An Tionól Saoránach The Citizens' Assembly

Workshop on options for legal frameworks in relation to illicit drugs

August 2023

1 Introduction

1.1 Why have a Workshop on legislative issues?

Generally, whenever a Citizens' Assembly has an item on its agenda that deals with technically complex issues, the Secretariat will prepare a paper with background information for members to read ahead of the meeting.

For the Citizens' Assembly on Drugs Use, the session planned for Sunday 3rd September 2023 to look at legislative issues is one of the more technically-challenging sessions that the members will experience.

To support the Assembly, the session has been designed as a workshop, which provides members with more time than usual to engage in Questions and Answers with a panel of experts, and allows additional time for roundtable discussions, and opportunity to provide feedback to the Secretariat.

It is important for members to understand that they are not being asked to decide on Sunday what legal changes, if any, they might want to recommend. The main objective of the workshop is to help members come away with **a methodology** that they can continue to use over the coming weeks to reflect on the strengths and weaknesses, or advantages and disadvantages, of alternative systems that might be considered in relation to illicit drugs in Ireland.

Remember, there are still six weeks or so before members will have to make any decision in relation to this and other questions. Members still have plenty of time to reflect on the issues they have already heard about. They will also have the opportunity to continue to read the submissions from members of the public and other stakeholders, and of course to factor in new considerations based on the fifth meeting, which focuses on education and prevention.

Meanwhile, 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.

Our intention is that this will be a 'living document' that can be updated with additional and new information following the meeting if members would find that helpful.

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

1.2 Background

The fourth meeting of the Citizens' Assembly on Drugs Use, scheduled for 2-3 September 2023, will consider two important topics: a) the criminal justice system, and b) the legislative framework.

As with previous meetings, members will explore the central question in the Terms of Reference[1], namely: what legislative, policy and operational changes could the State make to significantly reduce the harmful impacts of illicit drugs on individuals, families, communities and wider society?

The first day of the programme, Saturday 2nd September, follows the format that members are already familiar with. Members will consider potential policy and operational changes in the criminal justice system, with a focus on policing, courts, prisons, probation services, community-based supports for offenders, diversion interventions with young people, community initiatives to tackle drug-related intimidation and violence, and so on. The session will feature inputs by panels of guest speakers, followed by Q&A and roundtable discussions. The three standard questions posed to both speakers and members are:

i) What is working well?

ii) What is not working well?

iii) What might make a significant difference?

The second day of the programme, 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.

1.3 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 4 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 **Criminal 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

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 EUR 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. [🔗]

1.4 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.

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, policy-makers, 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.

1.5 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.

1.6 Visibility and Prominence vs Relevance and Importance

It's important for the Assembly to be aware that certain issues and debates in relation to drugs legislation tend to receive greater public attention and prominence than others. Sometimes this can be because of their importance or urgency, but other times it may be because certain issues are more prominently featured in the media, or are more topical within the political system, or are the subject of organised lobbying campaigns.

As this paper, and the workshop on Sunday, attempt to highlight, there is a wide range of issues related to drugs legislation that fall under the scope of the Terms of Reference.

1.7 Timeline towards balloting

Working backwards on the Work Programme, the sixth and final meeting of the Assembly, scheduled for the weekend of 21-22 October, will provide the opportunity for members to finalise any ballot papers and cast their votes on the questions appearing on those ballot

papers. The results of those votes will determine the recommendations of the Assembly, which will then be published in the final report of the Assembly.

In the period leading up to the final meeting, the Secretariat will prepare one or more draft ballot papers, which will be circulated to members for feedback. Based on the feedback, updated draft ballot paper(s) will then be prepared, which members will then discuss and finalise at the last meeting (if not beforehand, depending on how complex or straightforward the drafting process proves to be). Once a ballot paper has been finalised and agreed by members, it is then ready to be voted on.

1.8 Recommendations are non-binding

Technically speaking, the recommendations made by any Citizens' Assembly are advisory and non-binding. In other words, none of the three branches of Government - the Legislature (Oireachtas), the Executive (Government), or the Judiciary (the Courts), is legally or otherwise obligated to accept any recommendation from the Assembly. This has always been the case, and indeed could not be otherwise under the Constitution [🔗], which vests legislative authority with the Oireachtas, executive authority with the Government, judicial authority with the Judiciary, and the power to change the Constitution with the citizens of Ireland.

Having said that, it's clear that the recommendations of previous Citizens' Assemblies have carried a lot of weight with both the Oireachtas and the Government, as well as with the general public. Over the past decade, recommendations from various Citizens' Assemblies have had a significant impact on government policy, legislative change and, in certain cases, on Constitutional change. There are very few, if any, other examples around the world of Citizens' Assemblies that have achieved such a level of impact within their respective jurisdictions as has been the case in the Irish experience.

That's not to suggest that each and every recommendation from a Citizens' Assembly will be accepted. Certain recommendations made by previous Citizens' Assemblies have simply not been accepted, while others have been accepted subject to modifications.

Reassuringly, the Terms of Reference for the Citizens' Assembly on Drugs Use [🔗] contain an explicit commitment regarding how the Oirechtas and Government will respond when they receive the final report. The Oireachtas will refer the report to an Oireachtas Committee, which will consider the report and bring its conclusions back to the Houses of

the Oireachtas for debate. The Government will also consider the report and then provide a reasoned response in the Houses of the Oireachtas, setting out a timeframe for implementing those recommendations which it accepts. In other words, the Citizens' Assembly can be confident that its report and recommendations will be carefully considered and fully debated by both the Oireachtas and Government, each of which will then give a detailed response in the public domain.

1.9 'Rules of thumb' to underpin the quality and credibility of recommendations

The question of how the Oireachtas and Government might respond to the recommendations is entirely beyond the control of the Assembly. Similarly, the Citizens' Assembly is established to operate independently of the Oireachtas and Government, and is free to make whatever recommendations it wishes. However, there are several things the Assembly itself can do, with the support of the Secretariat, to enhance the prospects of its recommendations being accepted and implemented.

As members prepare to progress through the second half of the Assembly's work programme, the following 'rules of thumb' might help members anticipate how draft recommendations for balloting will be arrived at. While these observations have general relevance to every Citizens' Assembly, they are particularly worth bearing in mind ahead of the upcoming workshop on legislative options.

- **Recommendations should not be proposed on issues the Assembly has not adequately deliberated on**. The Oireachtas has set clear deadlines for the Citizens' Assembly to conclude its work. The inevitable time constraints on the Assembly mean that members have to limit and prioritise the issues they can deliberate on. The Work Programme adopted by the Assembly sets out the priorities for the Assembly. In the event that a matter is proposed for balloting where there has not been adequate deliberation, it is the role of the Chair to adjudicate as to whether or not that issue is featured on the ballot paper. The Secretariat can offer constructive suggestions as to how issues not adequately deliberated on might be otherwise dealt with in the Assembly's report, outside of the recommendation process.
- **Focus recommendations on issues within the Terms of Reference**. If the Assembly were to make recommendations on matters not included in its Terms of Reference,

the prospects of those recommendations being accepted are likely to be diminished, and could also have wider implications for the way in which the Assembly's report is received. It is the role of the Chair to adjudicate in the event that any questions arise as to what issues are within and outside the Terms of Reference.

- **Recommendations should be well-formulated**, with language that minimises ambiguity and makes the meaning and intent of the recommendation as clear as possible. This has particular relevance for deliberations on matters as complex and detailed as Ireland's legal framework and legal options in relation to drugs use.
- **The Assembly should avoid 'technical over-engineering' of recommendations**. For example, it is one thing for a Citizens' Assembly to recommend a change to legislation, or to propose a Constitutional Referendum, or to recommend a change to policy or strategy. It is another thing entirely for the Assembly to attempt to precisely specify the language or the mechanics of that proposed change. The drafting of legislation, for example, is an onerous, complex, time-consuming and highly technical task which is rightfully the responsibility of the Oireachtas, where legislators can avail of significant technical, policy and legal expertise from sources including the Office of the Parliamentary Legal Advisers (OPLA) and, in the case of Government-sponsored legislation, the Office of the Attorney General. The Citizens' Assembly has no such expertise or time at its disposal, nor does it have the mandate to do so. Similarly, decisions about the allocation of public funding require careful analysis and adherence to public expenditure guidelines, budgetary planning, procurement and contractual processes, and, of course, Oireachtas approval. So while the Assembly might wish to make a recommendation in relation to public funding, it should avoid over-engineering the solution, by, for example, specifying a precise quantum of funding to be allocated to a particular objective or initiative. As a rule of thumb, the Assembly is best advised to focus on specifying the desired 'direction of travel', rather than prescribing 'how to get there', which is a matter for the Oireachtas and Government to resolve. Again, this principle will come into play during the workshop on legal options.
- **No 'assumption of change'**. The Assembly should bear in mind that, just because it has been asked to consider what changes to legislation, policy and operations the

State *could* make, does not automatically imply that, one way or another, members are expected to recommend change. In other words, as well as considering various options for change, members should also consider the option of maintaining the status quo. This will be teased out further in the workshop.

- **Quality versus Quantity**. While it is solely a matter for Assembly members to collectively agree on the number and nature of questions that the Assembly wishes to vote on (and by implication the number of recommendations that will issue), careful consideration needs to be given to the issue of quality versus quantity. There is merit in considering the "less is sometimes more" argument, meaning fewer, higher quality, more strategic recommendations are preferable to a lengthier list of more detailed recommendations.

1.10 A population-based perspective on harmful impacts

The Terms of Reference ask the Assembly to consider the harmful impacts of illicit drugs use on *individuals, families, communities and wider society*.

Members have heard extensively from different sections of the population impacted in different ways by drugs use in Ireland. Across, and within, these groups, there is a range of harms associated with illicit drugs use, and different perceptions about the relative importance of these harms. The harms associated with drug use depend on the type of drugs involved and how they are used, by whom and in what settings. The many different ways in which these factors can interact result in a wide array of possible drug use scenarios, which are associated with health and social effects of varying severity.

At the opening of the workshop on Sunday 3rd September, the Assembly will hear from four different stakeholder voices, who are likely to again demonstrate the diverse perspectives about what are the important harms to focus on.

One potentially useful way to look at the complexity of legal issues in relation to drugs is to consider it from a population perspective. The harms that affect one cohort of the population can be very different from the harms experienced by another. For people who use drugs, the harms they experience can vary considerably depending on what type of drug, or drugs, are involved, the intensity of use, the person's socio-economic status, and underlying vulnerabilities including mental health issues, social capital deficits, and so on.

By extension, the harms they might experience will also vary depending on the extent to which they have engagement with the criminal justice system.

In fact, what is considered to be a harm varies widely across different cohorts of the population, depending, for example, on the level of personal or professional experience of drugs, and so on. Someone who has never engaged with the criminal justice or healthcare systems in relation to their drug use may have a very different life experience and understanding of harm than someone who has uses drugs problematically and has extensive experience of engaging with the health and justice systems. Likewise, someone who lives in a community that is disproportionately affected by high prevalence rates of drugs use and dependency, or drug-related intimidation and violence, will likely have a different perspective on harms than someone who is more insulated from exposure to these issues.

Developing an understanding of how different harms can affect different parts of the overall population can help to conceptually clarify the origins, and motives, of various arguments that are put forward in relation to potential legislative change.

1.11 What harms are under consideration?

The Assembly has heard numerous examples of how individuals, families, communities and wider society are negatively impacted by illicit drugs use. Differing perspectives have been offered about what constitutes harm, and which harms the Assembly should be most concerned about. While there appears to be broad consensus about physiological and psychological harms, there are other issues where there is considerable divergence. For example, some contributors focus on the harms caused by the State's response to drugs use, while others argue that the Assembly should focus more on the benefits people can derive from using illicit drugs. The following is a non-exhaustive list of just some of the examples of harms that the Citizens' Assembly has considered or heard about:

Table 4 Examples of harms that can be experienced people who use drugs

Addiction / Substance Use Disorder;
Acute adverse incidents (e.g. poisoning psychotic episodes, etc.);
Drug-induced deaths;
Drug-related deaths;
Drug-induced damage to physical health (e.g. cirrhosis, seizures, strokes, heart disease, stomach ulcers, etc.);
Drug-related damage to physical health (e.g. blood-borne viral transmission, emphysema, etc.);
Cognitive impairment and behavioural changes;
Stigmatisation and shame;
The personal, social and economic implications for an individual who incurs a criminal record, including for employment prospects and international travel;
Damage to family life and relationships;
Impacts on specific groups, such as children, women, people who are homeless, people living in poverty, people with a dual diagnosis, members of the Travelling and Roma communities, members of the LGBTQI community, students.

Table 5 Examples of harms that can be experienced family members of people who use drugs

The demands of supporting a family member with problematic drug use, including the challenges of engaging with services and authorities;
Damage to family relationships and family life;
Harms to children's welfare and emotional well-being;
The experience of drug-related intimidation and violence;
The financial and emotional burden of dealing with drug debt;
The physical, emotional and financial burden on family members caring for children of people with problematic drug use;

Table 6 Examples of community and wider societal implications of illicit drugs use

Drug-related intimidation and violence in communities;
Drug-related criminality and the impact of Organised Crime;
Economic burden (e.g. costs of funding health and criminal justice responses, lost productivity, impact on labour market participation, etc.);
Social and economic impact on other countries in the global supply chain

1.12 Visualisations of key statistics

The Assembly has previously heard details presented by the EMCDDA and HRB about prevalence of drugs use in Europe [🔗] and Ireland [🔗], and drug-induced and drug-related harms in Ireland [🔗]. The following graphics provide visual illustrations of key statistics, which some members may find useful.

Figure 1 Population prevalence (approximated from HRB prevalence data 2019 and CSO Census data 2016).

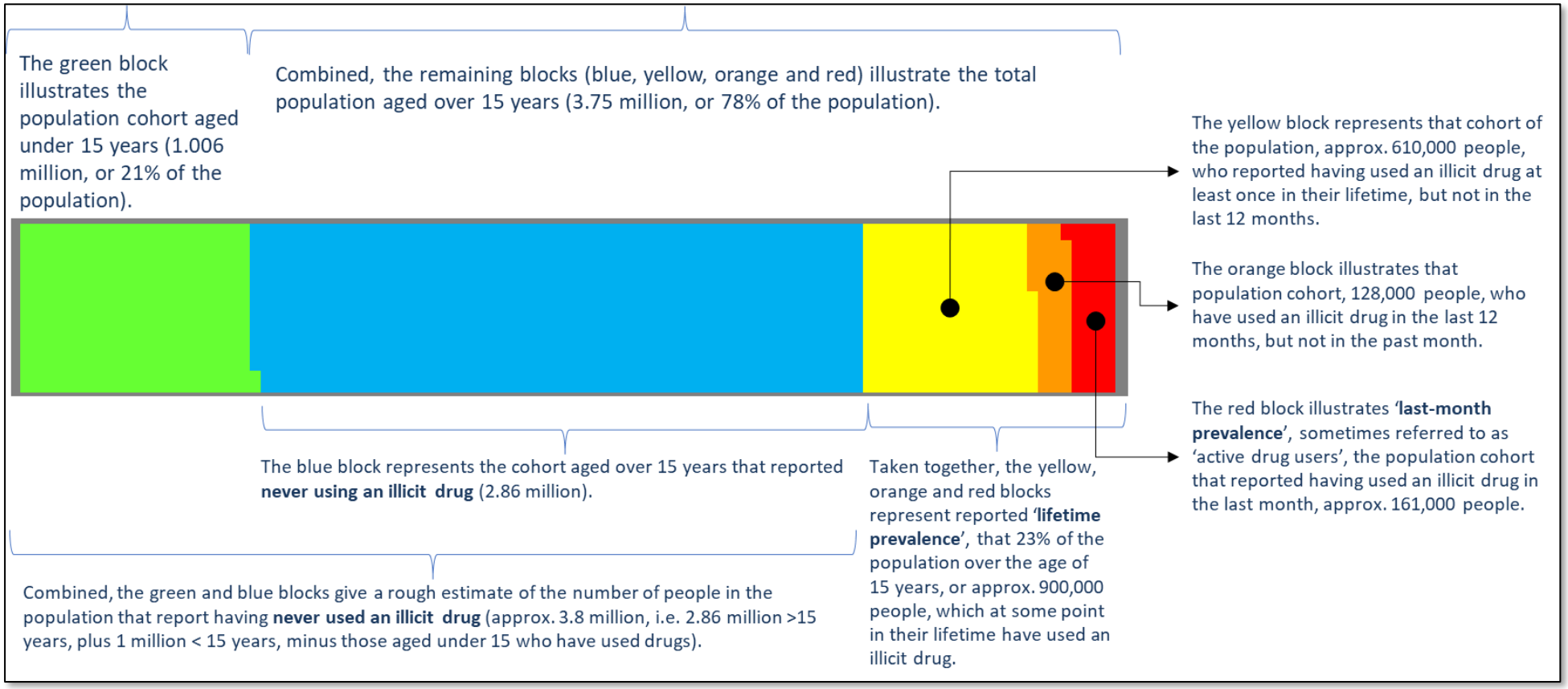
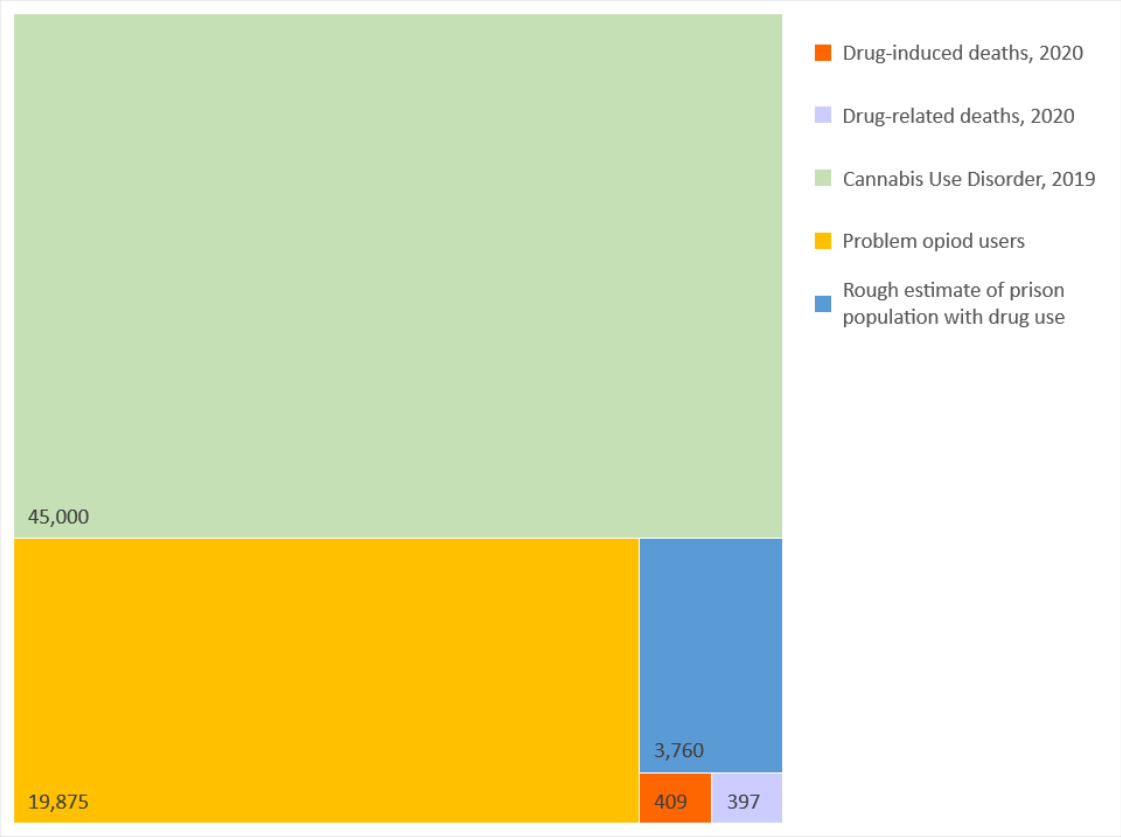


Figure 2 illustrates the scale of some of the diverse drug-related harms across different cohorts of the population. The graphic is for illustrative purposes only, and presents only a small number of harms and costs, based on latest available data.

Figure 2 Examples of harms



Arguably, across each of these cohorts the individuals directly affected, their families, and the services providers and professionals working to support them, will have different perspectives on what the focus and objectives of any potential legislative change should be, in order to achieve different objectives.

For example, someone who would characterise themselves as a recreational cannabis user might advocate primarily for the legalisation and regulation of cannabis to avoid criminalisation of those engaged in an activity without adverse consequences for them personally, to uphold the human rights of the individual and to facilitate access to safer, regulated cannabis products. Meanwhile, a medical professional working with patients presenting with Cannabis Use Disorder or acute psychiatric issues triggered by cannabis use might advocate primarily for a health-led response coupled with effective dissuasion measures to reduce the prevalence of cannabis use and decrease the incidence of Cannabis Use Disorder in the general population. Someone concerned primarily about reducing the level of drug-induced or drug-related deaths in the population might consider that the most immediate priority is to ensure adequate measures to reduce the harms suffered by that cohort of the population with problematic drugs use. As members of the Assembly deliberate on legislative change, it will be useful to identify your underlying motivations, objectives and policy priorities, as the basis for deliberating on possible legislative changes.

2 Workshop on legal frameworks and options

2.1 Instructions for Members

The core objectives of this workshop are:

1) To introduce members to some stakeholder viewpoints about legislation;
2) To familiarise members with some of the main legislation pertaining to drugs;
3) To help members consider the advantages and disadvantages of legislative changes, using a methodology that sets out different concepts of legislative approaches to drugs;
4) To generate feedback and insights that will inform the Secretariat as they begin the initial drafting of ballot questions on potential legislative change.

Remember, the workshop is not designed to bring members to the point of decision-making regarding what legislative changes might be recommended. It is simply to ensure that members have had exposure to a range of possible approaches to legislative change, that they have a method for evaluating these, and any other approaches they might want to consider, and to help the Secretariat and Assembly in designing ballot questions for later in the process.

2.2 Workshop Programme

The programme for Sunday morning's workshop is [provisionally] structured as follows:

Day 2: Sunday 03 September 2023

09:00 – 10:00	**Session 5 – Stakeholder Perspectives (livestreamed)**	
	09:00 – 09:07	Eddie D'Arcy, Youth Workers Against Prohibition
	09:07 – 09:14	Prof. Anne Doherty, College of Psychiatrists of Ireland
	09:14 – 09:21	Graham Temple, Crainn
	09:21 – 09:28	Prof. Bobby Smyth, Cannabis Risk Alliance
	09:28 – 09:38	Roundtable discussions
	09:38 – 10:00	Q&A

10:00 – 10:45	**Session 6 – Exploring Legal Frameworks (livestreamed)**	
	10.00 – 10:45	Brendan Hughes, EMCDDA; Prof. Tom O'Malley, Galway University; Dr. James Windle, UCC; Prof. Yvonne Daly, DCU; Prof. Andrew Percy, QUB; Prof. Deirdre Healy, UCD
10:45 – 11:00	**Coffee Break**	
11:00 - 13:00	**Session 7 – Workshop (livestreamed)**	
	11:00 - 11:35	Q&A
	11:35 – 12:45	Facilitated workshop
	12:45 – 13:00	Private deliberations

2.3 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, that 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.

2.4 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 Gardai 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. Gardai have no formal powers to divert to health or social services. A number of pilot diversion programmes (eg. LEAR) are in place, but do not have a clear legal underpinning. Gardai 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

2.5 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 Gardai 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 Gardai 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, Gardai 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.

2.6 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 Gardai 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 Gardai, 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 – eg. fines, community service), or have the procedure struck out if appropriate. Gardai 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 Gardai into health-led services.
Availability of diversion options and alternatives to coercive sanction: Strong. Gardai 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);

2.7 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 Gardai, 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 Gardai.
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;

2.8 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;

3 Private Deliberation Exercise

This exercise will take place on Sunday. Members are *not* expected to fill in these worksheets before Sunday

3.1 Private deliberations on Model A: 'The Status Quo'

1. What kind of effect does Model A have, in your view, on each of the following?

Please tick one box in each row	Positive effect	Negative effect	No clear effect (neutral)	Don't know
People who use drugs generally				
People who use drugs problematically				
People found in possession of drugs for personal use				
People serving custodial sentences in prison				
Families				
Communities				
Wider society				
Police service				
The Courts				
Probation service				
Prison system				
Community and Voluntary Sector				
HSE				
The Taxpayer				

2. How effective do you think Model A is in terms of:

	Very Effective	Quite Effective	Neutral	Quite ineffective	Very ineffective	Don't know
Prevention and dissuasion (i.e. reducing the extent of drug use in Ireland)						
Reducing drug-related harms (e.g. overdoses, poisonings)						
Improving treatment and recovery						
Protecting the human rights of people who use drugs						
Reducing drug-related violent crime						
Reducing supply and availability of drugs						
Reducing stigmatisation of people who use drugs						

3. In your own words, please identify the main benefits of Model A:

4. In your own words, please identify the main disadvantages of Model A:

5. What could be done within the existing legal framework to improve Model A?

6. What things cannot be done within the existing legal framework to improve Model A?

3.2 Private Deliberation on Model B: 'Dissuasion with Limited Health Diversion'

1. What kind of effect does Model B have, in your view, on each of the following?

Please tick one box in each row	Positive effect	Negative effect	No clear effect (neutral)	Don't know
People who use drugs generally				
People who use drugs problematically				
People found in possession of drugs for personal use				
People serving custodial sentences in prison				
Families				
Communities				
Wider society				
Police service				
The Courts				
Probation service				
Prison system				
Community and Voluntary Sector				
HSE				
The Taxpayer				

2. How effective do you think Model B is in terms of:

	Very Effective	Quite Effective	Neutral	Quite ineffective	Very ineffective	Don't know
Prevention and dissuasion (i.e. reducing the extent of drug use in Ireland)						
Reducing drug-related harms (e.g. overdoses, poisonings)						
Improving treatment and recovery						
Protecting the human rights of people who use drugs						
Reducing drug-related violent crime						
Reducing supply and availability of drugs						
Reducing stigmatisation of people who use drugs						

3. In your own words, please identify the main benefits of Model B:

4. In your own words, please identify the main disadvantages of Model B:

3.3 Private Deliberation on Model C: 'Dissuasion with Comprehensive Health Diversion'

1. What kind of effect does Model C have, in your view, on each of the following?

Please tick one box in each row	Positive effect	Negative effect	No clear effect (neutral)	Don't know
People who use drugs generally				
People who use drugs problematically				
People found in possession of drugs for personal use				
People serving custodial sentences in prison				
Families				
Communities				
Wider society				
Police service				
The Courts				
Probation service				
Prison system				
Community and Voluntary Sector				
HSE				
The Taxpayer				

2. How effective do you think Model C is in terms of:

	Very Effective	Quite Effective	Neutral	Quite ineffective	Very ineffective	Don't know
Prevention and dissuasion (i.e. reducing the extent of drug use in Ireland)						
Reducing drug-related harms (e.g. overdoses, poisonings)						
Improving treatment and recovery						
Protecting the human rights of people who use drugs						
Reducing drug-related violent crime						
Reducing supply and availability of drugs						
Reducing stigmatisation of people who use drugs						

3. In your own words, please identify the main benefits of Model C:

4. In your own words, please identify the main disadvantages of Model C:

3.4 Private Deliberation on Model D: 'Decriminalisation with Depenalisation for personal consumption'

1. What kind of effect does Model D have, in your view, on each of the following?

Please tick one box in each row	Positive effect	Negative effect	No clear effect (neutral)	Don't know
People who use drugs generally				
People who use drugs problematically				
People found in possession of drugs for personal use				
People serving custodial sentences in prison				
Families				
Communities				
Wider society				
Police service				
The Courts				
Probation service				
Prison system				
Community and Voluntary Sector				
HSE				
The Taxpayer				

2. How effective do you think Model D is in terms of:

	Very Effective	Quite Effective	Neutral	Quite ineffective	Very ineffective	Don't know
Prevention and dissuasion (i.e. reducing the extent of drug use in Ireland)						
Reducing drug-related harms (e.g. overdoses, poisonings)						
Improving treatment and recovery						
Protecting the human rights of people who use drugs						
Reducing drug-related violent crime						
Reducing supply and availability of drugs						
Reducing stigmatisation of people who use drugs						

3. In your own words, please identify the main benefits of Model D:

4. In your own words, please identify the main disadvantages of Model D:

3.5 Private Deliberation on Model E: 'Legalisation with Regulation'

1. What kind of effect does Model E have, in your view, on each of the following?

Please tick one box in each row	Positive effect	Negative effect	No clear effect (neutral)	Don't know
People who use drugs generally				
People who use drugs problematically				
People found in possession of drugs for personal use				
People serving custodial sentences in prison				
Families				
Communities				
Wider society				
Police service				
The Courts				
Probation service				
Prison system				
Community and Voluntary Sector				
HSE				
The Taxpayer				

2. How effective do you think Model E is in terms of:

	Very Effective	Quite Effective	Neutral	Quite ineffective	Very ineffective	Don't know
Prevention and dissuasion (i.e. reducing the extent of drug use in Ireland)						
Reducing drug-related harms (e.g. overdoses, poisonings)						
Improving treatment and recovery						
Protecting the human rights of people who use drugs						
Reducing drug-related violent crime						
Reducing supply and availability of drugs						
Reducing stigmatisation of people who use drugs						

3. In your own words, please identify the main benefits of Model E:

4. In your own words, please identify the main disadvantages of Model E:

3.6 'Pick and Mix' exercise

Remember, you are not limited to the five models set out in this document. If you could choose to combine the best elements of each of the models A-E, which would be your baseline model (starting point), and what elements of other models would you incorporate, if any?

3.7 Additional comments

Are there any important areas of legislation in relation to drugs policy that you believe have not been adequately addressed during the meeting?

4 References

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