted to work as part of the support services within prisons. To have somebody with practical experience of prison life is really important, because prisoners listen to prisoners, and they really have an impact.

Ms. McCaffrey explained what the Prison Service is doing to curtail the supply of drugs into prisons. The Service takes endless steps every day to keep drugs out of prisons, but drug-seeking behaviour doesn't stop at the prison gate. People in prison, particularly people in the throes of active addiction, spend a lot of time coming up with ways to get drugs into prison. There is netting over prison yards, perimeter security, drug dogs, screening arrangements for front of house, but regrettably a lot of people who come to prison carry drugs internally. The Service is currently looking at new technology and x-ray machines that will identify internal carrying. A lot of people bringing drugs into prison are doing so under duress and pressure, because they have a drug debt to settle.

Responding to a question about governance and implementation, Ms. Connolly explained her view that having a single national entity to deliver all services would be problematic, given that services need to be tailored and customised depending on the particular features of the drug issues within different localities. The issues affecting parts of rural Cork and Kerry might need a different response to what is required in the city, for example.

Ms. McCaffrey referenced the innovative approach being taken in Northern Ireland, where authorities have developed community-based support hubs to tackle the root causes of offending. These hubs provide integrated, co-located services involving the local council, housing agency, Justice, Probation and Education, with the aim of providing accessible services to families and children within their own communities. There are some green shoots in Ireland, with the Child Poverty Unit in the Department of the Taoiseach developing a more integrated model for responding to child poverty, economic marginalisation and access to education.

4.4.9 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Preventative education and harm reduction education in schools
- This session spoke positively about prison compared to previous sessions
- Decriminalise drugs
- Decriminalise cannabis
- Need a pathway to addiction services if drugs were to be decriminalised
- Decriminalise for young people

4.5 Session 4 – Pathways and options

4.5.1 Assistant Commissioner Justin Kelly, An Garda Síochána

AC Kelly presented to the Citizens' Assembly on the work of An Garda Síochána in relation to controlled drugs. The Gardaí's powers of search are provided for in sections 23 and 26 of the Misuse of Drugs Act. Section 23 allows a Garda to stop and search someone when there is reasonable cause to suspect that that person is in possession of controlled drugs. The Garda must explain the reason for the search, and, if not in uniform, must identify themselves. Gardaí can also use this power to search vehicles for drugs.

Section 26 allows Gardaí to search premises including homes and businesses. To do this, the Garda must obtain a search warrant, usually from a judge, and must satisfy the judge that such a search is necessary.

Section 3 of the Misuse of Drugs Act outlines the offence of possession for personal use, otherwise known as 'simple possession'. If the Gardaí seizes drugs that are for personal use, this is recorded as a Section 3 incident on the Garda Pulse system.

The Misuse of Drugs Act outlines the penalties for those who are found in possession of controlled drugs for personal use. The legislation differentiates between cannabis and all other drugs. For cases of cannabis possession for personal use, a person on their first offence will be able to avail of an Adult Caution, which will be issued by a Garda inspector. The Adult Caution does not lead to a criminal conviction. For a subsequent second offence, the individual will be prosecuted, but on conviction can only be fined, with no potential of imprisonment. The same applies for the third offence. Only on a fourth or subsequent offence can a judge, at their discretion, impose a prison sentence for up to a maximum of 12 months. For drugs other than cannabis, the judge will have discretion from the outset to impose a prison sentence.

AC Kelly explained that, in reality, it is not the norm in Ireland for people found in possession of drugs for personal use to be imprisoned. Citing data for 2022, he explained that in that year, Gardaí initiated approximately 11,000 Section 3 prosecutions, which resulted in 261 individuals receiving prison sentences or suspended terms of imprisonment. Every one of those people had multiple previous convictions. The median number of previous convictions was 76, and none of the people sentenced was a first-time offender. Many were convicted on the same day for other serious offences along with the Section 3 offence.

All children under 18 years of age found in possession of drugs for personal use are dealt with under the Juvenile Liaison Scheme, which is a well-established scheme to divert children away from the criminal justice process.

Section 15 of the misuse of drugs Act deals with possession of controlled drugs for sale and supply. If a Section 15 case is dealt with in the District Court, which deals with cases relating to smaller quantities of drugs for supply, a judge may impose a prison sentence up to 12 months and/or a fine. Cases dealt with in the Circuit Court, for larger amounts, can result in a term of imprisonment of up to life imprisonment and or a fine. However, the reality is that sentences are far less than this. If the amount of drugs seized is over €13,000 the minimum sentence is 10 years under Section 15a of the Misuse of Drugs Act. However, in exceptional circumstances, this sentence can be reduced, and often is.

AC Kelly explained that the focus of all the Garda Drugs Units around the country, and of the Garda National Drugs and Organised Crime Bureau, is on sale and supply, not on possession. The focus is on targeting those harming

communities through the sale and supply of drugs, and the Gardaí set no targets or metrics in relation to possession offences.

He reiterated a point he had made at his initial presentation to the Citizens' Assembly in April, which is that AGS is supportive of the current health-led approach but has grave concerns around any potential legalisation of controlled drugs. These concerns are based on the implications for the whole of society, not just for those who consume drugs. He explained that policing colleagues in North and South America have been very clear with him that legislation will not remove the influence of organised crime groups, who will continue to maintain the illicit black market, undercutting legal prices and increasing strengths of drugs. His policing colleagues in Canada had told him that such changes have significantly curtailed their abilities to approach and engage with suspects in British Columbia. In Canada, the first month of legalisation saw a record number of overdose deaths. He has also been told that legalisation will result in an increase in drug driving.

Commenting on the Portuguese approach to drugs, he explained that he had recently visited Lisbon and met those involved in running the scheme. His police counterparts in Portugal made very clear that the drugs remain illegal in Portugal. He explained that the Portuguese model was not a decriminalisation model, it is a diversion scheme. Possession of drugs in Portugal is dealt with as administrative offence, which is not an option available in Ireland. He said it was interesting that, despite the number of country delegations that have visited Portugal to examine the model there, not one has adopted the approach.

AC Kelly concluded his presentation by reaffirming that the Gardaí support harm-reduction measures that can prevent drug deaths, such as the use of naloxone and supervised injecting facilities, and also fully support those who work in the drugs rehabilitation and recovery area, and recognise the need for additional resourcing.

4.5.2 Mr. Mark Wilson: *The Probation Service*

Mr. Wilson outlined the role of the Probation Service in responding to drug-related offending. He described the well-documented relationship between drug use and offending behaviour, which includes crimes committed while under the influence of drugs, crimes committed to obtain money for drugs or crimes committed within the context of drug supply. These offences range from public order, road traffic, theft, burglary, violent sexual and non-sexual offending up to and including domestic violence, rape and murder.

When asked by the Courts, the Probation Service assesses the person to understand what has happened in the person's life that has led them to this point. The assessment takes into consideration the offence, the impact on the victim, the factors leading to that offence and the person's willingness and capacity to change. Where directed by the Court, the Probation Service manages the individual, under the conditions imposed by Court Order, to assist that person to change. The Service works to establish positive relationships with clients in order to supervise, guide and assist them towards successful social reintegration, using control where necessary.

Probation Service staff are social work trained, and work with adults and children, providing services to the District, Circuit and Central Criminal Courts. Importantly, the relationship between the Probation Service and its clients is involuntary, meaning people engage with the Probation Service because they are directed to do so by the Court, or are under an order of the Court.

This year, the Probation Service allocated approximately €18 million, equivalent to one third of its annual budget, to 60 community and voluntary sector organisations throughout the country. These service providers work with four and a half thousand people on probation. €2 million of this funding was provided directly to 18 drug treatment services to provide tailored community-based psychosocial interventions for problematic drugs use.

Recent research shows that 81% of its clients have some form of drug or alcohol misuse. The most at-risk group is the 25 to 34 age group and, for 50% of that age group, there is a direct relationship between their crime and substance misuse. Research published in 2021 found that 40% of adults on probation supervision presented with symptoms of at least one mental health problem. 50% of this group also presented with either an alcohol and drug misuse problem, difficult family relationships and/or accommodation instability. The report found there was significant unmet psychological and psychiatric needs amongst the client group.

He confirmed that the Probation Service fully endorses the current health-led approach to drugs use in terms of its emphasis on diversion from the criminal justice system. For those who do enter the criminal justice system, there is extra stigma attached to having a criminal conviction. There are options open to the Court in dealing with an individual which enables the judge not to proceed to convict but does influence the willingness of that person to

engage with services. The Probation Service encourages diversion from the criminal justice system, diversion from conviction, and diversion from the use of imprisonment.

Calling for the maximisation of the use of community sanctions in order to assist people engage with treatment, Dr Wilson explained that a Probation Order in the District Court is not a conviction, so a person can be placed under the supervision of the Probation Service and not receive a conviction.

In terms of building capacity for services, this is much broader than addiction treatment and requires a whole of government response. The lack of suitable accommodation to support those in recovery remains a critical problem. The need to strengthen psychosocial outreach, peer support and aftercare services are all still relevant in terms of overcoming societal barriers.

4.5.3 Mr. Tony Duffin: *Alternatives to Coercive Sanctions*

Mr. Duffin, Chair of the National Drugs Strategy Strategic Implementation Group on Alternatives to Coercive Sanctions, explained the work of the Group, otherwise known as 'SIG-5', which is one of six strategic implementation groups operating under the National Drugs Strategy.

The National Drug Strategy, launched in 2017, was drawn up in consultation with all stakeholders including State agencies, civil servants and civil society. Mr. Duffin noted that while it's a good strategy, there have been challenges around implementation. A midterm review by the Department of Health led to the creation of six new strategic implementation subgroups, which look at a range of issues from early warning and emerging trends to alternatives to coercive sanctions.

SIG-5 on Alternatives to Coercive Sanctions has a number of priorities, including an exercise to map the provision of alcohol and drug treatment services nationally, incorporating service availability and referral options for people with problematic drugs use. Another priority is to evaluate the Drug Treatment Court.

One of the primary issues for SIG-5 is the introduction of the planned Health Diversion programme. Under Health Diversion, drugs will remain illegal, but Gardaí will divert a person found in possession of drugs for personal use, for a first-time offence, to the HSE for a health screening and brief intervention, where their needs will be assessed and they can be referred onwards to drug treatment services, if required. On a second occasion, Gardaí would have discretion to issue an Adult Caution, while for third and subsequent offences the matter will be dealt with by the Courts.

Mr. Duffin explained that the key difference between Ireland's Health Diversion programme and Portugal's Dissuasion Committees is the number of times that an offender can avail of the diversion away from the criminal justice system. While in Portugal health diversion is available for every time a person is found in possession for personal use, Ireland's Health Diversion programme will apply for a limited number of offences.

Also, in Portugal, Dissuasion Committees have powers to apply administrative sanctions, including issuing fines. They can also decide to refer a case back into the courts if they feel that it is more of a criminal justice issue than a health issue.

He explained that other countries around Europe have also introduced versions of decriminalisation, including Croatia, Czech Republic, Estonia, Germany, Italy, Netherlands, Poland, Spain and Switzerland. Ireland, he explained, is not doing anything wildly different by moving towards a health-led approach. However, implementing the Health Diversion programme has been challenging. In October 2019, an interdepartmental group was established to implement the Health Diversion programme and examine the need for legislative change, the phasing of implementation and the costs involved. The group identified that legislation will be required to enable Health Diversion. An operational subgroup was established to advise on the operation of health screening and brief interventions, including operational procedures to support the recruitment of SAOR practitioners, the people who will deliver on the assessment and brief interventions. It also includes liaising with the HRB on data collection and developing an IT system to track cases.

€700,000 was provided to the HSE to establish a national network of health screening and brief interventions services for participants of the health diversion programme. Recruitment of those SAOR practitioners is at various stages in each of the Community Health Offices areas, and it is expected that the practitioners will be in place in all nine areas by quarter four of this year, so progress is now being made.

4.5.4 Questions & Answers session

The Chair invited Prof. Eamon Keenan, National Clinical Lead for HSE Addiction Services, who was in attendance at the meeting in an observer capacity, to respond to members' questions about how the HSE would be able to cope with an increased level of demand for addiction services, and whether it made sense for Health Diversion to apply to the 90% of drug users who do not have problematic use.

Prof. Keenan explained that it will be a challenge for the HSE to manage a significant influx of people into its treatment services, which don't have a huge amount of spare capacity. Initially in terms of the referrals that we would be getting through the Health Diversion Programme, the HSE will have nine extra staff employed, one for each CHO area. The intention is that those staff would see people for a screening and brief intervention, with onward referral to addiction services if necessary. So, if the 10% of people who are offered an onward referral take it up then there will be capacity issues within the addiction services. Once it sees the numbers coming through, the HSE will have to address the capacity constraints with the Department of Health through the Estimates process and seek an expansion of addiction services. The other 90% of people referred by the Gardaí will be getting a brief intervention, where they will be advised in relation to the harms that are associated with drug use. That brief intervention will provide an opportunity for people to pause and reflect on their drug use.

Mr. Duffin described the Health Diversion programme as a better system than criminal justice system at the moment. In terms of its application for non-programmatic drug users, in those circumstances people are spoken to about the illegality of drugs and reminded that drugs use is not okay. Where they don't have a problem with drugs, they still receive information about the health risks that they're taking by using drugs, and offered harm reduction advice. The 10% of people with problematic drug use will be offered a treatment or rehabilitation referral. Not everybody will take that offer up, as it's not mandatory to take up.

Responding to a question about what he would like to see changed in order to make things better, AC Kelly emphasised that An Garda Síochána, as key partners in the National Drugs Strategy, are closely involved in a series of policy changes that are currently taking place. For example, the Gardaí are currently exploring the possibility of officers carrying naloxone. The Adult Caution scheme for cannabis was introduced in 2020, and the Department of Justice has indicated that there is a move towards expanding that programme, which is something the Gardaí will look closely at. Also, the Health Diversion programme will mean a huge change for An Garda Síochána.

The Gardaí are fully supportive of increased funding for rehabilitation and treatment services, and also see great potential in expanding the Drugs Court model. They've also been involved in supporting the back of house drug testing that has been operating at the Electric Picnic festival and are involved in the planning of the supervised injecting facilities at for Merchant's Quay, which poses some complicated policing challenges.

He indicated he would like to see increased education about the harms caused by drugs, not only to people's health, but also to communities suffering violence from organised crime. He highlighted the direct connection between organised crime in Ireland and the violence that's being inflicted on communities in South America.

He reiterated that the Gardaí have no interest in pursuing problematic drug users and support the disadvantaged communities that are impacted disproportionately by drug use. Their primary focus is on the people who are making lots of money from the drugs trade, who are involved in money laundering, human trafficking, prostitution and firearms offences.

Responding to a question about the challenge of supporting people on probation during the current housing crisis, Mr. Wilson explained that housing is a very difficult issue at the moment. The Probation Service Homeless Team in Dublin currently has 500 cases, and in the absence of stable and suitable accommodation it is challenging for those people to move forward into more productive activity. Probation funds a range of housing providers for particular target areas, like DePaul Ireland, the McVerry Trust, Focus Ireland and PACE, which provide targeted accommodation for certain categories. Probation also works with local authorities and the Prison Service to support better outcomes where possible.

AC Kelly explained that Garda senior management are doing everything they can to support frontline Gardaí to do what is a very difficult job. There are not sufficient numbers of Gardaí in the force at the moment, and a number of initiatives to boost recruitment and retention are being rolled out. New and expanding areas of crime, such as cybercrime and domestic violence require the deployment of specialist Gardaí, which in turn puts pressure on frontline services.

Responding to questions about the status of the Health Diversion programme, and how that sits with the remit of the Citizens' Assembly, the Chair explained that it is up to the members of the Citizens' Assembly to decide themselves whether they agree with the Health Diversion programme, or whether it is going too far, or not far enough, and to make their own recommendations independently of what Government is currently proposing.

Mr. Duffin responded to a question about how women's issues will be dealt with under Health Diversion by explaining that there are no particular additional measures under Health Diversion for women, but that drug services in Ireland currently have a range of specific interventions for women.

AC Kelly indicated that he would be concerned about the impact on policing of any legislative change that would erode the Gardaí's current powers of search, which derive from Section 23 of the Misuse of Drugs Act. Legalisation of drugs would clearly lead to the loss of search powers, while it's not clear without sight of the detail whether decriminalisation would lead to loss of search powers. Police counterparts in Canada have described how their powers of search were entirely eroded with the legalisation of drugs, while police counterparts in Portugal explained that they have retained their powers of search, which are in fact essential for them to operate the health diversion model.

Prof. Keenan clarified that there would initially be 9 SAOR workers, one for each HSE CHO area. That was the initial ask of the HSE in terms of levels of resourcing, but that can be revisited if the level of demand on services warrants it.

Responding to a question about the policing approach to Electric Picnic, the presence of Garda sniffer dogs on campsites, and reports that a number of people were arrested for cannabis possession at last year's festival, AC Kelly explained that the policing issue is complicated, and that Gardaí cannot give any form of amnesty. However, Gardaí have a constructive role in supporting back of house drug testing at the festival, and have agreed they will not police the area tightly. They are taking a common-sense, discretionary approach, and want to be involved in efforts to alert people about the presence of dangerous and perhaps lethal substances.

Prof. Keenan explained that his team is delivering a very effective back of house drug testing facility at Electric Picnic festival, working in conjunction with the promoters and Gardaí. Despite some ill-informed commentary to the contrary, the arrangement is working very well, with Gardaí policing in a way that makes it comfortable for people to enter the tent and engage with HSE staff and volunteers. Ultimately, this approach is ensuring that public health messaging and risk alerts are being issued in real-time to festivalgoers.

4.5.5 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Services are working but they need more funding and resources
- Frustrated that the Assembly is being asked to come up with recommendations when there is already a strategy

4.5.6 Observations from the Lived Experience Group and Policy Observer Group

Lived Experience Group

Mr. Karl Ducque observed that it had been a heavy day with a lot of information presented. He described the barriers he had faced when he was stuck in a cycle of addiction. He gave an example of having to be in a methadone clinic but having a court date at the same time. Being an addict means you will go to get your methadone first, before going to court. He ended up getting warrants and being in and out of prison. There was no intervention within the prisons for him when he was there in the 1990s. The new policies and programmes within prisons now can be great, but there are too many barriers for people to get into these projects. He would be in favour of removing these barriers, removing the criteria which stop people from availing of amazing projects that are out there. Concluding, he explained how hard it is for young people to avail of good programmes when most are full. Young people have come to him looking for help, looking for a plan to recover, but he has had to turn them away. He asked how he can be expected to work intensively with these people when service capacity just isn't there.

Mr. Fionn Sexton-Connolly observed that he felt that perspectives were changing in relation to the appropriate response to drugs use. People had been questioning the health approach, and now there is a sense that people are questioning the criminal justice approach, and the morality of a society where the most deprived areas have the most

problems with drug use but are not receiving any of the resources, while getting all of the criminal justice sanctions applied to them. He asked the question, whether this is right, and moral, and the way forward? He explained that he himself had lost a brother to a drug-related death. His brother could not go to the health system for help because the resources were not there. When he did eventually go, it was more traumatic for him than staying away. He asked the question how much more can this be kicked down the road? He felt that the Assembly is now looking at drugs from an entirely new perspective, that of the people who use drugs, from recreational users to problematic. He asked 'How can we look down on a drug user from a pint glass'. How can we, as a society, differentiate which drugs are good and which are bad? He concluded by pointing out that we have thrust children, deprived of development and resources, into an expensive, unequal, and hostile society. Young people are overworked for little reason, and they are overlooked for no more than their name or their postcode. This is driving some of the inequality that is driving some of the drug-related issues that are being discussed.

Ms. Shannon Connors expressed her anger at the justice system and said she had little positive to say. Her own experience, since she has been a child, is that the justice system has been against her. She recalled one judge who would never say her second name, because she was a Traveller. She shared other experiences of her interactions with the Gardaí, expressed dismay at the current situation and said that the government doesn't know how to fix this issue, the people don't know how to fix it, but something needs to be done.

Mr. Andy O'Hara disputed comments made earlier in the day by the Gardaí saying they don't target people in addiction and that possession of drugs is not a big issue for them. His belief is that people are being targeted on a weekly basis, including young people, people in recovery, people who are currently taking drugs as well as people who are taking drugs recreationally. Referencing the Portuguese approach to drugs, he explained that the authorities in Portugal do not preset it as a solution to drug-related crime, rather as an approach that is intended to end the harms associated dependent drug use. From that perspective it has been effective, but it doesn't end discrimination against people who use drugs. On the question of whether decriminalisation causes an increase in drug use, he quoted the World Health Organisation finding that there is no clear link between punitive enforcement and lower levels of drug use. There are mixed findings. However, drug use in Ireland is more prevalent now than it was 5 years ago or 10 years ago, because we have an ever-increasing population of people who decide to take drugs. While decriminalisation of drugs is not going to be a panacea, we do not need to criminalise people in order to support them. All the support offered within prisons should be able to be offered outside of prisons. We already have open drug dealing, overcrowded prisons, high drug-related deaths and a high number of children going into care. If we continue with this approach one of the recommendations of the Assembly will have to be the building of more prisons and graveyards. Or we could do the opposite, which is to address poverty, create opportunities for people to progress and succeed and create safer homes and communities where all people can thrive. Support people, do not punish them. Decriminalise people who use drugs, whose two biggest crimes are that they have used drugs or experienced poverty or trauma. He characterised the current approach as a moral crusade against what we, as a society, see as 'dirty' or 'wrong' behaviour. He is aware that in the last 2 weeks, seven of his organisation peers have passed away from overdose. The current approach is not working and to continue it will not work. He appealed for decriminalising drug use and addressing inequality.

Policy Observer Group

Mr. David Kehoe, Department of Justice, acknowledged the importance of the Citizens' Assembly on Drugs Use and expressed his appreciation of the effort that members are giving to the task. He commended the bravery and selflessness of the people sharing their lived experiences. They have given up their time to help others, help their communities and society. Mr. Kehoe concluded that the Department of Justice is acutely aware that there is a job of work to find the proper legislative vehicle to introduce the Health Diversion approach as promised. It remains a priority for the Department.

Prof. Eamonn Keenan began by thanking the Chair for 'putting the boot' into the Health Diversion programme. The HSE believes that the Health Diversion programme is important and is committed to seeing it working. The HSE, with the resources in hand, will try to address the Health Diversion programme when it gets up and running. Prof. Keenan spoke about how powerful the meeting had been, and commented on the amount of information being given. It is clear that, concerning our drug services, the status quo is not working. Prof. Keenan thought one of the most interesting questions of the day was ' Why do we need to have a Citizens' Assembly?'. Thinking about that question, he explained that this is a 'wicked problem', which is why everyone is here today. We need to increase awareness related to drug-related problems. We need to direct the focus and provide recommendations for improvement.

Mr. Jim Walsh from the Department of Health acknowledged there was a sense of concern and ambivalence from the members of the Citizens' Assembly regarding what they are here to do, wondering if they will be listened to

and whether their work is relevant. Mr. Walsh assured the Assembly that their work is extremely relevant. The Assembly is pointing a light at certain systems, holding civil servants to account, and questioning why policies have not been implemented. He believes the Assembly is doing a great job and welcomes their work. These are live issues. Resources change, budgets change, and everything has an impact. On the Health Diversion programme, Mr. Walsh explained that the programme has a mandate to run for 1 year, after which it will be reviewed. He characterised this as a live issue, reassuring the Citizens' Assembly that what it is saying is extremely relevant and pertinent to the discussion.

4.6 Session 5 – Stakeholder Perspectives

Four stakeholders were invited to present their particularly perspectives on how the State should respond to drug use. In order to accurately present their views, lightly-edited transcripts of their presentations, rather than summary versions, are provided below.

4.6.1 Mr. Eddie D'Arcy, Youth Workers Against Prohibition

Transcript of presentation.

My name is Eddie d'Arcy. For the last 40 years I've been working in marginalised communities as a frontline youth worker. I represent a group of 200 frontline youth workers, most with over 25 years' experience in the Greater Dublin area. I spent 30 years from the mid-1980s in Neilstown in West Dublin, and during that time we were hit with the heroin epidemic. One of the responses to that was I set up an organisation called CASP which today continues to provide the whole range of services to young people, adults and their families in that community, who are struggling with addiction. I moved then to set up the SOLAS project in the southwest inner city where I spent 10 years as CEO, just retiring last year.

In relation to our own proposal, as far as we're concerned, the drug war has been going on for the last 25 years and we're getting absolutely nowhere with it. The situation at the moment is that drugs are more available in Ireland than ever before, more people use illegal drugs in Ireland than ever before, and what we're looking at is that the power and control that gangs have has now spread beyond the marginalised communities in Dublin and is now countrywide.

The level of profit that is made by the illegal drug gangs is so high that is no sooner is one gang broken up than another replaces them immediately. As soon as a dealer is cleared off the street, generally our experience is that within half an hour another dealer takes their place. This war is impossible to win the way it's being fought at the moment. It has never been won in any other country in the world. We're looking for a radical change in terms of how we're trying to fight this War on Drugs.

Drug gangs have no conscience when it comes to selling their products to children under 18. They've no conscience when it comes to the toxicity of their products. They continue to recruit young people. Many young people in the community I work in at the moment, the southwest inner city, young people from the age of 10, 11 and 12 are gradually being sucked into those organisations to work for them, on the basis that there's a chance to make big money, fear, intimidation, debt, all the reasons why people get sucked into these gangs. They continue to intimidate individuals, families and communities, and intimidate them through severe intimidation which includes a high level of violence.

There's been reports recently of a drug gang in Wexford whose modus operandi is chopping off the fingers of people who owe them money. So, your debt never disappears; if you owe money and decide to do a runner to England, the debt passes on to your parents or your brother or your wife or some other member of your family. That debt will be collected. If you can't raise the money, you will be sucked into becoming part of the operation. You'll be used to ferry drugs, to carry drugs, to sell drugs or, in extreme cases, maybe to eliminate a rival drug gang member. So, for us, we have created this monster in these communities and we really need to do something about that.

As frontline youth workers, we recognise the harm and damage that drugs do to individuals and their families and communities. So we're not saying in any way that these drugs don't harm people. We recognise the harm, we see it every single day of our working lives. We're working with young people and families whose lives are directly affected by drugs. We recognise drugs do harm. However, we also recognise that the present approach by government creates even more difficulties, because we have communities and families living in terrible fear. We don't really have a response to that.

So if somebody calls into our youth centre or calls in to see one of our staff on a Friday afternoon at half four, and says 'two lads called to my door, my son's run up a debt of three thousand euros, and they're going to be back at six o'clock looking for the money, or they're going to put through my front door and batter the crap out of my son, and they're going to keep doing it until we raise the money….', we don't really have an answer to that. Maybe people who haven't experienced that themselves, or maybe people who don't live in communities where the violence is often very obvious and very public, don't understand how difficult it is for people in that situation.

They can't, won't and don't approach the Guards because they know the repercussions are going to be much more serious. Their house could be petrol bombed, their windows will be put in, their son will be beaten up beaten up, and if they can't get him, they'll get somebody else.

I spoke at a conference down in Limerick where CASP also runs programmes and I met a woman from the small village of Ennistymon, and she told me about her experience of having to wait at the seafront in Lahinch to hand over a large brown envelope full of money. She said 'I never in my life thought I'd have any connection with any criminal activity, and here I am, never been in trouble in my life, meeting these two young men and handing over a brown envelope.' That goes on every day of the week all the way around this country.

The other thing I am concerned about is the number of young men we have criminalized. We went from a prison population of 750 adults in prison in 1975 to almost 4,000 people in prison today. 90% of those young men are in prison because of criminalisation of drugs. They may be serving a sentence of 18 months or two years, or three years. However, it's a life sentence because it's very difficult to get a mortgage, quite difficult to get a, job you can't even be involved in community activity if you have on your record the fact that you were involved in the drug trade. So that's a life sentence for many young men. I'm going to appeal to you today to consider a really, really bold move and regulate the sale of illegal drugs. Get it out of the hands of the illegal gangs. I'm going to ask you to be brave. In fact, I'm going to plead with you to be brave and to think about a really bold step. Let's get rid of that monster that we've created. Okay, we accept the fact that a considerable number of people use drugs, they are always going to use drugs. What I'm asking you to do is consider a really bold move and let's take the trade out of the hands of the drug gangs, because we are never going to defeat them the way we're doing it at the moment. If we don't take a brave move now, in 25 year's time we are going to be back here talking about the same problems. So please consider what I've said today. Think about those families and communities that are being influenced by the drug gangs and consider a really, really bold move. Thanks very much.

4.6.2 Prof. Anne Doherty, College of Psychiatrists of Ireland

Transcript of presentation.

Thank you very much, and I'm very glad to be here. Thank you so much for giving me the time to talk to you on behalf of the College of Psychiatry. We are the professional and training body for psychiatrists, who are specialist doctors in mental health care. I'm going to talk a little bit about the current types of problems that we have and the potential impact that legislation may have on what we're actually seeing in terms of real harm and real suffering at the front line.

This is a slide from the Euro-Den study, a Europe-wide study which looks at substance misuse in emergency departments. It's got two Irish sites, and what's actually quite interesting is that the two Irish sites are quite different in terms of both the numbers and the types of substance use in those populations. One is Drogheda, which as you can see has cannabis and cocaine as the leading issues. Then the Mater Hospital, which as you can see is one of the bigger centres in Europe in terms of substance misuse, even though it's certainly not as big hospital as Thomas's which is the large one there in London. Again, we're seeing obviously heroin, cocaine, cannabis etc. being the main issues.

I work in the Mater Emergency Department. We see people who present with mental health crises, people who come in really, really bad ways and present with very severe problems. We're talking about people who are presenting with self-harm or suicide ideation – and those are in general about two-thirds of the people that I see in the emergency department - or people who've tried to kill themselves or are having strong thoughts about doing that. A lot of the rest are people who have what we call psychotic symptoms, which is where they maybe are having experiences where they are seeing visions, hearing voices or feeling that they're in grave danger, and they can be very behaviourally disturbed. It can be a really upsetting experience for somebody to be having an experience like that.

What we find in the Mater is that, on the whole, 74% of the people that I see will have a substance use problem

as part of their presentation. Of the people who present with self-harm, over 80% of those will have an addiction problem alongside that. What we see specifically in that is that drugs play a really large part of that and they're more than half of the substance use that we see, alcohol being about one in five. So it's a real problem at the front line, and I suppose sometimes a lot of these debates get boiled down to numbers, but these are people who are having the worst day of their lives. If you're seeing me in the Emergency Department, you're having a really bad day. I think we cannot underestimate the very real suffering that comes with these kind of illnesses.

When we move on to self-harm and suicide more generally across the country what we know from the National Clinical Programme for self-harm and suicide-related ideation is that alcohol is a factor in over half of the presentations we see. Of course, alcohol is a legal drug, and we see problems with legal drugs as well as illegal drugs. We see problems with alcohol, we see problems with benzodiazepines and with methadone, all of which are legal drugs. Alcohol and drugs together are a factor in 25% - 30% of attempted suicides in Ireland, and the risk is highest in males and in the Traveller population, whom as we know have a higher risk of suicide anyway. So these are a population that are very much at high risk, and having substances in the picture increases their risk of suicide dramatically.

In terms of people who get admitted to mental health hospitals, to psychiatric units, these are very much the most severe end of the spectrum in terms of illness. These are people who are very unwell, usually people who are very suicidal and maybe who have very severe psychotic symptoms. Of those who have an addiction problem as part of that, we see cannabis as being present in about 46%, so nearly half, followed by cocaine and other medications as well.
This graph is from Canada, and this basically is a peer-reviewed study that was published earlier this year and basically shows the patterns of cannabis-related emergency department presentations that happened over a four-year period from the three years prior to legalisation to post legalisation. As you can see, that line there with the big arrow on it is when legalisation happens, and I think we can see that in the run-up to that, and this is possibly due to the fact that it became more socially acceptable to use cannabis because the legislation was imminent, we're seeing a great increase in the amount of people presenting to the emergency department with real problems.

When you read the data around this study, you can see that the problems that they're presenting with are mainly mental health related, so people are presenting with psychosis, they're presenting with suicide attempts and they're also presenting with some physical health problems that can come from cannabis. One of the really common things that we see is something called cannabis hyperemesis disorder, where people have really, really bad vomiting that just won't stop. It's a really horrible condition.

So what we're advocating for is a health-based approach where we think about prevention, early intervention and treatment as being the cornerstones of whatever happens. Regardless of whatever legislative approach is taken, we need to make sure that these approaches are very firmly embedded in what we do. In terms of prevention we need to make sure that there's very robust Public Health messaging, particularly around the harms of the drugs that we see most commonly having an impact on people's health and on their lives, which are obviously cannabis and cocaine.

We need early intervention for at-risk groups, like people in pregnancy, the children of parents who use drugs, and the Traveller Community, all of whom are very, very vulnerable groups who need extra support. We need to intervene quickly, and we need to provide people care where they are. If people are in primary care, the intervention needs to be accessible in primary care. If they are in the emergency department that's a really important place to be able to open the door to treatment and provide a window.

Finally, in terms of treatment, we need to have clear pathways and joined up services. We don't have those, and we need to make sure we have the full availability of all supports including residential. Bobby will probably talk more about adolescent addiction services, but they are absolutely key. Finally, the dual diagnosis model of care is absolutely essential, this needs to be properly funded and properly rolled out across the country, where people have mental health problems and addictions together. This is a real significant need and they need support. Thank you very much.

4.6.3 Mr. Graham Temple, Crainn

Transcript of presentation.

Hello everybody. Before I formally begin, I'd just like to thank you all for giving us the opportunity to be here. Crainn is a non-profit organisation and we do everything in our own spare time, no funding, nothing like that. In my day job

I work as a mental health nurse. Today I'm going to be speaking about regulating cannabis primarily, and about how we feel we can take back control, as Eddie has said, from criminal markets.

To begin with, who is Crainn? It means 'trees' in Irish. We're a harm reduction organisation and we do online harm reduction primarily, and we keep our ear to the ground for emerging drug trends in Ireland, and spread that awareness. We also do education. We've had volunteers on the streets of Dublin last year, giving out information about medical cannabis. This year we had volunteers giving out pamphlets about how people could submit to the Assembly here today. We also do community aspects, so we have meet ups, movie nights and so on. We're also trying to bridge the gap between non-problematic drug users and the government, which we feel are quite underrepresented at national level.

Today, I'm going to have a look at cannabis. As you've heard already, we're seeing increased use. We heard yesterday how policies were set up to reduce harms and reduce use, but that doesn't seem to be happening. Instead, we measure success with seizures. Just some numbers that I'm going to mention: we have about 24% lifetime use for cannabis in Ireland with adults. 50% of college students use drugs, and it's about 17% yearly use here in Ireland as well.

One of the big issues here is, if more people are using the drug, in the market at the moment these synthetic cannabinoids exist. These are chemicals that are made to attempt to mimic the effects of cannabis. They have big, long names, they're all in the report if you want to have a look at their scientific names. Ireland has been listed as a country of concern by the EMCDDA and there have been deaths in the EU due to these chemicals.

As you can see, sometimes they come in edible form or vape form, and this can appeal to young people, mainly due to the stealth aspect. These don't smell or anything like that. Dogs can't detect them when they're brought in and, due to their nature, they're making new chemicals all the time. If you look at Public Health advice in legal jurisdictions, they'll tell you to vape or to consume edibles instead of smoking cannabis, but if you try to follow that advice in Ireland you're probably going to run into synthetic cannabinoids. As you can see in the headlines, there's a lot of hospitalisations.

Moving on from synthetic cannabinoids to look at actual cannabis. We'll look at medical cannabis. In Ireland we have 47 people on the Medical Cannabis Access Programme. Just to compare it to Germany, or to the UK, there's a much larger amount of people getting medical cannabis. That's through private prescription in both of them. In Germany about €51 million euro worth of medical cannabis was given out in the first quarter this year to patients.

This map shows that, if you have a prescription in the UK, where you can bring it. So as you can see there, if you had a prescription in the north of Ireland you couldn't bring it down to the Republic, you could be a criminal with your prescription. Irish medical cannabis refugees exist. We know people that have had to move to Spain or to Poland to get access to cannabis, including someone with MS who doesn't meet the criteria and was told he doesn't have enough spasticity to gain access to cannabis here, so he's actually moved to Spain.

From an enforcement point of view, and as you heard yesterday, Stop and Search is used. These are just some figures to highlight. The London Met police last year, with a population of 9 million, actually conducted less searches than the Gardaí conduct under the Drugs Act, and this data is from 2014, the last statistics the Gardaí released on this. These powers of stop and search are used under the Drugs Act pretty much for all stops and searches, and it's the only way they can do it, so there is a big fear of them losing that power around policing.

Now if you are caught, and you heard about the Adult Caution scheme yesterday. Now, if you already have a conviction you're not going to get that so, if you've been criminalised because of the old laws it doesn't apply and it's also up to the discretion of the Garda whether you get that scheme or not, so not everybody that was found in possession of cannabis was offered that scheme, and it's also a three strikes and you're out system, so if you're a problematic user or you're in an overly policed you're going to be met again and again by the guards, so they're probably going to use their three strikes up before someone else would

We'll talk about what regulation is, what we're going to do, what we advise. It gives us more control than decrim. If we just decrim, we leave the market out there. Also, the market remains in the shadow, how can we study it and see the effects of the drugs and that type of stuff. So it would be to mainly to shrink the black market. I know we can't remove it completely, but we'd have some successes on that. Regulation would offer safe supply. We'd recommend setting up a regulatory body to research on cannabis.

We already have some activities that we regulate in Ireland: alcohol, tobacco, food and different sports and driving, for example. People can't drive any old banger, you have to wear a seat belt, this type of stuff. Instead of just saying

cars are being used recklessly, let's ban them', we regulate around that.

There is a nuance to regulation. Like I was saying about the black market, around half of Canadians now purchase their cannabis in a regulated store, after five years of regulation. In America, it took about 10 years post-prohibition of alcohol for that to happen. Again, Ireland highlighted as an area of concern for synthetics. We do not see the same prevalence of synthetics in a market where people can get legal access to cannabis. If you think about demand, if someone wants to purchase cannabis they can go and purchase regulated cannabis versus buying on the street and not knowing what they're getting.

Underage usage is controlled in legal jurisdictions. There are some studies that show where youth rates have remained around the same, maybe a slight increase, which could be down to people being more open to reporting. In my opinion, if a young person wants to take an edible or vape something, at least if you're talking to the hospital if they were having a bad time, you could say to the doctor 'this is exactly what they took.' For example, if they drank a naggin of vodka or something like that, you know they've consumed this much alcohol and this is the effect of it.

This graph shows that we need to not over regulate the market. We actually are going to be in competition with the black market, so we need to think about that when we regulate and try and have sensible Public Health regulation.

Our harm-reduction based regulations would be to allow home cultivation of cannabis immediately. There's no regulatory implementation. Straight away, that will remove people from the black market. Then also allow Cannabis Social Clubs, non-commercial smaller spaces where people can purchase and consume cannabis. Then, further down the line you'd look at State-led regulations that would involve licensing, quality standards and traceability from seed to sale.
Finally, a harm reduction campaign, not to say not just use cannabis, but also safer ways of using it. We'd just like to thank everybody. Our full submission where we argue these points much more strongly is available, and also the Joint Committee on Justice Report. Thanks very much.

4.6.4 Prof. Bobby Smyth, Cannabis Risk Alliance

Transcript of presentation.

Thank you. I'm one of about 25 senior doctors who've expressed a lot of concern about cannabis and the harms it's causing across society over the past four or five years. These are doctors from backgrounds in emergency medicine, psychiatry, general practice and addiction.

In terms of drug policy, this is, I think a simple way of trying to segment the Irish population and everyone's relationship with drugs. We know that drugs are legal but, in spite of that, obviously some members of our community and society choose to use drugs. This is how things break down across the entire population, and that includes children.

Five million people in Ireland, 82% of us, say we've never taken a drug, so that means about one in five who have used the drug at some point in their life. The majority of those are in that green section there, that means they haven't used a drug in the last year. So it's something that they may have done impulsively or intermittently, perhaps, in the past but it's not part of their current life. So 6% of the entire population reports use of a drug in the last year. The group we worry most about are those who are using in the past month, particularly those in red there, who have a drug use disorder.

If you stretch out those different segments of the population and look at the movement forwards and backwards between the different areas, this to me captures the challenge I suppose within wider drug policy, and the huge challenge you guys have been presented with in terms of grappling with this pretty massive and complex issue. Ultimately as a society I would hope we have the ambition to ensure that as few members as possible move into the world of drug use. And for those who do move into the world of drug use ,we ideally want them to step back out of it again and if they choose to remain there or if they do remain there we want them to experience the minimum amount of health problems for themselves and the minimum amount of problem for those around them so that's why we have drug policy and that's why we have regulations, rules about substance use and this way of thinking about substance use and the challenges within it and policy applies just as well to alcohol or cigarettes as it would to heroin crack cocaine or cannabis.

What we're trying to do is minimize the amount of substance use across society, so we've laws, rules, regulations. We also have primary prevention, where we're trying to persuade people to avoid stepping into the world of

substance use in the first place, largely school-based, largely focused on children. We have secondary prevention where those who have taken a step into that world, we're trying to avoid them establishing a pattern of more regular use.

In our hospital settings we have brief interventions where, as health professionals, we talk to people we meet who are using alcohol or drugs about their relationship with those substances, and try to nudge it in a less harmful direction. Then, at the end of the spectrum here we've got the subset of the population who've run into an addiction issue, or a substance use disorder is the more modern term.

Historically, the demand was you had to become abstinent if you had an addiction issue, but over the last 25 years harm reduction approaches have come to the fore, where there's a recognition that only a minority of people in any given treatment interaction will actually sustain a period of prolonged abstinence.

As I said, my primary concern relates to cannabis and that's because I work in adolescent addiction services and have done so for the last 20 years. My job was created because of the heroin epidemic. The great news is that from an adolescent age range we've done a fabulous job as a society in pretty much ending adolescent heroin use, and we should celebrate that and notice that, and avoid the narrative of nihilism and hopelessness which suggests that 'All Is Lost' in terms of our relationship with drug policy

As a society there have been huge successes, particularly heroin addiction, but there are current challenges. The drug that dominates my work now is cannabis. 80% of the referrals into our services not just in Dublin but nationwide are due to cannabis. Up to the age of 25, no substance is generating more demand for addiction treatment than cannabis, even ahead of alcohol. The groups we're seeing are mainly male, probably four boys for every one girl. It's all social economic groups, it's certainly not just confined to areas of deprivation, and these young people are presenting with very substantial problems.

Would I rather deal with a cannabis dependent teenager or a heroin dependent teenager? Certainly, you know, but it shouldn't be a swap for heroin to cannabis. Cannabis dependence really derails young lives. It is associated with very significant mental health issues, damages family relationships. Parents who are living with a teenager with a cannabis use disorder, the big thing they describe is anger and aggression within the home. So this is really a significant health problem and it is everywhere, as I said, it's across all those economic groups.

This is a survey that was done in a local drug task force area in West Dublin, a community that has had way more than its fair share of heroin problems in the past and the members of the community were asked what drugs can causing problems in your community and cannabis topped the list. You see crack cocaine is second there on the list. That's what got all the headlines. The media seem to love crack cocaine but everyone just ignores cannabis. But this community is not ignoring cannabis, it's saying it is the top problem or biggest problem that they're seeing within their community

If we're going to think about drug policy and prevention, we've got to look at why people use drugs and the most common reason that young people report for using drugs is pleasure seeking, it's looking for fun, looking for a bit of a laugh. Doctors who've looked at drug policy and the doctors internationally who've seen most in terms of drug policy options are those in the United States, the American Medical Association have been looking at what's happening there, they think legalisation is a mistake. The American Academy of Pediatrics also say legalisation is a mistake. Why? Because it's not delivering what it promised, it's resulting in more people in emergency departments, more young adults with addiction and it's not getting rid of the black market. The idea that we can get rid of organised crime groups is a fantasy.

They will retain probably 50% of the market at least, and who will go to the criminal gangs when you've got a competing illegal and legal market? It's those with the least money and the most addiction and the youngest children will obviously have to go to the drug dealers. So our view in terms of drug policy, the focus should be on prevention and on treatment. We do across a whole range of health risk behaviours, driving even during covet and when we've got health-led approaches we do have a balance in terms of information recommendations and a degree of enforcement.

We can have a conversation about what deterrence we use, but legalisation is a step far too far.

4.6.5 Questions & Answers

Panellists responded to a question about their views on legalising and regulating drugs.

Mr. D'Arcy agreed that quality control, prevention and regulation would be a brave but welcome step. Not just for cannabis, but cocaine, which he described as the big money-maker for gangs. He highlighted the merits of a regulated model that takes the huge profits out of drugs by selling drugs at below the minimum price that organised crime could make money at. While there would still be criminal activity, it wouldn't be at the same level as now. Prof. Doherty commented that what is seen in other jurisdictions is that when drugs become more available and more acceptable, there is an increased rate of usage. She recalled the situation ten years ago when there was a major surge in Headshop drugs. At the time, she was working as a junior doctor in the Mater Emergency Department and recalled passing 10 or 15 Headshops each day on route to work. Every single day the Emergency Department would see three or four young people who were extremely unwell and acutely intoxicated, needing high levels of security because they were so agitated. When they sobered up and were able to converse with the medical staff about their acute episode, they would always turn around and respond along the lines of 'What's wrong with you? They're legal, and I'm perfectly entitled to take them.' It became very difficult to make an effective health intervention, because there was a real perception of acceptability, that these drugs are legal, ergo they are okay.

Mr. Temple replied that regulation would enhance the safety of people who use drugs. Recalling his experience of working in the Mater A&E department, he described once talking with a man who had overdosed, who explained that he normally takes blue pills, and on the particular day he overdosed he didn't have blue pills so got yellow pills instead, and took two of them. If society responds to a dangerous drug like alcohol by regulating it, so that people aren't drinking paint striper and going blind from it, that seems like the most sensible step. It removes morality from the issue. He stated that the fact is that people will do drugs. Cannabis for example, has been used for thousands of years, as far back as ancient Egypt. If people are going to use drugs people to alter their minds, why not create an environment that allows them to do so safely.

Prof. Smyth replied that, if Ireland were to legalise drugs, we could look to the US and Canada right now to see the evidence of what might happen. What's happening is you get a race to the bottom in terms of competition between the criminal suppliers and the regulated suppliers. Drug potency increases and prices drop, making drugs more affordable and more dangerous. Ultimately, this is driving up health problems. It has nothing to do with morality, this is entirely a health-based issue. If we regulate drugs, we will have more people in our emergency departments with health problems. Just look at the drug that is already regulated in Ireland – alcohol. In terms of single substance overdoses in Ireland alcohol is the drug that causes the most fatal overdoses, more than heroin or cocaine. The fact it's legally available and regulated, with products of known purity and potency, does not stop the deaths.

Mr. D'Arcy added that nobody is suggesting we return to a situation where cannabis or cocaine will be sold from unregulated outlets like Headshops, which everyone agrees was an absolute disaster. That's one of the reasons why Youth Workers Against Prohibition want regulated distribution through either government outlets or pharmacy chains, which already distribute drugs like methadone to 10,000 people every day.

Panellists responded to a question about the importance of funding leisure activities to help younger people avoid getting involved in drugs.

Mr. Temple replied that, having grown up in an area that was over-policed, he recalled being stopped and searched numerous times by the Gardaí, saying that that approach is not doing much good to build community relations or to encourage young people to engage. He said that he was lucky that he was never convicted of a criminal offence, meaning that he was able to attend college and get a degree. He would never have been able to get any of the jobs that he has worked in had he been prosecuted. In terms of engaging young people from the kind of communities he grew up in, he explained that there was a Youth Club but it was very difficult to get people to engage, particularly in any kind of Garda-led community facilities.

Mr. D'Arcy referenced the Icelandic model, which seems to have been very successful. While it's been piloted in Ireland, it needs to be significantly invested in and mainstreamed. He explained that Iceland, which had one of the highest levels of teenage alcohol misuse and anti-social behaviour, developed the Reykjavik Card. This provided free or subsidised access for every young person, every day after school, to youth activities. This meant a huge investment in sport, the arts, recreation, and transport, and had a huge impact in terms of addressing the issues.

He continued by observing that he has never seen, either on social media or national media, a really good health promotion campaign around the dangers of drug use. While we've seen how successful that has been in terms of issues like smoking and drink driving, he doesn't understand why we don't invest in health promotion around the dangers of drug use. Young people aren't stupid, and can be seen to respond to public health messaging. 50% of young people have made a decision by age 16 not to drink alcohol for the moment, and 75% of them have made the decision not to smoke cigarettes, even though they're legally available, because they recognise and understand the harms. Giving young people information about the harms of drug use would have an impact.

Responding to a question about how regulation/legalisation would work, Prof. Smyth pointed towards the experience of other jurisdictions following the legalisation of drugs. In the event of Ireland legalising drugs, we should expect to see organised crime groups relocating operations into the State to supply the European market. As has been seen in North America, organised crime groups operate from those locations with the most liberal drug policies, and so they've moved into California and Colorado, from where they then supply the rest of the States.

Commenting on the SPHE drug prevention programme, Prof. Smyth described it as a decent programme, but observed that schools need a little bit more support in rolling it out. He argued that it's only one source of information for young people. He referenced international research indicating that the majority of social media posts about cannabis are positive, with four positive messages about cannabis for every negative comment, which is part of why attitudes are changing. The Cannabis Risk Alliance would argue that the government or some statutory body needs to step in and communicate the facts and hazards and harms of cannabis to young people more clearly, because they do not understand the problems that this drug can cause.

Prof. Doherty commented that drug prevention messaging must be properly tailored to target groups, which is going to be a big job for public health authorities. This will need to be properly resourced and means getting accurate messaging to young people across social media channels.

Mr. Temple elaborated on Crainn's recommended approach to a legalised and regulated drug market, explaining that, particularly for cannabis, it would look the same as what the Oireachtas Joint Committee on Justice had recommended. This would include home cultivation for personal possession, which could also supply small social clubs, which would straight away remove income from criminal gangs and provide people who want it access to safe cannabis. Then, further down the line, the State should step in and set up a regulatory quality control system similar to alcohol, whereby people can go and choose to buy a beer or to choose a stronger spirit. He explained that in those parts of North America that have legalised drugs, the tax revenues coming from sales are then ringfenced and reinvested into preventative services or healthcare facilities and argued that this would be important to do as part of a regulated model.

Responding to a question about the prevalence of crack cocaine, Prof. Smyth explained that it doesn't feature as an issue with the under 18s that he works with, which includes deprived communities that were badly affected by the heroin epidemic. The bulk of the crack cocaine problem seems to be in the exact same group of people who were caught up in the 1990s heroin epidemic. A proportion of those who continue to struggle with a range of polysubstance addictions over the last 20 or 30 years are now using crack cocaine. In five years', time it will be a different drug, but for now, crack cocaine is having a devastating impact on the lives of those people who use it. The media love hyping up crack cocaine as a story.

On the question of whether a regulated market with legalised drugs that removed just 50% of criminal activity was better than an approach that left the market entirely in the hands of criminal gangs, Prof. Smyth explained that as a doctor, the purpose of drug policy is about keeping people healthy, and that's his only priority. He's resigned to the fact that there is always going to be criminal gangs, and he is not interested in making that issue more important than keeping people healthy. If the argument is that we need to regulate the market in order to give the criminal gangs a bit of a bloody nose and remove half their income, that's not a price worth paying for the additional health problems that will flow from legalisation. The simplest way of reducing the income of criminal gangs is to reduce drug use.

Concluding the Q&A session, Mr. D'Arcy agreed with Prof. Smyth that the vast majority people using crack cocaine are polydrug users, where they are on heroin or methadone, along with benzos and crack cocaine. He agreed it is a devastating drug that you wouldn't want to see anybody using.

In terms of legalisation, the Youth Workers Against Prohibition group is calling for the regulation of both cannabis and cocaine. Cocaine is a huge money spinner for the drug gangs, and we're not going to get rid of drug gangs by just regulating cannabis, so we're looking at regulating both those particular drugs, which would remove the vast majority of the profit from the criminals.

In terms of drug prevention and education through SPHE, a lot of research around drugs education in secondary schools suggests that it really has no lasting impact on young people beyond the first two or three weeks. This is possibly because it's delivered sometimes by people who know less about drugs than the young people themselves. Another reason why young people are often attracted to illegal drugs is for the very fact that drugs are illegal, so drug use is part of that risk-taking behaviour by teenagers.

4.7 Secretariat Working Paper on Legal Frameworks

The final two sessions of the fourth meeting of the Citizens' Assembly focussed on options for a legal framework. These sessions were supported by a Secretariat working paper circulated in advance to members. The following is an extract from that working paper. The full original version is published on ***www.citizensassembly.ie.***

4.7.1 Introduction

This document has been prepared to support the workshop on Sunday. It does not purport to be a definitive analysis or an exhaustive examination of the legal framework or criminal justice system in respect of drugs use. It simply provides some background reading material, explains key terms and concepts, and provides material for use during the workshop.

It also references and provides links to a range of more detailed reading material including legislation and policy at international, EU and national level, as well as previous analyses of some of the issues. It also draws on submissions made to the Assembly by stakeholder groups and the general public.

An early draft of this paper was reviewed by an ad-hoc group including people with expertise in law, criminology, sociology, criminal justice, drugs policy and deliberative democracy.

Editorial control and full responsibility for any errors or omissions rests entirely with the Secretariat.

Table 1 Ad-hoc group

- **Prof. Tom O'Malley**, Associate Professor of Law, Galway University, Senior Counsel and member of the Inner Bar of Ireland
- **Dr James Windle**, Lecturer in Criminology and Director of the BA Criminology Degree, University College Cork
- **Prof. Yvonne Daly**, Professor of Criminal Law and Evidence in the School of Law and Government, Dublin City University
- **Prof. Andrew Percy,** Quantitative Criminologist and Professor of Sociology and Social Work, School of Social Sciences, Education and Social Work, Queens University Belfast
- **Mr. Brendan Hughes,** Principal scientist, Drug legislation, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
- **Prof. Deirdre Healy**, Director of Institute of Criminology and Criminal Justice and Associate Professor at the Sutherland School of Law, UCD
- **Prof. John Garry,** deliberative democracy expert on the Assembly's Advisory Support Group, and Professor of Political Behaviour and lead at The Democracy Unit, Queen's University Belfast

The second day of the programme [for the fourth meeting of the Citizens' Assembly], Sunday 3rd September, switches the focus to legal issues. This will be the first time the Assembly has considered what *legislative* changes the State might make. The previous three meetings had intentionally steered clear of discussing legislation, focusing instead on looking at policy and practice/operations.

Sequencing things in this way means that members are now well-versed in the range of issues that might, or might not, be impacted by legislative change. The knowledge that members have now acquired means that discussions about potential changes to the legal system will not happen in a vacuum. Instead, the stage is set for members to deliberate on these questions with the benefit of a well-informed understanding of the real-world problems that they might wish to tackle.

By the time they begin their deliberations on legal issues, members will have had approximately 50 hours of presentations and deliberations on policy and practice in the health, criminal justice, community and voluntary sectors. They will have heard from professionals and volunteers working in these sectors, as well as academics and policy experts from Ireland and internationally. Importantly, they have also heard from people with lived experience of drugs use and their families, as well as service users with personal experience of the health and/or criminal justice systems. Members have also had online access to the almost 800 submissions from members of the general public,

service providers and other stakeholder groups. These submissions offer invaluable insights into the diverse and divergent perspectives, concerns and priorities of individuals, organisations and stakeholder groups.

4.7.2 Legislative framework governing illicit drugs and related matters

Ireland's legislative framework governing illicit drugs and related matters is based on an extensive body of international, EU and national law.

International law is primarily specified in three UN Conventions, each of which Ireland is a party to. These are the 1961 UN Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Substances, and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, known collectively as the 'International Drug Control Conventions' [🔗]. Ireland's adherence to the three conventions is monitored by the International Narcotics Control Board [🔗].

EU law in relation to illicit drugs is primarily specified in the 2004 Council Framework Decision (2004/757/JHA) [🔗].

National legislation in relation to illicit drugs is specified through an extensive range of primary and secondary legislation (statutory instruments, by-laws, etc.).

Table 2, below, provides a non-exhaustive list of relevant topics and legislative instruments.

Human Rights law also has an important bearing on drugs legislation and policy. Ireland is party to international and EU human rights conventions including the Universal Declaration of Human Rights [🔗] and the European Convention on Human Rights [🔗]. The Council of Europe Pompidou Group (2022) provides a detailed account of human rights and drugs policy [🔗], while the Assembly heard at its first meeting from Mr. Thomas Kattau, Deputy Director of the Pompidou Group. [video] [presentation].

To describe this body of legislation as detailed and complex would risk understating the matter. The scale and complexity of this legal framework poses an obvious challenge for Assembly members. On the one hand, members are being asked to consider whether and how the legal framework should change, but on the other hand they are not, and should not be expected to become, legal scholars.

Added to this, the time constraints under which the Assembly is operating mean that members will not have enough time to deliberate on all aspects of the legal framework, and therefore must prioritise the issues that they consider most important.

Table 2 below illustrates just some of the issues covered by primary and secondary legislation. Members wishing to explore this legislation in further detail can follow the links to the source information by clicking the 🔗 symbols.

Table 2 Examples of topics related to drugs, and associated legislative instruments

The following non-exhaustive list illustrates just some of the issues dealt with under primary and secondary legislation.

Instrument	Examples of issues covered
Misuse of Drugs Act, 1977 [🔗]. Scheduling of controlled drugs; drug trafficking, importation and exportation; cultivation and manufacturing; transportation and storage of controlled drugs; permissive offences (i.e. allowing someone to use your home to sell or store drugs); possession of controlled drugs for personal use; possession with intent to sell or supply; prescribing controlled drugs; Garda powers of search, detention, inspection, arrest, rearrest; questioning of suspects; powers to remand, provision to arrange for medical treatment or care; penalties, custodial sentences, fines; sentencing;	
Criminal Justice (Drug Trafficking) Act 1996 [🔗] drug trafficking, importation and exportation; powers of search, detention, inspection, arrest, rearrest	
Criminal Justice (Psychoactive Substances) Act 2010 [🔗] Control of new psychoactive substances, prohibition of sale and advertising, Garda powers to enter, search and seize.	
Criminal Justice Act 2006 [🔗]. Supply of controlled drugs into prisons and places of detention. (S99) Power to suspend sentence, including with the condition that the person undergo such (i) treatment for drug, alcohol or other substance addiction, (ii) course of education, training or therapy, (iii) psychological counselling or other treatment, as may be approved by the court.	
Misuse of Drugs (Supervised Injecting Facilities) Act 2017 [🔗] Supervised injecting	
Criminal Justice Act, 1994 [🔗]. Forfeiture, confiscation and destruction; trafficking; money laundering; seizure and detention of cash/money;	
Misuse of Drugs Act 1984 [🔗]. Analysis, proof and valuation of controlled drugs	
Adult Cautioning Scheme [🔗] Adult caution	
Children Act 2001 [🔗]. Youth diversion	
Probation of Offenders Act, 1907 [🔗]. Probation	
Parole Act 2019 [🔗]. Parole	
S.I. No. 167/1960 - Prisoners (Temporary Release) Rules, 1960 [🔗] and C**riminal Justice (Temporary Release of Prisoners) Act, 2003** [🔗]. Temporary release	
Prisons Act, 2007 [🔗] and **S.I. No. 252/2007 - Prison Rules, 2007** [🔗]. Remission	
Criminal Justice (Community Service) Act, 1983 [🔗] and **Criminal Justice (Community Service) Amendment Act, 2011** [🔗]. Community service, Community Return Scheme,	
Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016 [🔗]. Spent convictions	
Misuse of Drugs (Amendment) Act 2016 [🔗] and **S.I. No. 237/2022 - Misuse of Drugs (Prescription and Control of Supply of Cannabis for Medical Use) (Amendment) Regulations 2022** [🔗] Prescription and control of supply of cannabis for medical use	
Criminal Justice (Psychoactive Substances) Act 2010 [🔗]. Psychoactive substances	
Criminal Assets Bureau Act, 1996 [🔗] and **Proceeds of Crime Act, 1996 to 2016** [🔗]. Freeze and seize assets which are the proceeds of criminal conduct.	

Table 3 Human Rights and Drugs Policy – a brief overview

The following is extracted from 'Human Rights and Drug Policies: International instruments, case law and reference texts' (Council of Europe (2022) [🔗].

Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination. Human rights entail both rights and obligations. States assume obligations and duties under international law to respect, to protect and to fulfil human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights. At the individual level, while we are entitled our human rights, we should also respect the human rights of others.

Some of the rights set out in the European Convention on Human Rights are absolute. They cannot be the subject of interference by the state, without exception (such as the right to life, or the prohibition of torture or inhuman or degrading treatment or punishment. Other rights may be limited under certain circumstances, such as the right to liberty or personal freedom, where the deprivation of liberty is allowed when it is prescribed by law and subject to various procedural safeguards. Article 5.1.e of the ECHR appears to permit the detention of 'alcoholics, drug addicts and vagrants'. Similarly, the right to private life and the freedoms of thought, expression and association are not absolute and their enjoyment can be subject to conditions or restrictions in specific cases (e.g. for the prevention of disorder or crime, the protection of health or morals, or the protection of the rights and freedoms of others).

Human rights specifically relevant to drug policy enshrined in Council of Europe Conventions include:

- The right to equitable access to health care
- The right to information about one's health, including the right not to be informed
- The protection of personal data concerning health
- The prohibition of medical treatment without consent
- The prohibition of inhuman or degrading treatment
- The prohibition of compulsory labour

4.7.3 Key definitions: uses and limitations

Internationally and in Ireland, various terms such as *criminalisation*, *prohibition*, *depenalisation*, *diversion*, *decriminalisation*, *regulation* and *legalisation* are referenced extensively by academics, legislators, policy makers, stakeholders and media commentators.

However, some of these popularly-used terms are so loosely defined that their use in discussions and debates can very often serve to confuse the listener. In some instances, people use different terms interchangeably as if they meant the same thing (e.g. *legalisation* and *decriminalisation*), while in other cases, two people can use the same term but mean entirely different things (e.g. *decriminalisation* can result in radically different systems, depending on how the law is designed and implemented.)

The following definitions, drawing on sources including the EMCDDA (2023), are helpful in so far as they provide some degree of conceptual clarity around frequently-used terminology. Perhaps more importantly though, the accompanying commentary from EMCDDA makes it clear that there are limitations to the usefulness of these terms.
Prohibition refers to forbidding something by law. In Ireland, the possession, sale and supply of controlled drugs is deemed illegal and is prohibited by law. Possession is prohibited under Section 3 of the 1977 Misuse of Drugs Act, while sale and supply is prohibited under Section 15 of the same Act.

Criminalisation refers to the act of determining in law that the commission of a specified illegal act constitutes a criminal offence.

Decriminalisation refers to the removal of criminal status from a certain behaviour or action. However, it does *not* mean that the behaviour becomes legal, nor does it mean the elimination of sanctions or penalties for the commission of an offence. It generally means that the nature of penalties and sanctions change from criminal to non-criminal. Therefore, the likelihood of an offender receiving a criminal record and custodial sentence can be significantly reduced, or indeed entirely eliminated following decriminalisation. However, other sanctions and penalties can still be applied. For example, drugs can be confiscated and non-criminal penalties such as fines may still be applied. Such non-criminal penalties are not always 'small'; in Spain, a first drug use offence may result in a (non-criminal) fine of €600. In Portugal, a range of penalties can be applied to people found in possession of drugs for personal use: they may be diverted to health or social services, or have a fine imposed, or be required to do community service. In debates about drugs policy, 'decriminalisation' is usually used to describe laws related to personal possession or use (typically of small amounts without any intent or attempt to supply) rather than drug supply. Examples of countries which have decriminalised drug use or personal possession include Luxembourg (only cannabis), Croatia, Portugal and Slovenia.

Depenalisation refers to the policy of closing a criminal case without imposing punishment, for example because the case is considered 'minor' or if prosecution is not in the public interest. Examples include Austria, Germany and Poland. Another well-known example of depenalisation model is found in the Netherlands ('coffee shop model'), whereby selling and possessing scheduled drugs remains illegal and punishable under law, but the State does not prosecute possession of cannabis for personal use, and tolerates the sale of cannabis in 'coffeeshops' provided vendors adhere to detailed guidelines.

Diversion refers to any mechanism that moves an offender away from the path of punishment by the criminal justice system and towards a health-oriented response such as counselling, treatment or social reintegration.

The system in Portugal, whereby people found using drugs or in possession of a small quantity of drugs for personal use may be diverted away from punishment towards a health-oriented response, is often referred to as 'decriminalisation' but it is important to note, as the Portuguese authorities themselves have been at pains to point out, that the model is set up primarily to support 'diversion'. In fact, the authorities also have the option, frequently used, of closing the case ('depenalisation'). It is an illustration that there is not only one option but there may be combinations.

Legalisation refers to the process of moving from prohibition to regulation, making an act that was previously prohibited now lawful. A regime of regulation may limit the extent of permissions involved, as is the case for regulations related to alcohol and tobacco purchase and use (e.g. age rules). It would remain illegal for non-regulated bodies to sell drugs. There are different ways to regulate the sale of currently controlled drugs, ranging from State monopolies to free market approaches. Penalties for breaching these regulations may be criminal or non-criminal. The term 'legalisation' is often used in the context of removing penalties for some forms of drug production, supply and sale. Examples of this kind of approach can be found in Uruguay, Canada and over 20 US states. In addition, this could include the system established to permit home-grown and private use of cannabis in Malta and in the Australian Capital Territory.

Harm reduction encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies. Harm reduction interventions emphasise working non-judgmentally with people who use drugs in order to reduce the risks associated with behaviours that are mostly associated with adverse health outcomes, and more generally to promote health and well-being. Probably the best known of these is the provision of sterile injecting equipment to people who inject drugs, with the aim of reducing the risk of contracting an infectious disease. [🔗]

Health-led responses are those which focus in the first instance on actions or interventions that address drug use and associated health and social harms, such as deaths, the spread of infectious diseases, dependency, mental health disorders and social exclusion. [🔗]

4.7.4 Other considerations to bear in mind

The design and implementation of drugs legislation, policy and practice in different countries within the EU, and beyond, is both highly complex and diversified. As the EMCDDA and other commentators have pointed out, even where there is high-level consensus on the meaning of terms, in practice each can be implemented in many different ways.

As well as the definitions above, it may be useful to consider some of the following points regarding the role of legislation.

4.7.5 Interplay between legislation, policy and practice

Apart from the question of what the legislation does or does not provide for, is the question of how legislation, policy and practice interact with each other. It is not simply the legal code that determines how a country's health, justice, social and community care systems respond to people who use drugs. The interplay between legislation, policy and practice is crucial.

The Citizens' Assembly has already heard a lot about policy and practice in the health, community and voluntary sectors. It has seen examples of practices that may not work well, and other examples of things that are working. The day preceding the workshop, the Assembly will hear further examples of good practice, and perhaps bad practice, within the criminal justice system.

Positive interactions between legislation, policy and practice tend to occur where there is a clear sense of the underlying values and strategic objectives of national policy, combined with good leadership, adequate resources, a commitment to strategic partnerships between actors, and scope for discretion and innovation in practices.

The examples of good practice, or innovations that lead to better outcomes, that are possible within the existing legal framework, are often enabled by something as simple as a newly-agreed guideline, protocol or pilot initiative. They are typically driven by motivated leaders and innovators, be they legislators, policymakers, professional and service providers in the community and voluntary sectors, criminal justice or health systems, volunteers, family members, or service users themselves.

A notable illustration of the interplay between legislation, policy and practice is seen in the concepts of *de-jure* and/or *de-facto* policies.

So, for example, ***de-jure decriminalisation*** means decriminalisation has been legislated for, as Portugal has done for cases of simple possession. ***De-facto decriminalisation*** means that while the law has not explicitly decriminalised the act of possession, the situation on the ground (the policies or practices followed by police, prosecutors and courts) means that decriminalisation exists *in effect*, or to all intents and purposes.

In some cases, a country that has 'de jure' decriminalisation for simple possession may not necessarily have as lenient a regime as a country that has 'de-facto' decriminalisation. For example, in one EU Member State that has de-jure decriminalisation, people found in possession of drugs for personal consumption can receive administrative detention of up to 30 days. Meanwhile, other countries that have not decriminalised in law can be said to have effectively decriminalised in practice, because of the existence of informal tolerance (e.g. Netherlands), formal diversion protocols, sentencing guidelines and other mechanisms that support a comprehensive health-led approach.

4.7.6 Research, Assessment, Piloting, Monitoring and Evaluation

Any legislative change comes with the general risk that by attempting to fix one problem, another problem can be unintentionally created – the phenomenon of 'unintended consequences'.

As a general principle, legislative changes should be subject to careful consideration and evaluation, both at pre-legislative (e.g. pre-legislative scrutiny by Oireachtas committees) and post-enactment stages, informed by primary research, regulatory impact assessment, cost-benefit analysis, risk analysis, impact assessment and so on.

Any new approach should be flexible and changes may need to be made at a later stage if it is found that a particular element is not working as intended.

As a rule of thumb, the Assembly should avoid 'over-engineering' any recommendation it might make in relation to legislative change. In other words, identify the course of direction to travel in, but don't build the plane to fly there. Leave that to the legislature and legal experts.

There is also scope for the Assembly, if it wishes, to qualify any recommendation for legislative change with, for example, supplementary recommendations that it be subject to regulatory impact assessment, risk analysis, successful piloting, phased or staged introduction, or all of the above.

4.7.7 A range of legal frameworks

The typology presented here sets out five different models to illustrate plausible but hypothetical alternative approaches that a legal framework might take.

It is important to note that the five alternative approaches presented here, referred to as Models A – E, are not five 'options', but five 'examples' to illustrate the possible characteristics of different legal frameworks in dealing with the range of harms that have been identified.

Each example has flexibilities within it to 'dial up' or 'dial down' its responses.

Each example may also have elements within it that could be transposed into another of the models. In some cases, there may be legal or constitutional constraints as to what can be done. However, this is something for the Assembly to explore.

During the workshop, members will have an opportunity to hear from and question both stakeholders and experts about any aspect of the legal debate that they wish to explore.

At the end of the workshop, members will be asked to respond to the evaluation worksheet that tries to capture their initial impressions about each model, including the potential advantages and disadvantages of the model for different groups and sectors.

Finally, members will be asked to indicate whether, if they could combine the best of different elements of models A-E, what would be their preferred 'baseline model, and what elements of other models would they ideally like to incorporate.

It is entirely conceivable that, during or after the workshop, members will identify other model, or models, which are not captured by the ones set out here. The intention is that the feedback and evaluation forms that members fill in, anonymously, at the end of the workshop will give the Secretariat information that will assist in designing draft ballots.

Model A: 'The Status Quo'

This model represents the 'status quo', or the system currently in place in Ireland. The Assembly has already heard a considerable amount of evidence about ways that this model works, and doesn't work. It has heard of examples of good practice, and examples of poor practice, resource constraints, suggestions of a lack of strategic coordination and other challenges. On the day preceding the workshop, members will hear additional perspectives on what works, and doesn't work, this time in terms of what is happening within the criminal justice system.

Model A could be characterised as having an emphasis on generally dissuading people from using drugs (primarily through the criminal justice system, underpinned by the sanctions provided for in the 1977 Misuse of Drugs Act), and on providing health-led responses to people with problematic drug use (e.g. harm reduction, treatment, rehabilitation and recovery services provided by a wide range of statutory, community and voluntary organisations under the National Drugs Strategy).

Relative to other models explored in this workshop, Model A has limited provisions within the legal code, both pre- and post-conviction, to divert people with problematic drugs use into health-led interventions, and limited options to de-penalise people found in possession of drugs for personal consumption.

In terms of policing, there are certain provisions available within the existing legal code, such as the use of the Adult Caution scheme for first-time Section 3 offenders (a depenalisation and dissuasion measure), as well as informal diversion protocols between the Gardaí and service providers (e.g. LEAR). In terms of flexibilities available to the Courts, the Probation of Offenders Act 1907 permits courts to dismiss a charge or strike out a case following a successful prosecution, thereby ensuring the avoidance of a criminal conviction (depenalisation). It also allows the Courts to divert offenders away from custodial sentences to alternatives such as the Drugs Treatment Court or equivalent (diversion). There are also provisions available to enable people serving prison sentences to avail of parole or early release schemes subject to participation in community-based services (diversion).

The extent to which these available options are generally utilised is arguably limited. As members begin to reflect on the status quo, perhaps a good starting point is to consider whether there is adequate scope and flexibility within the current system to significantly reduce the harmful impacts of drugs use on individuals, families, communities and wider society? For example, if the status quo were to be reinforced and strengthened (for example, with changes to policy and practice to make more widespread use of existing flexibilities to depenalise and divert, or with the investment of significant additional resources into the criminal justice and/or health systems, overseen by more effective strategic coordination, etc., might those measures suffice, without the need for legislative change? If not, which issues specifically cannot be adequately resolved within the existing legal framework?

Key features of Model A

General characterisation: Possession, sale and supply of controlled drugs is illegal, and punishable in law through criminal sanctions. The health, community and voluntary sectors provide a range of services for people who use drugs problematically. Resources to run these services are currently constrained, and there could be scope to increase these resources. Similarly, there could be scope to overhaul the strategic coordination of services. For its part, the criminal justice system has a range of mechanisms at its disposal, pre- and post-conviction, to depenalise and/or divert people with problematic drugs use away from the prison system into health services. The degree to which these mechanisms are used in practice is limited and has scope to be expanded.

Possession for personal use (Section 3 offences): Illegal, prosecuted under the criminal code. Punishment for possession of drugs other than cannabis: up to 12 months imprisonment (summary conviction), up to 7 years imprisonment (conviction on indictment). Possession of cannabis is punished by a fine of up to €381 (first offence, summary conviction), €508 (second offence, summary conviction), €1270 and/or imprisonment up to 12 months (third or subsequent offence, summary conviction). For conviction on indictment, the penalty ranges are elevated: fine up to €635 (first offence), fine up to €1270 (second offence), then up to 3 years imprisonment (third or subsequent offence). For a brief explanation of summary and indictable offences, see here [🔗].

Sale and Supply (Section 15 offences): Illegal, prosecuted under criminal codes. Supply of drugs is punished by up to 1 year imprisonment on summary conviction; up to 14 years imprisonment on conviction on indictment. Minimum punishment of 10 years imprisonment, and maximum of life, is set for when the value of drugs exceeds €13,000.

Dissuasion: Strong dependence on the dissuasive power of the Misuse of Drugs Act 1977 and related legislation.

Health, treatment, rehabilitation: Many examples of good practice and effective interventions, but consensus among stakeholders seems to be that much more needs to be done in terms of resources and coordination. This may become even more apparent following deliberation on the criminal justice system.

Diversion and alternatives to coercive sanction. Limited. Gardaí have no formal powers to divert to health or social services. A number of pilot diversion programmes (e.g. LEAR) are in place, but do not have a clear legal underpinning. Gardaí can apply the Adult Caution Scheme as an alternative to prosecution for first offences under S3 (possession for personal use) in the case of cannabis only, but currently this does not apply to other drugs. The Courts have the option of referring a person to the Drugs Treatment Court or equivalent (members will be presented a case study on this at the next meeting), but there is limited availability of such courts around the country. In turn, the Drugs Treatment Court has the option to either apply the Probation Act, to strike out a case entirely or to refer the offender back to the original court for sentencing. There is also judicial discretion available under the Probation of Offenders Act 1907 which permits courts to dismiss a charge or strike out a case following a successful prosecution, thereby ensuring the avoidance of a criminal conviction.

Non-custodial options post-conviction. Following conviction for simple possession for personal use (S3 offences), a number of alternatives to custodial sentences are open to the Courts, including fines (under the Fines and Recovery Act 2014), Probation Orders (under the Probation of Offenders Act 1907), and Community Service Orders (under the Criminal Justice (Community Service) Act, 1983). For convictions for offences beyond simple possession, including drugs-related offences of sale and supply, a similar range of non-custodial options including probation or fines is augmented by the option (where available) of referring to the Drugs Treatment Court or equivalent (for health-focused treatment, education programmes etc.) or applying a Treatment Order under S28 of the Misuse of Drugs Act.

Examples of relevant submissions CADU778; CADU396; CADU684; CADU401

Model B: 'Dissuasion with Limited Health Diversion'

This Model is essentially the 'Health Diversion' approach being planned under the current National Drugs Strategy. It is similar to Model A ('Status Quo') in that there is a continued emphasis on dissuasion, with possession, sale and supply of controlled drugs remaining illegal, with convicted offenders continuing to be subject to criminal sanctions.

It differs from Model A in that there is a modestly-increased emphasis on health diversion, providing first-time 'Section 3' offenders (people found in possession of drugs for personal use) the opportunity to avoid prosecution and possible criminal conviction by being referred to a health-led 'Brief Intervention'.

The Assembly heard at its first meeting in April that while resources have been put in place by the HSE to operationalise this model, the legislation to give Gardaí the legal powers to refer people to SAOR / Brief Intervention is still awaited, with no indication of when that legislation might be enacted.

Under the model, for second or subsequent Section 3 offences, the person will follow the existing pathway through the criminal justice system, with the same opportunities for depenalisation and diversion as set out above for Model A. People arrested for possession of cannabis for personal use would still have an opportunity to avoid prosecution through the application of the Adult Caution scheme, while people convicted of drugs-related or other offences could still benefit from the flexibilities provided under the Probation of Offenders Act, the Parole Act, temporary or early release schemes.

Model B as it is currently planned would likely result in a relatively modest increase in referrals by the Gardaí into the HSE, which has appointed [9] individuals, one per CHO, as SAOR coordinators. The model could increase its capacity to support diversion, if the number of times a person found in possession for personal use were eligible to be diverted to a brief intervention were increased.

Otherwise, the Model would operate the same as Model A, and benefit in the same way from any improvements to policy, practice, resources or strategic coordination.

Key features of Model B

Possession for personal use (Section 3 offences): Illegal, prosecuted under the criminal code. Punishment for possession of drugs other than cannabis: up to 12 months imprisonment (summary conviction), up to 7 years imprisonment (conviction on indictment). Possession of cannabis is punished by a fine of up to €381 (first offence, summary conviction), €508 (second offence, summary conviction), €1270 and/or imprisonment up to 12 months (third or subsequent offence, summary conviction). For conviction on indictment, the penalty ranges are elevated: fine up to €635 (first offence), fine up to €1270 (second offence), then up to 3 years imprisonment (third or subsequent offence).

Sale and Supply (Section 15 offences): Illegal, prosecuted under criminal codes. Supply of drugs is punished by up to 1 year imprisonment on summary conviction; up to 14 years imprisonment on conviction on indictment. Minimum punishment of 10 years imprisonment, and maximum of life, is set for when the value of drugs exceeds €13,000.

Dissuasion: Continued strong emphasis on the dissuasive power of criminal sanctions.

Health, treatment, rehabilitation: Weak to moderate. Compared to Model A (Status Quo), it offers first-time S3 offenders access to a health-focused SAOR or 'Brief Intervention'. For other offences (e.g. S15) there is no change. Nor does it envisage or necessitate any significant change to the level of resources for community-based, residential or prison-based treatment, rehabilitation or recovery services.

Diversion and alternatives to coercive sanction: Limited, though greater than Model A. When legislated for, Gardaí will have formal powers to divert first-time S3 offenders to health services for a SAOR brief intervention. Otherwise, no change from Model A, including for offences other than S3.

Non-custodial options post-conviction: No change from Model A

Examples of relevant submissions: n/a, but see a Department of Health presentation on members' area of website.

Model C: 'Dissuasion with comprehensive Health Diversion'

This Model would continue to prohibit and seek to dissuade the possession, sale and supply of controlled drugs, but would see the State's response to drugs use pivot to a comprehensive health-led approach, enabled by appropriate adjustments to legislation, policy, practice and resource allocation across the criminal justice, health and community and voluntary sectors.

This Model attempts to encapsulate the intent and priorities of a significant number of inputs and submissions the Assembly has received from organisations and representative groups across the community, voluntary and health sectors that support people with problematic drug use. Areas of broad consensus among these groups include the view that the existing level of resources within the health, community and voluntary sectors needs to be improved, that the dissuasive impact of criminal sanctions, by itself, does not decrease prevalence or improve health outcomes for people with problematic drugs use, that there should be a more comprehensive health-led approach, and that there is an argument for not criminalising people found in possession of drugs for personal use.

Model C would have similar objectives to the systems in Austria and Portugal, which the Assembly has previously received presentations on. Both the Austrian and Portuguese responses to drugs use depend on having health and social care systems with sufficient capacity and resources to provide health-focused interventions for people with problematic drug use, including assessment, treatment, rehabilitation and recovery. They also provide for assessment and education for people with non-problematic drug use.

Under Model C, as with Models A and B, the possession, sale and supply of drugs would continue to remain both illegal and subject to sanctions intended to dissuade and support. The sanctions regime would be re-designed to prioritise health objectives where appropriate.

The possession of controlled drugs for personal use would be decriminalised but would remain illegal and subject to non-criminal sanctions (such as obligations under a health diversion scheme, fines or community service). In designing a legislative framework that decriminalises personal possession, it is not entirely clear whether Ireland could legislate in the same way as Portugal has done to achieve de-jure decriminalisation, or whether it would opt instead for de-facto decriminalisation, as Austria has done. This is an issue that can be examined further during the workshop.

One way or another, a core feature of Model C would be 'Assertive diversion', whereby Gardaí would have the power and mandate to refer people found in possession for personal use to the appropriate health-led intervention, while Courts and prisons would have the mandate and objective to divert people in the first instance to appropriate health-led interventions. This is likely to lead to an increase in the number of people being referred into health-based systems, and to place further demand on services, necessitating increased levels of resources.

Under Model C, people caught in possession of drugs for personal consumption could/would avoid prosecution, criminal records and custodial sentences, either all of the time (with de-jure decriminalisation), or 90% plus of the time (with de-facto decriminalisation), on condition that they cooperated with appropriate health-led interventions where recommended. Subject to possible constitutional and legislative constraints, a range of administrative sanctions may be possible in the event that a person declined to cooperate. As in Portugal, there would be the opportunity for procedures to be 'struck out'.

For a person with problematic drug use who face charges for any offence, be it drugs-related or otherwise, a range of options would be readily available to the Courts, and some to the Gardaí, to divert the person away from prosecution and custodial sentences towards community-based or residential treatment and other supports (e.g. the Cork District Court diversion model, which members will hear about).

For a person with problematic drug use who ends up receiving a conviction, that person would have a greater prospect of avoiding a custodial sentence through the application of the Probation Act, the involvement of the Probation Service and community-based or residential treatment and recovery services, and the more extensive roll-out of programmes such as that operated by the Dublin Drugs Treatment Court in conjunction with the Education and Training Board and other partners.

In the case of someone who receives a custodial sentence, that person would have better prospects of in-prison treatment and early release through schemes diverting them out of prison and back into community-based or residential treatment services [e.g. the Probation / Cork Alliance Centre model].

Key features of Model C

Possession for personal use (Section 3 offences): Illegal, but not prosecuted under the criminal code. Law would require that the person found in possession would be referred for a health-led intervention (e.g. SAOR-style Brief Intervention, or Portuguese-style meeting with Dissuasion Committee for assessment and onward referral if appropriate, or for other sanction if deemed necessary – e.g. fines, community service), or have the procedure struck out if appropriate. Gardaí would retain powers of search and seizure, as is the case in Portugal and Austria.

Sale and Supply (Section 15 offences): Illegal, prosecuted under criminal codes. But with increased emphasis on health-based responses and utilisation of existing flexibilities available to the courts, prisons and probation services.

Dissuasion: Less reliance on the dissuasive power of criminal sanction, more reliance on health-led responses, but the continuing illegal status of drugs reinforces the main societal message that the use of narcotics is not allowed or encouraged under law.

Health, treatment, rehabilitation: Strong. Model C depends on significant additional capacity being introduced within prisons, and in the health, community and voluntary sectors. It also depends on 'assertive/proactive' rather than 'passive/reactive' referral to services, meaning that more people are likely to be referred by the Gardaí into health-led services.

Availability of diversion options and alternatives to coercive sanction: Strong. Gardaí and courts would both have legal powers to mandate people to present for health-led interventions (as is the case in Portugal and Austria). In addition to mandatory powers, the pivot to a comprehensive health-led system would encourage greater use of discretionary actions (e.g. by police, judges etc.) to support health-led responses where appropriate.

Non-custodial options post-conviction: Significantly enhanced due to the greater availability of community-based and residential treatment options, the prioritisation of health-led responses by the criminal justice system, and the more extensive use of available powers.

Examples of relevant submissions: CADU619; CADU693; CADU777; CADU792 (video);

Model D: 'Decriminalisation with depenalisation for personal consumption'

Model D would see the State's approach to drugs use pivot to an approach that significantly reduces the extent to which people who use drugs, specifically people found in possession of drugs for personal consumption, are subject to criminal sanction. Under Model D, as with Models A, B and C, the possession, sale and supply of drugs would continue to remain illegal, but for cases of possession for personal use, criminal sanctions would be removed entirely (through either de-facto or de-jure decriminalisation), with minimal non-criminal sanctions (depenalisation).

In submissions to the Assembly, this approach was advocated for by a range of individuals, stakeholder groups and representative bodies whose perspective, broadly characterised, is that the State's approach to drugs use should be less punitive, more compassionate towards people who use drugs, and more respectful of their right to do so should they choose. Underpinning these views is a strong sense that, rather than helping the situation, the State's current approach (Model A) is causing additional harm to people who use drugs, including by reinforcing the shame and stigma associated with drugs use, and causing people who use drugs to receive convictions, fines and/or custodial sentences, and criminal records that have long-term consequences, including possibly hindering their chances of moving towards a positive life with fewer drug problems in future.

Many of the submissions informing this Model make the specific proposal that possession of drugs for personal use should no longer be a criminal offence, while others make a less specific and broader-reaching proposal that 'people who use drugs should not be criminalised'. Underpinning these views are arguments that the legal framework should be informed by an empathetic appreciation of the often difficult personal circumstances (e.g. trauma, mental or physical health issues) that underpin drugs use, by a clearer recognition of the social and economic determinants of drugs use (e.g. the increased vulnerability of people who live in disadvantaged areas, or who live in poverty), and increased prioritisation of the human rights of the person who uses drugs.

Model D is based on the view that the use of criminal sanctions for people who use drugs has demonstrably failed in so far as it has not lessened prevalence and instead has caused additional harm to many people who have been prosecuted, convicted and in some cases given custodial sentences for simple possession. This is popularly characterised in statements like 'the war on drugs has failed'. Proponents of this approach also tend towards the view that the solution to problematic drugs use lies in tackling many of the root causes of drugs use (i.e. poverty, trauma, social exclusion etc.) rather than intervening with people who use drugs, other than responding to people with problematic drug use who seek help. Some advocates of legalisation of drugs support this form of decriminalisation as a 'first step' towards full legalisation.

In legal terms, Model D is similar to Model C to the extent that possession of drugs for personal use, and for sale and supply would remain illegal, but the offence of personal use would not be subject to criminal sanctions.

There are, though, important differences between Model D and Model C. While both would result in decriminalisation for personal possession (whether that is de-jure or de-facto decriminalisation), Model C retains comprehensive non-criminal sanctions as a means of underpinning assertive health-led responses within an enhanced health and social care system, while Model D features a significant reduction of sanctions, retaining perhaps administrative sanctions such as on-the-spot fines (as is the case in France). Instead, the focus in Model D is on tackling the wider socioeconomic issues that underpin problematic drugs use, such as poverty, homelessness, mental health issues and so on.

One of the arguments made is that the introduction of powers (as would be required under Model B or C) to divert people from the justice system to treatment services is contrary to human rights law and standards, as healthcare should be only provided on a voluntary, non-discriminatory basis, and based on informed consent.

Model D could also have consequences for the Gardaí, in that they might not retain the powers of search and confiscation available to them under the current legislation.

Key features of Model D – 'Decriminalisation with Depenalisation for personal consumption'
Possession for personal use: Illegal, but not a criminal offence, and minimal sanctions, other than perhaps confiscation of drugs seized by Gardaí.
Sale and Supply (Section 15 offences): Illegal, prosecuted under existing criminal codes.
Focus on prohibition: Minimal, though the continued illegal status of drugs would reassert the societal message that the use of narcotics is not allowed or encouraged under law.
Focus on health, treatment, rehabilitation: Emphasis on harm reduction and ensuring adequate treatment and other services for people who seek these services, but in the context of a society where underlying social and economic factors are emphasised as policy priorities.
Availability of diversion options and alternatives to coercive sanction: Minimal diversion, minimal sanctions.
Non-custodial options post-conviction: Tbc
Examples of relevant submissions: CADU789; CADU689; CADU614;

Model E: 'Legalisation with regulation'

Model E would see the State adopt an entirely new approach, whereby drugs would be legalised and subject to regulation. This would represent a significant departure from Models A – D, in which narcotic drugs remain illegal.

Model E could be applied to all drugs, or limited to certain drugs, such as cannabis.

Legalisation with regulation is an approach suggested by a number of submissions to the Assembly. Some submissions limit their focus to the legalisation of cannabis, while others call for legalisation of all drugs. If Ireland were to legalise and regulate the sale and supply of drugs, it seems logically inevitable that it would also necessitate the decriminalisation of possession of drugs for personal use, within agreed regulations (e.g. possession in schools or prisons might still be prohibited).

The case for legalisation with regulation typically includes the argument that prohibition has been ineffective, and that legalisation offers significantly more benefits for individuals and society generally than decriminalisation. Under legalisation with regulation, people who use drugs would benefit by a) being able to possess (and consume) drugs without fear of arrest or prosecution, and without the stigma that they currently experience; b) not having to purchase drugs from the black market controlled by Organised Crime groups; c) knowing the source and quality of drugs, reducing the risk of poisoning from contaminated products.

Under Model E, the Exchequer would also benefit from a new revenue stream from taxation of drugs sales, hypothecating these revenues for investment in education, treatment and recovery services for people with problematic drugs use. Some proponents of legalisation make the further point that Ireland has the potential to develop a vibrant cannabis industry, with significant export potential and economic dividends including job creation.

A decision to legalise drugs would require significant redrafting of the legislative framework and regulatory system. Proponents of legalisation frequently assert that North America has seen a series of positive benefits following legalisation, while opponents of legalisation would dispute these assertions and highlight several negative consequences. The EMCDDA representative at the workshop will explain the experience of other EU countries and the findings to date regarding different legalisation regimes in the Americas.

Key features of Model E
Possession for personal use: Legal, not a criminal offence.
Sale and Supply (Section 15 offences): Legal, subject to regulatory requirements imposed on suppliers and vendors.
Focus on prohibition: Minimal.
Focus on health, treatment, rehabilitation: Emphasis on ensuring adequate treatment and other services for people who seek these services.
Availability of diversion options and alternatives to coercive sanction: Not applicable.
Non-custodial options post-conviction: Not applicable.
Examples of relevant submissions: CADU554; CADU635; CADU741; CADU416;

4.8 Session 6 – Exploring Legal Frameworks

4.8.1 Mr. Brendan Hughes, EMCDDA

Mr. Hughes, who brings 20 years of experience and expertise on legislative frameworks in over 30 jurisdictions, explained the nature and basis of reforms to drug law internationally.

He suggested that the first question the Citizens' Assembly should ask is 'Why' Ireland should consider changing drug policy or legislation? Different countries cite various reasons for wanting to reduce or increase penalties. For example, Portugal and Poland have decriminalised personal possession in order to encourage people with addiction into treatment, while Belgium and the UK have changed cannabis laws mainly to save law enforcement resources. A few countries have cleaned up their criminal codes because they decided that very short prison sentences were simply a waste of time. Sometimes, countries can move to increase penalties for the normative purpose of sending a message, or to give law enforcement more powers.

On the specific question of regulating cannabis, again, different jurisdictions do it for different reasons. Some want to concentrate on more serious crime, reduce the burden on law enforcement resources or raise tax revenues. Others want to limit access for children and improve product quality and safety.

At the same time, there may be very legitimate concerns around regulating cannabis. Reasons not to do so may include concerns about increased use and increased addiction, increased drug trafficking, and increased road crashes (a big concern with cannabis legalisation), decreased productivity and the normative impact of sending the wrong message.

To be able to assess whether legislative changes have been a success or failure, there needs to be clarity about what the objectives of the changes were in the first place. This can be lost sight of in the years following legislative change.

Legal terms used in relation to drug control (which are explained in the EMCDDA video and the Secretariat discussion paper) include decriminalisation, depenalisation, diversion and legalisation. 'Decriminalisation' means reducing the size or significance of the penalty, and usually impacts on the user or the court system. 'Depenalisation' means removing the application of the penalty, and just closing the case. 'Diversion' means moving from punitive responses, which is the usual justice system approach, to rehabilitative responses. 'Legalisation' means some form of regulated supply, not necessarily shops, and can include permission to grow your own plants and consume them in private, as is now permitted in Malta, Spain and a few other countries.

He drew attention to the fact that, grammatically, the first three terms suggest *moving away from* something, but don't say what they're moving *towards*.

One of the key tasks for the Citizens' Assembly is to consider what it is recommending going towards, rather than focusing on what is being moved away from.

Mr. Hughes presented an EMCDDA analysis of the relationship between changes in penalties and levels of drug usage. The analysis looked at rates of cannabis use amongst young adults in 8 different jurisdictions and tracked what happened following changes to penalties. The results show no conclusive pattern, probably for a few very simple reasons. Firstly, the average cannabis user doesn't read the details of what's written in the drug law. Secondly, usually it is the maximum penalty that's changed and, generally speaking, nobody gets the maximum penalty. This makes it difficult to reliably measure the impact of changes to penalties.

EMCDDA has looked at how and why different countries are introducing alternatives to coercive sanctions. It found three basic reasons: first, to affect the individual by treating addiction; second, to affect society by reducing drug-related crime and drug-related disease (as was the case in Portugal and several other countries in the 1990s when they wanted to stop the spread of HIV and Hepatitis C); and third, to alleviate some of the pressures and demands on the State's criminal justice system.

The big question is 'What is success?'. Referencing the case study provided earlier in the meeting of Ireland's Drug Treatment Court, while relatively few participants made it to full graduation, what about the people who made it halfway through?

If someone succeeds in stopping using heroin, but insists on continuing to smoke cannabis three times a day, is that a success or a failure? Different people will have different answers to that question.

Commenting on the debate about whether a country should pursue a strategy of punishment or rehabilitation, he explained that it's not an either-or dilemma. There are various types of punitive responses, which can be non-criminal for all drugs, non-criminal for some drugs, or criminal for all drugs. Similarly, there can be different levels of emphasis on rehabilitation. It's not an all or nothing issue. The Portuguese system, and many other systems including Ireland, feature a blend of punishment and rehabilitation. In Ireland, perhaps the numbers are not the way they should be
.
The key question is, who coordinates the response? People misunderstand why the Portuguese is different. It's not because of decriminalisation, it's because their system is coordinated by the Ministry of Health, whereas most other countries in Europe and beyond coordinate their response to drug issues via the Justice or Home Affairs ministry, where the entire ethos is different.

Mr. Hughes outlined an EMCDDA comparative database that shows the specifics of, and differences between, drug laws in different European jurisdictions, which reveals the diversity of approaches possible.

Concluding his presentation. Mr. Hughes showed a chart illustrating data from Portugal over a 10-year period, showing the range of outcomes to referrals to the Dissuasion Committees. It showed that the majority of cases were suspended following the initial assessment and brief intervention. The next most frequent outcome was the issuing of penalties (fines or non-pecuniary penalties). The third most frequent outcome that was suspension of the case following referral for specialist addiction treatment. The lowest frequency outcome was acquittal. Mr. Hughes' parting question to members was to ask themselves whether the Irish legal system is flexible enough to respond to so many variations of situations and still produce a just result?

4.8.2 Prof. Yvonne Daly, DCU

Prof. Daly, Professor of Criminal Law and Evidence in the School of Law and Government, DCU, offered members a high-level perspective on the functions, purposes, and limitations of Criminal Law.

Prof. Daly described Criminal Law an area of public law in which the State, on behalf of society at large, takes action against an individual because that individual has gone beyond the rules which society has agreed to live by, in which transgression of the law is considered so grave as to be deemed a criminal activity meriting sanction.

The punitive sanction is attached by way of penalties such as community service, or fines, or imprisonment. However, Criminal Law isn't the only means that the State has for setting the Rules of Engagement of society. There are also other legal approaches, such as designating certain acts as regulatory offences or administrative offences. These approaches are currently used more frequently in areas like Commercial Law and Environmental Law on, rather than in relation to acts by individuals.

Prof. Daly outlined various schools of thought regarding the purposes of Criminal Law. The first perspective is that Criminal Law should be employed only to stop people from doing harm to one another and to maintain general good order in society. Another perspective is that Criminal Law has a more active role in promoting a society whose members observe certain social values and morals. This, of course, gives rise to a question about whose morals and values are being prioritized, and who decides what acts are criminal. Essentially, it is the citizens, through their elected representatives in the Oireachtas, who decide what is and is not criminal.

Criminal Law isn't universal and unchangeable. Societal perspectives as to what is, or is not, a criminal activity can evolve over time.

Sometimes the legal perspective on criminal acts can lag behind changing societal views. Examples of acts that were previously criminal in Ireland include abortion and homosexual acts, while, conversely, rape within marriage was previously not criminalised.

Prof. Daly suggested a thought experiment to imagine criminalising something which currently is not criminalised. She invited assembly members to imagine a scenario in which the government of the day decided that smartphones are a danger to citizens. While some people can use smartphones without difficulty, and they are very beneficial

in certain circumstances, others struggle to regulate their use of smartphones, are dependent on the dopamine hit they get from 'likes' on their social media postings, and are staying up all night trolling other people. The victims of trolling online are suffering, and young people in particular are finding it very difficult to self-regulate their use of smartphones.

In such circumstances, the government would have various options to consider as to how to deal with smartphones as a societal issue. It could provide resources to fund support for people who want to reduce their smartphone usage. It could provide education through schools, social media messaging and so on to inform people about these issues. It could regulate the sale of smartphones to restrict ownership to people over a particular age threshold. Or it could outright ban the possession of smartphones and make possession a standalone criminal offence, in which case the simple possession of a smartphone would bring someone into contact with the criminal justice system.

While the issues relating to drugs are not the same as those relating to smartphones, the point of the exercise is to help think about Criminal Law from a more theoretical perspective, and to show that there are lots of options, both within and outside of the Criminal Law, that could be considered. Each option has both seen and unforeseen consequences.

Society justifies punishment for criminal offending on several grounds, including retribution, deterrence and incapacitation.

Retribution is an expression of society denouncing a crime and the person who has committed it. Deterrence is an expression of a society's wish to deter the individual who has committed a criminal offence from any future repetition of that offence. Punishment of a criminal offence also serves a broader deterrence objective, which is to give a general warning signal to society about the consequences of criminal activity. Incapacitation is intended to constrain the perpetrator's capacity to commit the crime again, generally through imprisonment.

The concept of rehabilitation and reformation is very important within the criminal justice system, but it is not the purpose of Criminal Law itself to reform or rehabilitate anybody. That's an issue for the Probation Service, the Prison Service and so on.

Criminal Law is called upon whenever society identifies a new issue that it feels should be criminalised by the creation of an offence in law. Recent examples include the creation of criminal offences for acts including stalking and coercive control. Sometimes, the criminalising of an act can be a very important expression of society's disapproval and refusal to accept this behaviour.

But there are also certain limitations to Criminal Law.

For example, is the Criminal Law implemented equally across all aspects of society, and all people in society? Are young people in certain communities who are in possession of cannabis more likely to find themselves stopped and searched than businessmen on their way to the office who are planning to snort some cocaine before a high-level meeting? Is the funding necessary to implement the law available? Are there sufficient Gardaí to target high-level serious offending? Are there sufficient judges and criminal defence lawyers to ensure that the system is working appropriately?

Sometimes, the Criminal Law can reinforce inequalities. Are we bringing people into contact with the criminal justice system who are already suffering multi-generational trauma, lack of education, lack of employment opportunities and so on? Are we more interested in 'crime on the streets' as opposed to 'crime in the suites' (white-collar crime)? Is Criminal Law compounding issues by giving people criminal records that prevent them pursuing future employment opportunities, particularly where they want to give back to society?

Concluding her presentation, Prof. Daly emphasised that, while criminal law is very important in society, it has a very narrow focus. There's only so much it can do, and doesn't really deal with health issues, or education or early childhood interventions.

There's only so much Criminal Law can do, and only so much that we can expect of it.

4.8.3 Prof. Deirdre Healy, UCD

Prof. Healy, Director of the Institute of Criminology and Criminal Justice, and Associate Professor at UCD's Sutherland School of Law, reflected on the ideas and questions raised by the Secretariat working paper. Her particular focus was on people with substance misuse issues in the Criminal Justice System, how they come to stop offending, and the impact of Criminal Justice sanctions on these change processes.

> ***Research tells us that when people manage to successfully stop offending, they tend to experience a sense of hope about the future as well as a belief that change is possible.***

They also tend to have strong social bonds in work, family and community life that enable them to construct a meaningful non-criminal identity. Furthermore, they report feelings of belonging and social inclusion, and encounter State systems that help, rather than hinder, the change process. This idealized pathway to desistance is, of course, difficult to achieve. Many people, including those who have been drug or crime free for long periods of time, continue to experience social exclusion as well as stigma.

In terms of system contact, all of the models described in the Secretariat working paper, apart from Model E (legalisation) include some sanctions, either criminal or administrative, for possession of drugs. Several of the models are based on the assumption that sanctions have the power to dissuade people from engaging in harmful behaviour. However, evidence from research suggests that deterrence-based approaches do not reduce reoffending in all cases, and in some cases may even increase it. Studies show that even brief contacts like being stopped by police can actually increase reoffending, and also undermine the legitimacy of the police in the eyes of those targeted.

Conversely, there's substantial evidence that enabling people to avoid a criminal record can in fact reduce reoffending. This may be because contact with the criminal justice system may result in labelling, stigmatisation and social exclusion. Even the language used in the criminal justice system can be stigmatising. For instance, someone who is drug free is often described as 'clean' while somebody who is still currently using drugs is often described as 'dirty'. Stigma can make it harder for people to create and maintain the kind of meaningful, positive sense of self that we know is associated with the move away from crime.

There's a large body of evidence to show that a criminal record can restrict access to employment, education, and housing, while social stigma can disrupt community and societal bonds. Generally, criminal sanctions tend to escalate in line with criminal history. However, research tells us that the majority of people, including those involved in persistent offending, actually tend to move away from crime in their mid-20s. This means that approaches that divert first-time offenders only, like Model B [in the Secretariat Working Paper], can thus exclude a large cohort who could potentially benefit from these provisions. Meanwhile, non-custodial and non-criminal justice options can mitigate, or avoid, some of these harms.

It's important to remember that non-custodial and non-criminal justice options can be experienced as punitive by those subject to them. For instance, fines can be burdensome for low-income groups.

In terms of treatment, again, many of the models set out in the Secretariat Working Paper focus on treatment as a way of mitigating some of the harmful impacts of illicit drug use. This is important because we know that offending and addiction are closely intertwined, and substance misuse issues are prevalent in criminal justice populations. We also know from research that diversion into treatment can be effective for drug-using offenders. However, it's important to ensure that any new or existing programs are actually effective as well as evidence-based.

Prof. Healy suggested that assembly members take into consideration the fact that evidence suggests that overly-intensive interventions with low-need groups and recreational drug users can actually increase criminality among these groups.

Concluding her remarks, Prof. Healy highlighted that, under some of the proposed models in the Secretariat Working Paper, treatment participation is a condition of health-led diversion. She suggested that the Citizens' Assembly might want to consider the consequences that could ensue if people don't comply with these conditions. Non-compliance can actually lead to harsher criminal justice sanctions. Where treatment participation is a condition of Probation Orders, for instance, non-compliance with treatment can have legal consequences for the person even if no new offence has been committed. The relationship between sanctions and rehabilitation thus needs careful consideration and she suggested that the assembly might want to consider ways to decouple treatment and punishment to avoid further criminalisation and harm.

4.8.4 Prof. Tom O'Malley, Galway University

Prof. O'Malley, Barrister, Senior Counsel and recently-retired Associate Professor of Law at Galway University, focussed his remarks on sentencing of drug offences.

He drew the distinction between sentencing and punishment, explaining that the sentence is the formal penalty imposed by a court following a criminal conviction. In the case of a conviction for drugs offences, that penalty could be a fine and/or a prison sentence. However, the punishment that a person may endure can extend well beyond the judicially-imposed penalty. This is referred to as the 'collateral consequences' of conviction.

For example, a person who is imprisoned would likely lose their job (if they have one), and will probably find it difficult to secure employment on release. This can cause hardship not only to the offender but to their dependents as well.

There are similar collateral consequences for both serious drug offences and more minor drug offences, such as possession of cannabis for personal use. While the judicially-imposed penalty in the case of more minor offences might be very light, such as a small fine, the collateral consequences can be far more punitive and long-lasting. For example, a conviction may have serious consequences in terms of securing certain kinds of employment, or gaining admission to certain countries. That could very often prove to be the real punishment, rather than the judicially-imposed penalty.

A distinction must also be drawn between drug crime and drug-related crime. A great deal of acquisitive crimes such as theft, robbery and burglary, including aggravated burglary, is attributable to drug addiction. The impact on victims of drug-related offences can be very serious indeed, with long-lasting effects. Even more serious is the harm resulting from gang-related warfare, again drug-related, which has resulted in many fatalities over the years.

Prof. O'Malley highlighted the sentencing provisions in the Misuse of Drugs Act 1977 for two categories of drug offences. 'Section 3 drug offences' concern possession of small quantities of drugs for personal use only, while Section 15 offences concern more serious offences of having drugs for sale or supply.

The more serious offences created by Section 15 and Section 15a of the Act provide that at a person convicted of any controlled drug for sale or supply is liable to a sentence of up to life imprisonment. While it is rare in the extreme for a life sentence to be imposed, in fact the vast majority of people convicted of Section 15 offences will receive a custodial sentence, very often quite a significant one.

The statutory amendment in 1999 provides that, if a person is caught with drugs which have a street value of €13,000 or more for sale or supply, then they are liable to a presumptive minimum sentence of at least 10 years imprisonment. A judge does have the power to impose a lower sentence than 10 years if satisfied that there are specific circumstances that justify doing so.

So the vast majority of people caught with drugs for sale or supply do get prison sentences, and very often significant prison sentences. This is reflected in the prison population. For example, a snapshot of the Irish prison population for late November 2021 showed that there were about 320 convicted drug offenders serving sentences in Irish prisons, which amounted to about 10% of the overall prison population at the time. About one-third of these were serving sentences of five years or longer.

For the less serious charges relating to the possession of drugs for personal use, under Section 3 of the Act, there is a distinction for sentencing purposes between cannabis and other drugs. In the case of cannabis, the sole penalty available in the first or second conviction is a fine. After that, there is a possibility of imprisonment for up to 12 months following conviction in the District Court. If the drug is something other than cannabis, then there is a possibility of imprisonment even on a first conviction
.
There are two strategies available to avoid the consequences of conviction. Available in the District Court only, the Probation Act permits the court to refrain from formally convicting a person even though they're satisfied that the person has committed the offence. The application of this provision means the person won't get a conviction, and thereby avoids a criminal record. This is a very valuable provision, which can be used in cases of an individual who's found in possession of drugs for personal use.

Secondly, under the Children Act of 2001, anybody under the age of 18 who was found to have committed an offence can be admitted to a Juvenile Diversion programme, whereby they can be cautioned and placed under

supervision. This diverts them away from prosecution and a criminal conviction. A very considerable number of children, approximately 10,000, are admitted to that programme each year. In 2020, there were about two thousand referrals to the Juvenile Diversion programme for drug offences.

Concluding his remarks, Prof. O'Malley drew the assembly's attention to an important but seldom-used provision in the Misuse of Drugs Act 1977. Section 28 of that Act allows a court, on convicting a person of certain drug offences, instead of imposing a penalty, to allow the offender an opportunity to enter into a commitment to undergo supervision or treatment at a designated custodial facility. That provision is seldom used, largely because the State does not have a designated custodial facility for treatment, but that is something that the assembly might consider discussing.

4.8.5 Prof. Andrew Percy, QUB

Prof. Percy, Professor of Quantitative Criminology at the School of Social Sciences, Education and Social Work at Queen's University Belfast, explained that his academic background is in adolescent development, with 25 years' experience researching teenage alcohol and drug use.

When he first began his career in the early 1990s, the assumption was that society was going to see inevitable increases in drug use. But, in fact, in the late 1990s and early 2000s evidence began to emerge of declines amongst young people in terms of alcohol and tobacco consumption in particular, but also declines in offending behaviour and substance use.

He observed that, while society has a tendency to see the current generation of teenagers as worse than previous generations, teenagers today are, in fact, so much better. He described today's teenagers as a 'golden generation of young people', who commit less crime, use less alcohol, use less tobacco, use less drugs, are less racist, less homophobic, and less sexist than his generation in particular.

The majority of drug use by teenagers is adolescent-limited. Most teenagers who use drugs progress from experimental into recreational use and then stop their drug use as they transition into adulthood. So, for most young people who use drugs, this is a temporary phase where they experiment with risk-taking behaviours, with no significant or long-term consequences. As they make that transition to adulthood, they mature out of these risk-taking behaviours. In some cases, it can be argued that drug use is a relatively normative activity undertaken by the vast majority of teenagers to some degree.

During this phase of risk-taking, young people learn, through trial and error, to control their behaviours and manage their intoxication. They make mistakes, they learn from those mistakes and change their behaviour.

From a prevention perspective, one of the key objectives is to allow young people engage in this risky behaviour in safe environments, to begin to teach them the necessary skills to regulate and control their own behaviour, and to avoid any long-term consequences as a result of their drug use.

Young people use alcohol and drugs to have pleasurable experiences of becoming intoxicated, and one of the things that they need to learn is to manage that intoxication process. One of the key risks young people face as a result of acute intoxication is their increased vulnerability to becoming a victim of violence, and particularly sexual violence.

Concluding his remarks, Prof. Percy suggested that perhaps the single biggest risk that the vast majority of teenage drug users face is being drawn into the criminal justice system as a result of their drug use. This contact with the criminal justice system, particularly if they are cautioned or receive a criminal conviction, will have a more serious impact on long-term outcomes for young people than any recreational use of drugs such as cannabis. He urged the Citizens' Assembly to reflect carefully about unintended consequences of the decisions they make in terms of policy and legislative changes. In particular, policy options that increase the likelihood of young people coming in contact with the criminal justice system need to be understood as probably likely to have more detrimental impacts on the long-term outcomes than most of their drug use. He suggested finding ways of keeping young recreational drug users out of contact from the criminal justice system, and then allowing services to be developed and funded for those that progress from this recreational use into more problematic use.

4.8.6 Dr James Windle, UCC

Dr Windle, lecturer in Criminology and Director of the Bachelor of Arts Criminology Degree in UCC, examined the merits of four of the options set out in the Secretariat working paper on legal frameworks.

He explained that, given that much of his own research has focused on the manufacture, distribution and use of heroin, the initial part of his presentation would focus on the more problematic aspects of drug use, while he would conclude with some more general observations, drawing on some of the evidence regarding the merits of legalisation.

Dr Windle first considered Model A ('the Status Quo'), which emphasises prohibition. He offered the view that prohibition has worked, up to a point. Drug law enforcement and prevention measures have contained drug use within the population at a relatively low level. Prohibition generally makes the price of drugs unnaturally high and constrains availability. This explains why a gram of heroin is more expensive than a gram of gold (although cannabis is much cheaper). There are also costs associated with the time that it takes to buy drugs. While the advent of mobile phones has probably reduced search costs, for most people, sourcing drugs is still relatively difficult. Of course, regular buyers have less search costs, and can text a dealer or, more often than not just, text a friend. In effective, the current system means that drugs remain more expensive and scarcer than if they were legal. But the degree of scarcity and cost depends on our age, on the drugs being sought, and on where we live.

Dr Windle made a number of observations about the challenges that need to be borne in mind when considering policy changes. First, we need to consider how we measure success. While drug use prevalence is an important measure, it may not be the most important. So when policy is being devised, it is important to be clear about what the underlying objectives are. Also, policy needs to be cognisant not just about the current challenges, but also about future issues. Drug markets are changing, with new synthetic drugs emerging. We need to be prepared for heroin to be replaced by synthetic opioids such as fentanyl. We need just look at what's happening now in Afghanistan [in terms of the decline of opium production], consider how drug traffickers think, and realise that we are likely to see the arrival of synthetic opioids.

Dr Windle explained that he is not convinced that the 'status quo' approach of prohibition, in which people are criminalised for simple possession, achieves its stated goals of reducing drug consumption and improving public health. Indeed, it may well be counterproductive and certainly has unintended consequences.

There's evidence that the severity of a punishment has little impact on behaviour, especially for a person where drug use is valued by their friends and within their social network, and when role models are consuming drugs problematically or heavily.

From a deterrence perspective, if a person is addicted to heroin, the pain of withdrawal is a much more immediate pain than the potential future pain of being arrested.

Turning his attention to Models C and D, each of which features a version of decriminalisation, Dr Windle explained that it's difficult to measure the impact of decriminalisation on drug use. However, countries which have decriminalised in conjunction with health diversion haven't reported large booms in drug consumption, with many studies showing a reduction in harmful drug use. Decriminalisation can theoretically reduce the risk of overdose and drug-related deaths, and people can be diverted to services if they need to be.

He quoted an individual who had been addicted to heroin, who explained that he supported decriminalisation as it would have helped him access services earlier.

'I think if I was offered help I could have went down a different path. I knew nothing about recovery from addiction. I didn't know there was another avenue to go. Decriminalisation could have been used as an intervention.'

Dr Windle described research he had been involved in along with Dr Graham Cambridge and Dr Orla Lynch. This shows that rehabilitation from addiction often comes before desistance from crime. He argued that, if we can help people on that journey into recovery at an early stage, through some kind of diversion scheme, this can be beneficial not just to the individual but to society. At present, many people first begin addiction treatment in prison.

However, prison can also cause more trauma, which sometimes people will cope with by consuming more drugs.

Referring to Model E, he described himself as cautious about legalising drugs. Drawing from the research literature, he suggested that, if drugs were to be legalised then it should be done in a way that avoids commercialisation.

Much of the evidence from the U.S cannabis markets and from our own experience with gambling, tobacco and alcohol shows that we can't really trust the market to regulate harmful drugs.

Companies will lobby for lighter regulation, they'll aggressively advertise, they'll normalize the drug, they'll probably diversify their products and focus their attention on the heaviest drug users.

We know from studies in the US that consumption will probably increase following legalisation, but we don't know by how much. Some studies have shown reductions in youth consumption, but that may be due to what Prof. Percy highlighted in terms of desistance through maturation. We don't know the long-term impact on health and will probably have to wait another decade to see what the long-term impact on public health is in jurisdictions that have legalised.

In terms of sale and distribution models in a regulated market, State monopolies are an option to take to avoid commercialisation, while cannabis social clubs are that middle ground between decriminalisation and legalisation. They're a bit like co-ops, where members pay a fee, the co-op cultivates cannabis and then distributes to members. Concluding his remarks, he argued that that there is no silver bullet and that, while legislative change is part of the answer, it's not the full answer. Irrespective of whether Ireland were to legalise drugs, or decriminalise or keep the status quo, we need to invest more in treatment services, in harm reduction services, in mental health services, and in housing. We also need to tackle our underlying culture of excessive consumption. That may need to start with the alcohol industry.

4.9 Session 7 – Workshop

4.9.1 Questions & Answers

Educating young people about self-regulation

Prof. Percy responded to a question about the approach to educating young people about self-regulation and self-awareness. He explained that there is considerable emerging evidence about the efficacy of school-based programs looking at the reduction of harm around substance use, particularly when delivered to slightly older teenagers. These interventions have already been shown to be effective in relation to alcohol, but there's now emerging evidence about their effectiveness in relation to drug use. They seem to be most effective when there is also parental involvement. One of the key things in these interventions is ensuring that parents have clear and strict rules about their teenagers' access to substances, reinforced with consistent messaging at home. Most of these interventions would start with young people aged around 12 and would continue right through their school years, through adolescence. The sophistication of those messages would change as the young people get older and the nature of their engagement with substances evolves. A key to this is providing young people with realistic scenarios of situations where they might get into difficulty as a result of their substance use, and getting them to brainstorm better ways to avoid those situations. A simple example of this is a scenario where young people are out socialising and see a fight break out between other teenagers. The first thing they want to do is to go and completely the opposite direction and not get drawn into it. Thinking through solutions for those situations can help them avoid the harms that are associated with learning through trial and error.

Oversight of drugs policy

Responding to a question what he would suggest in terms of a single body to oversee drugs policy, Mr. Hughes explained that different European countries have different structures. Some are based in the Ministry of Health, focused on countering the health impacts of drugs use. Others are based in the Ministry of Interior or Justice, because it's considered a law enforcement issue. Some countries have recognised that drugs use is a cross-sectoral issue and sometimes have elevated it as high as the office of the Prime Minister, President or Cabinet, with the idea that they are more powerful and have more authority to instruct the various ministries to work together.

He explained that the Portuguese system is the only one he's aware of where a drug user will be judged by someone under the Ministry of Health rather than the Ministry of Interior or Justice. That gives an entirely different ethos to the response towards the drug user, where the primary idea is no longer punishment, it's a health-led response. Most countries have punishment with some health exceptions, whereas in Portugal they have health with some punishment exceptions.

ADHD screening

Prof. Percy responded to a question about the role of ADHD screening for young people as part of a prevention strategy. He explained that research shows that young people who are more impulsive are at greater risk of engaging in substance use, so ADHD is a clear risk factor for substance use. While not in a position to comment on widespread screening for ADHD, he was of the view that there probably needs to be increased services and increase support for young people who have problems with impulsivity and self-regulation.

Section 28 of the Misuse of Drugs Act 1977

Prof. O'Malley responded to a question about Section 28 of the Misuse of Drugs Act 1977, saying that while that section of the legislation is in force, the question is whether facilities are available to permit that kind of diversion to take place. While there shouldn't be any difficulty about a person entering into a recognisance, or a formal commitment to remain under the supervision of the Probation Service, we've been falling down when it comes to having specific treatment programmes [that judges can refer people into] available. He suggested that he would like to see a general legislative review of Section 28 to see what possibilities it has as it currently exists, and to examine whether there's a case to be made for introducing some kind of replacement for it. Either way, having that legal provision in place that allows for people to be diverted away from punishment, if they're willing to cooperate, and into treatment, is a very valuable one that we should be doing everything possible to promote it.

Switzerland's regulatory approach to drugs

Responding to a question about the merits of the regulatory system in Switzerland, Dr Windle explained that, while he was not sufficiently familiar with the model in Switzerland, he could say in general terms that each country's approach legal approach to drugs needs to be tailored to their specific social and political structures. He cautioned that much of the academic literature highlights the dangers of a legalised / regulated model that features commercialisation of drugs.

Mr. Hughes disputed that Switzerland had a generalised regulated supply of drugs for recreational use, except for the recent changes where they're now allowing pilot studies in different cities for cannabis use of up to 5,000 cannabis users. They do have a regulated market for heroin, whereby heroin can be prescribed for heavy drug users under a model that has been described as controlled legalisation.

Legislative timelines

Prof. Daly responded to a question about how long it takes for legislation to be introduced. She explained that it takes a long time for government departments to come up with the appropriate wording for legislation, and anticipating the possible foreseen and unforeseen consequences of the legislation. She argued that the backup behind the legislation is critical. Section 28 is a really good example of where there is already legislative provision to allow for diversion, but this cannot be used because the resources are not there to allow it take place. Similarly, the Drug Treatment Court, which is doing really good work, has been operating on a pilot basis for over 20 years, and there's never been a push to roll it out across the country.

She added that the Citizens' Assembly need not worry too much about the details. Its job is to give an indication to society in general about recommended policy changes, and leave it to the government of the day to work out the details of how they put that into effect. But it is also important for the Citizens' Assembly to articulate the need for resources behind any of the policies that it recommends.

Public support for changes to legislation and policy

Prof. Healy commented that the Citizens' Assembly also needs to think about the implementation of legislation and policy, and the need to win hearts and minds. You can put laws or policies in place, but if frontline practitioners, or society in general isn't on board then there's going to be an issue in terms of actually implementing it on the ground.

De Jure and De Facto 'decriminalisation'

A detailed discussion took place regarding different interpretations of the meaning of 'decriminalisation'. The backdrop for this discussion was the Secretariat Working Paper, which had been circulated in advance to Assembly members and panellists. That paper described two alternative legal approaches, namely '*de jure*' and '*de facto*' decriminalisation.

De jure decriminalisation occurs when legislation is changed to explicitly remove a criminal offence from the statute books, as was done in Portugal in 2000 in relation to the possession of drugs for personal use. In contrast, other jurisdictions may pursue the objective of decriminalising, while retaining the criminal status of an act. This approach, which could be described as *de facto* decriminalisation, can be achieved by introducing such additional diversion and depenalisation measures as to render the act effectively, or to all intents and purposes, decriminalised. So, for example, even if an act (such as the possession of drugs for personal use) were to remain a criminal offence, the threshold for prosecution and conviction could be set at a sufficiently high level as to provide extensive opportunities to implement early-stage health diversion and the avoidance of a criminal record and consequent punitive sanctions, including a prison sentence.

There are various reasons why a jurisdiction might opt for *de jure* rather than *de facto* decriminalisation. In the first instance, a country's legal system and/or constitutional provisions might either prevent the introduction of, or else severely constraint the desired impact of *de jure* decriminalisation, in which case *de facto* decriminalisation might offer a far more expedient and effective way to deal with the issue. As has been established by the 2019 *Report of the Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use*, there are unresolved questions about the extent to which Ireland's legal and constitutional system could satisfactorily provide for *de jure* decriminalisation.

Prof. O'Malley described an important difference between the Irish and Portuguese legal systems. Ireland has what would generally be referred to as a common law legal system, while European countries for the most part (including Portugal) have civil law systems, which can provide for the creation of civil offences. In contrast, common law jurisdictions such as Ireland have a clear divide between criminal matters, which are dealt with by the criminal justice system (including the courts, the police, the DPP and so on) and civil matters, which are purely private disputes.

He continued by explaining that, while there is a degree of overlap nowadays between civil and criminal matters, for example with regulatory penalties in respect of certain commercial activities, Ireland's legal framework doesn't provide for the imposition of civil sanctions for minor offences. Therefore, something is either in the criminal justice system or it is not. If something is deemed criminal it is dealt with by the criminal process (including the police, DPP, courts and prisons), but if it's not a criminal matter there can be no involvement by the criminal justice system.

(Editor's note: the main implication here seems to be that the Gardaí might not have the legal basis to engage in Health Diversion if simple possession were decriminalised on a de jure basis).

Prof. O'Malley explained that he has have been involved in discussions about decriminalisation for the past 30 years, with various Committees and working groups. The rock on which many previous discussions have floundered is disagreement, or confusion, over what decriminalisation actually means. He offered the view that decriminalisation means rendering conduct that was once criminal no longer criminal, or in other words, rendering it 'quite legal'. He suggested that one of the reasons that there tends to be confusion about decriminalisation is that is such an infrequent event. He recalled that the requirement to have a radio license was abolished around 1972, whereas it was previously a crime to have a radio without a license. A more recent example of decriminalisation was in 1993, when homosexual acts between adult males, provided they were of a certain age and consenting, were decriminalised. Similarly, Ireland changed the law on prostitution in 2017, so that certain activities became criminal and others became no longer criminal.

Prof. O'Malley elaborated by explaining that, if one understands decriminalisation in the sense that the conduct itself is no longer criminal, then there can be no question of invoking the criminal justice system as part of the State's response. You clearly can't start arresting people, charging them, trying them or punishing them if the conduct in question isn't a criminal offence. He urged the Citizens' Assembly to be very clear and as united as possible about what they mean in their concept of decriminalisation. He disagreed with the proposition that decriminalisation means you can no longer impose imprisonment, saying that imprisonment is just a question of sentencing. The all-important consideration is to be clear and to reach consensus as to what is meant by 'decriminalisation'.

Prof. O' Malley remarked that it his interpretation of the phrase is on the basis of the way Irish law has decriminalised

other conduct in the past. But when it comes to drugs use, a wide range of different concepts of decriminalisation tend to emerge, one of which is specified in the Working Paper. He declared himself totally agnostic as to what the Citizens' Assembly might recommend, but called for clarity in what people are talking about. It's either full-blown decriminalisation in legal terms, or it remains a criminal act but with lesser penalties.

Mr. Hughes remarked that he has tried to define 'decriminalisation' across 30 different legal systems for 10 years, and has effectively given up on the challenge. His version of the definition is reflected in the Secretariat Working Paper. However, different countries do it in different ways, according to the provisions within their particular legal systems. Many continental European countries [including Portugal] have systems of civil or administrative offences. Prof. Daly had highlighted some examples in her presentation of administrative offences in Ireland, including environmental crimes and regulatory crimes. The EMCDDA video describes parking offences as an example of how an offence can be defined and penalties issued without it becoming a criminal offence.

Mr. Hughes emphasised that, if the Citizens' Assembly wanted to recommend decriminalisation, it would be important to find a way that works in the context of the Irish legal system. However, the task for the Citizens' Assembly would be to give the high-level direction, and leave it to the legislators to work out the appropriate legal mechanisms to achieve that. The important thing is to be clear on what objectives are being recommended.

Expanding on the point that legal changes in different EU countries can mean very different things, he offered the example of Greece, where a person could be sentenced to three months in prison for possession of drugs, but it will not be written on their criminal record. Malta, which completely revamped its law on cannabis, is insistent that these changes do not amount to decriminalisation. Laws, regulations and even the Constitution can be changed. Mr. Hughes urged the Citizens' Assembly to get clear on what it wants to accomplish: for example, does it want a person [caught in possession] to have a criminal record, or not? Does it want the police to have powers, or not? Does it want extra penalties for recidivism, or not? He suggested the Citizens' Assembly not get hung up on the terminology, which means so many different things to so many different people. Instead, clarify what the objectives are in terms of the harms it is trying to reduce. If the Citizens' Assembly's focus is on reducing the harms arising from contact with the criminal justice system, then it will need to propose a system that reduces those harms, perhaps by not giving a criminal record. If it would like to do something which still has an element of penalties, Ireland already has some systems that can impose penalties without giving a criminal record. It's not up to the Citizens' Assembly to design this perfectly, it's up to the legislature.

Prof. John Garry, member of the Advisory Support Group, emphasised that the Workshop is designed to help members to reduce the 'mad complexity' of this kind of wicked, complicated problem by setting out five broad approaches to it, one of which is the 'status quo', and the other four are possible alternatives, which vary in terms of the degree of change involved. He suggested that the important thing for members is to avoid getting bogged down in detailed definitions of individual words, and reflect instead on what the differences are between the small number of distinct models set out in the Secretariat Working Paper. The Workshop provides an opportunity to consider which broad direction of travel each model would result in, and what are the strengths and weaknesses of each.

Stop and Search

Prof. Daly commented in relation some questions previously about whether the Gardaí could be hampered in their work were the Stop and Search powers that they currently have under the 1977 Misuse of Drugs Act to be lost or diminished. She explained that if, for example, possession of cannabis for personal use was no longer to be an offence, the Gardaí would still have other stop and search powers. For example, Gardaí could stop and search if they believed someone to be carrying an offensive weapon, or in possession of stolen property. The point being that even if legislative changes in relation to drugs did impact on Stop and Search powers, other legal provisions by which Gardaí can stop and search individuals would still remain.

4.9.2 Facilitated workshop and private deliberations

Following the Questions and Answers session, members adjourned for deliberations in roundtable discussion format, followed by private deliberations.

5 Meeting #5

5 Meeting #5

Meeting #5

Figure 5.1:
Session 1 - Gregor Burkhart presenting via Zoom

Figure 5.2: Session 1 - Annette Honan, Dr. Michael Byrne, Celeste O'Callaghan, Karen O'Connor, Richie Stafford

Figure 5.3: Session 2 - Prof. Denis Cusack, Prof. Mary Cannon, Prof. Catherine Comskey, Prof. Breda Smyth

Figure 5.4:
Session 3 - Dr. Ian Marder, Nicola Corrigan, Roger Mehta

Figure 5.5: Session 3 - Video Presentation - Judge Olann Kelleher, Joe Kirby, Declan O'Riordan

Figure 5.6:
Session 4 - Jim Gavin, Fiona Ward, Andy O'Hara, Fr. Peter McVerry

Figure 5.7:
Session 5 - Aubrey McCarthy, Laura Dunleavy, Prof. Pat Dolan

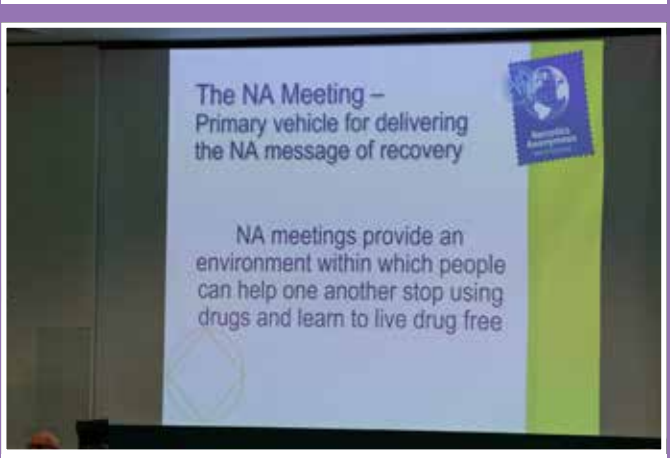


Figure 5.8:
Session 5 - Narcotics Anonymous - Andy R and Sean H

Figure 5.9: Session 6 - Dr. Orlaigh Quinn, Joe O'Neill, Dr. Peter Kelly, Brian Galvin, Jim Walsh

Figure 5.10: Clondalkin Drug and Alcohol Task Force Prevention Model - Sive Brennan, Trevor Bissett

Figure 5.11:
Roundtable discussions

Figure 5.12:
Roundtable discussions

Figure 5.13:
Workshop on legal options

Figure 5.14:
Roundtable discussions

Figure 5.15:
Questions and Answers

Figure 5.16:
Questions and Answers

Meeting #5

Figure 5.17:
Roundtable discussions

Figure 5.18:
Questions and Answers

Figure 5.19:
Questions and Answers

Figure 5.20:
Questions and Answers

Figure 5.21:
Questions and Answers

Figure 5.22:
Questions and Answers

Figure 5.23:
Questions and Answers

Figure 5.24:
Questions and Answers

5.1 Programme Overview

The focus of the fifth meeting, held on 30 September – 1 October 2023 at the Grand Hotel Malahide, was on drugs prevention strategies and practice. A range of speakers shared their perspectives on drugs prevention strategies ranging from early childhood education to tertiary prevention initiatives. The meeting also included presentations on health-led recovery, and governance and funding options.

5.2 Session 1 - Perspectives on prevention (Part I)

5.2.1 Mr. Gregor Burkhart: *An EU perspective on prevention*

Mr. Burkhart, Principal Scientific Analyst (Prevention), EMCDDA, presented an EU perspective on prevention. He outlined that one of the main challenges facing contemporary drug prevention strategy is the common but mistaken belief that if teenagers are simply given enough warning information, this will prevent them using drugs. A range of factors are known to be associated with young people drinking to drunkenness, including poor academic performance, not recognising social rules and having a poor relationship with one's parents. Social or descriptive norms, in other words, perceptions of what other people are doing, have a particularly powerful influence on people's behaviour. If a person believes all their peers are drinking to drunkenness, their risk of doing so increases nine-fold. The normative effect for cannabis is multiple times stronger: where someone believes their peers are using cannabis, their risk of doing so themselves increases 85-fold.

Mr. Burkhart criticised the argument typically made by representatives of the alcohol and cannabis industries, that alcohol or drug use is best limited by people exercising individual responsibility and self-moderation. By extension, if they don't moderate their own consumption then then it's their own fault and doesn't warrant public policy interference in people's private lives. He explained that consumer behaviour is only partly influenced by deliberate consumption choices, and significantly influenced by impulse-driven behaviours based on factors such as convenience of access, the purchasing environment, and visual marketing that normalises and glamourises consumption. While traditional prevention strategies rely on deliberate cognition (acquiring knowledge and understanding motivation and impulse control), we live in environments filled with direct and implicit cues, and react to cues without being aware of how these influence the choices we make. In this context, effective prevention strategies need to include a focus on environmental prevention, which recognises that regulatory, economic and physical measures have a strong moderating effect on risky behaviour. He cited evidence from England showing that the stronger local alcohol regulations are, the larger the effect on lowering the incidence of violent crimes, sexual crimes, public order offences and hospital admissions.

The EMCDDA operates a registry which details a range of prevention programmes across the EU that have been evaluated for their efficacy. Critiquing one of the more frequently-cited examples of a prevention programme, the Icelandic Model, Mr. Burkhart explained that the EMCDDA registry shows no convincing evidence that the model works outside of Iceland, and that more studies are required to determine its impact. Before introducing its prevention model, Iceland already a range of measures in place, including youth curfew hours, a committed national alcohol policy and a committed education and youth policy. Alongside these, the Icelandic authorities introduced behavioural change elements such as supervised free time, family dinners and parental monitoring. These comprehensive measures have not been introduced in other jurisdictions that have sought to roll out the Icelandic model.

The EMCDDA has developed a European Prevention Curriculum, which aims to challenge erroneous beliefs about prevention and encourage decision-makers to rely on evidence-based prevention approaches. He urged caution about investing in costly interventions that are not evidence-based, have no proof of transferability between countries, or do not yield any additional benefits beyond what is already being done.

Evidence-based prevention can tackle a lot of problems at once, if done correctly. The risk factors associated with substance use are also risk factors for other adolescent problem behaviours such as delinquency, teen pregnancy, school dropout and violence.

Summarising, he reminded the Citizens' Assembly that the perception of others' behaviour drives our own; environmental prevention works against 'normalisation' without criminalising; and prevention can be better achieved with good regulation rather than information. Prevention programmes can be effective, but require local environmental prevention policies and use of existing resources such as the police and legal frameworks. Finally,

prevention is about the 'silent majority', those people who do not make all the noise, but are people who just want to live a normal life.

'Prevention is primarily working upstream… where it can make a difference for a lot of people.'

5.2.2 Ms. Karen O'Connor and Mr. Richie Stafford: *A strategic national perspective*

Ms. O'Connor and Mr. Stafford from the Drugs Policy and Social Inclusion Unit, Department of Health, described how prevention sits within the National Drugs Strategy.

Mr. Stafford, a prevention specialist in the Department of Health, noted that drug use is a complex issue, with no silver bullets available. While we sometimes think that, by scaring the life out of thirteen-year-olds, they will never use drugs, it is much more complicated than that. He offered a three-part description of prevention: 'Universal Prevention' is aimed at the whole population; 'Selective Prevention' is aimed at groups based on a particular risk profile; and 'Indicated Prevention' is targeted at the individual or small group level.

Prevalence data at a whole population level is very important from a prevention perspective. While data can provide interesting insights into why people use drugs, it is also important for understanding why other people - the silent majority - do not use drugs. Latest data from ESPAD[5] (the European School Survey Project on Alcohol and Other Drugs), shows a worrying increase, for the first time in a long time, in 'drinking in the last 30 days' and 'smoking in lifetime'.

Mr. Stafford described prevention strategies used in Chile and Peru. Chile had seen a massive spike in cannabis use over a four-year period coinciding with the country's move to a decriminalisation model. While not as simple as saying decriminalisation caused this increase in usage, there is an argument that changing descriptive norms, including the increase in debate in the media at the time, had an influence. In response, Chile initially introduced Planet Youth, a survey based on the Icelandic model of prevention. Finding that Planet Youth had no impact on drug use levels, Chile then introduced 'Unplugged', a very effective classroom-based programme. Similarly, Peru introduced the Unplugged programme, finding that it worked more effectively when introduced in conjunction with training decision makers.

Mr. Stafford stressed that we need to stop doing what is ineffective, including talks aimed at scaring people. While we tend to think of ourselves as rational actors who listen to facts and then act based on those facts, in fact, we tend to choose the facts we want to believe. A young person who believes drug use is abhorrent will have their views reinforced by hearing a talk about the dangers of drug use. However, a young person who is partial to taking some risks, knows people who use drugs or uses drugs themselves will disregard that same message.

The EMCDDA's Xchange registry provides useful information on what approaches tend to be beneficial. Ireland has made significant progress on prevention related to public health, such as the indoor smoking ban, and minimum unit pricing. In addition, Ireland is implementing the European Prevention Curriculum. However, there is no office responsible for drug prevention, funding streams are disparate, and there's no real oversight of the standard of programmes being implemented. Ireland has a network of health promotion improvement officers around the country with an alcohol and tobacco prevention remit, but not a drug prevention remit.

Ms. O'Connor explained that while the National Drugs Strategy does contain actions on prevention, these are high level and vague, which has led to them not being implemented. Following the mid-term review conducted in 2021, the focus on prevention has been strengthened for the second half of the Strategy, aligning with Article 33 of the UN Convention on the Rights of the Child committing Ireland to implement measures that will prevent drug use for young people.

Ms. O'Connor referenced the National Drug Prevention and Education Forum in 2019, which brought together prevention workers from Drug and Alcohol Task Forces, and the arguments presented for evidence-based prevention and the need for coherence and structure in its delivery. Arising out of this, a network of national and international policy and prevention experts was formed and assisted with devising a prevention funding programme geared towards evidence-based prevention. As a result, €1.5 million has been allocated towards prevention projects via a dedicated programme. The programme is running for three years and has funded five key projects. Each of these projects will receive €100,000 a year for three years. The projects are implementing prevention programmes across a

5 http://www.espad.org/espad-report-2019

range of settings including schools, universities, communities, night-time economy and deprived areas. (*Further detail on some of these projects was presented to members during the course of the weekend meeting.)* These projects were selected because they are innovative, rely heavily on evidence and are implementing international evidence-based programmes in an Irish context.

The Department of Health, Ms. O'Connor explained, is working towards better prevention strategy, and she highlighted three key areas of implementation. The first is the development of a guidance framework with the aim of bringing coherence to the delivery of prevention across Ireland, addressing issues of standardisation and competency. The second area is funding, which Ms. O'Connor had earlier spoken about, to ensure evidence-based programmes can be rolled out across the country. The third area is working with Ireland's European partners and experts on prevention research aligned with the European Prevention Curriculum to ensure the Department's work remains in line with the best possible evidence and practice. Ms. O'Connor stressed that the longer an effective programme runs for the better the payoffs, not just for drug use but also the cost impact of drug use.

'Prevention is better, and quite often cheaper, than the cure.'

Ms. O'Connor finished her presentation by calling for evidence-based prevention to be made a key pillar of drug policy regardless of what legal framework exists. She proposed that this sends out a really strong Public Health message - we're telling people that we care first and foremost about their health and then on top of that, it's not a nanny State we're not telling people what to do we're just giving them the information and the strength to make strong decisions about their health.

5.2.3 Ms. Celeste O'Callaghan: *A perspective from the Education sector*

Ms. Celeste O'Callaghan, Curriculum and Assessment Unit, Department of Education, explained that the main way in which the Department of Education supports prevention is through the Social, Personal and Health Education (SPHE) programme, which is currently undergoing a major update. SPHE is compulsory both at primary level and for junior cycle at post-primary level. However, it is not compulsory for senior cycle children aged 16 years and over. The primary curriculum is being revised and a draft new programme will go out for public consultation next year. Meanwhile, a new SPHE programme for junior cycle, with a new curriculum in place from September 2023. Only a minority of schools offer SPHE at senior cycle, and a new curriculum for senior cycle SPHE is currently out for consultation.

The SPHE programme focuses on affirming young people's capacity for good decision-making and supporting them to develop the emotional and social skills that they need. It supports young people to critique and question the cultural and social norms and behaviours that they see around them. It involves discussing real-world scenarios and building strategies for young people to manage various situations.

The new Junior Certificate SPHE curriculum includes two learning outcomes particularly relevant to drug prevention:

- demonstrate skills and strategies to help make informed choices that support health and wellbeing and apply them in real-life situations that may be stressful and/or involve difficult peer situations.
- discuss the physical, social, emotional and legal consequences of using addictive substances –immediate and long-term.

It is essential to have confident and competent teachers to teach this SPHE programme in the classroom as well as to facilitate discussion and exploration of the learning outcomes. A teacher training seminar was introduced earlier this year and will continue through the coming year. The HSE has worked closely with the National Council for Curriculum Assessment to develop classroom materials and resources to support the programme.

While drugs misuse prevention education and SPHE is for everyone, Ms. O'Callaghan noted that there are areas of concentrated educational disadvantage and there are children who have particular challenges. The Department of Education has a more targeted focus for supporting these students to realise their full potential.

The data shows a correlation between higher levels of drug use and earlier school leaving. School retention and completion is a critical aspect of addressing this issue. The DEIS (Delivering Equality of Opportunity in Schools) Programme provides additional funding and supports to schools in areas of concentrated educational disadvantage. Within the DEIS programme, the Home School Community Liaison Coordinators work intensively with parents and guardians in supporting their children's educational journeys and achievements. The coordinator is the link between

schools, parents, the child and other community and family support services. A second programme, the School Completion Programme, is targeted at children in primary and post-primary who are identified as particularly at risk of early school leaving.

'We need to work in alignment with health and with other government departments so that the pieces match up and that we're making a collective and integrated effort.'

Ms. O'Callaghan concluded her presentation by referencing other areas of cross-government collaboration, including the North East Inner City Initiative (NEIC), the Department's funding support of the Local Drug Task Force Projects, and the *Know The Score* Evaluation Steering Group. *Know The Score* is a teacher training resource that supports the delivery of the Senior Cycle SPHE programme, which is currently being evaluated by the Department and the HSE to ensure the programmes are evidence-based and effective.

5.2.4 Dr Michael Byrne: *A perspective from the third level sector*

Dr. Michael Byrne, Head of Student Health Services, UCC provided an overview of data from the *Drug User in Higher Education in Ireland* survey (DUHEI). With the participation of 21 out of the 23 Higher Education Institutes in Ireland, yielding over 11,500 responses, the survey has produced the most comprehensive data set of young people gathered anywhere in Europe over the past 20 years.

The findings show that, of those that completed the survey, 43% had never used drugs, one in five had used drugs previously in their lifetime but not in the last twelve months, one in five had used drugs in the preceding month, while 16% had used drugs in the past twelve months but not in the preceding month. Males were more likely than females to be drug users across all categories. One in six females versus one in four males had used drugs in the month preceding the survey. Dr, Byrne outlined that drug use increases from year of entry through first year and second year to peak in third and fourth year, which is contrary to other data which suggested that drug use falls off in third and fourth year.

'One in six first year students, one in five second-year students, and one in four third- and fourth-year students were current users of drugs.'

Dr. Bryne explained that, excluding alcohol, the drugs most frequently used, in descending order, include cannabis, cocaine, ecstasy and ketamine. Over 50% of those that had used drugs had used cannabis. About one in four has used cocaine, which has displaced ecstasy as the second most prevalent drug being used by students.

With DUHEI data showing cocaine usage at 15.7% in 2021, this would suggest a near trebling of cocaine use over the two decades since data produced by the CLAN study in 2002 showed cocaine use at 5.8%.

The group at highest risk of harm are current users, those who report having used drugs in the preceding month. Among this group, the most common age of first use is when they commence university, between the ages of 19 and 21. However, a significant number start their drug use between the ages of 16 and 18. One in three current drug users had started cocaine use between the ages of 16 and 18, while one in four current drug users had started cannabis use before they were 16.

Amongst current drug users, the most commonly-cited reason for using drugs was for 'enjoyment'. Current drug users reported using cannabis to relax. The study shows that over half of current drug users are at moderate or substantial risk of harm. When asked if their drug use was having a positive or negative impact on their life, the data shows that drug users say it has a negative impact on almost most areas of their lives, including their academic studies, physical health, finances and work life. The exceptions are socialising and mental health, the latter perhaps suggesting that some students are self-medicating.

Finally, 33% of current drug users among the student population would like to reduce their use of drugs, for reasons including to improve their mental and physical health, their finances, academic performance and to avoid potential legal consequences that could impact on their future career. In contrast, 68% of current student drug users do not wish to change their drug habits, don't consider it a problem, don't consider they use drugs too often, don't consider cannabis a drug and simply use it for fun.

5.2.5 Questions and Answers session

Panellists for were joined by Ms. Annette Honan, National Council for Curriculum and Assessment, for the Questions and Answers session.

Members asked whether education or prevention measures actually reach people who are marginalised in society. Both Ms. O'Connor and Mr. Stafford noted that universal prevention, aimed at everyone, offers the most effective and best value prevention model. However, there are also targeted interventions designed to reach marginalised communities. Ms. Honan noted that the SPHE programme is mandatory for all children in primary and junior cycle, which is usually up to the age of 16. The current updates to the senior cycle programme is giving rise to the question as to whether SPHE should be compulsory for senior cycle students as well.

There was detailed panel discussions about delivering prevention modules, and the value of experts with lived experience, counsellors and increasing the focus in schools on mental health issues.

Ms. O'Callaghan noted that the SPHE programme equips children and young people with the social and emotional skills they need to deal with the situations they may find themselves in. She outlined that there are very different school contexts with children from different backgrounds and experiences.

Ms. Honan pointed to evidence showing that the most effective approach to prevention is for classroom teachers to be the facilitators of the conversations, provided they are well trained, equipped, confident and competent in this area. She stressed that more training and support for SPHE teachers is crucial. She explained that there are sometimes unintended consequences when an outside speaker comes into a school. While there can be value to bringing in external speakers, this should only happen as a complement to what's happening in the classroom, not as a substitute. Prof. Eamon Keenan, invited by the Chair to contribute to the discussion, offered the view that there is a risk that schools can unduly lean on invited lived-experience speakers to 'tick a box', rather than utilising an evidence-based prevention programme. He advocated getting teachers trained to incorporate prevention information into the curriculum.

Ms. O'Callaghan highlighted the Well-being Framework which is a whole-of-school preventative approach based on health and well-being. Through this framework there are supports for schools with regard to difficulties or mental health issues.

The panel was asked about regarding the therapeutic benefits of magic mushrooms for conditions such as addiction and depression. Dr Byrne noted that most drugs have both therapeutic and other effects associated with them, and that magic mushrooms have been and are used in therapeutic settings. The DUHEI study shows that students taking magic mushrooms do so largely for fun.

The Chair invited input from Prof. Jo-Hanna Ivers, who explained that she is currently undertaking a research study into the potential role of psilocybin in treating people with cocaine addiction. She remarked that this is very much an emerging science, and it is important to approach it in a careful and measured way.

Questioned about whether students in the DUHEI study were asked why they don't use drugs, and whether trauma was an option as a reason to take drugs, Dr Byrne explained that three-quarters of students who don't use drugs said they had no interest in drug use. The next reason cited was concern about the impact of drugs on their physical and mental health and well-being. One of the options listed for why students do use drugs was emotional distress, which had a very low ranking, suggesting that the majority of students who use drugs do so for reasons other than trauma and emotional distress.

Responding to a question about whether random drug testing in colleges could act as a deterrent, Dr Byrne replied that the short answer would be 'no'. Random drug testing might be a deterrent to some students, but they are more likely to be those students who wouldn't take drugs in the first place. Punitive measures can push people away from engaging with preventative strategies. He also asked why students should be subjected to random testing when it doesn't exist for society in general.

Responding to a question about when is the right time for a parent to bring up the subject of drugs with their children, Mr. Stafford offered the view that there is no one right time. Instead, he recommended that parents keep the lines of communication open with their children so they can feel safe coming to discuss issues as they arise. He also pointed members towards resources developed by the HSE and Barnardos on how to talk to your children about drugs and alcohol.

Following a request for more information on the Xchange Registry, Ms. O'Connor explained that it is a registry compiled by the EMCDDA bringing together prevention programmes that have been evaluated in a European setting and rating them as likely to be harmful, beneficial or likely to be beneficial, or more research is needed. Ms. O'Connor noted that the Department of Children are compiling the 'What Works Hub' which is a registry of prevention programmes that work in Ireland. As of yet, the Hub does not have any programmes relating to drugs but there is work being undertaken to get evidence-based drug prevention programmes included in the Hub.

Mr. Stafford explained that there are a range of methods used to evaluate prevention programmes, with the gold standard being randomised control trials. Evaluating prevention programmes can be both tricky and expensive, as it needs longitudinal evaluation. For example, an intervention with a group of twelve-year-olds might not produce any measurable pattern of change for perhaps ten years. Ms. O'Callaghan highlighted that the evaluation of the Know the Score initiative includes engagement with young people in focus groups to find out what they thought of the programme. She also referred to the School Completion Programme and the increase in children engaging successfully with that programme as a measure of success.

5.2.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Teachers responsible for offering drug prevention and/or SPHE courses need to receive appropriate evidence-based training on to increase their personal knowledge on the subject and increase their skills in effectively engaging and teaching young people about this topic.
- The Department of Education should make SPHE compulsory for every year of secondary school including senior cycle.
- Implement prevention programmes in schools that are age appropriate, evidence-based, and evaluate these regularly for quality control and effectiveness.
- SPHE should primarily be delivered by qualified teachers and occasionally invite in external specialists or people with lived experience form the community as guest speakers if this is deemed appropriate.
- Establish a statutory oversight group / government office that includes representatives from relevant governmental departments to promote interdepartmental communication, oversee public health messaging, drug prevention funding and programming.
- The emphasis on prevention programmes in schools should be on providing information on the effects of drug harm reduction strategies rather than placing the emphasis on harm, deterrence, or scare tactics.
- Provide training to parents on how to talk about drug prevention with their children.
- Increase funding for drug prevention and intervention such as task forces, prevention efforts in schools, home school liaison programme, and outreach programmes.

5.3 Session 2 - Perspectives on prevention (Part II)

5.3.1 Prof. Breda Smyth: *A public health perspective*

Prof. Breda Smyth, Chief Medical Officer, described drug use in Ireland as a significant public health problem. Substance use is responsible for a considerable number of premature deaths, each one of which leaves a family devastated. Drugs use has a significant impact on the health system, with drug-related hospitalisations accounting for approximately 53,000 in-patient bed days each year. 70% of Hepatitis C cases are IV drug users, and the risk of HIV is 25 times greater in IV drug users compared to the general population. In addition, there is also increased risk of HIV and Hepatitis C linked to injection of stimulants. Mental health is also a significant problem associated with drug use and there has been a steady increase in admissions to Psychiatric Services associated with drug-related causes over the last decade and a half.

The data on cannabis use is of great concern, showing that one in five adults in Ireland who use cannabis likely to have a dependence on it, and one in three young people likely to become addicted if they use cannabis weekly or more. The increasing strength of cannabis is a concern, with a 57% increase in cannabis potency in the 10 years from 2011 to 2021. The profile of cannabis use has also changed over time, with people now using it more frequently, many on a daily basis. The latest data shows 45,000 people with Cannabis Use Disorder, while under 18s account for 80% of new presentations to cannabis addiction treatment services.

Prof. Smyth described the hidden harms of drugs use. Children experience a range of harms as a result of compromised parenting, which can affect their social, physical and emotional development. Latest drug treatment figures show that, in 2022, almost half of cases in drug treatment were parents.

Prof. Smyth explained the factors that come into play at different stages along the pathway into problematic drug use. When someone first starts using drugs, the key influence is their environment, or their perception of what is normal at home and in their community. However, as a person continues their use of drugs, personal characteristics become a stronger influence. These personal characteristics are informed by our formative years at home and by our environment. It is only at a much later stage that the pharmacological characteristics of drugs become influential. Prof. Smyth argued that legalising a drug and increasing its access is a form of normalisation, changes the perception of normality, and decreases the perception of risk associated with drug use.

Prof. Smyth posed the question as to how the State might best engage people who use drugs with its health-led approach. She suggested that stigma acts as a barrier to those who wish to seek treatment, and that we need to change the narrative regarding drug treatment. The Health Diversion programme is a good example of how to engage people, with diversion from the criminal justice to the health system. Sláintecare, the health system reform plan, gives the opportunity to provide the right care, in the right place, at the right time and this approach should also apply to our drug treatment services. The development of the new Regional Health Authority (RHA) structure is an opportunity to provide drug services at a regional level on an integrated basis, with better integration between Primary Care, Mental Health and Social Inclusion. She stressed the need to include local authorities in the discussion and the need for seamless integration into the wider determinants of health.

Prof. Smyth concluded with reference to her earlier statement regarding how a person's perception of normality influences their behaviour. She argued that legalisation would increase drug use and the normalisation of that use. Peer-reviewed evidence from jurisdictions where drug use has been legalised shows an increase in prevalence of cannabis use as well as cannabis-related problems, including emergency department admissions and hospitalisations. A 2021 research article focussing on adolescent cannabis use found high and low frequency cannabis usage are associated with significant increases in the risk of schizophrenia. She finished by reminding members that there is no silver bullet solution, we need a multi-layered public health approach with primary, secondary and tertiary prevention based on evidence.

5.3.2 Prof. Catherine Comiskey: *Research and evaluation*

Prof. Catherine Comiskey, Professor in Healthcare Modelling and Statistics, Trinity College Dublin highlighted three key points: first, the need to tackle stigma; second, the need for progressive policy; and third, the need for independent research.

Describing the impact of stigma, Prof. Comiskey highlighted the experience of 'John', who began using heroin at the age of 13, and had smoked cannabis from an even earlier age. John's childhood experiences and family history explained much of the context in which he ended up using drugs. John's father, who suffered from mental health problems, committed suicide when John was still a young child, while his mother suffered throughout her life from alcoholism. Eventually, John entered treatment and has had a positive outcome. However, he would have benefitted significantly from early intervention and a more compassionate response from a system that instead had shamed and stigmatised him as a young person.

Prof. Comiskey highlighted that there are currently an estimated 19,000 - 20,000 people using heroin and opiates in Ireland, suggesting there are approximately 18,000 - 19,000 children are in an environment where there are opiates. She asked the Citizens' Assembly to consider the stigma those children are experiencing, children who know what mam and dad are doing but can't talk to anybody about it.

Making the case for progressive, evidence-informed policy, Prof. Comiskey described the research that supports earlier commencement of prevention programmes in school, trauma-informed, stigma-free schools, teacher education about Adverse Childhood Education, and an understanding of the protective factors that delay the onset of drug use. The strongest factor impacting adults who use drugs was feeling unloved as a child.

Underpinning her call for progressive policy, Prof. Comiskey presented the case of 'Patricia', who at age seven was sexually abused. At age fifteen, when everyone else was sitting the Inter Cert, Patricia was injecting drugs, at a time when there was no needle exchange. By her early 20s Patricia had her first same-sex encounter, which at the time was an illegal activity. By age 23, Patricia was diagnosed with HIV, another stigmatisation. Due to progressive policy

changes, Irish society now has less stigmatisation and better care for people who have experienced sexual abuse, for people with HIV, same sex marriage is legal and there are harm reduction services for people who inject drugs. She concluded by calling on the Assembly to be progressive and bold in their decision making, noting that Patricia was let down by this country and we should never again let down another Patricia.

5.3.3 Prof. Mary Cannon: *Building Prevention Capital*

Prof. Mary Cannon, consultant psychiatrist at Beaumont Hospital and the Royal College of Surgeons in Ireland, presented the case for taking a developmental approach to mental health and substance use. She explained that most adults presenting with mental health disorders, including substance use, have already had a mental health problem before the age of 18. Therefore, a key aspect of effective prevention is early intervention with young people.

Before turning her attention to Primary prevention, Prof. Cannon briefly explained Tertiary and Secondary prevention. Tertiary prevention focuses on giving people the best possible help, with an emphasis on improving outcomes. This is not just about providing effective treatment, it's about promoting recovery, building recovery capital and providing wraparound care such as employment benefits, education, social and financial supports, housing and so on. Secondary prevention focuses on early interventions to catch people before they fall off the cliff edge of problematic substance use or mental health problems. The key thing about secondary prevention supports is they need to be accessible, there needs to be no 'wrong door', and they need to be integrated, so people don't fall through the gaps. Drug and Alcohol Task Forces, General Practitioners, adolescent addiction services all play important parts in secondary prevention.

Primary prevention, which aims to 'keep people away from the cliff edge' and prevent them from starting to use substances in the first place, requires a public health approach, focused on reducing the level of risk across the whole population. This means enhancing protective factors for young people, and needs coherent Public Health messaging, with strong, clear messaging from the top. Primary prevention also needs education to happen not just in schools but across communities and the whole of society.

The 'prevention paradox' means that there are greater gains to be made by focusing on reducing risk factors in the whole population rather than focusing just on the cohort of people with substance use disorder, who experience the most harm. Given that the majority of the population does not use drugs, any new policies should have regard to unintended consequences and should not increase the risk for the whole of society.

Prof. Cannon suggested that it is instructive to look at prevention strategies in countries that have low rates of drug use, such as Iceland. Historically, Iceland's rate of substance use was at its highest two decades ago, when their young people were binge drinking at epidemic proportions. The government and local communities implemented the 'Icelandic Prevention Model' and have driven down substance use to the lowest levels in Europe. The prevention model involves an iterative process of data collection, devising interventions and adjusting the interventions based on the updated data collected.

This model has been introduced in Galway, Mayo, and Roscommon, and has also started in North Dublin, Cavan and Monaghan. Data coming from these projects indicates that 7% of transition year students have used cannabis in the preceding month, which is about the European average. The data indicates that risk factors include other substance use and peer pressure, while the strongest protective factors are parental supervision, parental attitude to drugs and a young person's belief that drugs are harmful. This information provides insight into potential interventions in terms of social messaging and education. Of particular interest are the results relating to young people aged under 16 who have not touched any substance. Among this cohort, protective factors include access to public transport, participation in sports, parental factors and parents who can afford basic necessities.

Prof. Cannon described the influence of Adverse Childhood Experiences (ACEs) on substance use. A person who suffers three or more ACEs during their childhood is at higher risk of physical and mental health issues generally, but has a 10-fold increased risk of problematic drug use.

Prof. Cannon cited the work of Prof. Michael Marmot in the UK, who has taken a health equity and social justice approach to prevention. He has developed a set of principles, the first of which is 'give every child the best start in life'. A number of cities internationally have taken this approach on board and are striving to be a 'Marmot City'. Concluding her presentation, Prof. Cannon remarked that, while the supply of drugs cannot be stopped, we can try and stop the demand. The concept of prevention capacity is about focusing on the whole of society to achieve the best outcomes for the entire population, focusing not just on the individual, but on that individual within their

families, their school and broader society. She finished by acknowledging that drug use is a wicked problem, and complex problems require complex solutions.

5.3.4 Prof. Denis Cusack: *Drug Driving*

Prof. Denis Cusack, Director of the Medical Bureau of Road Safety, opened his presentation by highlighting the recent increase in road deaths, with alcohol being a contributing factor in about one third of those deaths and drugs similarly contributing to about one third of the deaths. The number of road deaths at this point in 2023 has surpassed the total for 2021, with many people's lives shattered. Preliminary drug testing at the side of the road is now done for cannabis, heroin and cocaine. Similar to alcohol, there are specified levels of these substances above which it is illegal to drive.

While there is a medical exemption available for people using cannabis under the Medical Cannabis Access Programme, this would still potentially be an impairment for driving and therefore an offence. Prof. Cusack outlined the categories of illness covered by medical cannabis use but noted that the programme hasn't been used that much. With regard to drug driving prevalence, Prof. Cusack highlighted the prevalence of cannabis, cocaine and benzodiazepines. He demonstrated the new testing device, similar in size to an antigen test, which will detect cannabis, cocaine, benzodiazepines, opiates and amphetamines. He highlighted the problems associated with the improper use of prescribable and over-the-counter drugs, suggesting the Citizens' Assembly needs to consider not just illicit drugs but also the improper use of licit drugs. If used off prescription or bought on the street, they can be as big a problem as illicit drugs.

Prof. Cusack recalled his experience as a coroner for more than 30 years, during which time he as seen terrible deaths and tragedies. Drug-related deaths can be as a result of fatal poisoning, causing direct death, or indirectly, such as through crashes, drownings or falls. Cannabis doesn't cause death on its own, it's usually in combination with another drug. Cannabis and alcohol depress the system while cocaine, methamphetamine etc. make you more of a risk taker. He outlined that the most at-risk group is young men under 35, and that targeted preventions measures for this group are warranted.

5.3.5 Questions and Answers session

The Questions and Answers session began with panellists responding to a question about the challenges in implementing preventative policies. Prof. Comiskey suggested that policy changes can be delayed by a fear of doing harm, and of not being ready, as a society, for change. She argued for prevention programmes for younger age groups, given that young people are initiating alcohol and drug use at a much younger age than prevention programmes are currently being targeted at.

Prof. Smyth reflected on the key role of health promotion and education within primary prevention, emphasising that effective primary prevention requires bespoke materials for particular target groups. Both the 'Know the Score' school initiative and the E-SHEILD app in higher education are good examples of targeted programmes. It's also important to have translated materials and to ensure prevention materials are culturally appropriate for all demographics within the population.

Prof. Cannon suggested that a lot of mental health and drug services have been late coming to the game in terms of prevention comparing the response of oncologists in identifying and reducing risk factors. She called for the integration of mental health services with public health services and pointed to the lack of a coherent message when it comes to drugs.

Prof. Cusack urged the Assembly to challenge the Ministers for Finance, Health and Education to allocate sufficient resources to tackle the problems, and to target at-risk groups.

There was detailed discussion regarding reducing stigma. Prof. Comiskey stressed the importance of not tolerating stigmatising language. She noted that decriminalisation is not the only answer, it's about providing education and proper supports, and it's also about how the media reports on the issues as well. Prof. Cusack asked how it is that people who use certain drugs do not suffer the same stigma as those that use other drugs. He made the point that stigma is not a universal concept.

Asked if a single body overseeing drug services would be useful, Prof. Smyth said the health system is currently being reformed into Regional Health Authorities, with greater emphasis on integration of services. She noted the importance of drug treatment services being included in this restructuring, and stressed that it is also important to

have integration across the wider determinants of health. There will be a National Health Improvement Office linking with the Health and Wellbeing Programme. She acknowledged the need for increased support, through the Public Health network at regional level linking in with the Drug and Alcohol Task Forces.

Prof. Cannon, replying to a question about public messaging on drug use, recalled how quickly and effectively the health authorities and government came together during Covid to provide clear public health messaging. She suggested it's not as simple with drug use, given the variety of opinion on the matter. One clear message that could be put out is on the harms of drugs use based on the evidence. She also noted the power of lobbyists some areas, and how this can impact on clear messaging. Prof Comiskey suggested instead of focusing on the harms we should focus on the positives around reducing harm, such as a positive school environment; access to sporting facilities; promoting reading; awareness of evidence-based harm reduction measures. Prof. Cusack compared the simplicity of the messaging for Covid – one virus, to the more nuanced messaging required for a range of different drugs impacting in a range of different ways. He suggested looking at other countries on what education campaigns have worked for them. Prof Smyth highlighted that messaging needs to be tailored and needs to reach people where they are at.

Prof. Comiskey noted that with regard to changes in drug use the European Monitoring Centre has done studies that show no pattern of change between countries who have prohibition, legalisation or decriminalisation approaches. Prof Cannon suggested one caveat in that this study conflated all age groups together. She noted other analysis in relation to adolescents which shows the more lenient the legal framework, the more likely it is for drug use to increase in this age group.

In response to a detailed question from a member, Prof. Cusack explained the roadside drug testing process in Ireland, noting that there may be cases where the substance stays in a person's system for longer while potentially not causing an impairment, but the same is true for alcohol. He highlighted that the aim of drug driving testing is to save lives, and reflected that the mean figures for those found to be drug driving was between five and twenty times the legal limit.

5.3.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Establish an oversight body office that includes representatives from relevant governmental departments to promote interdepartmental communication and information sharing and oversee drug prevention and intervention funding and programming.
- Greater focus on reducing stigma by developing stigma reducing policies and/or implementing a national anti-stigma campaign that includes use of social media and targets schools and teachers. Messaging should focus on UN principles of human rights and equality.
- Create a public health/awareness campaign on the risks of misusing drugs, which is intergenerational and tailored messaging for different groups of people, places an emphasis on targeting young men under 35 and features information on both licit and illicit drugs.
- Drug-related policy and prevention strategies should be based on a health-lead, non-punitive approach.

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Establish an oversight body office that includes representatives from relevant governmental departments to promote interdepartmental communication and information sharing and oversee drug prevention and intervention funding and programming.
- Greater focus on reducing stigma by developing stigma reducing policies and/or implementing a national anti-stigma campaign that includes use of social media and targets schools and teachers. Messaging should focus on UN principles of human rights and equality.
- Create a public health/awareness campaign on the risks of misusing drugs, which is intergenerational and tailored messaging for different groups of people, places an emphasis on targeting young men under 35 and features information on both licit and illicit drugs.
- Drug-related policy and prevention strategies should be based on a health-lead, non-punitive approach.

5.4 Session 3 - Perspectives on prevention (Part III)

5.4.1 Roger Mehta: *A personal and professional perspective on Dual Diagnosis*

Mr. Roger Mehta, Addiction Counsellor, Psychotherapist and prevention practitioner, described how he had misused and abused alcohol, street drugs and prescription medication for 16 years of his life, to deal with the effects of chronic childhood trauma. Explaining dual diagnosis, Mr. Mehta described how some people who develop an addiction can go on develop other mental health issues like anxiety, depression, paranoia and psychosis. In other cases, some people start out with an undiagnosed and untreated mental illness, and self-medicate to manage their mental health, which in turn can lead to addiction, which exacerbates the original mental illness. The World Health Organisation (WHO) reported a 13% increase in mental health conditions and substance use disorders in the decade to 2017.

Mr. Mehta painted a picture of his early family years. His father, he believes, developed an alcohol abuse problem trying to deal with an undiagnosed mental illness. Following the death of his father and the subsequent mental deterioration of his mother, Mr. Mehta and his brother, who tragically died from dual diagnosis in 2009, also struggled with mental health issues. Self-medicating with substances to cope with these complex issues has had a long-lasting effect on Mr. Mehta's health. Mr. Mehta found recovery in 1998 but struggled with his mental health for the first ten years of his recovery. Mr. Mehta notes that if he hadn't sought and received help for the poor mental health aetiology (root cause) of his substance use disorder in 2008, he wouldn't have been able to maintain his sobriety and recovery. While he has worked in the community since 2000, both voluntarily and professionally, without his trauma affecting his clinical work, there is still stigma.

Research has shown that music can have a beneficial effect on mental health. Mr. Mehta described how music has been his escape. He has been a DJ, radio broadcaster and singer/songwriter since he was aged 16. The lyrical content of hip-hop music addresses themes such as poverty, trauma, depression, anxiety and addiction. By sharing their personal narratives, hip-hop artists encourage open conversations about mental health and dual diagnosis, inspiring others to seek help and get support. Mr. Mehta played a brief extract of a song from Eminem, explaining how the song's lyrics help listeners to explore issues such as family breakdown, domestic violence, childhood trauma, low self-esteem, low self-worth and dual diagnosis. Mr. Mehta's harmony workshops allow participants to explore these issues by writing and performing rap songs in class, which is both a cathartic and educational exercise. He has used this approach in workshops all around Ireland, including in schools and in Mountjoy Prison.

The harmony workshops have been the only psychoeducation programme on preventing and managing dual diagnosis in Ireland. There has been growing awareness over the last few years on how hip-hop music is helping people deal with dual diagnosis, providing a vivid commentary on social angst, malaise and mental health. There is a huge burden on society arising from dual diagnosis, and our prisons are full of people dealing with trauma and substance abuse. The impact of childhood trauma is not only having a huge pack impact on dual diagnosis but also the physical health of populations. He advocated that evidence-based programmes need to be funded.

5.4.2 Dr. Ian Marder: *Restorative Justice and drugs-related offences*

Dr Ian Marder, Assistant Professor in Criminology at the School of Law and Criminology, Maynooth University, explained the concept of restorative justice, a process whereby a victim of crime and the person responsible are offered the chance to communicate, either in person or indirectly. This allows the people most affected by the crime to decide, together, how to address, repair and prevent recurrence of the harm that was done. It is a voluntary process, facilitated by a professional and can be done at any stage of the criminal justice process, with any type of crime.

Dr Marder offered the example of someone stealing from a shop or drunkenly damaging a car. Using a restorative justice approach, the victim can be offered the chance to meet the perpetrator, explain how the offence affected them and perhaps ask questions about why they did it. Both sides then explore together how to make amends and prevent it from happening again. Depending on the seriousness of the crime, this process might happen instead of prosecution, but might also occur where there a community or custodial sentence has been imposed by the judge.

Pointing to the evidence supporting the effectiveness of this process, Dr Marder noted the key outcome is that it helps both people. Restorative justice helps victims to feel better and recover from the crime, resulting in higher levels of victim satisfaction compared to the court process. Dr Marder explained that the criminal justice system is not designed to meet victims' needs and can sometimes be a very damaging experience for victims.

Restorative justice supports prevention by involving people in deciding how they can stop offending. It allows participants to explore questions such as whether they need drug and/or mental health treatment, whether they need to make amends to the victim or if they want to reconnect with their own family. People are more likely to follow through with outcomes where they have been involved in deciding what those outcomes will be, rather than having outcomes imposed on them. Dr Marder pointed to research that shows that giving people criminal records and sending them to prison often makes reoffending more likely.

Given its benefits, Dr. Marder advocated that restorative justice always be offered for offences with direct victims. He suggested it can also be used for crimes without direct victims, such as drug possession. For this type of crime, a little-used process exists whereby a court can refer someone who has been charged, at the point between conviction and sentencing, to meet with community volunteers and professionals representing the State, where a similar restorative justice-style conversation can be had to address the crime and to prevent further harm.

Dr Marder stressed that if the Assembly were to recommend the decriminalisation or legal regulation of drugs, which he was of the view the members should, then restorative justice for drug possession wouldn't be required. He made the argument that restorative justice is not punishing someone who has broken the law, rather it's about addressing and repairing harm and meeting people's needs. Research shows that the main responsibility for harm caused by problem drug use lies not with the individual person using drugs, but with the current legal framework, or in other words, the criminalisation of drug use. Criminal law is designed to stigmatise. Under decriminalisation, where drug use causes harm you would have a health response like with alcohol. Dr Marder suggested that where a person commits an offence with a direct victim as a result of having a drug problem, such as burglary or violence, then you can offer restorative justice within the criminal justice context.

Decades of research in criminal justice, policing and criminology shows that the current law, where the possession of drugs is criminalised, does not deter problem drug use, and in fact makes public and individual health worse. As a philosophy, restorative justice does not say that people caught with drugs should be punished or stigmatised. Restorative justice would say that we have to repair harm. Under an holistic model of decriminalisation with investment in health services, restorative justice could be used to repair the harm to the very communities and individuals that themselves have been actively harmed by the War on Drugs. An additional element being considered by countries looking at decriminalisation or regulation of drugs is the expunging or removal of criminal records for people who have been, they now accept, wrongly and unjustly criminalised.

Concluding his presentation, Dr Marder called on the Assembly to recommend offering restorative justice for all offences with victims, whether caused by problem drug use or not, at a minimum decriminalising drug possession and providing reparation to the people harmed by the War on Drugs.

Restorative justice is a way of doing things that requires compassion and a recognition that we should give people the opportunity to achieve their potential and contribute positively to society recognising that change is possible.

5.4.3 Judge Olann Kelleher, Mr. Joe Kirby and Mr. Declan O'Riordan: *The Cork Courts Referral Programme*

Judge Olann Kelleher described how, over the last few years, he had seen cocaine play an increasingly prominent role in cases coming before him in the Cork District Court. In contrast to cannabis-related possession offences, where the offender can avail of an Adult Caution and then requires three convictions before a jail sentence might be applied, first time offenders for cocaine-related possession offences can face serious consequences immediately. This could include a prison sentence of up to 12 months for conviction in the District Court, or up to 5 years for conviction in the Circuit Court, as well as the impact on a person's career.

Judge Kelleher explained how, in conjunction with the HSE, he designed a programme to divert first-time offenders for cocaine possession to dedicated health services, thereby avoiding a conviction and prison sentence, while receiving help, if needed, for any underlying drug addiction. Participation is voluntary, in the sense that offenders can still opt to face the court. However, everyone who has been offered access to the referral programme has accepted it, with most participants paying a €750 monetary penalty as part of the conditions imposed by the court. To date, 189 individuals have come through the programme.

Mr. Joe Kirby, HSE Social Inclusion Manager Cork/Kerry, described how the Referral programme works in operational terms. Using the revenues generated by the €750 fines, the HSE has contracted Coolmine to employ a SAOR worker.

The Judge makes referrals directly to the programme. If anyone has a difficulty paying the fine, that does not prohibit them accessing the service. The SAOR worker is part of the integrated health structure within the HSE Cork/Kerry Region.

Mr. O'Riordan, the SAOR worker attached to this programme, explained that SAOR is a brief intervention that can help a wide range of people. It can be very beneficial to someone who uses drugs recreationally, who may benefit from receiving information and education about the choices that they're making. It can help people who have developed a substantive issue with drug and alcohol use by giving them the opportunity to explore those issues and see what options are available to them if they wish to get help.

A standardised assessment tool is used to gain a comprehensive insight into exactly what is happening for someone in terms of their drug use, mental health, physical health and socioeconomic status. The assessment process can help people reflect on their drug use, and make an informed choice about whether or not they want to stop their use.

Mr. Kirby outlined the findings of an independent assessment of the Cork Courts Referral Programme by a team led by Prof. Jo-Hanna Ivers. That assessment has shown a 93% attendance rate, indicating that participants are motivated and want to engage with the programme. Of the people coming through, 81% were employed while 7% were students. This is a cohort of people that wouldn't normally present themselves to addiction services, allowing significant health interventions to a group of people who would not normally be seen. 11% of the people coming through required onward referral to a specialised drug and alcohol service.

5.4.4 Ms. Nicola Corrigan: *Health Diversion and the SAOR model of brief intervention*

Ms. Corrigan, HSE National Social Inclusion Office, explained the HSE's progress in establishing the SAOR brief intervention service as part of the planned Health Diversion Programme. The HSE is currently establishing a SAOR service in each of its nine Community Healthcare Organisation (CHO) areas nationwide. Funding has been secured to recruit nine practitioners, two of whom are already in place with seven in the process of being recruited.

SAOR practitioners will deliver a brief intervention to those people who opt into the service, will work to establish pathways for onward referral if needed, and will report on outcomes to the HSE and the HRB. A brief intervention is a motivational conversation with somebody about their drug and alcohol use. It can take place in a variety of settings; it can be delivered by a variety of people; and it can take anywhere from 5 to 25 minutes. A brief intervention is a tool to prevent substance use and reduce the risk of escalation into dependence or harmful use. It works well as an intervention where the nature and extent of a person's drug use is not known. It is not a long-term treatment; rather it is an early intervention and prevention tool.

SAOR is an acronym for **S**upport, **A**sk and assess, **O**ffer assistance and **R**efer. The first objective of the intervention is to try and establish a safe space for the person to talk. The next objective is to find out what has brought this person through the door, either using an evidence-based screening tool such as the Drug Use Disorder Identification Test (DUDIT), or by way of gentle conversation and questions. Based on that assessment and conversation, the SAOR worker can offer appropriate assistance, advice, information and referral options. Ultimately, it is up to the person themselves to decide their next step. For the vast majority of participants, the brief intervention itself may be enough. For the small cohort of people, approximately 10%, who do need onward referral, options can be discussed with the person's consent.

5.4.5 Questions and Answers session

The Questions and Answers session covered a wide range of topics.

Mr. Mehta explained that mental health issues can often exist before developing into a dual diagnosis, and could initially present as anti-social behaviour. As a prevention practitioner, he is particularly interested in identifying these issues before young people start misusing drugs or alcohol as a self-medicating mechanism. From his work in schools, he is aware that most teenagers are already drinking alcohol at fifteen, and believes that early intervention is schools is critical.

Responding to questions about assessing the outcomes of the various programmes discussed by the panel, Ms. Corrigan explained that, as part of assessing the SAOR brief intervention model, the HSE is looking at baseline consumption levels, using the National Drug Treatment Reporting System, and tracking referrals through the programme. Dr Marder explained that assessment of the restorative justice model is slightly complicated by the fact that it is voluntary, but referenced the studies he had mentioned in his presentation which look at a range of

improvements in a perpetrator's behaviour following engagement with the programme. In addition, studies show a much higher satisfaction rate for victims versus the courts.

Dr Marder responded to a question about whether removing legal sanctions would normalise drug use and see similar issues arising here that have arisen in Portugal, such as open drug taking and inaction from police. He acknowledged that Portugal is having problems with drug use, but these are the same problems countries that criminalise drugs are also having, and this points to the problem not being related to the legal framework in place. He suggested that where there are people causing problems, the police can deal with these issues under public order powers. Criminological research does not suggest that criminalisation deters problem drug use, indeed a criminal record makes it more likely that someone will engage in antisocial behaviour in the future. He also noted that prisons do not help people with drug problems, and in most cases it makes their situation worse.

Ms. Corrigan provided further detail on the Health Diversion programme, noting that it is not yet in place, but the HSE are putting structures in place in preparation for its rollout, including the operational establishment of SAOR service, and building relationships with the local Gardaí to ensure as quick a referral as possible following arrest. Currently, it is not possible to put a timeline on when the Health Diversion programme will be operational. There is funding in place for nine SAOR practitioners with two in place and seven more being recruited. The HSE will monitor the demand following commencement of the programme and can seek further resources if needed.

Some members stressed their belief that nine practitioners are not enough for twenty-six counties. Ms. Corrigan acknowledged the frustratingly slow progress being made with the Health Diversion legislation, but stressed that the HSE is putting as much as they can in place so once the legislation is enacted they will be ready to go. She agreed that nine practitioners is unlikely to be enough, but sees it as a pilot programme to get the data and information required to then seek further resources. SAOR practitioners will have a counselling background and must have experience working with people who use alcohol and drugs.

The Chair called on Prof. Eamon Keenan (HSE) to comment on the resource question. Prof. Keenan agreed that nine SAOR workers to deliver across the country is a challenge for the HSE, particularly given the geographical spread in some health areas. Once the scheme is up and running, it will be possible to measure demand levels and this data will provide strong evidence for additional resources, if needed.

The Chair expressed his frustration that a Health Diversion programme has been considered since 2017, there was government agreement for this approach in 2019 and yet, heading into 2024, we still don't have a Health Diversion in place.

Dr Marder was asked for his views on previous presentations to the Assembly from the Department of Justice and An Garda Síochána (AGS). He responded that it was useful to hear the Department's recognition of the challenges arising from legal frameworks in different jurisdictions, and to hear about the involvement of both AGS and the Prison Service in the rollout of naloxone. He also found AGS's honesty with regard to their stop and search powers useful, while noting his opinion that it's the wrong thing to do. He found less useful the assertions that criminalisation deters problem use and that violence and criminality is worse in Ireland than in Portugal. This, he said, this does not align with the international evidence.

5.4.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Accelerate the implementation of the HSE health diversion model.
- Evaluate the efficacy of drug treatment and prevention programmes.
- Restorative justice should be included in legislation on health diversion pathways.

5.5 Session 4 - Perspectives on prevention (Part IV)

5.5.1 Fr. Peter McVerry: *Prevention with vulnerable groups*

Fr Peter McVerry outlined what he described as two strongly-held convictions, based on 40 years working with drug users, ever since heroin first came to inner city Dublin. The first is that what we are doing now isn't working. We have

spent 40 years and billions of Euros primarily using the criminal justice system to reduce drug use, and the outcome is that a wide variety of drugs are available in every village in Ireland. The second is we need to treat drug use and misuse as a health problem, not a justice problem. Fr. McVerry elaborated by saying that when a parent rings him, having discovered their son or daughter is using drugs, they're not looking for the number of the local Garda station, they want to know what treatment options are available.

'No parent wants their child to have a criminal record because they caught in possession of a small amount of drugs for personal use. Every drug user is someone's son or daughter.'

Referencing the socioeconomic dimension to the drugs issue, Fr. McVerry noted that it is drug users from deprived areas that fill up our prisons and cause most concern to society. They cannot pay for their drugs without robbing. The temptation to use drugs is often stronger in deprived areas. Such areas have a higher rate of poverty, early school dropout and higher unemployment, creating a context in which drug use can be seen by some as a way of escaping the reality of their lives. He suggested that tackling deprivation would undoubtably reduce drug use, but the only people who know how to tackle this deprivation - those living in deprived areas themselves - may never be given the resources or power to do so.

Recalling people who he has worked with over the years who started using drugs at a young age, Fr. McVerry observed that they usually started because their friends offered it to them. For teenagers, the peer group is immensely influential and nothing we can do can counteract that peer group influence. Educating young people about drugs, talking about the danger of drugs, while very worthwhile, has very limited effect in reducing drug use. The only influence that might counteract the peer group is the family. Fr. McVerry shared his admiration of parents in deprived areas, who are often worn down with financial struggles and worry every time their child goes out, wondering what they may get up to or who they may meet. Many parents need support if they're to steer their children away from drugs but, family support services in deprived areas are often non-existent, and those that do exist have often experienced cutbacks when money is scarce.

Another area of concern is preventing people who have gone through treatment from relapsing. They need accommodation away from their familiar environment, where the temptation to relapse may be high. This is a particular issue for people who are experiencing homelessness, given that the risk of relapse in a hostel environment is all but inevitable.

Boredom is one of the biggest factors driving people back into drug use. People in recovery need something to do. Hence, reducing drug use requires coordination between all the relevant services, drug treatment services, accommodation providers training, employment services, social welfare services and mental health services.

If you can get government departments and statutory bodies to work together, you'll win the Nobel Peace Prize.

Turning to consider the prison system, Fr. McVerry noted that there are over 4,000 people in our prisons today, 70% of whom have an addiction, with only 10 or 12 beds in the prison service for those who want to address their addiction. While there are drug counsellors in the prison service, there could be a four or five month wait for a first appointment. The vast majority of drug users who go to prison get little or no help with their addiction while in prison, and are released again with an untreated addiction. Fr. McVerry highlighted the provision in Section 28 of the Misuse of Drugs Act 1977 which allows judges to remand a person to a custodial drug treatment centre with the intention that, if that person completes the treatment programme, then a community sanction could be imposed as an alternative to a prison sentence. Forty-six years on from the enactment of that legislation, there is still no custodial drug treatment centre. He contrasted the situation in Ireland with the practice in Scandinavian countries, where a person with an addiction is sent to prison, they are guaranteed a place in a treatment programme within four weeks of going into prison.

Concluding, Fr. McVerry emphasised the importance of family support services to help reduce the chances of young teenagers getting involved in drugs. Coordination between all the relevant departments and services is essential. So many people from deprived areas who have an addiction end up in prison, which is an opportunity to try and help them to address their addiction, but that opportunity is being wasted. We can reduce drug use, but we have to do things differently.

5.5.2 Mr. Andy O'Hara: *The social and economic complexities of prevention*

Mr. O'Hara began by proposing three broad themes for prevention: keep people alive; promote broader well-being and improve quality of life. He suggested that this can be done by decreasing inter-generational trauma and promoting equitable well-being for everyone. Recalling the arrival of heroin in the 1980s, Mr. O'Hara explained that heroin did not create the problem, it just filled the gap created by poverty and trauma. Both heroin itself, and some of the policies implemented in response to the heroin crisis, added to those existing problems.

Reflecting on the socioeconomic context of drug use today, he compared the high unemployment and poor quality of housing of the 1980s to today's situation of high employment, but despite this, more and more people of all social classes are struggling to survive and there are massive issues with housing.

Added to that, drugs are more potent and more widely available in every part of the country. We have an increase in drugs use; an increase in people presenting with issues around drugs and mental health; an increase in violence in communities, and an increase in deaths associated with drugs. While many areas have benefitted from regeneration, it could be argued that this was physical, rather than social, regeneration.

While there has been good progress, which should be promoted and built on, we also need to look at what is not working. Recent media reports relating to drugs and crime in Dublin serve to hype up a response that is based on fear and a lack of understanding. This leads to actions that further stigmatise and punish people. Mr. O'Hara recounted his personal lived experience, commenting that the worse you are treated, the worse you feel and the more drugs you take. He pointed to recent events in Dublin as examples of what happens when you have a lack of social policies, a criminalised approach and a lack of community-led analysis to inform responses and interventions. Explaining why people use drugs, Mr. O'Hara commented that people use drugs to seek pleasure, and the people who are seeking the most pleasure are the ones that are struggling the most and trying to escape from their current reality.

To prevent people who do not use drugs from taking drugs, he suggested that we have to address poverty and the environmental factors of trauma. We must create equal opportunities for people to progress in life; and create a society where you do not need to take drugs to cope with everyday life.

While 90% of people who use drugs do so recreationally, UISCE is seeing more and more of this cohort who are veering towards drug dependence, driven in part by the struggle to make ends meet, to get housing or to achieve a good standard of living.

Calling for a response that doesn't target and criminalize people who take drugs but do not have an issue with drugs, Mr. O' Hara said that we need to keep people from entering the criminal justice system, which can exacerbate the problems. He gave the example of a woman growing up in a disadvantaged area taking drugs to deal with trauma, who commits a crime, ends up in court and is sentenced to prison, and on her release months later she finds herself homeless, her children have been taken into care and, to cope with this, she takes more drugs. He described this as an approach that makes lifelong victims of the very people we need to be helping.

Proposing an approach to prevent people who are drug dependent from escalated harm, Mr. O'Hara called for trauma-informed services that are built around people's needs and are based on a human rights approach. He called for street level drug checking, naloxone available across the counter, safe drug consumption rooms and the removal of barriers for people accessing treatment. To achieve all this, he argued, we need a social determinants approach that recognises the non-medical factors that influence health outcomes, such as educational attainment, employment status, and housing. Another determinant is whether a person experiences discrimination created by social policies and norms, economic factors and political systems that shape the living conditions of people's lives. Structural violence, substance use and trauma left unaddressed will lead to generational impact and our response is to blame the individual and re-traumatise them.

Mr. O'Hara reassured the Assembly that while the issue of drugs use has been called a 'wicked problem', it isn't too complex to solve. UISCE's submission contains a number of practical proposals, which are based on the lived experience of people and backed up by evidence-based solutions. Mr. O'Hara advocated that the USICE approach be rolled out through an independent national framework.

Giving people a role, giving people a stake in our society is how they become actors for change in their own lives and communities.

5.5.3 Ms. Fiona Ward: *Social Protection and Employment schemes*

Ms. Fiona Ward, Assistant Secretary, Department of Social Protection outlined how the Department of Social Protection employment support service supports people in recovery. The primary support is provided through the Community Employment (CE) scheme, which has a dedicated drug rehabilitation stream. CE schemes offer participants part-time work and training of 19.5 hours per week. Schemes are typically voluntary and located within community-based organisations delivering benefits to local communities.

The CE Drug Rehabilitation Scheme has 1,000 places ringfenced to address the needs of people in recovery. The Scheme provides participants the opportunity to gain the experience, training and skills they need to obtain sustainable employment. There are currently around 900 participants on the Scheme. Places are located across 45 CE Drug Rehabilitation Schemes nationwide and supported by a staff ratio of 7:1, lower than mainstream CE Schemes where it is 25:1. This lower ratio recognises the additional barriers to employment and personal development that people in recovery face. Participants on the Drug Rehabilitation Scheme have different qualifying criteria, and are afforded additional flexibilities regarding their attendance, work and personal development requirements.

There are also pathways for ex-offenders to participate in CE schemes, either on referral from relevant agencies, or directly where they meet the criteria for time spent unemployed. Time spent in prison is considered reckonable.

Ms. Ward outlined some of the many benefits for someone to engage in a CE Scheme. These included meaningful work experience and development of skills; building confidence, self-esteem and self-worth; supportive environment; access to and financial support for education and training. On the employer side, Ms. Ward detailed some of the incentives offered to employers to recruit, including the Jobs Plus Scheme, a grant-based scheme whereby an employer is paid a grant, over two years, of €7,500, increasing to €10,000 if they recruit someone with a history of a drug addiction or who has a prison record.

Ms. Ward emphasised the cross-government approach, with the Department working in close cooperation with the Department of Rural and Community Development's Social Inclusion and Community Activation Programme (SICAP) as well as the local development companies. The Department also has a protocol in place with the Irish Association for Social Inclusion Opportunities (IASIO), the Prison Service and the Probation Service to ensure there is a streamlined approach to supporting ex-offenders.

5.5.4 Mr. Jim Gavin: The North East Inner City Initiative

Mr. Gavin, Chair of the North East Inner City Initiative (NEIC) explained that the vison of the initiative is to make the Northeast inner city a safe, attractive and vibrant living environment for the community and its families, with opportunities to live full lives. The initiative was established in 2017 at a time when the area had been lacking attention from a government level. A strategic plan was developed for the period to 2022, which has been extended to end 2023 because of the pandemic. A strategic review process is underway to extend to 2026. The NEIC Taskforce has six groups covering crime and drugs; education; family well-being; enhanced wellbeing and physical environment; substance use, misuse and social inclusion; and alignment of services. The strength of the initiative lies in the fact that it is cross-departmental, cross-community, and brings relevant State agencies and NGOs into the mix.

Drugs have had a major detrimental impact on the area. The legacy of the heroin epidemic is still evident, with many people in long-term methadone treatment. Currently, there is widespread availability of drugs in the area, with associated intimidation and violence perpetrated by the criminal gangs who control the drug trade. The NEIC supports a health-led approach to drug use in the area, in line with the National Drugs Strategy. While policing is important, the NEIC's view is that, in the long term, we must treat drug use as a health issue, we need to make people safe in communities, which goes hand in hand with promoting recovery from drug use.

The NEIC supports a number of initiatives to meet the health and social needs of people who use drugs. The Inclusion Health Hub is a one-stop-shop for person-centred health and social care services. Service providers operate a case management system, a shared framework for managing the care of people who use drugs with complex needs, which has provided 800 client assessments and 18,000 sessions in the NEIC catchment area. The Career's Edge programme provides focused supports to enhance the employment prospects of people in recovery from substance use. Following a twenty-week programme, 50% of participants have progressed to employment and 40% have progressed to education. The focus of this programme is on the question of 'what matters to you'? rather than 'what's the matter with you'?

The LEAR (Law Enforcement Assisted Recovery) programme supports people to move away from criminality and antisocial behaviour and towards recovery. In 2023 to date, LEAR had worked with 380 people in the NEIC & wider Dublin 1 area. Another relevant initiative is case management for people in private emergency accommodation, with 649 people offered case management supports in 2022. The NEIC also has a dedicated residential drug treatment service with a ten-bed stabilisation unit serving the area.

5.5.5 Questions and Answers session

Before the Questions and Answers session got underway, the Chair invited Mr. Karl Ducque, a member of the Lived Experience Group, to comment. Mr. Ducque welcomed how far prevention had come since his own experience at age sixteen. He remarked that, in terms of prevention efforts, we have to reach far and get many people on board to really make a difference. He highlighted the particular challenges facing early school leavers and people in isolation, and the interventions out on the ground at the moment. Reflecting on his own work with at-risk young people, while he can point to some clear positive outcomes in terms of people who have progressed on to college, perhaps some of the best outcomes might relate to people who are still doing 'bad things' but interventions have helped moderate the situation. These outcomes, however, are not easily quantifiable or explainable to an oversight committee or government department.

Mr. Gavin outlined that one of the NEIC subgroups is focussed on family well-being. As part of this there are after school services, youth diversion projects, youth clubs to provide a safe place for kids and young people in the area. Currently there is a budget of €7.2 million for the entire project.

Ms. Ward explained that there is a specific section dealing with access to CE Schemes for people experiencing homelessness. There is usually no wait time where someone is referred from another service or agency, including the prison service.

Mr. O'Hara explained that UISCE is fully independent and based around people with living experience. While there are good, well-meaning programmes developed by the State or other service providers, people who use drugs have reported poor experiences or poor outcomes from those programmes. It's important for these people to have a voice within the system, while maintaining independence. While UISCE may have a seat at some discussion tables, often it's not clear whether UISCE's view is being listened to. He advocated for a return to the collaborative approach that existed when the Drug and Alcohol Task Forces were first set up. He noted the work being done by the NEIC initiative but queried how successful it has been. Responding, Mr. Gavin noted that a lot of good work has been down within the NEIC but there is lot more to be done, and this is currently being reviewed. Mr. O'Hara clarified that the NEIC cannot address the underlying issues on its own, it requires a cross departmental response.

Fr. McVerry expressed frustration with what he saw as a lack of political will to address the drug issue, referencing the immense levels of intimidation associated with drug use in deprived areas, and the long waiting times or complete lack of access to treatment. He underlined this by highlighting that there are only ten stabilisation beds for the entire Dublin north inner city.

Responding to a question about what lessons could be taken from the 'Gregory Deal', Fr. McVerry noted that Tony Gregory was in a unique situation in that his vote was needed by the government of the day. One of the things he advocated for was a 'local CAB' (Criminal Assets Bureau) that would go after the street dealers to show young people growing up in these areas that drugs don't pay, but this never came to fruition. Fr. McVerry proposed a local CAB be set up in every area to go after the street dealing.

Reflecting on the costs of running a drug rehabilitation facility, Fr. McVerry explained that it costs approximately three-quarters of a million euros per year to run the drug detox centre, with maybe seventy to eighty people a year going through the centre. He stressed that while this may be expensive, it includes the costs of specialists such as addiction counsellors. It is more expensive and costly not to invest in detox and treatment facilities, when one considers the costs to society and to the victims of crime, and the costs incurred by the criminal justice system, where 70% of the prison population have addictions.

Asked about the options for people who finish school at or before sixteen, given that the minimum age for the CE schemes is eighteen, Ms. Ward referenced the Youthreach programme under the remit of the Department of Children, Equality, Disability, Integration and Youth, which is aimed at early school leavers and has close ties with the CE framework. While some young people are participating on CE schemes, education schemes are prioritised over CE schemes for this age group.

The Chair invited Prof Jo-Hanna Ivers to comment on the NEIC initiative. Prof Ivers said the outcomes are not yet

fully established, given that it's quite a new initiative. She characterised it as a micro-example of what she had called for in her earlier presentation to the Assembly, a targeted initiative with political support, investment, a focus on bringing along the people affected most and underpinned by an evidence base.

Fr. McVerry called for greater investment in services, saying that no one should have to wait more than four weeks for treatment after being assessed. The biggest problem is that politicians are distanced from the issue, as most of the drug misuse happens in areas where they don't live.

Mr. O'Hara called for a social determinants approach to address inequalities, promote broader wellbeing and improve quality of life. He said this needs to be informed by a ground-up process that is designed, delivered and evaluated by people who use drugs, and families and communities most affected.

Ms. Ward advocated for timely access to services and embedding of collaboration across government and the services. Mr. Gavin called for strong local representation, including people with lived experience, and holding government to account by having clear, tangible and measurable targets.

5.5.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members

- Establish an independent umbrella agency to oversee and monitor efforts related to drug use.
- Adopt a cross-sectoral and inter-departmental response.
- Regional CABS should be implemented nationwide

5.6 Session 5 – Resilience and Wellbeing

5.6.1 Prof. Pat Dolan: *The Case for Prevention and Early Intervention*

Prof. Pat Dolan, UNESCO Chair in Children, Youth & Civic Engagement, University of Galway, explained resilience as the capacity to bounce back or recover from adversity or trauma, and to do better in life than might be expected. He outlined the moral, scientific and economic case for investing in prevention and early intervention to build resilience and as a response to drug use.

Prevention and early intervention accelerate a person's capacity to do well and deal with issues in their lives. The evidence is overwhelming that where you support young people and families in their communities, even in very basic ways, it has amazing results, but it requires investment in capacity. The social return on investment around preventative interventions and early intervention services that enable resilience in young people, families and communities, is outstanding. Nobel Prize-winning economist James Heckman showed that for every €1 spent in early childhood education, there is a return in the region of €12.

Resilience is seen where a person's protective factors in life outweigh their risk factors. Protective factors include family, friends, community, staying in school, being involved in a hobby. Five important aspects of resilience include relationships; giving somebody responsibility; ritual and routine; reciprocity, or the idea of giving something back; and civic engagement, where young people and families, even in situations where they are in extreme adversity, are kept engaged and give something back, where they are seen and respected as part of civil society.

Where a person has good family support and good social support, they have greater capacity for resilience, the ability to thrive in the face of adversity. Empathy education, building the capacity for effective cognitive, or active, empathy, is important. Empathy and compassion are key ingredients in the context of early intervention where people are involved in drug use. A new school-based programme – 'Activating Social Empathy', is being introduced into the updated SPHE programme, but needs support to grow. We know what works, we know the importance of having a caring adult present in a young person's life; of being involved in your community; and staying at school. These things work because of relationships. For young people or adults who feel they are on the margins, the reason they can get back in the mainstream is because of relationships. Prof. Dolan made the argument that in any budget at least 20% of expenditure must be on prevention and early intervention, concluding that we have learned the benefits of intervening early in medical matters, and now need to do the same with social interactions with young people, adults and communities that are experiencing drug misuse.

5.6.2 Andy R and Sean H: *Peer-based recovery and talk therapy*

Sean H introduced himself and Andy R as members of Narcotics Anonymous (NA), both recovering drug addicts with many years of 'clean time' – defined as absence from all forms of mood-altering drugs. Sean H explained that they were at the meeting to provide the Assembly with information about the organisation, and to carry the message of NA, that any addict can stop using drugs, lose the desire to use and find a new way to live. NA as an organisation was started in 1953, adapting the Alcoholics Anonymous Twelve Steps approach. NA is a non-drug specific programme and welcomes anybody who takes any drug or has a problem with any drug, whether legal or illegal. NA considers alcohol to be a drug. The NA programme is one of complete abstinence from all mood-altering substances. NA started in Ireland in 1979, and, as of September 2023, there are over 237 physical weekly meetings in Ireland (North and South) and 80 online meetings, with 30 meetings in prisons and treatment centres.

Andy R described NA as a vital peer-based recovery resource, noting the therapeutic value of one addict helping another. NA's 12-Step recovery programme is a complementary resource for professionals providing treatment and supports the continuing care of their clients. The NA meeting is the primary means of delivering the NA message of recovery, with two or more members gathering together constituting a meeting. Members often share their personal experiences, with more experienced members supporting newer members. Meetings are free and are self-supported by those who choose to contribute.

An informal membership survey undertaken in 2018 shows that 55% of respondents rated their first NA meeting as important or very important with the top three influences to attend that first meeting being another NA member, a treatment/counselling agency or family. Members attended an average of 2.19 meetings a week. The gender breakdown is approaching 50/50 as the fellowship has grown. Sean H suggested that, anecdotally, the age profile for NA Ireland would tend to be quite a bit younger, with a lot of members in their 30s. Survey results indicate that NA has improved a range of areas in members' lives including family relationships, social connectedness, hobbies, stable housing, employment and educational advancement.

Sean H explained that NA runs meetings in treatment centres and prisons. NA is keen to emphasise its complete independence from professional service providers. NA is based in the community and members are encouraged to take part in their lives and attend as many meetings as they feel they need. It is an ongoing peer-based support network and every person involved in NA is a recovering drug addict. NA literature is available in a range of languages, including Irish. Sean H provided contact details for the organisation for anyone who may wish to get copies of the NA literature or make contact.

5.6.3 Ms. Laura Dunleavy: *A Social Care perspective on supporting families*

Ms. Laura Dunleavy, a senior social care worker with Kinship Care Ireland, described kinship care as the full-time care of a child by a relative or close family friend when a parent cannot do so. She explained that the circumstances leading to kinship care are rooted in trauma and often tragedy, such as the death of a parent, significant substance misuse, mental health illness, physical illness, imprisonment, parental abandonment or parental incapacity.

Ms. Dunleavy suggested that the State's response to most social issues and challenges that communities are facing across Ireland could be likened to trying to empty a bath with the taps on full. She referenced a quote from the Prevention and Early Intervention Summit: 'There comes a point where we need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in'. She suggested that Ireland is so good at emergency responses that it seems as if we like to live in emergency response mode. She highlighted the need to invest in breaking that cycle and invest in prevention and early intervention, while continuing to respond to emergencies.

In her previous professional role, Ms. Dunleavy worked with an organisation providing intensive family support within the community. Families attending the service could access early years services, substance misuse counselling, youth and community clubs, one-to-one peer work, key work support to help children develop strategies for coping with challenges in the home or school engagement. Ms. Dunleavy argued that an effective response to drug use needs to respond also to poverty, housing needs and mental illness. There is a need to invest in communities where there is a high level of need.

She argued that a child cannot go into an educational setting and learn if they are coming from trauma, or if their basic food and safety needs are not being met. Instead of looking at the individual and their right to access supports when they need, people are often told they are not in enough crisis, or that there are no beds available. These are missed opportunities for intervention.

Kinship care is one way of investing in early intervention and prevention that supports families with recovery.

Sometimes the most loving act a parent can say is I don't have the capacity to care for this child right now.'

She argued that, while we are entrusting kinship careers to be that 'one good adult' in a child's life, we are not supporting them to fulfil that role. Concluding, Ms. Dunleavy called for top-down support and investment in supporting families and communities entrenched with poverty and trauma.

5.6.4 Mr. Aubrey McCarthy: *Maintaining recovery and well-being*

Mr. Aubrey McCarthy, Co-founder and Chairman of Tiglin, described how encouraging he finds it to witness recovery in action, explaining that he had recently attended an event at Tiglin, where people were celebrating recovery, getting on with their lives and reunited with their families. He explained that recovery can come undone unless the right supports are provided to maintain the progress made, so there can be a permanent exit from addiction. While prevention and education are important to prevent people going down the road of substance abuse, more effort is also needed to prevent relapse for those that have already taken action to rehabilitate themselves.

'A man begins to die when he ceases to expect anything from tomorrow' – Abraham Miller.

Noting that there is no magic formula, Mr. McCarthy described what Tiglin does to inspire hope for those in recovery and prevent their return to addiction. He gave the example of 'Conor', who at the time he came to Tiglin was sleeping in a tent, in heavy addiction and was in a wheelchair as a result of his body shutting down from substance abuse. Conor went through Tiglin's rehab program, a tough evidence-based programme and got sober. However, without the aftercare provided, including supported housing, community employment and reconnection with the community, Conor's journey would have led to relapse. Now, a few years on, Conor is a martial arts teacher. He is out of the wheelchair, running his own craft business and also working part-time in Tiglin's Social Enterprise Café, where he leads a team. He is actively participating in a social life, holidaying and has helped to set up an after school group for young people.

Tiglin believes the key areas that matter for people like Conor are housing (in particular, creating a habitat where there is an environment of accountability and responsibility); community engagement (getting to know yourself within the community); access to employment; access to education; and peer supports. Tiglin works with local businesses, where mentorships are hugely important.

Explaining that faith can be a key aspect in an individual's recovery, Tiglin works from a biopsychosocial and spiritual model, employing a non-denominational chaplain. Noting Prof. Dolan's earlier comments regarding resilience being where your positive factors outweigh the negative, Mr. McCarthy described how Tiglin invests heavily in those positive factors.

Mr. McCarthy repeated his earlier comment that Tiglin's approach to recovery is not magical. Step One, after completion of a rehab programme, is a link to seven months of supported accommodation. This is followed by Step Two, where Tiglin works with the individual in supported independent housing. Step Three involves working with the individual to secure private rented accommodation. In addition, there is wrap around care for residents who have moved on, a range of Community Employment schemes, links to educational opportunities, internship opportunities, voluntary work with Tiglin's Lighthouse Homeless Café, bakery and/or carpentry workshop. The whole aim is to get people back into the community. Concluding his presentation, Mr. McCarthy explained that Tiglin strongly believes that there must be life beyond addiction, and that support from the community to help people integrate with independent living is vital.

We cannot go back to the start and change the beginning but, by God, we can change the ending – C.S. Lewis

5.6.5 Questions and Answers session

Prof Dolan explained that the social empathy element of the SPHE programme is currently being introduced following ten years of research, and is also being introduced into the Transition Year programme as part of the TY curriculum review. The first part of the programme covers four core lessons including understanding what empathy

is; barriers to empathy or being empathic in your own life; what's stopping you from showing compassion; practicing empathy with others in the class and doing an act of social good in your community. While the full programme is available through community youth organisations, he would advocate for it being compulsory all the way through secondary school. He also said that there have been developments within the programme around peer-led learning, but he stressed the important thing is the programme is now being embedded in the system and can hopefully grow from there.
Responding to a question about how they measure success, Sean H explained that NA do not keep membership records and the only data generated is through self-reported responses to surveys.

Ms. Dunleavy noted an art competition Kinship Ireland ran for children living in kinship care and recited from memory a poem written by an 11-year-old:

Lost and Alone
Through no fault of my own I was lost and alone
I didn't know what to do and had no place to call home.
To my delight my auntie shone a light
And guided me into their life.
I found happiness and love and a bedroom of my own,
In my happy ever after home, no longer alone.

She noted in terms of prevention and early intervention that the child's worldview, her sense of self-esteem, her connection and her worth within her family unit being cared for by extended family is their measure of success. While there is quantitative data on success, it's this qualitative measure that hits the heart.

Prof Jo-Hanna Ivers referenced the strong emerging evidence around the cost effectiveness of Fellowship programmes, including NA and AA. The literature is finding that membership of a Fellowship has a direct effect on quality-of-life connection with community and recovery capital.

Explaining their operational cost base and scope for expansion, Mr. McCarthy said that Tiglin have a residential programme with a men's and women's centre. The cost per person is roughly €35,000, including aftercare, across a 16-month program. This breaks down to roughly €450 per person per week. He explained that the social enterprises that Tiglin runs in the local community not only provide employment opportunities for clients but also subsidise Tiglin's costs. He agreed that Tiglin-style centres could be rolled out nationwide, but it doesn't have to be Tiglin delivering it, and in time better models could well emerge.

Mr. McCarthy agreed that in an ideal world the services provided by Tiglin should be provided by the State, but explained that one can't necessarily wait around for that to happen. Tiglin and organisations like it are on the ground helping people.

Ms. Dunleavy noted that in some communities there are a host of services, and we need to ensure collaboration and joined up thinking to ensure no duplication.

Prof Dolan argued that there is a moral case for the State to invest in this area through working in partnership with, and properly funding, community and voluntary organisations. He also suggested considering giving people physically what they need to survive as a State investment.

Prof. Eamon Keenan noted that many of the services have grown from grassroots level within the community. The HSE works in partnership with the NGO sector and communities to deliver services.

Reflecting on discussions the previous day on experts coming into schools to talk to children, Prof Keenan highlighted that parents are the primary influence on their children yet often feel de-skilled when it comes to drugs. He suggested that upskilling parents to be able to discuss drug use with their children would be very valuable.

Following up on comments made at the meeting in May, Ms. Dunleavy was asked about funding for kinship carers. She explained the kinship care is often an alternative to formal foster care or State care, but kinship carers are closed off from social work interventions. She strongly advocated for a support pathway for kinship carers including access to financial, legal, trauma, recovery support and other interventions. Of an estimated ten thousand children in kinship care in Ireland last year, there were just over two thousand guardian payments paid out. This is the only accessible social welfare payment that kinship carers can apply for and stands at €203 per week versus €325 per week for the foster carers' payment.

Prof. Dolan referenced a Nobel prize study that for every dollar spent in the first five years of life the return to the State/civil society is ten dollars. He argued that a minimum 20% of service budgets should be put into prevention and early intervention services rather than acute services.

Regarding stigmatisation, Ms. Dunleavy noted that the gap in Ireland is widening in terms of people's day to day experiences and the empathy people might have for communities that they may not be aware of or exposed to. She emphasised that language is important and the words we use stick and have lasting impact. Sean H from NA responded to a member's comment regarding his use of the word 'clean', noting that language changes across time, and clean was used as an alternative to sober to perhaps differentiate NA from AA at the time. He stressed that all meetings of NA are open to any member of the public who may be interested in the Narcotics Anonymous programme and would like to sit in.

5.6.6 Key themes emerging from roundtable discussions

Note: the following is a list of thematic issues discussed at three or more roundtable discussions. The list does not necessarily indicate areas of consensus or agreement among members.

- Increase the guardianship payment to the same level as foster carer payments.
- The State and non-governmental organisations should closely collaborate to bring about greater change and mobilisation on drug-related issues in Ireland through a combination of increased State funding for successful models and clear pathways in the education, housing, and healthcare sectors.
- The Department of Education should create a school's programme, aligned with or included in SPHE, where parents receive information / support about drug-related issues and how to talk about drugs with children.
- The Tiglin model should be scaled and replicated nationally.
- The State should establish an independent oversight body to direct resources to and coordinate existing service providers, so as to identify best practices and value for money of existing service models.
- Kinship carers should receive supports for ongoing needs e.g. mental health supports.

5.7 Session 6 – Perspectives on Governance and Funding

5.7.1 Mr. Jim Walsh: *Funding and Governance*

Mr. Jim Walsh, Department of Health, provided an overview of drug-related funding and governance, including the budgetary process through which additional funding is secured. Mr. Walsh explained that drug-related expenditure known as 'labelled expenditure' is reported on by the Health Research Board (HRB) to the European Drugs Agency. In 2021, total labelled drug expenditure was €238 million. In addition, 'unlabelled' drug-related expenditure, for example, the costs incurred when a person ends up in hospital for treatment, or the cost of running prisons, and the loss of productivity costs associated with premature death, were estimated to amount to an additional €147 million.

Mr. Walsh provided a breakdown of the allocation of labelled expenditure across six main recipient entities, including the departments of Health, Children, Social Protection, Justice, Education, and Revenue. The largest share, €146 million, or 61% of total labelled expenditure, was allocated to the Department of Health. This sum was disbursed to three main areas of expenditure: HSE Addiction Services (€67 million); Community Based Services (€57 million) and GPs & Pharmacies (€22 million). The HSE and Department of Health have an expenditure reporting structure, which measures what the funding is delivering in terms of services and key performance indicators.

Changes to resources, or request for additional resources for drugs policy, are managed through the Estimates and budgeting processes. Mr. Walsh provided figures on the money allocated over the last four budgets, 2020 to 2023, noting that the data distinguishes between allocations to maintain existing levels of service (responding to changing demand levels), and allocations for new developments. The latter saw an average of €4 million for new service delivery per year over the last four years.

Mr. Walsh referenced the factsheet he had provided to the Citizens' Assembly summarising how the additional €4.4 million allocated in Budget 2023 was used and provided three examples. The first was the provision of €200,000 to Tiglin to provide a new aftercare service for women, the second was the provision of €0.5 million for Family Support Services, while a third example was the provision of €0.5 million to increase service delivery for cocaine treatment support.

Turning to governance of the National Drugs Strategy, Mr. Walsh described the levels of oversight, including the Cabinet Committee on Social Affairs and Public Services; the Minister for State with responsibility for National Drugs Strategy; the Joint Oireachtas Committee on Health and the National Oversight Committee. The Department of Health and other Government departments and agencies, as well as the Drug Task Forces and Civil Society, are connected in various ways to this governance structure. Mr. Walsh explained that Civil Society is recognised as a partner in the drug strategy.

Mr. Walsh also outlined the membership of the National Oversight Committee and explained how the Drugs Policy Unit sits within the Department of Health. The Unit is part of the Department's Social Inclusion Division, which also deals with issues such as healthcare services for people experiencing homelessness and members of the Travelling community.

5.7.2 Mr. Brian Galvin, *Strategic Research*

Mr. Brian Galvin, Programme Manager for Drug and Alcohol Research at the Health Research Board (HRB) Evidence Centre, presented a perspective on the role of evidence in drugs policy and practice, emphasising that evidence is essential to every stage of the policy process. The HRB is concerned not just with generating evidence, but also with making that evidence available to decision-makers. The research ecosystem model works well in relation to drugs policy. Evidence ecosystems are networks that help the creation, dissemination and use of evidence. Mr. Galvin explained three evidence types that have particular relevance to drugs policy.

First is the analysis of raw data. For example, data previously presented by the HRB to the Citizens' Assembly on drug deaths is hugely important in supporting harm reduction measures such as the supervised injecting facility. Current treatment demand data is essential in planning services and the types of treatment needed. The HRB estimates heroin use by combining different data sources, which is essential for observing trends and planning reduction programmes. Another type of data is obtained through qualitative research, which provides evidence and insights into experiences, using this to determine treatments. Evidence synthesis involves gathering the best quality international evidence to provide a good overview of a topic. Mr. Galvin provided two examples of systematic reviews undertaken by the HRB – the first on gang violence, which informed the DRIVE initiative; the second on service user involvement, which has been a common theme throughout the Assembly.

Ireland already has many of the elements of a good evidence ecosystem, including the HRB National Drugs Library, a committed community of researchers and other resources. However, there are certain gaps and opportunities to do more work and increase our knowledge. Mr. Galvin suggested Ireland needs more secondary data analysis to fully use the evidence resources we have, including by combining information across data systems in health, criminal justice and other sources. While treatment services in Ireland are based on evidence, we need more information on the impact of those services. He described how innovative research by the HSE in areas such as drug testing and syringe analysis is supporting system preparedness, and called for more of this work in what is a changing drug environment.

In order for Ireland to further develop this ecosystem and create the type of collaboration and openness to ideas that will result in better informed decisions, Mr. Galvin proposed establishing a Substance Policy Research Centre. This could be put together through a collaboration across universities, government bodies and research centres to provide the opportunity to research across different disciplines. The Centre would be a place to test a range of new ideas and models, connect to international research and help us to proactively identify threats and opportunities.

5.7.3 Dr Peter Kelly, *Considerations for the next national strategy*

Dr Peter Kelly, Assistant Professor School of Nursing and Midwifery TCD, asked the Assembly to visualise a scenario in the year 2035 where the next National Drug Strategy, into which many of the recommendations from this Assembly will have been integrated, will have run its course.

He asked members to picture a service user walking into a treatment service, where that service user is happy with the treatment service and feels respected; the buildings are comfortable and inviting; the service user has a care plan, written collaboratively in conjunction with their keyworker; they have timely access to a choice and range of treatments, social supports, therapy, detox, rehab and employment opportunities; they have absolute confidence in the complaints process; they live in a hostel with lots of other drug users and tell five or six other people how good the treatment service is, bringing more people into the service. This experience is replicated throughout treatment services across the country.

The staff member who greets this service user is happy with their workplace; feels respected; is well educated and feels competent; has access to ongoing training, supervision and support; has a career pathway and job security that is equal to or better than other healthcare workers; works in a multi-disciplinary team that communicates well, works collaboratively and has a flat hierarchy; the service is well resourced and has good governance, undergoes regular audits and is subject to independent inspection; the service is person-focused, supports human rights and follows best practice; and this staff member is particularly proud to work in this service.

To move to this point in the future, Dr Kelly suggested that we first need to listen to the best available research. Research shows that satisfied service users have access to well-run and well-resourced services and are more likely to attain better health outcomes when the staff in those services are happy, healthy and educated. He explained that the environment in which the workforce operates is like an ecosystem. All too often in healthcare services, including in addiction treatment, research can identify the best treatments and approaches, like recovery-orientated services, trauma-informed care, human rights orientated treatment, or case management, but when we try introduce these, little consideration is given to whether the ecosystem has the capacity to support them.

Dr Kelly presented a slide depicting the different levels and domains that make up the ecosystem. These are the areas that need to be targeted in the next Strategy. However, he stressed that it is not that they need to be targeted, but rather *how* they are targeted which is important. He then outlined key strategies to achieve this including:

- Strong service user involvement at all levels, with service users front and centre in every decision made;
- Specific quantifiable and measurable key performance indicators for services, as well as the National Drugs Strategy;
- Fully independent oversight of policy. Those providing oversight should in no way be dependent on the Department of Health or the HSE for funding;
- An independent inspectorate for all drug services;
- Full accountability for all expenditure on treatment;
- National mapping of the staffing skill mix and resource allocation of services onto the population need, population density, deprivation index, population projections, etc.;
- A treatment model developed from this mapping should be rolled out nationally;
- Collaboration with educational providers and researchers in order to education the workforce over a long period of time;
- A universal IT system with unique patient identifier.

Dr Kelly noted that all these suggestions are likely to require reform of the current structures including the Drug and Alcohol Task Forces, more standardisation of service delivery, and greater centralisation. He acknowledged that this may involve a loss of autonomy for some service providers but argued that this is necessary.
Dr Kelly concluded by suggesting the development of a comprehensive national workforce development and service development strategy for drug treatment, arguing that this should be a priority for the Government, the Department of Health and the HSE. It should be developed in conjunction with Sláintecare, and have at its core full accountability and transparency.

5.7.4 Mr. Joe O'Neill: *Considerations for the next national strategy*

Mr. Joe O'Neill, Chair of the Western Region Drug and Alcohol Task Force, offered some reflections on the current and next iterations of the National Drugs Strategy. The current strategy was first developed in 2017, and contained 50 actions, each of which was assigned to a lead agency or agencies, which were responsible for delivering that action. The mid-term review undertaken in 2021 led to positive changes to the governance structures and a clearer focus on strategic priorities. It is important to maintain accountability for delivering or not delivering an action.
The long-overdue Health Diversion programme is an example of a priority that has not been delivered. The current National Drugs Strategy runs to 2025, meaning there's another 18-24 months for a lot of good things to happen before we move onto the next strategy. There is an urgency about implementing the National Drugs Strategy. Every day, and every hour, there are people in this country suffering from drug use, and since the Citizens' Assembly commenced in April, 150 people have died from drug poisoning.

The next National Drug Strategy should take into account the different needs that arise in various regions of the country, and in different Drug and Alcohol Task Force areas. Funding allocations and services should be based on population needs, and the Department of Health Drug Policy Unit should engage with the Task Forces to see how best they can contribute to addressing the needs and delivering on the actions in the Strategy.

Established standards should be used in identifying needs and unmet needs. The Western Region DATF previously undertook a needs analysis to determine the level of service standard that should be applied. He referenced the suggestion by Fr. McVerry of a maximum four-week waiting period for prisoners to access treatment services. These types of standards motivate service providers and make it easier to hold them to account if the standard isn't being met.

As to whether the State should be providing services directly or indirectly through NGOs, Mr. O'Neill suggested that the most important thing is the service is sustainable, with sufficient resources and parity for staff in terms of pay and conditions. Concluding his presentation, Mr. O'Neill suggested that we need to ask why it is that things do not happen. The reason, he suggested, is that power in Ireland tends to be centralised, and that people suffering from drug addiction are well outside the circle of influence. People with drug addictions are criminalised for that addiction, which in turn has a significant impact on public attitudes to drug addiction.

5.7.5 Dr Orlaigh Quinn: *Implementation and Governance options*

Dr Orlaigh Quinn, a former senior Civil Servant, shared her perspectives and experience as a former Secretary General, offering insights into the type of structures and principles that support effective implementation of complex cross-cutting issues. She explained that Ireland has a crowded landscape of departments, agencies and interest groups, and no single model is perfect. She urged caution about making definitive decisions about whether drugs services should be delivered exclusively by statutory bodies or NGOs. The reality is that we have a mixed system, and we are not starting with a blank page. The Citizens' Assembly needs to first consider the current system and identify what can be done better. Cabinet Committees and Joint Oireachtas Committees matter greatly, as ultimately this is where decisions are made and where money gets allocated. Allocations for new initiatives don't necessarily have to come from the annual budgetary process – it's important to look at existing programmes to see if there's an argument for closing certain things down in order to start new things.

In terms of getting something onto an agenda and making it a priority, Dr Quinn explained that government ministers have busy agendas. Aside from their roles as TDs and their focus on getting re-elected, they are managing the work of their departments, and potential also have roles within their political parties. To get something important on a Minister's agenda you have to build a strong vision and a very strong proposal, it has to be tied in with the Programme for Government, and it has to work. She advised the Assembly to think about the six or seven big things that are going to matter. The Assembly will have heard a lot of worthy proposals and suggestions and will need to sift through them all. While they all have value, she suggested the recommendations agreed on by the Assembly need to be important and need to have an impact. They also need to be effective and measurable.

Dr Quinn cautioned against getting bogged down in research and data, advising that the Assembly needs to be selective and aware of who's doing the research and what their angle is. NGOs, and quite often State agencies, are competing for the same scarce resources, all doing the same research from slightly different angles. She advocated having one or two reliable sources of research.

A minister dealing with hundreds of different issues has a limit to what they can take in. Her advice was to be concise, realistic about what can be achieved and to prioritise what is most important. Monitoring is also very important; it needs to be on an agenda every quarter or six months to ensure people account for their actions or inaction. Things can happen all the time that change the agenda or the current priorities, Covid-19 being an example.

Remarking on the tendency to call for the establishment of a new agency to deal with a particular issue, Dr Quinn explained that agencies do not sit at Cabinet Committee meetings, and usually do not sit at the centre of power. She suggested looking to see if there is an existing agency that could be adapted, particularly given that it can take two to three years to set up a new agency.

Concluding her presentation, Dr Quinn reminded the Assembly of the need to have a powerful vision that shows how important the issue and why it matters; to look for where it best lands in terms of getting it done; having a small number of measurable items, resources allocated, accountability; ensure it is in the Programme for Government, and ensure the right people at the right level are in the room.

5.7.6 Questions and Answers session

Mr. Galvin reflected on the high quality of data available in Ireland in comparison to other European countries. As a member of the EU network there are a number of key indicators that we must report on. However, individual countries have their own autonomy over additional data. The HRB carries out population surveys as well as gathering

data on people registering for treatment. While there is good coverage, there is always room for improvement. He emphasised the importance of speaking directly with treatment centres and explaining to them the importance of good data collection.

Regarding the potential use of AI and machine intelligence in policy research, Dr Kelly responded that he was not aware of any impact with regard to drug treatment as of yet, but highlighted the practical benefits of having the unique patient identifier number and a shared IT system, as well as developments in digital health. Dr Quinn referred to the AI Strategy and highlighted that AI can be a tool for good. She also referenced the length of time it is taking to introduce a unique patient identifier, which would be highly beneficial in terms of healthcare delivery, noting the public's concern with sharing data with the State.

Mr. Walsh provided further detail on budget allocations, explaining that each department identifies its own priorities and allocates its resources accordingly. The money allocated to Health is set out in the National Service Plan that the HSE implements every year.

Mr. O'Neill outlined that Drug and Alcohol Task Forces can seek funding for specific projects, which come out of competitive funds available across the regions. The Western Region DATF receives no funding for treatment facilities. That funding is allocated directly to the treatment support services.

The panel responded to the recurring question about whether governance and oversight of all drug services should be carried out by a single entity.

Dr Quinn emphasised the importance of accountability, explaining that without effective accountability it doesn't really matter whether it's one agency or another. There are 20,000 groups in Ireland funded through the public purse, and each of those has some sort of reporting line into a government department. She suggested identifying the biggest current agency, empower them and give them an accountability line right up to the Cabinet.

Mr. O'Neill stressed that the State needs to start taking responsibility for the quality of services, with the HSE being central if it is to be health-led, and a role for the NGOs.

Dr Kelly noted that the expertise lies within the HSE and the Department of Health's Drug Policy Unit, and he would not suggest changing this, but agreed with the need for accountability and quantifiable, measurable objectives.

Mr. Walsh suggested starting with the current reporting structure and determining what, if anything, needs to be changed. He also noted that having involvement at a political level with the Department of the Taoiseach has elevated the matter.

Asked about key performance indicators (KPIs) relating to drug related expenditure and the resulting number of potential drug deaths saved each year, Mr. Walsh drew the distinction between outputs and outcomes. The Department is currently measuring the quantum of people in treatment, and on that metric have seen an increase of 12% in the last year. Additional measurements include length of waiting time to access services. He said the next stage is considering the impact of these measures in terms of key outcomes, with drug related deaths being one key outcome. There are a range of measures, from treatment to harm reduction to addressing homelessness, which need to be built into the system to reduce drug deaths. Reflecting on the increasing number of drug deaths, Mr. Walsh noted that the drug situation is not a static issue, it is evolving with the arrival of new, more potent drugs and increasing polydrug use.

Dr Quinn cautioned against concentrating on one indicator, saying it is a complex issue across multiple issues and multiple departments. To ensure collaboration across a broad agenda, there should be a few high-level indicators. Mr. Galvin agreed with Dr Quinn's point and noted that it is difficult to measure something that does not happen, such as an avoided drug-related death.

5.7.7 Mr. Trevor Bisset and Miss Sive Brennan: *the Clondalkin Drug and Alcohol Task Force Prevention Model*

The final session of the fifth meeting featured a case study of the Prevention model used by Clondalkin Drug and Alcohol Task Force, with a presentation from Mr. Trevor Bisset and Miss Sive Brennan.

Mr. Bisset, the DATF coordinator, provided an overview of the Task Force's work on prevention in the Clondalkin area. He defined prevention as 'policies, programmes and practices designed to reduce the incidence and prevalence

of drug and associated health, behavioural and social problems.' The Task Force's role is to design a local strategy based on the needs of the Clondalkin area. It does this in collaboration with partners and with the community. This involves meetings, consultation and community engagement. Through the National Drugs Strategy, the Task Force has a mandate to support the SPHE programme and teachers in schools as fully as possible.

Schools are very open to receiving help, particularly around prevention. Young people use drugs, and drug use does not stop at the school gates. Numerous studies show how big an issue drug use is, and the Task Force tries to support schools with 'a whole school approach.' Clondalkin is fortunate to have this service available, as due to a lack of prevention workers, this is not always possible in all areas.

The Task Force uses an inter-agency approach, which requires a lot of patience and a lot of work, with each school requiring a bespoke approach. The Task Force leads on this approach but is supported by Cross-Care Youth Services and Clondalkin Youth Drug and Alcohol Programme, which is a new under-18's service recently established. Funding was received from the Department of Health to assist in rolling out this project, and this funding aided in providing additional workers to undertake the research element of the project, which underpins the work.

The education part of the model is assisted by the 'Unplugged' programme, previously mentioned by Mr. Gregor Burkhart, a programme that has been tested in a randomised control trial, and is proven to be effective at significantly reducing cannabis and alcohol use in young people. It is rated beneficial by the EMDCDA Xchange registry.

The Task Force works with schools to provide prevention support to parents in the form of talks, advice, and mentoring. The Task Force supports schools in reviewing their policies, and also provides professional development opportunities for teachers.

The Task Force also works with schools to provide intervention supports. Where a situation is flagged in a school, the Task Force can go into the school to work with that young person to try and keep them in school and support them through a case management process.

Miss Sive Brennan then provided the Assembly with a young person's perspective on the preventative work of the Task Force. She began by talking about the importance of teaching about drugs and their effects in the school classroom. Having the module taught in school makes it easier for students to reach out and know they can ask for help.

She outlined the sessions provided, under the Education section of the Task Force programme, while she was in Transition Year. Even though it was a serious topic, Miss Brennan and her classmates were still able to enjoy the talks and have fun, while also learning and understanding the topic. By the end of the module, they understood the effects of drug use, recognised the seriousness of the issue and knew who they could talk to if anyone in the class was facing issues. Ms. Brennan said she would 100% recommend other schools to take the Education module. The classes were engaging and interesting and students did not want the classes to end.

Questions were then invited from the floor. Responding to a question regarding the frequency of lessons, Miss Brennan explained that there was one lesson a week for an 8-week period. She suggested that the programme should be rolled out from 2nd year all the way to 6th year. She learned more about the dangers of drugs in those 8 classes than she would have in normal class lessons.

Regarding the value of the programme being delivered by teachers, Ms. Brennan explained that, through her involvement in the youth club, she personally knew the teachers who delivered these classes, which made the experience easier. Most of the other students did not know the teachers providing the lessons. But they soon became comfortable and got to know them.

Regarding the importance of family interaction and support in these programmes, Ms. Brennan explained that the classes are very helpful in the sense that some of her classmates feel they cannot go to their parents to speak about these issues. Mr. Bisset explained that the Task Force offers information sessions to parents, but acknowledged the pressures on families in terms of free time. The current SPHE programme recommends that parents should get a module of training to help them speak to their children, but this is not always done.

Regarding whether it might be appropriate to roll out the module to students in 6th class of primary school, Miss Brennan suggested that a stripped-down version of the module might be better for students at that age, as they may not be mature enough to fully understand the topic, and it would be better to concentrate on the basics and explain to them that they will learn more as they move up through the secondary system.

The session concluded with members thanking Miss Brennan for her valuable contribution to the work of the Citizens' Assembly.

6 Meeting #6

Meeting #6

Figure 6.1:
Opening of the Final Meeting for the Citizens' Assembly - Paul Reid, Chairperson

Figure 6.2:
Electoral Specialist - Ciarán Manning

Figure 6.3:
Citizens' Assembly Ballot Box

Figure 6.4:
Members discuss Ballot Papers

Figure 6.5:
Members decide on the wording of Ballot Papers

Figure 6.6:
Members decide on the wording of Ballot Papers

Figure 6.7:
Members discuss Ballot Papers

Figure 6.8:
Paul Reid discusses proceedings with Members

Figure 6.9:
Members discuss Ballot Papers

Figure 6.10:
Members discuss Ballot Papers

Figure 6.11:
Members discuss the wording of Ballot Papers

Figure 6.12:
Members discuss Ballot Papers

Figure 6.13:
Selection of voting scrutineers

Figure 6.14: Sealing of Ballot Boxes by Ciarán Manning, Returning Officer, with scrutineers Jessie Smyth and Marcus Byrne

Figure 6.15:
Members Vote

Meeting #6

Figure 6.16:
Members Vote

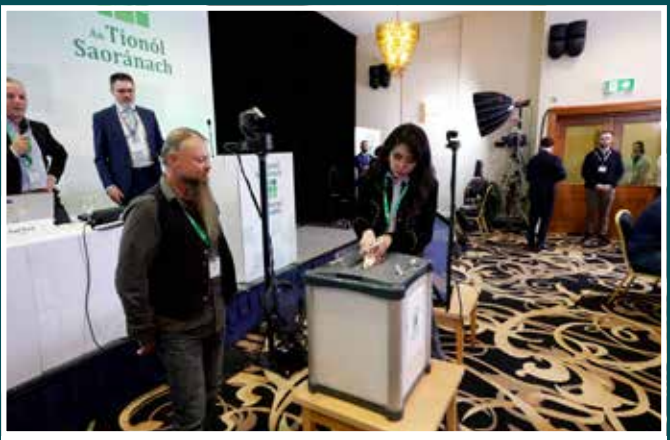


Figure 6.17:
Oversight of voting by Marcus Byrne, member and scrutineer

Figure 6.18:
Members Vote

Figure 6.19:
Members Vote

Figure 6.20: Getting ready to open the Ballot Boxes: Marcus Byrne, Jessica Smyth and Ciarán Manning

Figure 6.21:
Ballot Boxes opened ahead vote count

Figure 6.22:
Citizens' Assembly Secretariat with Chairperson Paul Reid

Figure 6.23:
Members applaud the end of the Citizens' Assembly on Drugs Use

The sixth and final meeting of the Citizens' Assembly on Drugs Use, focused on finalisation of the ballot papers and voting, took place on 21-22 October 2023 in the Grand Hotel Malahide.

Draft ballot questions were identified based on those issues that had emerged as priorities for the members during the five preceding meetings. In advance of the sixth meeting, the Secretariat circulated members with initial draft ballot papers. Based on detailed feedback, received from members, updated and refined draft ballot papers were prepared and presented to members at the final meeting. Members then determined the final wording of each question on each ballot paper, through an iterative, democratic process.

In addition to the wording of the ballot question, members were able to discuss and propose substantive amendments to the explanatory narrative that accompanied each question. That narrative provides greater detail and specification to the recommendations, and it is intended that the recommendations be read in conjunction with the accompanying narratives.

Once finalised, members voted by secret ballot on each ballot paper. Voting operations were conducted with the assistance of an electoral operations specialist, Mr. Ciarán Manning of Manalog Ltd., who acted as Returning Officer.

The casting and counting of votes was overseen and scrutinised by two members of the Citizens' Assembly, Ms. Jessie Smyth and Mr. Marcus Byrne, who had been selected randomly from the large number of members who had volunteered for the role. Ms. Smyth and Mr. Byrne verified the integrity of each stage of the process.

Counting was conducted by designated members of the Secretariat team, under the supervision of the Returning Officer and under the scrutiny of the two member observers.

The following details the voting results of each ballot question, and supplementary information including number of eligible voters, number of votes cast, number of invalid votes and total valid poll.

6.1 Ballot Paper 1: Recovery, and supporting people with problematic drug use within the criminal justice system

Question 1.1: The next National Drugs Strategy should prioritise a systemic approach to recovery.

Option	Votes	Percentage
Agree	80	(95%)
Do Not Agree	2	(2%)
Don't Know	2	(2%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

Question 1.2: The Government should introduce a 'Health in all Policies' approach to policy development.

Option	Votes	Percentage
Agree	78	(93%)
Do Not Agree	2	(2%)
Don't Know	4	(5%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

Question 1.3: The State should formalise, adopt and resource alternative, health-focussed options for people with a drug addiction within the criminal justice system.

Option	Votes	Percentage
Agree	77	(93%)
Do Not Agree	3	(4%)
Don't Know	3	(4%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	3
Total Valid Poll	83

Question 1.4: The Department of Justice and the Irish Prison Service should develop and fund enhanced prison-based addiction treatment services.

Option	Votes	Percentage
Agree	79	(94%)
Do Not Agree	2	(2%)
Don't Know	3	(4%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

6.2 Ballot Paper 2: Legislative Options

Ballot Paper 2 was designed to allow members to express their preferences from six alternative legislative approaches to the possession of drugs for personal use. These six alternative approaches are described in Appendix H.

Question 2.1: Retain the current legislative approach to possession of all drugs for personal use.

Option	Votes	Percentage
Agree	11	(13%)
Do Not Agree	74	(85%)
Don't Know	2	(2%)

Number of Eligible Voters	88
Number of Votes Cast	88
Invalid Votes	1
Total Valid Poll	87

Question 2.2: Preferred option for a single Universal approach for all drugs or a Hybrid approach for different drugs.

Option	Votes	Percentage	Rank
Status Quo (for all drugs)	4	(4.6%)	5
Health Diversion (for all drugs)	7	(8.0%)	3
Comprehensive Health-Led (for all drugs)	16	(18.4%)	2
Tolerance (for all drugs)	2	(2.3%)	6
Legalisation & Regulation (for all drugs)	7	(8.0%)	3
Hybrid (different approach for different drugs)	51	(58.6%)	1

Number of Eligible Voters	88
Number of Votes Cast	88
Invalid Votes	1
Total Valid Poll	87

Question 2.3a: Preferred option for Cannabis				Total Votes Cast 87 Invalid Papers 1 Valid Poll 86 Quota 44	
Option		**First Count**	**Second Count**	**Third Count**	**Fourth Count**
		No. of Votes	**Elimination of B**	**Elimination of D**	**Elimination of A**
A.	**Status Quo**	10	+3 13	13	-13 -
B.	**Health Diversion**	8	-8 -	-	-
C.	**Comprehensive Health-Led**	23	+2 25	+7 32	+7 39
D.	**Tolerance**	9	9	-9 -	-
E.	**Legalisation & Regulation**	36	36	+2 38	- 38
Non-transferable votes			+3 3	3	+6 9
CHECK TOTAL		**86**	**86**	**86**	**86**

Question 2.3b: Preferred option for DMT, Psilocybin / Mushrooms, Ayahuasca, Ibogaine, etc.				Total Votes Cast 87 Invalid Papers 2 Valid Poll 85 Quota 43	
Option		**First Count**	**Second Count**	**Third Count**	**Fourth Count**
		No. of Votes	**Elimination of B**	**Elimination of D**	**Elimination of A**
A.	**Status Quo**	13	+3 16	16	-16 -
B.	**Health Diversion**	7	-7 -	-	-
C.	**Comprehensive Health-Led**	28	+2 30	+6 36	+6 42
D.	**Tolerance**	13	13	-13 -	-
E.	**Legalisation & Regulation**	24	24	+7 31	- 31
Non-transferable votes			+2 3	2	+10 12
CHECK TOTAL		**85**	**85**	**85**	**85**

Question 2.3c: Preferred option for Cocaine				Total Votes Cast 87 Invalid Papers 1 Valid Poll 86 Quota 44	
Option		**First Count**	**Second Count**	**Third Count**	**Fourth Count**
		No. of Votes	**Elimination of E**	**Elimination of B**	**Elimination of D**
A.	**Status Quo**	19	19	+3 22	22
B.	**Health Diversion**	11	11	-11 -	-
C.	**Comprehensive Health-Led**	35	+4 39	+4 43	+13 56
D.	**Tolerance**	13	+4 17	17	-17 -
E.	**Legalisation & Regulation**	8	-8 -	-	-
Non-transferable votes			-	+4 4	+4 8
CHECK TOTAL		**86**	**86**	**86**	**86**

Question 2.3d: Preferred option for all other drugs			Total Votes Cast 87 Invalid Papers 2 Valid Poll 85 Quota 43	
Option		**First Count** **No. of Votes**	**Second Count** **Elimination of E**	**Third Count** **Elimination of B**
A.	**Status Quo**	20	20	+3 23
B.	**Health Diversion**	11	11	-11 -
C.	**Comprehensive Health-Led**	38	+1 39	+6 45
D.	**Tolerance**	10	+5 15	15
E.	**Legalisation & Regulation**	6	-6 -	-
Non-transferable votes			-	+2 2
CHECK TOTAL		**85**	**85**	**85**

6.3 Ballot Paper 3: Governance and Implementation

Question 3.1: Government should give greater political priority and prominence to drugs policy and related issues. A dedicated Cabinet Committee chaired by the Taoiseach, supported by a Senior Officials Group, should consider and publish a detailed annual report on drug trends and emerging risks. The Department of Health must be supported in providing effective leadership and coordination of the work of the National Oversight Committee for the National Drugs Strategy.

Option	Votes	Percentage
Agree	81	(96%)
Do Not Agree	3	(4%)
Don't Know	0	(0%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

Question 3.2: The State should take urgent, decisive and ambitious action to improve its response to the harmful impacts of drugs use, including implementing necessary legislative changes.

Option	Votes	Percentage
Agree	83	(98%)
Do Not Agree	2	(2%)
Don't Know	0	(0%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	1
Total Valid Poll	85

Question 3.3: Government should prioritise drugs misuse as a policy priority, as part of an overall socio-economic strategy.

Option	Votes	Percentage
Agree	79	(94%)
Do Not Agree	5	(6%)
Don't Know	0	(0%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

Question 3.4: Government should recognise that an effective national response to drugs-related issues requires whole of government policy coherence, operational cohesion and effective leadership.

Option	Votes	Percentage
Agree	83	(98%)
Do Not Agree	1	(1%)
Don't Know	1	(1%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	1
Total Valid Poll	85

Question 3.5: Government should publish a new iteration of the National Drugs Strategy as a matter of urgency. A first draft should be published by June 2024 for consultation, with the recommendations of the Citizens' Assembly as a key input. The Strategy should contain annual action plans with measurable targets and objectives, clear designation of responsibilities, and regular reporting on implementation and expenditure.

Option	Votes	Percentage
Agree	82	(96%)
Do Not Agree	1	(1%)
Don't Know	2	(2%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	1
Total Valid Poll	85

Question 3.6: The Government must assign accountability, at the highest level, related to the State's response to problematic drug use, including the implementation and tracking of the progress of the recommendations of the Citizens' Assembly.

Option	Votes	Percentage
Agree	81	(96%)
Do Not Agree	3	(4%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 3.7: Government should ensure effective stakeholder involvement in implementing the next iteration of the National Drugs Strategy.

Option	Votes	Percentage
Agree	77	(93%)
Do Not Agree	4	(5%)
Don't Know	2	(2%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	3
Total Valid Poll	83

Question 3.8: Drugs policy should prioritise the needs of vulnerable and marginalised groups and disadvantaged communities.

Option	Votes	Percentage
Agree	74	(88%)
Do Not Agree	7	(8%)
Don't Know	3	(4%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	2
Total Valid Poll	84

Question 3.9: Drugs policy design and implementation should be informed by service users and people who use drugs as well as family members of people affected by drugs, with provision of appropriate supports to enable this involvement.

Option	Votes	Percentage
Agree	73	(88%)
Do Not Agree	7	(8%)
Don't Know	3	(4%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	3
Total Valid Poll	83

Question 3.10: Government should work with key stakeholders to build an effective whole of society response to drugs-related issues.

Option	Votes	Percentage
Agree	77	(93%)
Do Not Agree	5	(6%)
Don't Know	1	(1%)

Number of Eligible Voters	86
Number of Votes Cast	86
Invalid Votes	3
Total Valid Poll	83

6.4 Ballot Paper 4: Funding and Resources, Service Design, Research

Question 4.1: Government should allocate significant additional funding on a multi-annual basis to drugs services across the statutory, community and voluntary sectors, to address existing service gaps, including in the provision of community-based and residential treatment services, to support the implementation of the recommendations of the Citizens' Assembly. This funding should ensure geographic equitability in terms of access to statutory services, as well as providing for accountability, transparency and traceability of allocations.

Option	Votes	Percentage
Agree	82	(98%)
Do Not Agree	1	(1%)
Don't Know	1	(1%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.2: The Government should allocate additional resources to fund community-based and residential treatment and recovery services as an alternative to custodial sentences for people with problematic drugs use.

Option	Votes	Percentage
Agree	78	(93%)
Do Not Agree	5	(6%)
Don't Know	1	(1%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.3: The Government should examine the potential of novel funding sources to support increased drug services within the health and criminal justice systems, and in the community and voluntary sectors. Any novel funding should be secured, tracked and ringfenced for drug services expenditure

Option	Votes	Percentage
Agree	77	(93%)
Do Not Agree	2	(2%)
Don't Know	4	(5%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	2
Total Valid Poll	83

Question 4.4: Key stakeholders should publish a joint report on an annual basis detailing total and disaggregated expenditure and channels of funding provided for drug-related services in Ireland, audited by the Comptroller and Auditor General.

Option	Votes	Percentage
Agree	79	(94%)
Do Not Agree	3	(4%)
Don't Know	2	(2%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.5: The National Drugs Strategy should include a strategic workforce development plan.

Option	Votes	Percentage
Agree	80	(95%)
Do Not Agree	2	(2%)
Don't Know	2	(2%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.6: A minimum, mandatory basic training should be implemented for personnel across education, health, criminal justice, prison and social care services on trauma-informed and problem-solving responses to addiction, and health-led response options for those presenting with problematic drug use or addiction.

Option	Votes	Percentage
Agree	80	(95%)
Do Not Agree	2	(2%)
Don't Know	2	(2%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.7: The Government should recognise, value and adequately resource the role of family members and extended support network in supporting people affected by drugs use, and their children. Kinship carers and children should have the same rights as foster carers and foster children, and this should include legal rights and monetary rights on a non means-tested basis.

Option	Votes	Percentage
Agree	75	(89%)
Do Not Agree	6	(7%)
Don't Know	3	(4%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 4.8: The National Drugs Strategy should seek to optimise services to ensure continuity of care and joined-up care for all service users, including people with complex and/or specific needs.

Option	Votes	Percentage
Agree	76	(93%)
Do Not Agree	2	(2%)
Don't Know	4	(5%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	3
Total Valid Poll	82

6.5 Ballot Paper 5: Reducing supply, prevention, protecting young people and communities, harm reduction

Question 5.1: The National Drugs Strategy should continue to prioritise the objective of reducing illicit drugs supply and associated structures, at international, national and local level within communities.

Option	Votes	Percentage
Agree	81	(98%)
Do Not Agree	2	(2%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	2
Total Valid Poll	83

Question 5.2: The Government should develop and expand the use of alternative pathways for young people engaged in low-level sale and distribution of drugs. The Assembly recommends that the judiciary adopts the widespread use of restorative justice and diversion initiatives in these cases, with enhanced investment in community-based youth work and community development projects and initiatives.

Option	Votes	Percentage
Agree	82	(99%)
Do Not Agree	1	(1%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	2
Total Valid Poll	83

Question 5.3: The National Drugs Strategy should focus on building resilient, sustainable communities though local partnerships in both urban and rural settings, and stronger community policing.

Option	Votes	Percentage
Agree	76	(92%)
Do Not Agree	7	(8%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	2
Total Valid Poll	83

Question 5.4: The National Drugs Strategy continue to prioritise the objective of tackling the source and impact of drugs-related intimidation and violence, and take a zero-tolerance approach

Option	Votes	Percentage
Agree	79	(98%)
Do Not Agree	2	(2%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	4
Total Valid Poll	81

Question 5.5: The National Drugs Strategy should use evidence-based approaches to harm reduction, and take measures to reduce the barriers to implementing harm-reduction approaches without undue delay.

Option	Votes	Percentage
Agree	79	(96%)
Do Not Agree	3	(4%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	3
Total Valid Poll	82

Question 5.6: The National Drugs Strategy should include a detailed action plan to enhance Ireland's approach to prevention of drugs use.

Option	Votes	Percentage
Agree	78	(96%)
Do Not Agree	2	(2%)
Don't Know	1	(1%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	4
Total Valid Poll	81

Question 5.7: The Department of Health should develop a strategy to enhance resilience, mental health, well-being and prevention capital across the population, including a focus on providing therapeutic supports for children and young people, and for people dealing with trauma and adverse childhood experiences and dual diagnosis.

Option	Votes	Percentage
Agree	80	(98%)
Do Not Agree	2	(2%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	3
Total Valid Poll	82

Question 5.8: The Departments of Health and Education, in conjunction with the HSE, should design and implement a comprehensive, age-appropriate school-based drug prevention strategy for primary school children, junior and senior cycle secondary students, and wider community settings, as well as their parents/guardians and teachers. Prevention programmes should utilise external experts to deliver to classrooms, supporting teachers, with regular updating by the experts to the schools.

Option	Votes	Percentage
Agree	81	(99%)
Do Not Agree	1	(1%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	3
Total Valid Poll	82

Question 5.9: The Department of Health should roll out regular national public health information campaigns, focusing on reducing shame and stigmatisation of people who use drugs, prevention, risk mitigation and advertising services.

Option	Votes	Percentage
Agree	81	(98%)
Do Not Agree	2	(2%)
Don't Know	0	(0%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	2
Total Valid Poll	83

6.6 Ballot Paper 6: Innovation, Research, referral of submissions

Question 6.1: Referral of submissions received by the Citizens Assembly from the general public and stakeholders on Drugs Use to inform the development and implementation of the National Drugs Strategy.

Option	Votes	Percentage
Agree	79	(94%)
Do Not Agree	4	(5%)
Don't Know	1	(1%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 6.2: Referral of certain submissions received by the Citizens' Assembly on Drugs Use, in relation to the potential therapeutic benefits of certain substances, to the appropriate authorities for consideration.

Option	Votes	Percentage
Agree	68	(81%)
Do Not Agree	15	(18%)
Don't Know	1	(1%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 6.3: The next National Drugs Strategy should incentivise and promote evidence-based innovations in service design and delivery, prioritise the evaluation of pilot projects and emphasise the timely mainstreaming of best practice nationally and internationally.

Option	Votes	Percentage
Agree	78	(93%)
Do Not Agree	4	(5%)
Don't Know	2	(2%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Question 6.4: The National Drugs Strategy should include a plan to strengthen the national research and data collection systems for drugs to inform evidence-based decision-making.

Option	Votes	Percentage
Agree	77	(92%)
Do Not Agree	4	(5%)
Don't Know	3	(4%)

Number of Eligible Voters	85
Number of Votes Cast	85
Invalid Votes	1
Total Valid Poll	84

Appendices

Appendix A: Rules and Procedures of the Citizens' Assembly

1. Timing, Frequency and Openness of meetings

Meetings of the Assembly will generally take place at weekends (Saturdays and Sundays). Full details of the dates for meetings are available on www.citizensassembly.ie. Members of the public will not have access to the meeting venue, but plenary sessions will be livestreamed at www.citizensassembly.ie, and recordings of all plenary sessions and presentations will be available online.

2. Role of the Chairperson

The Chairperson, as the sole judge of order, shall be responsible for the smooth running of Assembly meetings, and where appropriate shall make recommendations to the Assembly on the management of its business in accordance with the Terms of Reference. It is the sole prerogative of the Chairperson to establish whatever advisory groups that he or she deems are needed, and to appoint whichever members to those advisory groups that he or she deems appropriate.

3. Work Programme

The work programme shall be agreed by the Assembly on foot of a proposal by the Chairperson and Secretary. The work programme shall be reviewed regularly, with subsequent changes only taking effect with a broad consensus of members.

4. Steering Group

A Steering Group shall be established to assist the Assembly with planning and operational issues associated with the overall work programme and meeting programmes. The Steering Group shall consist of a sub-group of the members, the Chairperson and the Secretary.

5. Members' Privacy and Deliberative Freedom

Members of the Citizens' Assembly are entitled to their privacy, and members' personal details will be treated in strictest confidence, in accordance with data protection legislation. The Citizens' Assembly as a whole is entitled to deliberative freedom, such that it can operate without pressure being exerted on it by stakeholders or interest groups. Any individual, organisation or lobby group that contacts, or attempts to contact, a member of the Assembly to seek to influence that member's views on a particular topic will be automatically excluded from taking part in the proceedings of the Assembly.

6. Debates/speaking arrangements

The format and structure of interventions by members during the meetings shall be determined by the Chair. As a general principle, all contributions by members should be brief, respectful and non-repetitive.

7. Deliberative roundtable discussions

During roundtable discussions, members are encouraged to express their views, deliberate on the issues and request clarifications, if required, from speakers and support groups. The outcome of roundtable discussions can be reflected back to the Assembly during Plenary Sessions. Notes of roundtable discussions will be captured by the notetaker and reported in detail and summary form to the Secretariat, to identify emerging issues and recurring themes. Members will be provided access to the reports of each meeting.

8. Submissions

Submissions received by the Assembly secretariat shall be made available to all members of the Assembly via the **www.citizensassembly.ie** website.

9. Presentations

Following receipt of submissions, the Assembly may choose to hear oral presentations from any representative group or individual to assist in its deliberations. Invitations shall be issued by the Chairperson on behalf of the Assembly.

10. Voting

Decisions by the Assembly can be taken informally by a show of hands or through formal voting, as appropriate. Voting shall be by secret ballot. Counting of votes shall be overseen by the Chairperson and Secretary and at least 2 members of the Assembly.

11. Advisory Support Group

The Chair shall establish such advisory and other support groups as are considered necessary and appropriate to assist with the work of the Assembly in terms of preparing information and advice.

12. Accessibility of Services and Information for Persons with Disabilities

The Assembly will ensure that services and information will be accessible to all Members including those with a disability, insofar as is practicable and appropriate.

13. Press and Communications

Accredited members of the media shall be permitted to attend plenary sessions of the Assembly, subject to such terms and conditions as may be laid down by the Assembly. As a general principle, the Chairperson shall act as spokesperson in relation to administrative or procedural matters relating to the work of the Assembly.

14. Media and Public Commentary

Until such time as the work of the Citizens' Assembly has been completed and its final report published, members of the Assembly and advisory support groups shall refrain from making public comment about the substantive issues under consideration, including to members of the media or on social media platforms. However, public comment on more general issues such as the Assembly process and members' experiences of being involved in the Assembly, is not subject to the same restrictions.

15. Quality Control and Continuous Improvement

To ensure a high-quality process and to support continuous improvement, members are requested to complete a post-meeting evaluation form following each meeting of the Assembly. Members are encouraged to notify the Secretariat of any issues of concern regarding arrangements for meetings.

Appendix B: Guiding Principles of the Citizens' Assembly

1. Openness

The Citizens' Assembly will operate in a spirit of openness. Plenary meetings will be livestreamed on www.citizensassembly.ie, as well as recorded and available after the meeting. Documentation including submissions, speeches and presentations will be published on the website.

2. Balance

It is important that the Assembly hears a diverse and balanced range of viewpoints during the course of proceedings.

3. Transparency

Contributors including speakers, presenters and members of advisory support groups, and contractors, shall disclose any roles, associations or positions that might give rise to an actual or perceived conflict of interest.

4. Equality of voice

Each member will have fair and proportionate opportunity to voice their opinions at plenary session or roundtable discussions.

5. Respect

Members will respect each other's opinions and ensure that everyone feels free to express their views without fear of personal attack or criticism.

6. Privacy and Confidentiality

Members are entitled to privacy and confidentiality during their involvement in the Citizens' Assembly. Any effort to lobby or otherwise pressure members will not be tolerated.

7. Inclusivity

The Citizens' Assembly welcomes engagement from all sections of society and all stakeholders on issues within the remit of the Assembly.

8. Collegiality

Members will work in a spirit of collegiality, with the aim of formulating and agreeing recommendations in a democratic manner.

9. Professionalism

The Secretariat and contracted service providers shall act at all times with professionalism, respecting the guiding principles of the Citizens' Assembly.

Appendix C: Public Consultation

Overview

Stakeholders and the wider public were invited to provide submissions detailing their views and perspectives on the matters being considered by the Citizens' Assembly on Drugs Use. The consultation period ran from 4 May to 30 June 2023.

An online submission form was provided via the Citizens' Assembly website, and submissions were accepted in written or video format.

Guidance was offered about the broad parameters of the consultation, explaining that the consultation was focused on those issues derived from the Terms of Reference. Terms and Conditions were set out, explaining the channels through which submissions would be accepted, the approach to dealing with anonymous submissions, the verification process, the handling of personal information, and the intention to publish all valid submissions, subject to data protection and other legal requirements.

A total of 794 submissions were received, of which 775 were published. Of the submissions published, 118 were made by organisations and 657 were made by private individuals. Published submissions are available to view online at **www.citizensassembly.ie.**

Overview of submissions from individuals.

A total of 657 valid submissions were received from individuals. 19 submissions were not published for reasons including: withdrawn at the request of the submitter; duplicate submissions; did not meet validation requirements; or were outside the scope of the Terms of Reference.

Of the submissions published,

- 138 referenced personal drug use, including reference by the submitter to either previous and/or current drug use in Ireland and/or in jurisdictions where the drug use was permitted;
- 48 referenced third party drug use by family members or close friends;
- 32 identified that the person submitting worked in areas connected with frontline delivery of services or connected with support services for people who use drugs.

The vast majority of submissions from individuals (633 out of 657) were received from people living in Ireland, with 10 from Great Britain, and a small handful from people living in Australia, Canada, Germany, Spain, France, Greece and the Netherlands.

Overview of submissions from organisations

118 valid submissions were received from organisations and groups. The vast majority of the organisations (110 out of 118) were based in Ireland, with six coming from organisations or groups based Great Britain, and one each from Spain and the USA.

53 of the submissions were from Advocacy and Representative Bodies (Table 4), 32 were from service providers in the community or voluntary sectors (Table 5), 19 were from organisations such as Drug and Alcohol Task Forces and other statutory/community partnership organisations (Table 8), nine were from public or statutory bodies (Table 7), and five were from political parties or elected representatives (Table 6).

List of Organisations that made submissions to the consultation

Table 4: Submissions from Advocacy and Representative Bodies

Alcohol Action Ireland	CADU692
Althea	CADU537
Athlone Drug Awareness Group	CADU307
Belong To - LGBTQ+ Youth Ireland	CADU691
Cannabis Homegrowers Coalition	CADU446
Cannabis Industry Council Ireland	CADU626
Cannabis Risk Alliance	CADU791
Citywide Drugs Crisis Campaign	CADU412
Citywide Drugs Crisis Campaign - Untold Stories Project	CADU591
College of Psychiatrists of Ireland	CADU794
Consultations with Young People for the Citizens Assembly on Drugs Use *	CADU566
Crainn	CADU635
D HEMP SHOP	CADU568
Dublin Town	CADU599
Flor das Fadas, Flower of the Fairies - Santo Daime	CADU167
Former Coalition of Communities Against Drugs Members	CADU778
Help Not Harm	CADU750
Hemp Cooperative Ireland	CADU787
Iaso Institute	CADU760
International Centre on Human Rights and Drug Policy	CADU488
Inwardbound Institute Limited	CADU678
Irish Association of Social Workers (IASW)	CADU688
Irish Council of Civil Liberties	CADU630
Irish Doctors for Psychedelic Assisted Therapy	CADU681
Joint submission to the Assembly	CADU638
Kinship Care Ireland	CADU631
Local Drug and Alcohol Task Forces' Chairs' Network	CADU572
MindFreedom Ireland	CADU040
National Network of Regional Drug & Alcohol Task Forces	CADU592
National Peer Family Support Group	CADU555
National Voluntary Drug and Alcohol Sector	CADU680
Patients for Safe Access Ireland	CADU660
Patients for Safe Access Ireland	CADU726
PsyCare Ireland: Welfare and Harm Reduction CLG	CADU246
Queen's Communities and Place at Queen's University Belfast	CADU748
Release	CADU689
Santo Diame	CADU418
Service Users Rights in Action (SURIA)	CADU785
Shatterbox	CADU696
SSDP Maynooth University	CADU322
Swan Regional Youth Service	CADU434
Tao Climate Limited	CADU469
The Cannabis Review	CADU493
The European Society for Prevention Research	CADU540
The Futures Green Project	CADU618
The Ireland Chapter of The International Nurses Society on Addictions [RCN 20206101]	CADU596
The Union of Students in Ireland (USI)	CADU534
Future is Green Ltd.	CADU489
Transform Drug Policy Foundation	CADU741
Tryp.ie	CADU780
UISCE	CADU581
Uplift, People Powered Change	CADU546
Youth Workers Against Prohibition	CADU554

Table 5: Submissions from Community/Voluntary Service Providers

ACET Ireland	CADU669	Jobstown Assisting Drug Dependency (JADD Project CLG)	CADU728
Aiséiri	CADU548	Matt Talbot Community Trust, Ballyfermot	CADU667
Amnesty International Ireland	CADU789	Merchants Quay Ireland.	CADU501
Ana Liffey	CADU792	Northstar Family Support Project	CADU406
Ballyfermot Advance Project	CADU734	NOVAS	CADU790
Ballyfermot STAR CLG	CADU625	Pavee point Traveller and Roma Centre	CADU664
Bray Community Addiction Team CLG	CADU641	Peter McVerry Trust	CADU719
Clondalkin Addiction Support Programme	CADU445	Poppintree Youth Project	CADU603
Community Action Network (CAN)	CADU496	Ringsend Community Services Forum	CADU317
Coolmine	CADU743	Sankalpa CLG	CADU400
Cranstoun	CADU668	SAOL Project	CADU004
Depaul	CADU580	South East Regional Family Support Network Submission	CADU784
Dublin Simon Community	CADU588	Tabor Group	CADU619
Family Addiction Support Network and Irish Bishop's Drugs Initiative	CADU378	Talk About Youth Project	CADU328
Hope House Foxford Co. Mayo	CADU492	The Cornmarket Project Wexford	CADU467
Inner city Organisations Network (ICON)	CADU628	Tolka River Project CLG	CADU323

Table 6: Submissions from political parties or elected representatives

Labour Youth	CADU695	The Labour Party	CADU711
Neasa Hourigan TD, Cllr Janet Horner & Feljin Jose	CADU717	The Social Democrats	CADU722
Sinn Féin	CADU608		

Table 7: Submissions from public or statutory bodies or agencies

Addiction Team, HSE National Social Inclusion Office	CADU564	Inclusion Health Team, St. James Hospital, Dublin	CADU683
City of Dublin ETB Adult Education Service	CADU698	Medical Bureau of Road Safety	CADU402
Cork City Council	CADU597	National Poisons Information Centre	CADU640
Cork City Council	CADU617	National Poisons Information Centre	CADU725
HSE Clinical Programme for Dual Diagnosis	CADU788		

Table 8: Statutory - Community/Voluntary Partnerships

Ballyfermot Local Drug and Alcohol Task Force	CADU693
Ballymun Local Drugs and Alcohol Task Force	CADU694
Blanchardstown Local Drugs & Alcohol Task Force	CADU438
Bray Local Drug and Alcohol Task Force	CADU727
Canal Communities Citizens Assembly Group on Decriminalisation/Legalisation	CADU472
Canal Communities Local Drug and Alcohol Task Force	CADU542
Clondalkin Drugs and Alcohol Task Force	CADU590
Cork Local Drug & Alcohol Task Force	CADU675
Dublin 12 Local Drugs and Alcohol Task Force	CADU616
Dún Laoghaire Rathdown Drugs and Alcohol Task Force (DLRDATF)	CADU793
Finglas Cabra Local Drug and Alcohol Task Force	CADU427
Midwest Regional Drugs and Alcohol Forum	CADU605
North central Joint Policing Sub Committee meeting	CADU264
North Dublin Regional Drug & Alcohol Task Force	CADU672
North Eastern Regional Drug & Alcohol Task Force	CADU633
South Western Regional Drug & Alcohol Task Force	CADU777
Tallaght drug and Alcohol Task Force	CADU786
The South Inner City Drugs & Alcohol Task Force	CADU583
Western Region Drug & Alcohol Task Force	CADU567

Appendix D: Membership of the Citizens' Assembly

The Citizens' Assembly on Drugs Use was comprised of 100 members, including 99 members of the general public and an independent Chairperson.

Optimising the representativeness and diversity of the Assembly

Recruitment of members for the Citizens' Assembly was based on the selection method first introduced in 2022. This method is designed to optimise the diversity of the Assembly membership and ensure it is as representative as possible of the general public.

The improved member recruitment method is informed by international best practice, with reference in particular to the OECD Recommendation on Open Government[6], the OECD Good Practice Principles for Deliberative Processes for Public Decision Making[7] and countries with extensive experience of Citizens' Assemblies, including Canada and Australia.

Invitations

A total of 20,000 households right around Ireland received a postal invitation from Taoiseach Leo Varadkar T.D., inviting them to nominate one adult from that household to apply to become a member. The sample of households that received invitations was randomly generated from the GeoDirectory database of households, which is the most comprehensive available database of households in the country.

Applications

Written invitations were addressed generically to 'The Householder', as distinct from named persons within the household. Each household that received an invitation was entitled to nominate just one adult from that household to apply. It was up to household members themselves to decide who might apply. Invitations were non-transferable between households.

Applicants from eligible households were required to register their interest in becoming a member of the Assembly, either online or by phone. As part of the registration process, key demographic information was requested from applicants.

The Secretariat then used this demographic information to select members using a stratified random selection process, which ensured that that the overall composition of the assembly broadly mirrored wider Irish society in terms of gender, age, geography, socioeconomic status and nationality.

Response rate

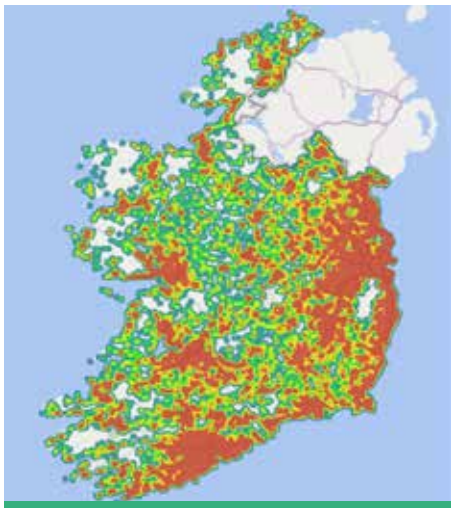
A total of 20,000 invitations were issued, with approx. 1,400 responses received, which is in line with expectations based on international experience.

6 OECD (2017) https://www.oecd.org/gov/Recommendation-Open-Government-Approved-Council-141217.pdf

7 Chwalisz, C. (2020), 'Good practice principles for deliberative processes for public decision making', in Innovative Citizen Participation and New Democratic Institutions: Catching the Deliberative Wave, OECD Publishing, Paris, https://doi.org/10.1787/b40aab2a-en.

Geographic distribution of invitees, applicants and members

Figure 1, below, shows the spread and concentration of invitations, applications and members across Ireland.



Invitations (20,000 households)

Applications (1,400)

Assembly Members (100)

Sortition criteria

The final selection of public members of the Assembly was based on a stratified random selection of 99 members of the public, using six demographic variables:

- Gender
- Age Group
- Place of residence
- Employment status and occupation (proxy indicators for socio-economic status and disability);
- Language (as a proxy indicator of nationality).

Demographic profile of members

Using a demographic profile of the general public based on CSO Census data, targets were set for selecting members by gender, age group and location by region.

Supplementary criteria of employment status, language and occupation were used to optimise diversity and inclusivity of membership.

Tables 1 – 3 below show the targets, and results, of the stratified random selection, while Tables 4-6 indicate the diversity and inclusivity achieved among the group.

Table 9 Gender profile of assembly members

Gender	Target	Result
Male	49	49
Female	50	49
Non-Binary		1
Total	**99**	**99**

Table 10 Age profile of assembly members

Age	Target	Result
65 years or older	20	20
45-64 years	32	32
25-44 years	36	36
18-24 years	11	11
Total	**99**	**99**

Table 11 Geographic profile of assembly members

Age	Target	Result
1. Dublin	28	28
2. Rest of Leinster	27	27
3. Munster	27	27
4. Connacht & Ulster	17	17
Total	**99**	**99**

Table 12 wider indicators of diversity within the 99 members

The 99 members of the Assembly included four people with disabilities, a wide range of socio-economic backgrounds, and 15 non-nationals including 11 whose first language was not English. Languages spoken included Latvian, Romanian, Polish, Mandarin, Arabic, and French.

Participation, attrition, replacement and retention

The Assembly maintained a high participation rate. A total of 6 members withdrew from the Assembly at various points during the process, meaning that at the conclusion of the Assembly there were 94 members, remaining compared to the initial cohort of 100. The effective attrition rate for this Assembly compares very favourably to most previous Citizens' Assemblies.

Appendix E:
Terms of Reference for the Steering Group

'A Steering Group shall be established to assist the Assembly with planning and operational issues associated with the overall work programme and meeting programmes. The Steering Group shall consist of a sub-group of the members, the Chairperson and the Secretary.' Extract from Rules and Procedures.

The Steering Group is essential to the success of the Assembly. Its members shall support the Chairperson in ensuring the efficient operation of the Assembly, and the effective conduct of the Assembly's business in line with its Terms of Reference. Except in cases where it is more appropriate to seek the views of the full Assembly membership, the Chairperson will consider the views of the Steering Group to be broadly reflective of the views of the wider Assembly.

The Steering Group's responsibilities will be to assist the Chairperson in:

- Advising the Secretariat in the planning and operation of Assembly meetings;
- Overseeing the implementation of the Work Programme and the design of individual meeting programmes such that the Assembly's business is being conducted in line with its Terms of Reference and in a fair and balanced manner;
- Overseeing the selection of speakers to appear before the Assembly such that the Assembly's business is being conducted in line with its Terms of Reference and in a fair and balanced manner;

Each member of the Steering Group should be available to meet by video conference on approximately two evenings per month, for approx. 1 hour each. Members of the Steering Group should also be available to deal (by e-mail, phone call etc.) on an ad hoc basis with issues as they arise during the run-up to Assembly weekends.
The Steering Group shall comprise 6 members of the Assembly, plus the Chairperson and Secretary. Where there is a significantly larger number of volunteers, the final membership will be randomly selected so as to be broadly demographically representative of the full Assembly membership.

Appendix F:
Terms of Reference for the Advisory Support Group

The Advisory Support Group (ASG) to the Citizens' Assembly on Drugs Use will support the Chair of the Assembly in developing a fair, balanced and comprehensive work programme, in line with the Assembly's Terms of Reference, by:

- Offering suggestions and feedback on the design of a draft programme;
- Identifying options for specialists, experts, stakeholder groups and others to appear before the Assembly;

It will be a matter for the Chair and members of the Assembly to determine the final Work Programme. It will be a matter for the Chair, in consultation with the Steering Group and supported by the various support groups and the Secretary to the Citizens' Assembly, to agree the speakers to be invited to appear before the Assembly.

Where possible, members of the Advisory Support Group will attend the meetings of the Citizens' Assembly. Their role at those meetings will be as follows:

- To observe proceedings and reflect on how the material being presented is received by members;
- To consider how best to incorporate feedback from roundtable discussions and post-meeting evaluations into programme design for subsequent meetings;
- Where appropriate, and at the discretion of the Chairperson, members of the Advisory Support Group may also provide clarification on questions from the members, with answers being provided either in plenary session or in documentation.
- Where appropriate, and at the discretion of the Chairperson, members of the Advisory Support Group may be invited to present to the Citizens' Assembly in plenary session.

Members of the Advisory Support Group:

- are appointed by, and serve at the sole discretion of, the Chairperson;
- are required to perform their role in a balanced and independent manner;
- shall not act, during the course of performing their role as a member of the ASG, in an advocacy capacity on their own behalf, or on behalf of any other individual or group;
- shall refrain, during the course of performing their role as a member of the ASG, from making public comment on their work for the Citizens' Assembly, or on the proceedings of the Assembly, whilst the Assembly is ongoing;
- agree to undertake their work on a pro-bono basis;
- will be entitled to transport and accommodation expenses for attending meetings of the Citizens' Assembly, in accordance with public sector guidelines and rates;
- will be offered a token of appreciation to the value of €500 at the conclusion of the Citizens' Assembly.

Appendix G:
Terms of Reference for the Lived Experience Group

The Lived Experience Group will support the Chairperson in developing a fair, balanced and comprehensive work programme, in line with the Assembly's Terms of Reference, by:

- Offering suggestions and feedback on the design of a draft programme;
- Identifying options for specialists, experts, stakeholder groups and others to appear before the Assembly;

It will be a matter for the Chair and members of the Assembly to determine the final Work Programme. It will be a matter for the Chair, in consultation with the Steering Group, or with the full membership where appropriate, and supported by the Secretary and various support groups, to determine the speakers to be invited to appear before the Assembly.

Where possible, members of the Lived Experience Group will attend the meetings of the Citizens' Assembly. Their role at those meetings will be as follows:

- To observe proceedings and reflect on how the material being presented is received by members;
- To consider how best to incorporate feedback from roundtable discussions and post-meeting evaluations into programme design for subsequent meetings;
- Where appropriate, and at the discretion of the Chairperson, members of the Lived Experience Group may also provide clarification on questions from the members, with answers being provided either in plenary session or in documentation.
- Where appropriate, and at the discretion of the Chairperson, members of the Lived Experience Group may be invited to present to the Citizens' Assembly in plenary session.

Members of the Lived Experience Group:

- are appointed by, and serve at the sole discretion of, the Chairperson;
- are required to perform their role on the Group in a balanced and independent manner;
- while participating in the business of the Group, shall not advocate or lobby on their own behalf, or on behalf of any other individual or group;
- while the work of the Citizens' Assembly is ongoing, shall refrain from making public comment on their work for the Citizens' Assembly;
- agree to undertake their work on a pro-bono basis;
- will be entitled to transport and accommodation expenses for attending meetings of the Citizens' Assembly, in accordance with public sector guidelines and rates;
- will be offered a token of appreciation to the value of €500 at the conclusion of the Citizens' Assembly.

Appendix H: Explanatory Notes for Ballot Paper 2 on Options A – F for Possession of Drugs for Personal Use

Explanatory note for members of the Citizens' Assembly:

Ballot Paper 2 provides members an opportunity to select their preferred approach, or approaches, to the issue of possession of drugs for personal use.

The Ballot Paper presents five primary options for legislative approaches to deal with possession of drugs for personal use. Each option has previously been considered by members of the Assembly, who have heard case studies from other jurisdictions, as well as inputs from legal and policy experts and from advocacy groups. Each option has explanatory text, below, that summarises the essential features of the approach.

The five primary options are also accompanied by a sixth option, Option F, which is a hybrid model that allows for a combination of different approaches to be used for different drugs.

- **Option A:** The 'Status Quo', or current legal framework
- **Option B:** Health Diversion
- **Option C:** Comprehensive health-led response
- **Option D:** Tolerance of possession of drugs for personal use
- **Option E:** Legalisation and regulation of drugs, including possession for personal use
- **Option F:** A hybrid model, allowing a combination of different approaches (from options A-E) for different drugs.

Option A: Status Quo / options within the current legal framework

Text of recommendation: Retain the current legislative approach to possession of drugs for personal use, including offences specified under S3 of the 1977 Misuse of Drugs Act, and sentencing as specified under S28 of the Act.

Explanatory Narrative: Members voting to support the 'status quo' approach are likely to be of the view that the current legislative approach to possession of drugs for personal use is essentially the correct one and should not be significantly altered. This means that the offence of possession of drugs for personal use, as legislated for under Section 3 of the 1977 Misuse of Drugs Act, and the sentences provided for under Section 28 of the Act, should be retained. Under this approach, possession of drugs remains illegal, and the Section 3 offence of possession for personal use can ultimately result in a criminal conviction and prison sentence, as specified in Section 28 of the Act. There are, however, provisions that allow for leniency in the treatment of first-time offenders caught in possession of cannabis for personal use.

Under the status quo, there is no legal basis for direct referrals by Gardaí to health-led services. Consequently, all S3 offences are dealt with by the criminal justice system.
The current approach, which gives Gardaí the legal basis to issue an Adult Caution for first-time offenders caught in possession of cannabis for personal use, has scope to be expanded. Also, the current legal framework gives judges the basis to allow people an opportunity to avoid a criminal conviction and prison sentence, for example, through schemes such as the Cork Courts Referral Programme, and/or through the imposition of fines.

Option B: Limited Health Diversion

Text of Recommendation: The Government should introduce the planned Health Diversion legislation as an urgent legislative priority.

Explanatory Narrative: Members favour 'Limited Health Diversion' approach to people found in possession of drugs for personal use (S3 offences) are likely to be of the view that the Government's 'Health Diversion' model, which the Assembly has heard is planned but not yet implemented, is the correct approach.

The Health Diversion model as currently planned would mean that the offence of possession of drugs for personal use, as legislated for under Section 3 of the 1977 Misuse of Drugs Act, and the sentences provided for under Section

28 of the Act, would be retained. Under this approach, possession of drugs remains illegal, and the Section 3 offence of possession for personal use can ultimately result in a criminal conviction and prison sentence, as specified in Section 28 of the Act.

The Health Diversion model, however, provides for leniency in the treatment of first-time offenders found in possession of any controlled drug for personal use. Under Health Diversion, Gardaí would have the power to divert first-time offenders to a health intervention known as the SAOR Brief Intervention model. First-time offenders, therefore, would avoid an appearance in court, with the prospect of a criminal conviction, fine and possible prison sentence.

Option C: Comprehensive Health-led approach

Text of Recommendation: The State should introduce a comprehensive health-led response to possession of drugs for personal use.

Explanatory Narrative: Under a 'Comprehensive health-led' approach, the State would respond to drug use and misuse primarily as a public health issue rather than as a criminal justice issue. While possession of controlled drugs would remain illegal, people found in possession of illicit drugs for personal use would be afforded, first and foremost, extensive opportunities to engage voluntarily with health-led services.

This would minimise, or potentially completely remove, the possibility of criminal conviction and prison sentences for simple possession. A member of An Garda Síochána, on finding someone in possession of illicit drugs for personal use, would refer that person directly to a SAOR Brief Intervention, designed to assess, inform, dissuade and prevent people from developing problematic drug use, and where appropriate, offer a person an onward referral to addiction services. The mirrors the practice in both Austria and Portugal, which both combine health diversion, decriminalisation and dissuasive sanctions, which the Assembly has heard about in some detail.

There are several open questions about how Ireland might best legislate for this model combining diversion, decriminalisation and dissuasion. Changes are likely to be required to the Misuse of Drugs Act 1977, in conjunction with the enhanced use of existing legislative provisions, such as those contained within the Probation of Offenders Act 1907. New legislation may also be required. Given the important legal and constitutional issues to be considered, the Citizens' Assembly views it as the responsibility of the Oireachtas, informed by legal advice and detailed pre-legislative scrutiny, to determine the most appropriate legal mechanisms to achieve this goal.

The Assembly has identified a number of key questions that the Oireachtas should consider in balancing the objectives of health diversion, decriminalisation and dissuasive sanctions, including:

- Does the Irish legal system allow for the criminal offence of possession of drugs for personal use to be reclassified as an 'administrative' offence? The answer to this question has an important bearing on whether 'decriminalisation' can be done on a de-jure or de-facto basis.
- Should the sanction of prison sentences for simple possession offences be removed entirely from the statute book?
- What limits, if any, should there be on the number of times a person found in possession of drugs for personal use can be diverted to health interventions? Should no limit be set, or should a threshold be specified, beyond which a person would be referred back to the Courts for potential dissuasive sanctions (e.g. a fine)?
- What dissuasive sanctions, if any, should be available for repeat offenders, and which body should apply those sanctions? Should the Courts continue to have the role of applying sanctions such as fines, Community Service Orders, the Probation Act, referrals to Restorative Justice programmes, etc. Alternatively, can, and should, another entity be authorised to impose administrative sanctions?

Option D: Tolerance of possession of drugs for personal use

Text of recommendation: The State should take a more tolerant approach to people found in possession of drugs for personal use.

Explanatory Narrative: Under this approach, while possession of controlled drugs would continue to remain illegal, people found in possession of drugs for personal use would be treated with tolerance, combining decriminalisation and depenalisation. People found in possession of drugs should simply have those drugs confiscated, with no further

consequences or charges to follow, and no required referral to health or other support services. (Drug Treatment services would, of course, be available for people with problematic drugs use should they wish to access them). While legislative change is required to support this form of decriminalisation and depenalisation, it will be a matter for the Oireachtas, informed by legal advice and detailed pre-legislative scrutiny, to determine the most appropriate legal mechanisms to achieve this, on either a de-facto or de-jure basis.

Option E: Legalisation and regulation of drugs

Text of Recommendation: Drugs should be legalised and made available to adults on a regulated basis.

Explanatory narrative: This option would see the State adopt an entirely new approach, whereby drugs (some or all) would be legalised and subject to regulation. This would represent a significant departure from other legal approaches that have been considered in previous parts of Ballot Paper 2, and would have implications for the production, sale and distribution of drugs, as well as for possession of drugs.

If Ireland were to legalise and regulate the sale and supply of drugs, it seems logically inevitable that it would also necessitate the decriminalisation of possession of drugs for personal use, within agreed regulations (e.g. possession in schools or prisons might still be prohibited).

Under legalisation with regulation, people who use drugs would benefit by a) being able to possess (and consume) drugs without fear of arrest or prosecution, and without the stigma that they currently experience; b) not having to purchase drugs from the black market controlled by Organised Crime groups; c) knowing the source and quality of drugs, reducing the risk of poisoning from contaminated products. In addition, a decision to legalise drugs could have beneficial implications for efforts to reform legislation in relation to Spent Convictions.

Under this approach, the Exchequer would also benefit from a new revenue stream from taxation of drugs sales, hypothecating these revenues for investment in education and prevention for the wider population, and treatment and recovery services for people with problematic drugs use. Some proponents of legalisation make the further point that Ireland has the potential to develop a vibrant cannabis industry, with significant export potential and economic dividends including job creation.

A decision to legalise drugs would require significant redrafting of the legislative framework and regulatory system. Given the important legal and constitutional issues to be considered, the Citizens' Assembly views it as the responsibility of the Oireachtas, informed by legal advice and detailed pre-legislative scrutiny, to determine the most appropriate legal mechanisms to achieve this goal.

Another important question, which may be explored in Stage 4 voting, is what supply models the members of the Assembly favour.

Published by the Citizens' Assembly,
January 2024
www.citizensassembly.ie

ISBN 978-1-4468-8108-8

9 781446 881088

Le ceannach díreach ó
FOILSEACHÁIN RIALTAIS,
BÓTHAR BHAILE UÍ BHEOLÁIN, BAILE ÁTHA CLIATH 8.
D08 XA06
(Teil: 046 942 3100 nó Riomhphost: publications@opw.ie) nó trí aon díoltóir leabhar.

To be purchased from
GOVERNMENT PUBLICATIONS,
MOUNTSHANNON ROAD, DUBLIN 8.
D08 XA06
(Tel: 046 942 3100 or Email: publications@opw.ie) or through any bookseller.