DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 30 Samhain 2016

Wednesday, 30 November 2016

The Joint Committee met at 1.30 p.m.

MEMBERS PRESENT:

Deputy Pat Buckley,+	Senator Colm Burke,
Deputy Bernard J. Durkan,	Senator Lynn Ruane.*
Deputy Billy Kelleher,	
Deputy Margaret Murphy O'Mahony,	
Deputy Jonathan O'Brien,*	
Deputy Kate O'Connell,	

* In the absence of Deputy Louise O'Reilly and Senator John Dolan, respectively.

+ In the absence of Deputy Jonathan O'Brien, for part of meeting.

In attendance: Deputy Jack Chambers and Senator Aodhán Ó Ríordáin. .

DEPUTY MICHAEL HARTY IN THE CHAIR.

The joint committee met in private session until 1.59 p.m.

General Scheme of Misuse of Drugs (Supervised Injecting Facilities) Bill 2016: Discussion

Chairman: I thank Mr. Tony Duffin, Mr. Mark Kennedy and Professor Gerard Bury for coming before the joint committee to give evidence. I also welcome those in the Visitors Gallery and those watching on the live stream. The purpose of the meeting is to engage in pre-legislative scrutiny of the general scheme of the misuse of drugs (supervised injecting facilities) Bill 2016. There will be two sessions. Following this session we will meet representatives of An Garda Síochána and the Department of Health.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Any submissions or opening statements that they have submitted to the committee may be published on the committee website after this meeting. Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against any person outside the House or any official either by name or in such a way as to make him or her identifiable.

I call on the witnesses to give their opening statement. I am unsure who is going first. Is it Mr. Duffin?

Mr. Tony Duffin: I thank the committee for the opportunity to make a presentation to it. I am the director of the Ana Liffey Drug Project. Established in 1982, the Ana Liffey Drug Project works directly with people who use drugs, many of whom are injecting drug users. We currently have centres in Dublin, the mid-west and the midlands and we work with over 2,500 people annually. There are at least 3,000 injecting drug users in Dublin with approximately 400 openly injecting in the city each month. We believe this number could be far higher, but due to the furtive nature of public injecting it is difficult to give a more precise figure. People who inject drugs in the public domain do not want to do it; they find the act degrading and shameful. However, there is currently nowhere for them to go to inject where they can be safe or supported to make healthier choices.

Since January 2012, one of the strategic objectives of the Ana Liffey Drug Project has been to secure stakeholder support for the provision of supervised injecting facilities. Many organisations have stated their support for same, including the Better City For All group, the CityWide Drugs Crisis Campaign, the National Family Support Network, Safetynet Ireland, the Dublin Region Homeless Executive and many more organisations and institutions.

We understand that concerns exist about an intervention that seems counter-intuitive to some people. To those of us working to help our most vulnerable people with complex and multiple needs who inject drugs in the public domain, however, the provision of supervised injecting facilities is an important step in the right direction. For our part, the argument for

supervised injecting facilities is not in question – they are an empathetic and effective response to the issue of public injecting. It is obvious to us that, as with our current services, supervised injecting facilities must work within the existing health system by offering referral pathways and working in partnership with An Garda Síochána. This view is reflected in international research on the delivery of supervised injecting facilities. With this understanding, and based on the latest available evidence, we expect that supervised injecting facilities will achieve the following outcomes: they will attract the target group; they will reduce health risks; they will address public order and safety concerns; and they will not increase drug-related crime or local drug use. More importantly, they will save lives. No one has ever died from an overdose in any of the 90-plus drug consumption rooms throughout the world.

I wish to express some words of thanks on the record. Ana Liffey Drug Project has worked closely with the voluntary assistance scheme of the Bar Council of Ireland to produce an initial draft of the legislation that the committee is considering. I wish to note our thanks to the Bar Council for its support in this regard. I also wish to express thanks to the previous Government. In particular, I thank the former Minister of State, Senator Aodhán Ó Ríordáin, for championing this important issue, and the former Minister for Health, Deputy Varadkar, for bringing the issue to Cabinet in December 2015. I thank the current Government and, in particular, the Minister of State, Deputy Catherine Byrne, for continuing to prioritise supervised injecting and ensuring that funds have been allocated for this purpose for 2017. I wish to thank the other senior politicians with whom I have spoken on this matter. All have been open, engaged and alive to the fact that supervised injecting facilities are important evidence-based health interventions that will make a real difference to the health of drug users and to the amenity of the areas in which they are situated.

Moreover, I wish to thank the statutory agencies with which we work closely. These include the HSE, Dublin City Council and An Garda Síochána. An extraordinary amount of genuine inter-agency work takes place in Dublin city centre and this should be recognised. The introduction of a safer injecting facility is not without its challenges, especially from a policing perspective, but all the challenges have been met elsewhere. In Ireland, we are fortunate to have some of the most skilled, pragmatic and empathetic officers anywhere and I believe they will meet these challenges admirably.

It is a pleasure to be before the committee today. The Ana Liffey Drug Project has worked hard on this issue. It is fantastic that we no longer talk about whether an injecting facility is needed in Dublin. The conversation has moved to how it should be done. Essentially, it is a question of the issues these Houses need to consider in dealing with this legislation.

I will outline our advice to the Houses. The Houses should learn generally from the legislative experience of other jurisdictions and avoid pitfalls. The Houses should keep the legislation focused on the primary task of creating a legal framework within which injecting facilities can operate successfully. I appeal to the Houses not to make the mistake of legislating on operational matters. Adequate controls on the conditions that need to be met to operate a supervised injecting facility can be dealt with through a licensing process. This framework has the advantage that the conditions of a licence can be varied to respond to local or emerging needs.

In summary, there is considerable support for supervised injecting facilities. There has been and continues to be brave leadership across the political spectrum. Our hope is that this legislation will be sufficiently flexible to do what it is intended to do, that is to say, to create a framework under which supervised injecting facilities can be established. We urge all present to resist making it more complex than it needs to be. Experience elsewhere tells us that such an

approach creates unnecessary barriers to accessing support and further isolates the people we are trying to help.

Mr. Mark Kennedy: I am the head of day services at Merchants Quay Ireland. We have been providing low-threshold accessible services to drug users in the country since 1989. We provide supports to those who are chaotic drug users on the streets and many others all the way through to those who are in need of rehabilitation, detoxification and drug-free aftercare and employment.

The services at Merchants Quay Ireland provide a range of supports, including assistance with food, medical issues, drug treatment, accommodation, psychiatric, justice and welfare issues. In 2015 Merchants Quay Ireland provided services to approximately 7,500 individuals, up to 3,000 of whom were injecting drug users. A significant proportion of the intravenous drug users accessing our needle exchanges are homeless street injectors. Sadly, Merchants Quay Ireland has been operating on the front line in respect of over 5,000 drug deaths in Ireland in the past ten years. Ireland has one of the highest drug mortality rates in the EU.

Merchants Quay Ireland is keen to highlight several points in consideration of the misuse of drugs (supervised injecting facilities) Bill 2016. The central theme of the national drugs rehabilitation implementation committee case management protocols is the importance of a continuum of care from harm reduction through to recovery. While there is consensus that more resources are needed in areas such as methadone maintenance and residential recovery, the medically supervised injecting centre represents an evidence-based element of the continuum of care that does not currently exist in Ireland.

The latest research from the Centre for Global Health at Trinity College highlights the importance of understanding the needs of all stakeholders in an injecting centre, including drug users, the community, treatment services and justice. To this end, the proposed legislation represents an opportunity to address the limitations of Irish drug service provision. For example, to operate in line with the current Misuse of Drugs Act, services such as Merchants Quay Ireland have to exclude people based on the fact that they have sought a safe place within our services to inject drugs. These are precisely the people who most need our support. As a result, the only option available to such people is to inject in alleyways on the streets of Dublin, where the likelihood of overdose and death is far higher. Homeless and drug services such as the Ana Liffey Drug Project, the Simon Community and Merchant's Quay Ireland operate in line with the quality in alcohol and drug services organisational standards, which are currently being aligned to the national standards for safer and better health care. Such services have strong working relationships with hospitals, community GPs, gardaí, community groups and drug treatment providers. These relationships are critical to the operation of pilot injecting centre sites.

When injecting centres are being provided, it is important to learn from the evidence and experience of the earliest injecting centres in cities such as Sydney and Vancouver. We should also take account of the latest evidence from the European Monitoring Centre for Drugs and Drug Addiction on how injecting centres are evolving to include not just injecting facilities but also a full range of immediately accessible practical on-site supports to address the complexity of needs associated with street injectors, including medical, accommodation and psychological needs and basic needs such as food and clothing. The legislation should, therefore, support the development of existing specialised service provision to injecting drug users. It should maximise the ability of the existing network of services, which are highly skilled in working with injecting drug users across the county, to reduce harms, develop working relationships and provide treatment options on the basis of need. Many Irish homeless services in large urban

areas that are working with street-based injecting drug users now provide needle exchange and nursing supports. If the pilot sites are located within these services, this will empower such services to intervene and save lives. Such an approach would also engage synergies with existing services, thereby eliminating the need to reinvent the wheel and, in so doing, ensure cost-effectiveness.

The most recent evidence on implementing injecting centres indicates efficacy in reaching injecting drug users and in reducing health risks, public injecting, mortality and injecting harms. Injecting centres are most effective when they are integrated into a wider public policy framework as part of a network of services; when they are based on consensus, support and active co-operation among local key actors; and when they are seen as highly targeted services that aim to reduce problems of health and social harm involving high-risk drug use populations and to address needs that other responses have failed to meet. It is important to admit that, realistically, injecting centres in isolation are not going to eliminate drug deaths, street injecting and the spread of blood-borne viruses. An injecting centre would form part of a solution by operating at the harm-reduction end of the continuum of care. It is critical for the legislation to take advantage of the evidence-based operational and budgetary synergies that may be gained from locating injecting centre pilot sites inside existing services in urban areas with a high prevalence of injecting drug use. This should not be limited to Dublin. The ability to operate the licensed injecting centre model represents a natural addition to existing low-threshold harm-reduction services. In line with the case management protocols of the national drugs rehabilitation implementation committee, the injecting centres can operate as part of an inter-agency multidisciplinary response to high-risk drug use, with that response being provided in a caring ethos as part of a care plan which the client plays an active role in developing.

Chairman: I ask Professor Gerry Bury to make his opening statement.

Professor Gerard Bury: I thank the Chairman and the members of the joint committee for the opportunity to speak this afternoon. I am a GP and I work in the Dolphin's Barn area of Dublin. As I have been working in the south inner city since 1984, I have some experience of the conditions that have led to the serious drug problems that have been experienced in that area over the past three decades. I am also a professor of general practice at the UCD School of Medicine. One of my functions in that role is as director of the centre for emergency medical science, which is responsible for training paramedics, advanced paramedics and GPs in the care of pre-hospital emergencies. The centre is the only body in the State that is recognised as a trainer of advanced paramedics for all the statutory emergency medical services.

It is also worth mentioning that along with other doctors in my unit, I work as a volunteer to support the emergency medical services in the greater Dublin area. Approximately 100 GPs throughout the country provide similar services on a voluntary basis in extreme emergencies. My experience is of providing that service largely in the north inner city. Over the last year and a half or so, I have been providing care in cases of cardiac arrest. The three backgrounds I have mentioned give me some basis on which to comment on what is proposed.

Perhaps I will repeat the context for this proposal. Approximately 10,000 people in this country currently receive treatment for opiate dependence from the State on an annual basis. Opiate substitution therapy, using methadone, was formalised in 1998 and is delivered by drug treatment centres and accredited GPs throughout the country. However, injecting drug use, chaotic lifestyles, overdoses and drug-related deaths remain common and continue to devastate families in Dublin and elsewhere. I welcome the committee's interest in this matter because it highlights a health problem for Irish society which sometimes attracts little interest or urgency.

The first issue I want to highlight is the legislative proposal to provide for supervised injecting facilities. My colleagues have spoken very well about the mounting evidence that injecting rooms are an effective harm-reduction measure for certain groups of injecting drug users. The proposed initiative should certainly be supported in so far as it assists those with chaotic or uncontrolled drug use. While I am very happy that the Misuse of Drugs (Supervised Injecting Facilities) Bill 2016 is to be supported wholeheartedly by this committee and by those who want to see lives saved and improved, I am concerned that it may have a more limited effect on some of the more strategic issues relating to our drug treatment services. I will refer briefly to some of those issues.

Opiate substitution therapy has grown to the point where it has almost become an end in itself within our health services. Few services or incentives exist to help doctors, therapists or patients to reduce and stop methadone use, or to be of assistance in the recovery phase thereafter. I have no wish to undermine the key and absolutely essential role played by opiate substitution therapy. I was involved in the initiation of opiate substitution therapy and the introduction of methadone in the mid-1990s. It has saved countless lives and improved others. I emphasise that opiate substitution therapy should not be a *de facto* life sentence. It seems that research and service development to achieve the goal of offering discontinuation to those who are in a position to take up that offer should be explored and prioritised within the research and development plan of our drug treatment services.

Opiate overdose and access to naloxone is a further issue. Naloxone is a rescue drug which can reverse the respiratory depression caused by opiates. It must be given within minutes of the overdose. In Ireland, more people die from opiate overdose each year than are killed in road accidents. Some 387 poisoning deaths occurred in 2013, of which 203 involved opiates and 93 involved methadone. Access to naloxone is inappropriately restricted in Ireland. Urgent action is needed to allow GMS access to the drug for prescription to patients. A second possibility is co-prescription with methadone or other opiates. A third is the prescription of the drug to the family or friends of those who are on methadone. We have had some legislative change in recent months to allow rescue drugs to be introduced but the limitations on those rescue drugs, in particular naloxone, are inappropriate and inhibit its effect.

On the investigation of opiate overdose deaths, any patient who receives opiate substitution therapy and dies from an overdose has died in the care of the State's mental health services. Each of those deaths should be regarded as a serious adverse event and investigated in precisely the same manner as, for example, a suicide which occurs in a patient attending HSE psychiatry services. That does not currently occur.

The purpose is, of course, not in any way to create a culture of discipline, blame or attribution. However, in each of these awful events there is learning and the possibility for improvements in carers and services. The opportunity to have a root cause analysis of those events and explore the learning that is possible within them is something we, as a caring community, would benefit from.

I want to take this opportunity to thank those who care for those who are in difficulty because they are dependent on drugs. The NGOs like those represented by my colleagues have done an outstanding job and continue to do so. It is extraordinary to see the circumstances in which they work and the care and quality of that care.

I also thank my colleagues in the emergency medical services. Their work is also extraordinary, and is often without thanks. I thank my colleagues within mental health services and

general practice who work within drug treatment systems. They also have long, arduous and tough jobs. They deserve to be acknowledged for the work they do. I again thank the Chairman for the opportunity to put some points to the committee.

Chairman: I thank Professor Bury. We will now allow Deputies and Senators to ask questions of our witnesses.

Deputy Jonathan O'Brien: I have to leave in about seven or eight minutes as I have a Topical Issue matter in the Dáil, but my colleague will step in until I return.

An Oireachtas committee is finally dealing with this issue, which is long overdue. I also want to put on the record the Trojan work done by Senator Ó Ríordáin when he was a Minister of State. Without his perseverance, we would not be dealing with this issue today.

While I welcome the fact we are finally discussing this issue, I have issues with some of the heads proposed by the Department. I stand to be corrected, but I understand that this is the only document we have on the heads of the Bill. It is the only one with which I have been provided. It contains 12 heads, some of which are two sentences long. It is not a very detailed proposal.

Even with the lack of detail, I have some issues with the document on which I hope the witnesses could comment. I refer to the effectiveness of any legislation that we will introduce to establish medically supervised injecting centres, even on a pilot project basis. The fact that we are considering a pilot project is all the more important because the roll-out of future injecting centres will rely on the success or failure of the pilot project. We need to get this right from the outset.

Head 1 refers to interpretations and definitions. It states that: "authorised users will be required to provide for those individuals who will be exempted from the offence of possession of a controlled drug on a premises licensed under this Bill and the supervised injection facilities", and I have an objection to that. I do not think we should have registration lists of authorised users.

In many cases drug users lead very chaotic lives. To have a system whereby people would be required to register in advance in order to access a facility defeats the whole purpose of the facility. It is supposed to be a harm reduction measure. We need to have as few obstacles as possible when drug users want to access services.

I feel very strongly about this. I have studied how other regimes operate. In other countries which have registered lists, they have been used to prevent people from obtaining driving licences and, in some cases, to discriminate against people who are described as active drug users. I also have issues around data protection. I could be a recovering addict who was addicted to heroin and have a relapse in the morning, but if I needed to register before I could go to a medically supervised injection centre that defeats the purpose from a harm reduction point of view.

Can Professor Bury comment on that, given that drug users lead very chaotic lives? In many cases, there are literacy issues. By Professor Bury's admission, many of those who are openly injecting on the streets have a background of homelessness. I do not how know how the first head of the Bill will work in practice. I also have issues around the application for a licence, but they are minor and we can overcome them as we make progress.

I have another major issue around head 10 of the Bill. It provides that a member of An

Garda Síochána can enter a supervised injection facility without a warrant for the prevention or detection of offences. I have no issue with a garda being able to enter a facility if a crime is underway - if a serious assault is taking place within a unit a garda has to come in and enforce the law. However, it would defeat the purpose of having a safe place for people to go and inject if a person coming in the door behind them was a member of An Garda Síochána. I do not see the point in that. We are either moving towards a harm reduction model and away from the criminal justice system; there is no in-between.

I do not think there is any need for a garda to have access to these facilities unless a crime is being committed on the premises. The head is very specific when it states that a garda can enter a supervised injecting facility without a warrant for the prevention or the detection of offences. If a garda is entering a premises to detect offences, that is completely counter-productive to what we are trying to propose. The head needs to be tightened up.

I have concerns that we are only considering a pilot project, but that is the current situation and we cannot do anything about it. However, if we are considering the introduction of a pilot project we need to get it right. I still believe that there is an element within An Garda Síochána - I will put this point to it later - and the Department that is not convinced of this project. On the one hand, they are saying we need to examine the models but, judging by the brief heads of the Bill we have, they will try to make it almost impossible for the project to succeed.

Head 9 provides that an offence of possession of a controlled drug would not apply to an authorised user, provided he or she is lawfully on the premises of an injecting facility during its normal opening hours and with the permission of the licence holder or his or her agents. Therefore, technically, under the law, if a person is 10 ft. away and on their way to one of these facilities, they are breaking the law if in possession of a controlled substance. For me, this goes to the very heart of the issue. We are trying to bring in medically supervised injecting centres in the absence of a debate on decriminalisation for personal use. I believe this will be a very difficult task. I know people will argue that they are two separate issues, and they can have that opinion. In my view, however, if the Bill is only saying it is lawful to be in possession of a controlled drug on these premises, it means that as soon as a person steps outside, or if he or she is on his or her way to one of these facilities, once he or she is stopped and searched by a garda, even if it is an authorised user as described in head 1, he or she would be breaking the law, even though he or she was going to a facility which could potentially save his or her life if he or she overdoses.

We cannot have it both ways. We cannot move to a model of harm reduction while still trying to have this criminal sanction element. It is either one or the other. That is why I feel so passionately about heads 1, 9 and 10 of the Bill. If we do not get this right, it will fail, and the only people who will suffer if it fails are the drug users themselves, not us, as politicians, or members of the Garda. Drug users in Cork will never even get the opportunity to have a medically supervised injecting centre if this one does not get off the ground and does not operate correctly.

I am sure the gardaí will say it is not their intention to be harassing anyone on their way to an injecting centre and that if they do stop and search people, common sense will be applied. That does not wash with me. The law is the law in the eyes of many people and common sense does not come into it. If common sense did come into it, we would have a policy of decriminalisation across the board for personal use, although that is just my opinion. If it was my decision, we would not even be looking at medically-supervised injecting centres and we would be moving to the model every other country is now moving to, namely, that of drug consumption

rooms. We should not be confining it to medically-supervised injecting centres. We need to move to a model of drug consumption rooms. Even the briefing documents that we got from the Department of Health talk about drug consumption rooms.

I will finish for now. I am particularly interested in hearing the witnesses' comments on heads 1, 9 and 10.

Senator Lynn Ruane: I agree with most of what Deputy O'Brien said, apart from the authorised user piece. Although I agree with the whole point around data and anonymity, I think the continuum of care which Professor Bury spoke about is very important. While we do not want to always track people through the service, in order to provide that step-by-step care they might need, if they choose to move on through other services-----

Deputy Jonathan O'Brien: To clarify, I have no issue with those registers being put in place because that concerns after-care. I am talking about being on a register before the person can even access the facility, which is where I have a concern.

Senator Lynn Ruane: I imagine it would be for any sort of holistic needs assessment or safety-net service. Hopefully, it is people who are equipped and well used to working within the hostel services who would staff these facilities, such as anyone training under those like Dr. Austin O'Carroll and Dr. Fiona O'Reilly. The assessment when people first access the service should not rely on their being registered in order to use it. There should be a process whereby a user of the service is registered somehow with that service in order to provide that continuum of care.

I am not sure whether the term "authorised user" implies that people need to somehow authorise that they are going to use the service at a specific time or whether they just become regular users of the facility. While "authorised user" might be a strange term to use, a person should somehow be registered with the facility. It would also come into play if somebody was arrested on his or her way to use the facility. The fact he or she is a registered user of an injecting room could come into play in that there would be a way to find out if he or she is a registered user of the facility so he or she would not be arrested.

I have several concerns that I wanted to flag. Do the witnesses believe there is potential for needle exchanges around Dublin to be impacted in any way? I know the struggle of the harm reduction workers in the community sector to keep a constant flow of needles into the suburbs of Dublin city for people who are using in places like Tallaght and the canal communities. It is very difficult to keep that ongoing supply coming from the HSE. Do the witnesses foresee any form of backlash in the sense that people will be encouraged to use the facility whereas the supply of needles to harm reduction workers outside Dublin city will be minimised? Will this have any impact on people who do not want to come into the city centre to use, but still want to use within their own communities?

I have a question in regard to Professor Bury's point on overdose deaths, although it is slightly off the topic. Have the witnesses heard of the new naloxone spray product which will come on stream in 2017? What are their thoughts on that being accessible within all services, particularly the injecting rooms, and whether it will be taken up by Ireland? I do not know about the costs involved.

Do many women access needle exchanges? Accessing services can be difficult for women in the first instance, especially if they are mothers. In light of the fears around that, I am curious

to know if they do.

Professor Bury might be able to explain the position regarding the GMS contract. This is something I am pursuing in respect of methadone and the attempt to move all stable methadone users out of the clinics, out of Trinity Court, and into their doctors' surgeries. However, we need it to be written into the GMS contract that their own GPs cannot refuse to prescribe methadone, just as they would not refuse to prescribe diabetic medication, so we can free up some of the services within the city centre and make them better equipped to deal with the more chaotic users.

Deputy Jack Chambers: I welcome the witnesses. I have engaged very actively with Tony Duffin and Mark Kennedy in recent months, both of whom I have met with my team. I thank them for talking me through this but also for giving me a live experience of the services they provide and that interface with the people who use their services. I am also conscious of the broader societal picture around their service provision and all of the drug litter and paraphernalia. This is part of providing a future opportunity to users, who need the same care, intervention and multifaceted package of measures in their own lives. However, it is important they get that care.

Within my party, I have tried to change our position or to develop a position on this as part of our submission on the national drugs strategy. We support the legislation. It is important to give people an opportunity and to have evidence-based harm reduction moves towards treatment, rehabilitation and recovery. That cannot be done if we allow all the different drug users to operate very visibly on our streets, without getting the proper and substantive care they deserve, like everyone else.

Many of my questions have been touched on by Deputy O'Brien and Senator Ruane. I agree with Professor Bury that the number of people on methadone is quite high. That number has remained stagnant. What was a welcome and progressive measure at the time has become an end in itself. When one talks to people who are in recovery, one of their criticisms is that the transitional piece is minimal or non-existent for many users. They have the cycle of dependence, where we are not providing a future, and it becomes a permanent harm reduction piece for people who want to recover. With regard to Senator Ruane's comments, what can we do to build the transitional piece, to incentivise GPs to take the extra step and to encourage the other care providers to move from the harm reduction model to treatment, intervention and recovery? The number of GPs who are willing to provide the service is an issue. There are counties in Ireland where GPs are wholeheartedly refusing to prescribe methadone or to treat users, which, I believe, breaches the practitioners' entry requirement into the medical profession; namely, that it does not matter who comes through the door, it is important to care for and to treat everybody in the community.

I want to ask about Suboxone. I have been trying to pursue this with the Minister. We got a vague commitment on its use being legislated for, potentially in future legislative measures. We all know that is not an immediate response. I know that Tony O'Brien has corresponded with Senator Ó Ríordáin about this. I echo the comments made by other members in respect of Senator Ó Ríordáin. As Minister of State, he achieved a lot towards changing the discussion on the subject and that has helped this committee and the Oireachtas to try to address the measures positively. What are Professor Bury's views on Suboxone and what does he consider to be the legislative delay on its use? It is important - and all the witnesses have referred to it - that this is one part of the jigsaw. It will, however, become an end in itself if we do not talk about everything else relating to drug treatment and intervention. From what I have seen in this Parliament

in the past couple of months, the problem with politics is that sometimes it requires a blinkered focus in order to get something of this nature over the line. However, we also need to broaden the discussion on the other important care mechanisms and packages. This is in order to give people who are vulnerable and who have experienced significant difficulties in their lives a chance. While that includes our streets and communities, it also includes prisons. Hopefully we can engage with penal reform more actively in this Dáil or in future Dáileanna. I thank the witnesses for being here and I look forward to working with them all.

Mr. Tony Duffin: A number of points have been raised. Deputy O'Brien made reference to the pilot, which is to be welcomed. I understand that one pilot site will be established initially. In Dublin, we have a river that divides the people moving through the city. Our clients are no different. Ideally, we would have two pilot sites in Dublin, one to the north of the river and the other to the south. It would be remiss of me not to mention that colleagues and the local drugs task force in Cork have taken a position and have identified that they want to establish a pilot site there. So, it is not solely a Dublin issue. There are other areas where public injecting is deemed to be problematic for the local communities.

Members spoke about registering people and authorised users. We need to talk about this and work out what exactly we mean. I was fortunate enough to have worked in the Sydney medically-supervised injection centre in March 2015. While it is important to gather data so that we understand what is going on with the people who attend, it is a confidential service. In Sydney the process is managed whereby people give a name. It might not be their name, but they give a name and they give a password which they must remember. The centre then knows it is the same person coming back each time and knows the history of the person. However, we may not identify truly who that individual is. That appears to be a very pragmatic way to address the issue. If the person walks in to the centre and cannot match the name they give to the password then they must re-register and go through the process again. That is one example. There are other examples of centres where people do not register at all and where access is open. Other places may have a stricter registration process. It makes sense to me, however, that the pilot would emulate the Sydney experience.

With regard to Garda entry into a service, I know that the police in New South Wales can access the Sydney centre. The policing plan for that area says that the police will make contact ahead of coming in, which is more of a courtesy. I understand that the legislation provides for the police to access the centres as and when they like and they can walk straight in without any difficulty. In actual operations, one is working closely with a team of police officers who understand the nuance of what we would be trying to achieve and so they do not just storm in and walk around. They make contact before coming in. If, however, a police officer is in pursuit of a person for a crime, then of course they will come in and arrest that individual.

I will now talk about the issues of areas that surround a supervised injection facility or drug consumption room. Prohibition exists in New South Wales so I was able to see, at first hand, that people who were walking to the medically-supervised injection centre in Sydney were not stopped at all by police. I also saw people who were drawing attention to themselves perhaps by anti-social behaviour or by suspicious behaviour such as dealing. I saw police officers stopping them, arresting them and processing them as they would normally. There were no zones around the centre where the prohibition does not apply. It was not an offence to be in possession of drugs only within the designated premises. That is my experience and while it does not always make sense to people, I saw that it worked in action and it was manageable. I was fortunate enough to go to a local community policing meeting with the area commander who

used language like "our" medically-supervised injecting centre. The sense of ownership was quite obvious.

The gardaí on the ground and the people at the Ana Liffey Drugs Project, Merchant's Quay Ireland and the various other services are very pragmatic. We work together and we will find our way in managing the situation, notwithstanding obviously that legislation will be put in place.

I do not see how the needle exchanges would be impacted upon particularly. I do not envisage people travelling. The evidence is that people do not travel far to get to supervised injecting facilities. We have a very serious problem in Dublin city centre where public injecting occurs. Supervised centres would address that issue. We do not envisage people travelling from other areas. Once the pilot is over - all being well and the evidence being that it has worked - then people in other areas would be able to apply for licences which, if awarded, would enable them to establish the services themselves. I will leave the issue of Suboxone to my colleague Professor Bury.

Professor Gerard Bury: I thank the members for the questions. I will address a couple of them. Mr. Duffin has dealt appropriately with a number of them.

To deal with some practical matters, on the issue of naloxone, Senator Ruane raised the possibility of an intranasal delivery device being available. We have been using intranasal naloxone here for the past three years. It is restricted to paramedic, advanced paramedic and medical practitioner use. We have been using a number of formulations of injecting naloxone and saved countless lives through the availability of those drugs for use by paramedics and advanced paramedics.

The Department introduced legislation last year on rescue drugs, which restricts lay access to naloxone to a single product that is unavailable. It is not available on the general medical services, GMS, scheme. I thought it might be a bit bulky to bring here and that I might be stopped on the way in so I took a photograph of €2,000 worth of naloxone we purchased a year ago on the expectation of the implementation of the rescue drugs Bill, which was going very well until the detailed regulation made it clear that a single product was to be licensed which is not used by any clinical outfit in this country. The problem is that the Health Products Regulatory Authority, HPRA, the Pre-Hospital Emergency Care Council, PHECC, and the Pharmaceutical Society of Ireland have access only to a single product, which is effective but unavailable. If the regulation were changed to allow access to the pre-filled syringe product currently used by the emergency services, and if that were made available for GMS prescription, we could very quickly move towards a situation where overdose prevention, education and treatment might become a reality. We will save some lives. It is in itself just a desperate measure to help with those at the chaotic end of the scale but it will indicate the willingness of society generally to take an extra step on behalf of those people at the margins.

The second point is about the pilot, and I want to follow the point about people on the margins. What are the outcome measures for that pilot? We use the term all the time. It is clear sometimes what we mean by success and sometimes it is not. If the measure of success to be used for a pilot site is that the streets are cleaner, tidier or possess less obvious drug use, that is not much of a pilot. The purpose of the pilot must be to improve the lives and save some lives for this very large number of people who are currently not just marginalised, but forgotten about. The measure of success has to be how better off are these individual drug users and their families. That is not an easy measure to come up with and it comes somewhat to the issue

raised about registration and data collection, but it is not beyond the bounds of man to identify ways to collect good quality data and identify outcome and process measures that reflect the value of the people we are trying to serve, not the cleanliness of the streets.

The issue of access to general practice services is a thorny one. I cannot speak on behalf of my colleagues or of my profession but I can offer members some comments as an inner city general practitioner, GP, for the past 30 years. The difficulty is that this is not an evenly distributed problem for society. Opiate dependence is a reflection of societal difficulties. It has been medicalised endlessly over the past 30 years and is now regarded as a health problem - I give this issue being dealt with by the health committee as an example. Many of our problems with drug dependency arise from deprivation, poor education, hopelessness, awful homes and a chronic tolerance and dependence. Those problems are characterised in certain key areas and those are the areas, particularly of this city, which are vastly under-served by medical services and by general practice in particular. It is not simply a matter of putting into a contract an obligation for each individual GP to take on one, two or three individuals. That is a hopeless approach. It is a matter, at a broader level, of ensuring that those societies are served by the sorts of services that address their needs, some of which are unique to the communities that have been devastated by drug dependency over the past 30 years.

As part of his MD my colleague, Professor Fergus O'Kelly, who was one of the leaders in Dolphin's Barn in the late 1970s and early 1980s in bringing this problem to the attention of the health services, followed a cohort of his patients from 1981 through to the late 1980s. He stopped in the late 1980s because most were dead. There were very few left of the original 120 people he had identified in his practice in 1981 who were injecting drugs. An entire layer of that community was stripped out as if by war.

This is a problem of focused need which needs innovative and effective action. I completely agree that we as GPs need to come up to the plate and take on our responsibilities here. Most have done that. In the areas affected by these problems, it is extraordinary to see the level of commitment of my colleagues and the work they do but training, licensing and support services are essential.

I will conclude in a second but to take the point about Suboxone because it relates to this, the issue about general practice and services to address very damaged communities is not about more therapeutics. Drugs are not the answer to this issue. The evidence on Suboxone is mixed. I do not believe it offers any greater advantages than good quality methadone delivery but the potential to offer opiate overdose education and prevention strategies might give us some extra saving from the current opiate substitution therapy, OST, system. The point I want to make is that it is not simply about the class of drug we use for OST, rather it is about the psycho-social supports, the counselling, the reintegration to society and the addressing of those societal issues that have led to the drug problems in the first place. Clearly, that is a big ask but, at the end of the day, the evidence is that if we come back to whether people should be on methadone for the rest of their lives, and we would hope not, we have no well-proven method to remove people from that system safely and keep them abstinent for the rest of their lives. We know that most of the systems in use currently have success rates of not much better than 30% and the ones that work best address not just the drugs and therapeutics needs of these patients, but their psycho-social, personal development, psychological and other needs as well. Those are the services I would appeal to the members to consider in future rounds of their reflection on this problem to add to the available services we currently tap into.

Chairman: On the international experience, how many lives are saved by offering this

service? I know nobody dies in the service but how many are saved by providing the service? Are there any figures on that?

Professor Gerard Bury: I do not know if the evidence is that strong. I do know that there has been a reduction in overdoses in the areas surrounding those sites where they have been established in both Vancouver and Sydney. Those are the two sites where the data appears to be strongest. Vancouver relates back to almost 20 years in terms of the provision of these facilities. They tried to avoid the simple measure of enumerating lives saved but they have clearly shown a reduction in overdose incidence in the areas they serve. Mr. Duffin might want to come in on that.

Mr. Tony Duffin: There have been millions of injecting incidents within drug consumption rooms across the globe and nobody has ever died.

Mr. Mark Kennedy: To get a definitive figure a randomised control trial would have to be done and from an ethical standpoint, it would be very difficult to have a control group who were not allowed access such a facility.

Chairman: The 203 deaths in one year is a frightening figure. Did those deaths occur on the street? Professor Bury is suggesting they are not properly investigated and that there is not a proper assessment of the deaths as a learning process.

Professor Gerard Bury: I do not for a second want to reflect on the management of those tragedies by either the medical, Garda or coronial services. They do all that is appropriate within the current framework but I refer the Chairman to the relatively recently implemented Health Service Executive, HSE, serious adverse event policy, which has introduced a culture of learning, risk reduction and quality improvement at all levels within the HSE and has specifically constructed root cause analysis teams to explore certain types of serious events, including deaths, that occur in the State's care. My point is that methadone is provided purely in this State on the basis of a contract between the State and a doctor and the patient. If a death occurs involving methadone or involving attendance at a drug treatment centre, it seems to me that it should be managed in exactly the same way as the policy applies to all other deaths of people in mental health care services. It is an additional layer, not a reflection on the current provision of care. There is learning to be had at a clinical level from the investigation of those events.

Chairman: So that everyone gets an opportunity to come in, I will take three people in the next session: Deputy Durkan, Senator Colm Burke and Senator Ó Ríordáin.

Deputy Bernard J. Durkan: I thank our guests for appearing before the committee today. I compliment Senator Ó Ríordáin for his work in the previous Administration, as well as the Minister of State, Deputy Catherine Byrne, who is currently dealing with the issue. I have a couple of questions. In a previous incarnation, I had some experience of the Swiss experiments in Zurich and St. Gallen, as well as the Amsterdam ones. One of the first things they had difficulty with regarding registration was to stop intruders from superimposing themselves by benefitting from the scheme, while at the same time double-dosing outside the scheme. There is a need for controlled registration, otherwise the authenticity of the centres will become vague and they will not work.

Have the figures for mortality rates involving drugs users, including those injecting, been broken down? Are they mainly from habitual, occasional or accidental users? It is hugely important to have that information. I entirely agree with the remarks concerning some parts

of the inner city that have been beset with the problem over many years. It is distressing to see its effects and the colossal impact on those communities. Sadly, it is both debilitating and degenerating. However, it is positive to see this forward movement in the form of supervised injecting facilities.

Ireland has one of the highest mortality rates in the EU from drug abuse, including injections. I presume the Netherlands has a higher rate. I am not sure but I would be interested to know. Why are they such leaders in that dubious contest? What are the contributing factors there and have the witnesses studied them?

The societal issues are well known. However, one of the things we discovered in St. Gallen was that an emphasis was placed on the need to assist those who wish to recover, as opposed to those who do not wish to recover. They were discriminating between one and the other. In fact, they had provided work spaces so that people who were habitual and did not appear to be in any way disposed to recovery, would have employment. The employment was not great but it occupied the minds of those concerned.

In the past, methadone treatment was criticised because it went on forever in some cases, but it does not. There are people who have recovered successfully. I would like to hear the witnesses' comments on those who have successfully recovered from severe addiction. We must salute their cause and the work they have done, both as an example to everybody else and the manner and method in which they went about it. These are personal issues and personal confrontation is not easy. It is one of the most difficult things to handle but they have done it.

I am not certain how the operation will work through GPs. One of the problems GPs will always have is a huge queue in a waiting room, which takes time. I am therefore not so sure that that will work with habitual users. If my patience can be tested at a GP's surgery due to delays, how will it work for drug users?

To what extent will professional accountability manifest itself in operating these centres? Professional responsibility is required so that society knows that those in charge are disposed towards helping addicts and victims that, hopefully, are on the road to recovery.

What procedures will be followed in regard to suspending or withdrawing a licence? What kind of activities would result in the withdrawal of a licence? What kind of vetting will take place in providing and allocating a licence in the first instance? For example, to what degree will the authorities need to be satisfied that the person to whom a licence is granted to operate a centre is a responsible individual?

Under no circumstances should we allow cross-fertilisation whereby those in the illegal drugs trade outside can gain access either to the supply or the provision of supplies, both of which have happened in the past in various situations. If people are disposed to undertaking a programme, we should be certain that nothing interferes with it. Nobody should have any influence over it, except those disposed towards its success.

Senator Colm Burke: I thank the witnesses for their comprehensive presentations. While there is evidence that this programme has worked in other countries, we need to convince people here that it will work. Mr. Kennedy referred to the latest evidence of implementing these centres, which supports this as the way forward in dealing with this particular aspect. I wonder about the presentation of that evidence and how it can be used to get the public on board. For instance, we have received a letter from a Temple Bar company raising concerns about this pro-

posal. It was signed by a number of people who seem unconvinced. The only way of getting people on board is by producing clearer evidence and getting it out there. This comes back to some of the areas around methadone treatment facilities. I note that there have been complaints in Cork where the local authority had to take certain action to ensure the area was properly cleaned up so that no one was left exposed. How do we get the message across to convince people that we should move forward with this project? If we are talking about doing a pilot project, what timescale is involved before there is clear evidence that the project is working?

My apologies for being absent earlier but we had a vote in the Seanad.

Senator Aodhán Ó Ríordáin: I thank the members of the committee and the panel for their kind comments.

Professor Bury's presentation is one of the most impressive presentations on this issue that I have heard in the past number of years. He spoke in stark terms. He repeated one of his sentences in order to ensure that we all understood the magnitude of the situation and how drug overdose has reached epidemic level. He stated twice that in Ireland, more people die from opiate overdose each year than in road accidents.

I agree with much of what has been said by other members of the committee. I also agree with the sentiments expressed by Professor Bury about the day-to-day work done by the people who work on the front line. They save lives and deal in a very inglorious area of volunteerism or their professional life of caring for people who really live on the edge. It has been said that the term "junkie" is often used. It is one of the last derogatory terms that is politically acceptable or acceptable in the media to throw around the place. Even though the word "junkie" is a disgusting term it is deliberately used to undermine anyone who suffers from addiction. Whenever we discuss how an injection facility can save lives and alleviate the suffering of addicts the first question that is always asked is where will it be located. In other words, the debate feeds into the idea that the people who would benefit from a facility are undesirable and a subspecies. The media and others use the term "junkie" in a derogatory manner to underline that message.

Senator Colm Burke mentioned that people have yet to be convinced there is a need for an injection facility. During the many months that the facility was debated the Temple Bar traders never contacted my office when I was the Minister responsible for the drugs strategy. It is only lately that we got a letter from them. The traders are in an excited state and we are happy to debate the matter. Where have they been for the last period?

I ask the delegation to put this matter in a human context. I ask them to describe the visual nature of somebody who has died, and they can tell a story that they are aware of or give an instant that they have handled themselves personally. People die in toilets. People die behind dumpsters. People die in urine-soaked stairwells. They die surrounded by blood and faeces and they die all of the time. People do not like to hear that people die on the streets of this city and other cities around the country. I can appreciate Deputy Jonathan O'Brien's desire for a full programme of injection facilities to be rolled out rather than just a pilot programme because his city needs one. I ask the witnesses to explain in human terms the rationale for having a facility.

Professor Bury hit the nail on the head with his presentation. A campaign has been deliberately orchestrated to ensure that everybody is on board. The retailers who have a concern about the drugs paraphernalia have been convinced that a facility will alleviate the problem. I agree that it is unfair to expect Dublin City Council workers to pick up or sweep up this material and the accompanying excrement. A broad umbrella of people have reached the conclusion that a

facility is necessary for different reasons. Fundamentally, a facility is not about having cleaner streets but about saving lives. I ask the witnesses to explain in human terms that the facility will save the lives of people whose lives need to be saved. I ask the witnesses to describe in graphic terms what people need to know and I mean that with the best respect in the world for the Temple Bar traders or whoever else opposes the facility. I want them to hear what really happens in the city in which I live and in which many people here live, or in cities around the country. The Chairman has asked for statistics on the number of people whose lives have been saved as a result of the facility. I believe we will reach the point when this programme becomes more than a pilot and, as a result, we will be able to provide statistics in support of such facilities.

Professor Bury made an interesting correlation between opiate overdose and road deaths. It took between 20 or 25 measures to reduce the number of road deaths. An injection facility will not reduce the number of overdoses overnight. As Deputy O'Brien has said, the programme along with possibly 20 or more measures will eventually reduce the number of people who die from an overdose or are addicted in Ireland. A facility is not a panacea but is part of the jigsaw.

Chairman: I suggest in the interest of time and as another group is due to join us that Deputy O'Connell makes her contribution and then witnesses can make their final comments.

Deputy Kate O'Connell: I apologise for being late but this meeting clashed with another meeting next door. I do not have the gift of bilocation yet.

I have quickly read the presentation. I am, by profession, a community pharmacist and I originally come from the midlands. Twelve years ago I worked in both Athlone and Portlaoise at the height of the crisis. Beforehand I spent a short time studying in the UK and on my return to Ireland I was shocked at how drugs ravaged the communities and the extent of heroin use in the regional towns in the midlands. During the recession the problem spread to the smaller towns of Mullingar, Banagher in County Offaly and various places where the injection of drugs never happened before. It is fundamental that we view people as human beings and that it is not necessarily their poor choices that have led them to drug addiction. As Senator Ó Ríordáin has said, the aim of a facility is to save lives, limit harm, educate people, reach out to people and have services that engage with people. All of that means that when a bad batch of heroin reaches our streets that instead of finding out about it from the lad standing on the next corner that there is a facility that acts as a safe place where helpful information can be shared.

I fully support the use of injection centres. Anybody who opposes them is exercising a severe form of NIMBYism. It is important to point out that people have died on stairwells and in public toilets but middle class people have died in sitting rooms. We must open people's eyes to the fact that drug addiction transcends the class system.

When I worked in the UK huge needle-exchange programmes were rolled out in community pharmacies with great success. At the time there was huge resistance to the approach. The idea of people and drug dealers congregating around injection centres is an issue for the Garda and we must be vigilant about the problem.

It annoys me when people claim addicts receive methadone treatment forever. Methadone is quite cheap as medications go and its administration can be well managed in the community. I have often had patients receive 10 ml maintenance dose of methadone yet live functioning lives. Somebody who becomes addicted to heroin in their late teens should not carry a criminal conviction for the rest of his or her life if he or she manages to sort out their lives. I believe we should give people a second, third and fourth chance or whatever is necessary. I fully support

the work of the delegation. I shall work with my party to expedite this initiative to the best of my ability.

Mr. Mark Kennedy: Deputy Durkan asked where did we get the information on the number of drug deaths and how the information is broken down or classified. The Health Research Board has provided the information for the past ten or 11 years. Each year the data has shown that there are 600 drug deaths of which 300 to 350 are overdose-related deaths. The data is broken down into age, gender and the substances used or the groups of substances used. The big offenders are alcohol, methadone, opiates and benzodiazepines in combination. That information is gathered from the coroner's data.

I was asked the countries that are up at the top in terms of drug deaths - it would be a terrible way to look at it. We know what works in terms of preventing drug deaths. Certainly, having a national overdose prevention strategy, which would be multifaceted and would include measures such as injecting rooms and the provision of naloxone in the context of a multi-agency multi-disciplinary care plan for each individual, is something that works. There is no one thing that can be applied to all people.

In terms of trying to put a human face on it, those who I would know who have recovered and come through their own journeys with drug use all have a particular thing that worked for them. Sometimes it was getting a job. Sometimes it was getting into college or getting an education. Sometimes methadone helped them. There was family support involved. There can be dozens and dozens of contributing factors. We would see people who are in our services for many years and they do not show an inclination to change, but there often is a window which opens up. Generally, people do not want to be in this chaotic drug-fuelled life, but a window opens and they say, "Look, that's it. I want to go in and detox", or "I want to address my drug use." For us, as services, it is about being able to jump on that, seize that opportunity and be able to put options in front of people very quickly. From the evidence available, this medically supervised injecting centre is well positioned to do just that. There is this concept of the teachable moment where a person may overdose and medical staff can intervene to save the person's life and are then able to say: "Look, you nearly died. Here are the treatment options that would be available to you."

In terms of professional accountability, another point that Deputy Durkan raised, services in Ireland that are commissioned now come with a service level agreement. Often these are policed by agencies, such as the local authority or the HSE. Any provider that would apply or be granted a licence would have to sign up to a service level agreement. This would insist on compliance with all of the legislation, including safety legislation, ensuring that there are competent professional staff delivering the services, that the governance is in place, and that the service would be open to audit and would be accountable for its outcomes. Deputy O'Rourke asked when would be the appropriate time to audit such a service. The Sydney injecting room was audited after only one year and there was considerable evidence on the efficacy of the service that was being provided.

In terms of setting up an injecting room, it would need to involve all of the local stakeholders. That would include: community groups, such as the Temple Bar group mentioned earlier, where everybody would have a say because everybody, I suppose, has his or her own priorities in terms of what he or she would want from an injecting service. Primarily, they are about saving lives but they would have to consider the justice, community and other stakeholders that would be party to such a service.

Finally, in terms of the human face of this on which Senator Ó Ríordáin asked that we might speak, it is shocking seeing an overdose and seeing somebody there dead, cold, laid out. It is a cold experience. It is shocking for the staff team which may have been working with that person for many years. For us, it would be seen as a failure. There is a grief associated with that. There is a grief that one must process with the staff team to get them back on their feet.

One has got to talk to the family. This is very difficult. One is trying to arrange the care and support for the family after the death. I have spoken to mothers for whom after many years the grief is just as alive. It never ends. Particularly when we are talking about issues like injecting rooms, one sees mothers looking at one knowing that they are wondering if that had been around when their sons died if they would they still be here today, and that is very difficult.

It is devastating. One sees it in partners of drug users, and partners' sons and daughters. It just never ends. If one has 300 to 350 people die each year in this country, that is on average one person every day. That grief just ripples through a family.

Chairman: Following Mr. Duffin, Professor Bury will make some final remarks and we will conclude this session.

Mr. Tony Duffin: Deputy Durkan raised the Swiss model, registration and the double dosing. In Switzerland, if we are talking about the same matter, there is diamorphine prescribing and heroin-assisted treatment. We are not talking about that here and I would not envisage the double dosing being a problem.

I would agree with Mr. Kennedy on the Health Research Board. We have fantastic statistics from the drug-related death index from 2013 and we hope to have the 2014 statistics as soon as possible.

Obviously, professional accountability will be important. The licensing will take that into account as well. Insurances will need to be in place. People will inject themselves. People will not be injecting other people - that kind of thing will not be happening. The standards that Mr. Kennedy mentioned in his opening statement are in place and will be adapted and expanded upon to include new service provision such as this.

In terms of this issue of recovery and moving away from drug use, first, one cannot rehabilitate somebody who is dead. We have to keep people alive and, ideally, as well as they can be. It is difficult to motivate somebody who has HIV, hepatitis C, damaged veins and all sorts of complex health problems to motivate him or her. Such people do not see the point. If we can keep them as healthy as we can while they are in their drug use and keep them alive, then where there is life there is hope. I would strongly advocate that side of things.

The European drug report from the European Monitoring Centre for Drugs and Drug Addiction is clear that one gets people through to treatment and rehabilitation faster than otherwise where one has these services. If we leave people down alleyways, there is little option for intervention and for building a therapeutic relationship. On the issue of the Temple Bar letter, signed by the Temple Bar Company, the Restaurant Association of Ireland and the Licensed Vintners Association, the Ana Liffey Drug Project and Merchant's Quay Ireland had a seminar last week. We invited a wide range of people, including Deputies and Senators and local stakeholders. Representatives from that group were there. We had a healthy discussion. Professor Catherine Comiskey presented the latest information, which I can share with the committee. I have the presentation here. I hope that people heard what was said because at the presentation

Professor Comiskey was very clear about how well these services work and achieve what they are established to achieve.

Deputy O'Connell mentioned attracting people to the area. The evidence is quite clear that when these services are set up it is in an area where there is a problem of public injecting and as a consequence it is already meeting the needs of an established cohort of people and the honey-pot effect does not happen. The service works very closely with the Garda to ensure that drug dealing does not take place. We already have drug services in the city centre. I do not really envisage the policing of this to be much different from how we currently police the situation. The difference will be that people within that service will be safer and able to inject themselves with the drugs that they bring to the service.

In response to Senator Ó Ríordáin, it is not just death that is real for people. It is like a war-torn city for some people. We do not like to use words such as junkies and zombies. People who use them almost dehumanise the person in order to justify what they do to that group. They are very unwell people. The staff who work for me, such as the nurses, say that when people come in and take off their shirts they can see the scars and vein damage. We know about the referrals made to accident and emergency departments and to hospital where people have chronic illnesses. I know two people in the city who have necrotic legs. The leg is dead, maggots are crawling out of it. They can still walk around because they are addicted to heroin which is the most powerful of pain relievers. When they come in the nurse cleans them up and they go on their way. While the nurse is cleaning them up they swear and abuse the staff because they have mental health issues but those on the team are so good they just keep going. They are incredible. That is the kind of thing we are dealing with. We have a cohort of people who are groin injectors. That is risky behaviour. A study by the Maudsley in the UK on groin injecting found that everybody in that study had deep vein thrombosis. That is a very serious health problem. Unfortunately, I have found people dead and many of my colleagues have. We know people and work closely with them and we care for them. We would not be human if we did not. It is very very sad. It is hard to describe what it is like to come in and find that someone who is significantly younger than me has died prematurely and would probably still be alive if he or she had been in an injecting room at that time because no one has ever died in an injecting service, across the globe. The one that strikes me most is a 21 year old that I and a colleague found some years ago in the bed, her needle still sticking out of her arm, in a homeless hostel. A colleague from Crosscare said at the meeting last week that if there had been an injecting room in that hostel, where people who inject lived, that young woman would probably still be alive. Those things sit with one for a long time and never leave one.

Professor Gerard Bury: The really supportive role of the gardaí has been mentioned. I would hope the gardaí would support this initiative by offering protection to the users and clients of these services from the potential to be preyed on because a pilot is not without effect. It does not happen in isolation and the wholehearted support of the gardaí in protecting this clientèle is really important.

We have mentioned road accidents. In 2013 the Road Safety Authority had a budget of €40 million to effect road safety across the State. I can find no such ring-fenced budget allocated to the prevention of death from drug dependency, even for those who were in the care of the State at the time. Mention was made of an 18 year old being made to carry a criminal record for the rest of his life. Let us deal effectively with young people who are vulnerable. He does not need to carry methadone on his back for the rest of his life either. We must offer people an opportunity to normalise their lives as they would if they were insulin-dependent diabetics by

the use of appropriate drug therapies to stabilise their lives. Just as a diabetic does not sort out his or her problems with insulin alone, all the other necessary supports have to be offered.

I have been attending approximately 100 cardiac arrests a year in Dublin over the past year or two. I have been at three deaths in the past ten days or two weeks involving drug users who died at home. This is not just a street use problem. I am not convinced that some of these people did not intend to end their lives because of the arrangements they had made. It is most sad to see someone with a needle still stuck in his arm.

The committee wanted a human perspective but I would not dream of imposing on it the horror that goes with some of those situations. Sounds are what stick with me. The distress of families on finding their loved one in these circumstances is appalling and the sound of that distress is awful. The second sound I ask the committee to think about is phones. People's phones always go off: who is going to pick it up? Who is going to answer it? We do not know but the committee can imagine in that situation the horror that faces the person who is ringing.

Reactive care is what gets a lot of us into medicine, the idea that we will fix things and see an instant improvement. I appeal to the committee to push forward with its very well-founded initiative on the injecting rooms for that purpose but ask also that it consider the overdose-related issues. I am currently paying to dispose of €2,000 worth of out of date Naloxone. A simple change in regulations would enable us to do this better. Recovery needs to be part of our initiative as well as reaction to the crises and the horrors we have described. I thank the committee for the opportunity to speak to it.

Chairman: I thank Professor Bury, Mr. Duffin and Mr. Kennedy for coming in and giving us the human face that lies behind the injecting centre. It is extremely important that we understand the depth of the problem and at least try to address the solutions.

Sitting suspended at 3.39 p.m. and resumed at 4.05 p.m.

Chairman: We are meeting with representatives from An Garda Síochána and the HSE and officials from the Department of Health concerning pre-legislative scrutiny on the general scheme of the misuse of drugs (supervised injecting facilities) Bill 2016. On behalf of the committee, I welcome the delegation from An Garda Síochána - Mr. John O'Driscoll, assistant commissioner, special crime operations; Mr. Jack Nolan, assistant commissioner, Dublin metropolitan region; and Detective Superintendent Anthony Howard, drugs and organised crime bureau. I welcome Dr. Eamonn Keenan, national clinical lead, addiction services at the HSE, along with Mr. Eugene Lennon, Ms Susan Scally and Mr. Eamonn Quinn from the Department of Health. Representatives from the Department, HSE and An Garda Síochána will give their perspectives on the proposed Bill.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I also advise witnesses that any submissions or opening statements they have submitted to the committee may be published on the committee's website after this meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable. I invite Mr. Lennon and Assistant Commissioner O'Driscoll to make their opening statements.

Mr. Eugene Lennon: I am principal officer in the medicines, controlled drugs and pharmacy legislation unit in the Department of Health. I am joined by my colleagues, Ms Susan Scally, principal officer in the drugs policy unit, and Mr. Eamonn Quinn, pharmacist at the Department of Health, along with Dr. Eamonn Keenan, national clinical lead of HSE addiction services. I thank the committee for inviting us to address it today about the misuse of drugs (supervised injecting facilities) Bill 2016.

As we are all aware, there is a problem with public injecting in Dublin and other cities and towns in Ireland. This practice is unhygienic and unsafe and as a result, people who inject drugs are at an increased risk of contracting blood-borne diseases such as Hepatitis C and HIV and an increased risk of death as a result of overdose. Public injecting is antisocial behaviour that impacts on other citizens and businesses in the area in which it occurs. The wider community is also at risk due to unsafe disposal of syringes, needles and other drug paraphernalia. The establishment of a supervised injecting facility, SIF, has been proposed to ameliorate these problems. A SIF provides a clinical, controlled environment where drug users may self administer by injection drugs they have brought with them. Such facilities provide access to clean, sterile injecting equipment; medical and social care interventions; referral pathways to other treatment and rehabilitation services; and trained staff to provide emergency care in the event of an overdose. More simply, they provide a low-threshold point of contact for people who inject drugs.

A SIF is not a "free for all" for those who wish to inject drugs. Rather, it aims to attract and reach out to hard-to-reach or marginalised populations of drug users. It works to minimise the harm associated with injecting drugs until an individual is able and ready to address their problems. An injecting facility does not support or promote drug use. Rather, it works to prevent injury and death and to connect people with help. It is not a solution to the drug problem but rather should be seen as part of a suite of harm reduction measures that can be deployed to address what is a complex and difficult issue. There are almost 90 drug consumption rooms operating around the world, in cities such as Luxembourg, Copenhagen, Barcelona, Sydney and Vancouver. Evidence from these sites demonstrates: a reduction in fatal overdoses and transmission of blood borne diseases; a decrease in the incidence of public injecting; significant reductions in drug related litter, and no increase in the use of drugs or of drug-related crime.

Drug consumption rooms have been operating for more than 30 years and to date worldwide there have been no reported death as a result of an overdose in such a facility. The previous Government, and the then Minister of State at the Department of Health, the then Deputy now Senator Aodhán Ó Ríordáin, approved the drafting of additional heads to provide for supervised injecting facilities in the Misuse of Drugs (Amendment) Bill in December 2015. The programme for a partnership Government agreed in May reaffirmed the commitment to legislate for what was termed "injection rooms". Originally it was intended that the legislative provision for supervised injecting facilities would be included as part of larger Bill, but earlier this year it was decided that there would be two separate misuse of drugs (amendment) Bills. The first Bill was passed by the Oireachtas in late July. The second Bill, which is being drafted at present will deal with supervised injecting facilities.

The proposed legislation would allow the Minister for Health to issue a licence with conditions to operate a supervised injecting facility. This licence would be for a defined period of

time and could be revoked, suspended or the conditions of the licence amended by the Minister. The provisions of the Bill would also exempt authorised users of a supervised injecting facility from the offence of possession when in the facility, and with the permission of the licence holder; it would provide an exemption for licensed providers where it is an offence to permit the preparation or possession of a controlled substance in premises; it would enable the Minister to consult with the HSE, An Garda Síochána or others on matters relating to a supervised injecting facility and it would enable the Minister to make regulations relating to the operation of such facilities.

Possession of controlled drugs would continue to be an offence outside of an injecting facility. Possession for sale or supply will remain illegal both inside and outside the facility. There can be no suggestion of creating a "no go" area for An Garda Síochána. To support an Garda Síochána it is proposed the Bill would include a provision that Garda members will be able to access a facility, for the prevention or detection of offences, without the need for a warrant.

This Bill will not establish the location of a supervised injecting facility. However it is envisaged that the first facility would be in Dublin city centre where there is a significant, recognised problem of public injecting. This first facility would be a pilot service to determine the utility, safety and cost-effectiveness of a supervised injecting facility in an Irish context. It would be run by the HSE or a non-governmental organisation, working under a service level agreement with the HSE. Preparatory work would be required in advance of the establishment of such a facility. The HSE would consult with An Garda Síochána and other relevant authorities, NGOs and community groups prior to its establishment.

The aim of any supervised injecting facility in Ireland and therefore the aim of this legislation will be to reduce the incidence of public injecting and the impact this has on people who inject drugs in relation to their dignity, health and ability to access health and social care services; the wider community; in relation to public health, drug-related litter and public amenity; public services in relation to Garda and ambulance resources and most importantly, the number of drug-related deaths resulting directly from overdoses on our streets.

I thank the Chairman. I will be happy to address any follow-up questions.

Chairman: I thank Mr Lennon. I invite Assistant Commissioner John O'Driscoll to make his opening statement.

Mr. John O'Driscoll: On behalf of the Garda Commissioner, I thank the Chairman for the invitation from the Joint Committee on Health, to address them regarding the misuse of drugs (amendment) (supervised injecting facilities) Bill 2016. I am accompanied by Assistant Commissioner Mr. Jack Nolan, who is in charge of the Dublin metropolitan area and Detective Superintendent Howard, who is attached to the Garda Drugs and Organised Crime Bureau.

Members of the committee will be aware, I am sure, that Government policy on tackling the drug problem is set out in the National Drugs Strategy 2009-2016, which, it is planned, will shortly be replaced by a new strategy covering the period 2017 onwards. The overall objective of the strategy is to continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research.

Tackling the supply of drugs remains a key element of the national drugs strategy and in this regard, An Garda Síochána continues to place a particular focus on tackling misuse of drugs

from a supply control perspective. This is reflected in An Garda Síochána's policing plans, in which tackling drugs and organised crime is set out as a core focus of our work. To achieve relevant objectives, multi-disciplinary approaches are utilised with a view to ensuring that those involved in illicit drugs activity are effectively targeted, including through the use of drugs legislation, the proceeds of crime legislation, money laundering legislation and the powers of the Criminal Assets Bureau.

The National Drugs and Organised Crime Bureau continues to lead out the policing strategy for tackling drugs supply and working closely with the local drug units across the State. This approach allows for the co-ordinated use of Garda resources in tackling all forms of organised crime, including illicit drug activity nationwide.

An Garda Síochána has recently launched a modernisation and renewal programme which includes a plan to build on our expertise in the drugs and organised crime area by amalgamating our skills and introducing a special crime task force to focus on criminals working at lower levels in organised crime gangs. Results achieved to date include significant arrests and seizures which have substantially disrupted and degraded organised crime gangs by taking guns, drugs and cash from them. Lives have been saved and more than 12 assassination attempts have been foiled.

When the Garda Commissioner appeared before the Oireachtas Joint Committee on Justice, Defence and Equality on 12 October 2016, she stated that between 9 March 2015, when the drugs and organised crime bureau was established, and September 2016, An Garda Síochána had seized over €1.9 million in cash, as well as 35 guns and 1,000 rounds of ammunition, including AK-74 assault rifles, submachine guns, sawn-off shotguns, Glock pistols and other semi-automatic weapons and silencers. Drugs worth more than €36 million have been seized and we have arrested 167 people for drug trafficking, money laundering and possession of firearms. On that occasion the Commissioner referred to the fact that the many organised crime gangs that operate internationally cannot be tackled effectively without international co-operation, and that in this regard we work actively and effectively with our counterparts in Europe and with the Europol and Interpol organisations.

However, An Garda Síochána is acutely aware that supply reduction is but one of five pillars through which the harm caused to individuals and society by the misuse of drugs must be tackled. For this purpose, the Garda Síochána is committed to doing all it can to support initiatives undertaken by the State with regard to the other four pillars, namely, prevention, treatment, rehabilitation and research.

An Garda Síochána is aware that a commitment to support a health-led rather than criminal justice approach to drugs use, including legislating for injection rooms, was set out, in May 2016, in chapter 5, titled 'Health' under A Programme for a Partnership Government. We are also aware that on 15 December 2015, the Government decided to include additional heads in the Misuse of Drugs (Amendment) Bill, to provide enabling provisions for supervised injecting facilities. We understand these provisions will enable the Minister for Health to issue licences permitting the establishment of supervised injecting facilities to provide enhanced clinical support to, and mitigate the problem of public injecting by, chronic drug users.

There is no doubt that there is a problem with street injecting in Dublin and elsewhere. It is accepted that this practice is unhygienic and poses a significant health risk for the drug users themselves and results in discarded needles which present a public health risk to others. An Garda Síochána understands that the establishment of supervised injecting facilities has been

proposed to ameliorate this problem.

An Garda Síochána is aware it is envisaged that initially one supervised injecting facility will be established on a pilot basis in Dublin city centre. An Garda Síochána will do all it can to assist in ensuring the initiative succeeds in achieving its objectives. We are aware that an independent evaluation will be an intrinsic element to the initiative, designed to determine the utility, safety and cost-effectiveness of the supervised injecting facility in an Irish context and that the outcome of such an evaluation will inform any decision to licence further facilities. In this regard, we will ensure that the policing and law enforcement issues which arise from the existence of a supervised injecting facility will be shared with all concerned for the purpose of informing the planned independent evaluation.

Dealing with the law enforcement issues which arise as a consequence of opening a supervised injecting facility of the type proposed requires the making of necessary amendments to existing relevant legislation. We are aware that the drafting of a misuse of drugs (amendment) Bill, which it is intended will contain provisions that will allow for the licensing, provision and operation of supervised injecting facilities under specific circumstances, while protecting the public health and ensuring that the prohibition on possession and supply of illicit drugs outside such facilities is adequately maintained, is at an advanced stage.

Upon enactment of planned relevant legislative provisions, An Garda Síochána will be in a position to inform its personnel regarding the appropriate manner in which to address the law enforcement and policing issues which will arise following the opening of a supervised injecting facility. It will also facilitate the inclusion of relevant information in policing plans and operational orders. I am sure it will be appreciated that the less ambiguity and avoidance of grey areas in the legislation which will be introduced to underpin the undertaking of the proposed initiative, the less likely it will be that any law enforcement issue will impact negatively on achieving a successful outcome to the initiative. Meanwhile, An Garda Síochána will continue to develop necessary policing strategies in preparation for the opening of Ireland's supervised injecting facility. The planning, to date, has involved interaction with law enforcement authorities in jurisdictions where supervised injecting facilities have been in place for some time and visiting and observing the policing of such facilities elsewhere.

We welcome the opportunity to answer any questions which the committee may wish to put to us regarding relevant matters.

Chairman: How will the facilities be policed? During the last session much anxiety was expressed about how a user would gain access to or leave a centre while in possession of drugs and yet not be arrested. How will that be dealt with in the policing of the centres?

Mr. John O'Driscoll: That will depend on the legislation that is enacted. It is clearly recognised that amendments are required to the Misuse of Drugs Acts. We have heard that provision will be made for An Garda Síochána, for example, to enter a premises. That will assist in policing those proposed facilities but until we see the exact nature of the legislation, we cannot be sure how it will operate. Clearly, we are used to dealing with drug addicts in particular scenarios for many years. We have drug treatment facilities operating within districts where drug misuse is prevalent. I think most people would agree that we afford the drug addict the attention and concern that people who find themselves in that difficult situation should be afforded and that our efforts in tackling drugs is focused mainly on the sale of drugs and those who have visited this horrific situation upon the addicts, those people who make money out of the business of drugs.

Chairman: Yes. During the previous session Professor Bury suggested that this legislation should be in place to protect and respect the user in their mental and physical health difficulties and in their addiction. That seems to be the sentiment of the Bill, that it is there to protect them and to facilitate their coping with their illness as opposed to prosecuting or seeing that they stand outside the law.

Mr. John O'Driscoll: It is possible that the existence of a facility could be abused by people other than those for whom it is intended will receive the treatment involved or will benefit from the use of the facility. We do not know how this will pan out but in the event, for example, that people were to use it as a premises to sell drugs, there would have to be a police reaction to that. It is more to prevent others from not affording the facility the opportunity to operate as it should and providing the service to addicts that is intended. That is the aspect of policing the facilities that needs focus.

Chairman: I thank the Assistant Commission. I ask Deputy Durkan to submit his questions.

Deputy Bernard J. Durkan: I thank our guests for being with us this afternoon. From the point of view of the Garda, what importance does the Assistant Commissioner place on the need to have an indoor facility treating people who are addicts as opposed to having an uncontrolled treatment centre on the street, on stairwells and in unhygienic situations? What degree of emphasis does he place on the controlled centre?

From the Assistant Commissioner's point of view, what is the most effective example to give children in the course of their recreational hours on the way to and from school? I believe we know the answer to the question but it is no harm to hear it repeated. I have seen young people studying in the stairwells surrounded by used needles, users and injectors, which is hardly a good example for the next generation. How does the Assistant Commissioner value the need to have a facility that caters specifically for addicts who are in that situation without excluding them from society?

On the issue of the influence of open street injection in areas that are economically and socially challenged, has the Garda made comparisons with other jurisdictions as to the extent to which controlled injection centres can be of quantifiable benefit? I believe we also know the answer to that question.

I wish to make two further points. One relates to licensing oversight, which was raised with the witnesses who made the previous submissions, and the importance of preserving the integrity of the injection centres and to ensure they are not in any way interfered with by those engaged in the illicit drug trade who would have vested interest and an ambition in making intrusions into that area. How does the Assistant Commissioner foresee that those engaged in the illicit drug trade, who are very powerful as is very evident, could be prevented from attempting to gain access to treatment facilities of any nature, but particularly of this nature? By what means could the Garda intervene to prevent interference by the illicit drug trade? To what degree does the Assistant Commissioner foresee the injection centres competing in the marketplace, in other words, to draw people who are vulnerable addicts into a control system as opposed to allowing them free-fall in the open streets and thereby become victims of the traffickers?

Chairman: I will call the speakers in groups of three because of the time constraints. The next speaker is Senator Lynn Ruane.

Senator Lynn Ruane: I have a few comments and questions. I will be honest and say that I felt a great level of discomfort when we moved on to the policing presentation. I have worked in the addiction field and in the homeless sector for a long time. I find the words "policing this facility" distressful in that I would question why anybody would want to use a facility that is being policed in the first place. I could not even let the community garda anywhere near the front gates of a community project in which I was involved and if I did the young men would not come in and use the facility. We will fail from the very beginning if we see this as some sort of hub for dealers which will never be the case.

As someone who works in hostels with users with high needs, I can say that the staff of these facilities know what they are doing. People are removed from a hostel not by the police, but because the staff want to protect the most vulnerable within those services. I can guarantee that if there was any sale or supply in the injection rooms, it would be detected very quickly and the person concerned would not be allowed to use that facility. Then and only then could the Garda intervene if the staff telephoned to say they have a person dealing in the facility. That is not accounted for in head ten of the Bill under which the Garda can show up and come into the facility. The broad scope of that provision is extremely worrying.

If a member of staff telephones the Garda to seek assistance on an issue, that is different. As someone who has worked in these services for a long time, I believe we need to trust the people who work in them. Some of the narrative around this issue can be scary. Drug dealers have telephones now. They do not always hang around on a doorstep somewhere. It is much more organised and orchestrated. When we talk about people in stairwells with needles all around them, the question I would ask is why a child is studying in a stairwell. Bigger questions arise as to the reason those environments exist. They do not exist in a vacuum in terms of drug dealers.

I want to tease out further the question of the role the witnesses believe they play because the health model disappeared very quickly and the justice aspect is very heavy in terms of drug dealing and policing. Are we making any move towards a health-led approach to addiction because - this is a matter of concern to me - the injection rooms appear to be a justice-police led initiative? Head 10 overstates the power gardaí should have in accessing this facility, unless they are required to do so, much like in hostels. Injection rooms might as well be located within the hostels. We have had to set our place up to ensure people could inject safely. Regardless of whether that is against the law, it happens. We take someone out of their room, sit him or her between their two friends in a living room and tell them to watch that person to ensure that he or she does not overdose. That is already happening and we need to trust the staff that will operate the services in that if they need the assistance of the Garda, they will call them. There should only be intervention from the Garda when it is requested.

Deputy Jonathan O'Brien: Senator Ruane touched on the issue I wanted to raise, namely, head 10, which gives the Garda powers to enter without a warrant for the prevention or detection of offences. I presume the goal of all of those present - members of the Garda, Department officials, Senators or Deputies - is to get to a position where we have a facility in which drug users can safely inject and where, if they overdose, there is help on hand. People from different backgrounds will have different priorities in that regard but I strongly agree with Senator Ruane. If we start the conversation in this room, it will seep out into the wider public. If the conversations we are having in this room are about being able to police these facilities, users will not access them. That is a reality, regardless of whether we like it.

We talk about the interests of the Garda being about the sale and supply of drugs, yet over

86% of all drug convictions are for personal use. Those are the figures we need to examine when we talk about safe injection centres. Users will not use a facility if they know that the person coming in behind them might be a member of the Garda drug squad. Regardless of how good the intentions may be on the part of the Garda, the reality is that those to whom I refer will not use these facilities and we will not solve the issue as a result. As I said in the previous session, we cannot have it both ways in terms of moving to a public health model from a criminal justice model. If we are talking about drug users accessing a facility, they need to be able to do that in the knowledge that when they do it there will be no legal comebacks.

There are issues to do with the legislation that we need to examine. Eventually, we will have to move to a model of decriminalisation for personal use. It is proposed in head 9 that it would be lawful to be in possession of a controlled substance while in a facility but if someone steps two feet outside a facility, it will be unlawful to be in possession of that controlled substance. That is the law we are dealing with because we are not having the wider discussion on decriminalisation for personal use. We are trying to deal with a public health issue but we are not having the debate about moving away from a criminal justice issue. We are riding both horses at the same time and the only people who will suffer are the users.

Many people know my personal situation. My brother is 11 months clean and is doing extremely well, but he has four drug convictions for personal use. We talk about criminalising people for life. We talk about people being on methadone for life but a situation should not arise where someone is on methadone for life. Someone who is a chronic drug user should not end up with a lifetime of convictions for personal use. If there are cases where individuals are trying to use these facilities for the sale and supply of controlled substances, by all means that is an issue for An Garda Síochána. I will put the question to the assistant commissioner. Under what circumstances would he envisage members of the force having to enter these facilities? Can we tease out the discussion that way? If there is not a telephone call from the centre to say a crime is being committed within the facility or if somebody telephones to say they are just about to eject someone because he or she is trying to sell drugs within the facility, under what circumstances would the assistant commissioner envisage a member of the force having to enter one of these facilities and for what purpose?

I refer to head 7, which provides for a licence holder to be required to supply such information as may reasonably be required for the purpose of evaluating supervised injecting centres. I presume the legislation will be organisation specific in terms of who will have access to that information for the purpose of evaluation. I am not suggesting for one moment that it will be open-ended but I have concerns about head 1 and the officials from the Department might explain the rationale behind it.

To clarify what I said in the first session, I wrote in my notes that I would oppose the advance registration of users. I have no issue with people who access this facility, and there is some sort of database for that continuous care, but they have to be on an advance register to even access the facility. I do not see the rationale for that. We have situations where people who would not be on a register suffer a relapse. I have to leave shortly to raise a Topical Issue matter in the Dáil but I would like to know if it is the case that people would not be able to use these facilities unless they were on an advance register or is it the case that once they access the facilities they go into the system. If that is the case that is a different matter, but that is not clear from the head. I ask for clarification on that.

I do not want to come across as if I am being critical of the Garda. The force is doing tremendous work in trying to combat the sale and supply of drugs and target individuals who are

involved in the illicit drug trade, and everyone will support those activities. I am talking about the users from a public health point of view. If they are accessing a facility and they know that a member of the force can walk in the door behind them, we are lessening the chance of them using that facility. We are not addressing the very reason we are establishing these safe injecting areas, which is to enable people to have a safe place in which to inject. The assistant Garda commissioner might comment on that.

Mr. Jack Nolan: I will answer the questions on behalf of the Garda Síochána. Deputy Bernard Durkan raised the issue of street injection and the proliferation of needles on the city streets. It has been a problem for some considerable time. Dublin City Council, the Ana Liffey Drug Project and other NGOs have been working very hard to reduce the amount of detritus of self injection on the streets. A visiting academic from Australia produced a worrying report during the summer and Dublin City Council has bins in place. If a self injection centre is established in Dublin city centre, the level of drug detritus should decrease considerably and it would be welcomed by business people, tourists and the inhabitants of the city. The Garda Síochána would also welcome this outcome of a self injection centre.

There is a possibility that there will be vested interests associated with supervised injection centres. There is a possibility that people involved in the sale and supply of drugs would target individuals entering centres. There is no question about it. This is where the Garda Síochána's policing plans would come into operation. Those policing plans will be founded on whatever the final version of the legislation looks like, and this will be very important. Those plans happen now.

Senator Lynn Ruane asked us about the policing of the supervised injection facilities. I am heartened to see that the national drugs strategy refers to a health-led approach. The entire world has struggled with the criminal justice and policing-led approaches to trying to control the problem of drugs for many years. Besides all that, drugs are a fact of life in every one of our communities at various levels.

Deputy Jonathan O'Brien said there was a proliferation of prosecutions for possession, which we call section 3, and this is a concern for the Garda Síochána. There is also a very significant percentage of prosecutions for sale and supply under section 15 and other sections of the Misuse of Drugs Act. Within Dublin city and nationally there has been an increase in the numbers of prosecutions for sale and supply. The policing element of the issue is very important.

While we are not in a position to eliminate the sale and supply of drugs, we are making inroads. The members have seen the feuding in Dublin city and the policing responses to those feuds, the large numbers of arrests and seizures of guns and drugs. I have a list of highly significant seizures that have occurred. During the past month, over €1.1 million worth of drugs was seized in Tallaght and €400,000 in the Sheriff Street area. These are examples of the type of policing activity that is happening.

The draft legislation suggests power be given to the Garda Síochána to enter the supervised injection facilities. We have been conscious of the advent of the legislation and have engaged with our colleagues overseas in researching what has happened in their areas. In other jurisdictions, the police have the power to enter the supervised injection facilities. It does not seem to cause any problem. From professionals working in the area and other police forces, I understand this supervision and engagement is welcomed and supported by professionals in the area. I would expect and hope it would continue in this jurisdiction. Decriminalisation for personal

use is a different topic and not for us here.

Deputy Jonathan O'Brien: The assistant commissioner can say he supports it. I do not mind.

Senator Aodhán Ó Ríordáin: Deputy O'Brien would have six to one then.

Mr. Jack Nolan: We have to make that point. I see a significant role for policing in the overall context of supervised self injection. I see it reducing the visible presence on the streets of individuals in unfortunate, chaotic and troubled states. I see challenges for policing and how people get into the injection centres with the substances they intend to self inject. It requires further consideration and debate.

Mr. Tony Howard: Many thousands of miles away in Afghanistan, farmers are growing the opium poppy. Arising from that, people here in Dublin are injecting heroin. In between the two points, organised crime is involved in importing heroin into Ireland. Both assistant commissioners were correct when they pointed out that the national drugs strategy is the framework we use to inform Garda policy on how we tackle drug dealing and anything touching the subject, including drug-related intimidation which, for me, is a particular scourge. It is a hidden crime within communities, yet we are aware it causes significant harm. The Garda Síochána is involved in formulating the next national drugs strategy, and I sit on a number of the related committees. It will be a health-led approach to dealing with drug dealing and addiction, not only to drugs but also to alcohol.

Mr. John O'Driscoll: We have access to all sorts of premises. When a licence is issued for a licensed premises, the Garda Síochána has access. From the perspective of the public house, how many of the members who have consumed alcohol during appropriate hours have had a visit from a member of the Garda Síochána? Yet, we must have the power to enter such premises as needs be. This power applies to many other premises. For many years, I was in charge of a drug unit in the north inner city which was a stone's throw from where the methadone clinic was on the North Strand. There was great communication between the clinic and the Garda Síochána and the occasions on which we entered the premises were very few and far between. There was great collaboration between the community, those who ran the clinic and the Garda Síochána.

Being the Garda Síochána, we are going to talk about the policing aspect of the initiative, and that is why we are here. This is where the health dimension interacts with the criminal justice dimension, and we have to deal with the complications that arise. It is a task for the Oireachtas Members to frame the legislation in the most appropriate way and we look forward the outcome of the deliberations. For the Garda Síochána, we must make the law as simple as possible to adhere to and ensure it is not so complicated that it will cause a problem in how we interact with the facilities when they are introduced.

Deputy Jonathan O'Brien: There is one important line which Assistant Commissioner Nolan mentioned, and I hope it is the line the media picks up on. We do not want the media picking up on the policing of the facilities. The assistant commissioner said the Garda Síochána fully supported the model which was being progressed and was aware that it was a health-led model. This is the initiative we should all be working towards. If this is the message which goes out from all of us, it is a good basis on which to start. While the Garda Síochána has responsibility for policing, it is well aware that this is a health issue as well as a criminal issue for the higher levels in the sale and supply chain. There is a recognition that drugs use is increas-

ingly being dealt with as a health issue rather than a criminal justice issue.

Deputy Bernard J. Durkan: There was some reaction to a point I made earlier. To clarify, I did not refer to policing at all. I referred to the protection of the integrity of the centres, which is a totally different issue. Some people seem to have taken it as a reference to policing. Despite that some of us have hair that is reverting to blond, we have direct experience in these matters. Over many years, we lifted people off the streets and brought them to addiction treatment centres. We, too, know a little about the subject.

Mr. Eugene Lennon: On the policing issue, Dr. Keenan, the Minister of State, Deputy Catherine Byrne, and I travelled to Denmark last week to see how drug consumption rooms work there. We visited one of the newer centres in Copenhagen, saw how it all worked and spoke to senior people in the Ministry of Health and the people running the centre. They stressed that for such centres to be successful, there must be a partnership between the health authorities, police authorities and, in this case, city authorities, with most of the services being delivered through the municipalities. The director of the centre noted that police officers walk in once a day to have a look around and this does not seem to cause any particular problems for anybody. Indeed, it offers an element of reassurance for members of the wider community, some of whom had concerns about an injecting centre operating in their midst. Part of the reassurance given to the community was that police officers would be able visit the centre regularly and ensure everything is okay. It is a low-key look-around.

Some analysis has been done on how things are working in Denmark. The document is in Danish but the centre staff gave us a summary in English. The analysis shows that while there were concerns before some of the centres opened, there was generally a reduction in public nuisance incidents in the relevant areas once the services were up and running. In the part of Copenhagen we visited, the data show there have been fewer call-outs to the police following the opening of the injecting centre. The health-led approach being taken with the setting up of these centres seems to be leading to a win-win situation, with benefits for the drug users availing of the service, reduced demand for police resources and a positive outcome for the community in terms of reduced crime rates.

Regarding the concept of an authorised user, as set out in head 1, it is not the intention that people will have to register in advance. In the injection centres we have looked at abroad, there is a quick registration process for first-time users. We are conscious that these are people detached from the system, who often live chaotic lives and do not engage generally with authorities. In some countries they ask for a nickname and a year of birth but there is nobody checking up on that information. Each time a user presents at a centre and gives the name Jonathan 1984, for example, that will be recorded, along with the drug the person is using. This allows staff to track users' drug use through the system.

In regard to the proposed evaluation process, the intention is that all the data will be anonymised. The objective is not to create and maintain a register that will be handed over to anybody. The people in this room today are generally very open to the idea of injecting centres, but there are people in the broader society who have concerns. If we are to run a pilot service, we will have to justify any decision to go for a second or third centre. We must be able to offer a robust evaluation of any such proposal. From what we have seen of the studies on centres abroad, they do stand up and there are benefits both for drug users and the wider community. We hope the same will apply in Ireland but we will have to provide robust evidence to back up our arguments. The Minister has managed to secure some funding for next year, but if we are to acquire further funding, we must be able to provide an evaluation which shows the service is

working well in co-operation with the various authorities.

Dr. Eamon Keenan: From a HSE perspective, we are very clear that what is being proposed is a health care facility. Whether it is the HSE running the facility or the HSE running it by means of a service level agreement with an NGO, we are committed to making it work. We are looking to target the most vulnerable and chaotic group of people in our society, people whose voices have not been heard today. We have engaged with the service user representative group, UISCE, and are working with it to produce a survey of street injectors. The survey asks users their views on the operation of such a facility and any concerns they have about it. Deputy O'Brien mentioned the registration process. When somebody has drugs and access to a facility like this, he or she wants to use the drugs quickly, not to have to hang around and undergo a long process before being given access. Some people may be injecting into the groin and the facility will have to be able to accommodate that in a dignified way.

There are concerns among users that they will be hopped on when they visit the facility, engaged in counselling straight away or forced into a treatment process. We are saying we will work with anybody within the context of our national drugs rehabilitation framework, which offers a broad approach to ensuring a continuum of care. Our position is that a supervised injecting facility is at the far end of harm reduction and people can move from it right through to a situation where they are able to access services. In fact, they may be fast-tracked into those services when the time is right for them. We see it as an important element of the overall care the HSE can provide to drug users.

Deputy Jonathan O'Brien: Did any of the users who were spoken to raise policing issues as a concern in respect of their willingness to avail of an injecting facility service?

Dr. Eamon Keenan: Some of them did and we have been talking to the Garda about the issues they raised. The survey we are carrying out with the service users will be fed back to the Garda. We are sitting on a committee with them and if they have any specific concerns, that is where it will be raised.

Senator Colm Burke: I thank all the delegates for their comprehensive presentations. Following on from Deputy O'Brien's comments on head 10, if there is not provision for gardaí to enter a centre, do the Garda delegates see major disadvantages in that from their perspective? The witnesses referred to intimidation and people who may be afraid to report. If there is a change to head 10 such that there is no provision for gardaí to enter centres, do the delegates envisage problems in the long term?

Regarding engagement with centres in other jurisdictions, is there any feedback on the downside of having one of these facilities in an area? If so, how are those problems being dealt with? We must keep in mind that particular problems may emerge in different jurisdictions. Do the witnesses see issues presenting here in Ireland that may not have emerged in other jurisdictions?

Deputy Jack Chambers: I welcome the delegates. To expand on Deputy O'Brien's point, have the Department delegates fleshed out the concept of an authorised user? It is important we do not bureaucratise the process for a person who is in such a vulnerable scenario and such bureaucracy does not inhibit proper access to treatment. It is important that is clarified and it is probably clarified in the legislation. The Department delegates might elaborate on that.

On the licence application, Dr. Kennan mentioned there is a possibility it could be a HSE-

run pilot project or there would be a service level agreement, SLA, for it. Are stakeholder consultations with any such providers planned on the development of the requirements in a licence application? He might give a brief outline of what is planned in that respect.

Are there particular reasons a licence transfer would be necessary rather than a licence being awarded case by case? Will the number of active licences be tied to demographics in terms of the number of authorised users in the area? What is the logic for the transfer of the licence if the pilot project is successful, rather than examining the concept beyond the simple transfer of the licence?

I wish to ask about one aspect of the regulations that was not mentioned. Will the eligibility criteria for licenceholders include protective obligations towards the staff and volunteers working in a supervised injecting facility? One of the delegates outlined the regulations covering the licenceholder, the people who run the premises, but there was no specific mention of staff.

Is there anything further that could be added to improve what is included in the heads of the Bill or are the Garda representatives concerned about anything in the way the legislation is being drafted? Do they believe this legislation will be workable? Deputy O'Brien and I are members of the Joint Committee on Justice and Equality where we interact with members of An Garda Síochána. Having the Department of Health delegates before this committee on one side of the room and also having members of An Garda Síochána before it working beside them is a positive symbolic move. That is important to note in the context of where this should move generally.

In the context of international comparatives, which Senator Burke also mentioned, has the Department framed the heads of the Bill and the legislation around a particular model in a particular country or is it a mix of what the Department delegates have seen and examined elsewhere?

Chairman: I thank the Deputy for that. I call Senator Ó Ríordáin.

Senator Aodhán Ó Ríordáin: I will be brief. I understand that the witnesses are restricted in what they can say because the Department has to implement Government policy, the Garda has to implement law and personal opinions do not come into it. I understand that terminology is important and the idea of this centre being policed is not what we want to emerge from these proceedings, but streets and areas are policed. I visited a centre in Rotterdam and the injecting room there was one small component of the overall centre. There were a range of activities in the centre ranging from counselling to interactions. If what we achieve here is an injecting centre, just a room where people inject, then it will fail. It must be part of a much wider suite of services for people.

A common question that will be asked is how one interacts with an individual whom gardaí in the area know has an illegal substance on their person as they proceed to the centre. I would say, and many people would agree with me, that this person is making a leap of trust in engaging with these services and he or she probably has many reasons from personal experience not to trust the services. A comparison could be made between this centre and the average methadone clinic or health centre that people attend, and Mr. O'Driscoll mentioned the North Strand. The average garda on the beat knows there is a higher chance of a person attending such a clinic having something illegal on their person. I ask the Garda representatives about discretion and how that is policed. The situation will be same when it comes to an injecting centre. The Garda representatives, who are knowledgeable about the law, know the difference between a person

who is pushing drugs and a person who is the victim. If a person is interacting with this centre in a positive proper way, is it not similar to a person who has a chronic addiction but is going to a methadone clinic to get their methadone? Does An Garda Síochána not deal with that situation in a particular way? What we will be doing here is replicating that.

Chairman: Who would like to take those questions?

Mr. John O'Driscoll: On the question of how matters would operate if there was not a head 10 provision in the Bill, the existence of such a head 10 provision would prevent the need to use other sections, which are not being put aside, as a result of the opening of the centre. If there was not such a head 10 provision, in particular circumstances we would have to use powers that are in place to enter the centre with a search warrant. That is why we have this type of provision applying to many premises that have a licence. If a similar situation arose in a public house and we did not have the power to enter it, we would have to use some other legislative provision. This allows for ease of access and a friendly interaction. We would argue it is one that will help the facility to operate in the way it is intended to operate. We can be trusted, I hope, to use our capacity to enter the premises with the same discretion that we use entering any other premises we can enter by way of a similar provision.

This provision is being introduced from a health perspective, but we are not qualified to say whether lives will be saved as a result of it. We accept the evaluation of the professional people who have the capacity to reach that conclusion. Beyond anything else, the Garda Síochána is there to preserve life. As I said, I worked in the north inner city and a Christmas tree is put up outside St. Joseph's Mansions with a star to recall each of those who have died from heroin use. If there are fewer stars on that tree in the years to come because of an initiative such as this one, we along with everybody else would be delighted if that were the outcome.

As far as back as 1996, a holistic approach was being adopted in the north inner city. At that time I sat around a table with Dr. Joe Barry, Tony Gregory, Christy Burke, who was then a member of Sinn Féin, Cyprian Brady from the Fianna Fáil Party and representatives from all the political parties. There was a cross-party approach in terms of politics. It involved every Government agency interacting. While it was recognised the primary responsibility for law enforcement rested with the Garda, members of the force act, as we continue to do, through the national drugs strategy and with each of the other pillars, to offer whatever we can to ensure that, from a health, harm reduction and research perspective, we bring to the table whatever we can, in a common interest, to ameliorate and eliminate the drugs problem to the extent that this can be done. The first report of the ministerial task force on measures to reduce the demand for drugs, otherwise referred to as the Rabbitte report, has at appendix 3 a map that graphically displays that heroin use is very much associated with poverty and particular financial circumstances. We all agreed in all the State agencies that it needed this holistic approach even as far back as then. However long it has taken for initiatives such as this one to come forward, they are being put forward by those who have the qualifications to say that they will have the benefits that are being ascribed to them. We hope at the end of the pilot project that we will be able to report that they should be replicated.

Chairman: I thank Mr. O'Driscoll for that.

Mr. Jack Nolan: I might add a further comment in support of my colleague, Assistant Commissioner O'Driscoll. The research we have conducted and much of the academic literature on supervised injection facilities raises no objection to the police entering such facilities. I am making the point in the context of a type of comfort factor and also as a mechanism of un-

derstanding and knowing the individuals involved and what goes on there. I understand from conversations with professionals in this general area in Dublin city that there is no deep unease about this facility being afforded to An Garda Síochána. As my colleague said, if there is some other reason for entering, other legislative provisions would have to come into play.

Senator Ó Ríordáin touched on a deep issue associated with supervised injection facilities. It relates not only to injection but to detoxification, medical care and the other facilities that probably should be available to ensure that these unfortunate individuals get the other care required to keep them alive. There is significant research evidence regarding the minimal number of deaths associated with overdoses in supervised injection facilities. That should be kept in mind.

The third point I picked up from the questions relates to the requirement for a collaborative approach between all the agencies involved. The police force is only one element of the overall model that is being pieced together. There are health, social and aftercare elements as well. We should keep that in mind in eliciting wisdom from these deliberations. We are at a relatively advanced stage but there probably should be further deliberation.

Mr. Eugene Lennon: I wish to address some points made by Deputy Chambers. He raised a question about authorised users. The model is not intended to be overly bureaucratic. We are conscious of the group of users. These are people who may be living a chaotic lifestyle, for example, chronic users and hard-to-reach people. The aim is to make it accessible for them. Normally, there are some restrictions. These services operate in other countries. They tend to restrict children, pregnant women and what are termed naive users, in other words, people who we believe are not really drug addicts but who may want to try it out. They do not normally facilitate such people.

Reference was made to licences. Several of the heads relate to licences because the proposed legislation would represent a major change for Ireland. There are injecting centres in approximately 90 cities throughout the world. This has been a cause of debate in Ireland. We have to take the licence issue seriously. Five or six of the heads relate to how people get a licence, how a licence may be revoked and how conditions may be applied during the time the licence is in force. There is an issue with transfer. Let us suppose an operator is given a licence. Then, for some reason, the operator is unable to continue the service or the licence is revoked. We may need to transfer that licence relatively quickly to be able to maintain the service for users. That is the purpose of the provision.

Deputy Chambers also referred to the issue of safety for staff. There is a general duty of care for any employer but there will also be provision for regulations around managerial and clinical governance and related issues. This will be taken into account. These are important factors in other centres throughout the world. The security of staff has to be considered in all these situations.

Chairman: Do any of the witnesses wish to provide a summary or closing statement?

Mr. Eamonn Quinn: It has been rather daunting to be presented with so many official people of high capacity. They are so thoroughly involved and integrated into the various issues surrounding supervised injecting facilities. I am heartened by what I am hearing around the room and from the support from the Deputies and all the witnesses today.

I have been involved in this work for an extended period. I want to offer some reassurance

to Deputies O'Brien and Durkan in respect of their concerns regarding the heads of the Bill, especially head 10, which relates to the provision of access for An Garda Síochána. I wish to reiterate what my colleagues in An Garda Síochána said. These provisions are already in existence for nightclubs and public houses. The legislation is not envisaged to go beyond what is already in place for many other established licensed premises.

Ultimately, this is a health-led and harm-reduction initiative. It will be a low-threshold portal to reach out to marginalised individuals to allow them to access a safe environment to administer their own drugs. There will be people there to support them if things go wrong. They can also access other services as well. They will and should be integrated with other services provided by the State. The purpose of head 10 will not go beyond what is already in existence anywhere else, but it offers reassurance to the greater public.

I wish to address some of the issues raised by Deputy Durkan in respect of what has happened in other jurisdictions and the concerns that have arisen. People have concerns over what they call the honey-pot effect. This relates to people being attracted to an area and drawing in crime, drug users and various characters. The concern is a gut reaction to all of these things and it is understandable. However, we have a significant body of evidence gathered over a long period. These places have been established for over 30 years. In particular, in the past 16 since the foundation of the centre in Sydney there has been more evidence gathering. The same applies throughout European sites as well. There is significant evidence to show that there is no honey pot effect, no rise in criminality and no rise in drug use. However, we have improvements in drug overdoses and drug-related litter. A question was asked in the first session about how we manage and measure these things. It is a difficult thing to measure. There are few tangible things we can measure. However, we can measure perceptions. There are many different ways of data mining and gathering information and perceptions. In Sydney, they have measured perceptions before, during and after. They saw the support in the community rise and rise. We heard reference to the fact that the police in Sydney referred to it as "their" supervised centre or "our" medically-supervised injecting centre because they are so involved in it. These perceptions exist. The perceptions of people who inject drugs will be important, as will the perception of people in the local community. All the evidence gathered to date, especially during the past 16 years, shows that the concerns can be ameliorated quickly. There are legitimate concerns. The areas where these centres are located start to benefit from the provision of the service as well.

I wish to address some other concerns about the bureaucracy. The intention in the Bill is to keep bureaucracy to a minimum and to remove any barriers. At the same time there needs to be an element of monitoring and data collection to ensure that we can build more evidence in an Irish context to prove the benefit of these facilities and to engage any potential developments in future. I think I have addressed most of the issues that Deputies and Senators have raised.

Chairman: On behalf of the committee, I thank Dr. Keenan, Mr. Eugene Lennon, Mr. Eamonn Quinn, Assistant Garda Commissioner Jack Nolan, Assistant Garda Commissioner John O'Driscoll and Detective Superintendent Anthony Howard for attending. I also thank them for their valuable contributions. We will convey our findings of the hearing to the Minister of State, Deputy Catherine Byrne, for her consideration in drafting the legislation. The next meeting will examine pre-legislative scrutiny of the open disclosure provisions contained in the Civil Liberties (Amendment) Bill.

The joint committee adjourned at 5 p.m. until 9 a.m. on Thursday, 8 December 2016.