DÁIL ÉIREANN

AN COMHCHOISTE UM DHLÍ AGUS CEART, COSAINT AGUS COMHIONANNAS

JOINT COMMITTEE ON JUSTICE, DEFENCE AND EQUALITY

Dé Céadaoin, 14 Deireadh Fómhair 2015

Wednesday, 14 October 2015

The Joint Committee met at 2 p.m.

MEMBERS PRESENT:

Deputy Niall Collins,	Senator Ivana Bacik,
Deputy Alan Farrell,	Senator Martin Conway.
Deputy Anne Ferris,	
Deputy Seán Kenny,	
Deputy Pádraig Mac Lochlainn,	
Deputy Gabrielle McFadden,	
Deputy Finian McGrath,	
Deputy Fergus O'Dowd,	

In attendance: Deputy Jonathan O'Brien and Senator James Heffernan..

DEPUTY DAVID STANTON IN THE CHAIR.

The joint committee met in private session until 2.09 p.m.

Submissions on Drugs Review: Discussion

Chairman: The purpose of this part of the meeting is to have an engagement with some of those who made written submissions to the committee on its review of Ireland's approach to the possession of limited quantities of certain drugs. I ask everybody to turn off all mobile phones or to put them on aeroplane mode as otherwise they interfere with the sound and recording systems here.

In session one today, we are joined by the following: BeLonG To is represented by Mr. David Carroll and Mr. Gerard Roe, who are most welcome and I thank them for giving of their time in being here today; the Dublin North East Drugs Task Force is represented by Mr. Pat Carey, the former Minister and an old buddy of ours, and Mr. Shane Brennan; Students for Sensible Drug Policy Ireland, from DCU, is represented by Mr. Daniel Kirby and Mr. Graham de Barra, and I thank them for being here; the Association for Criminal Justice Research and Development, ACJRD, is represented by Ms Maura Butler and Professor Catherine Comiskey with whom we have engaged over the years on many occasions and I thank them for coming in and giving their time; the Irish Penal Reform Trust is represented by Ms Deirdre Malone and Ms Fíona Ní Chinnéide, and they are most welcome; the Irish Association of Social Workers is represented by Mr. Aidan McGivern and Ms Martina McGovern, whose input will be much appreciated; and Mr. Tony Geoghegan and Ms Denise Casement are here today from Merchant's Quay Ireland and I thank them for coming in to the committee.

I will invite each group to make a five minute presentation giving the committee the main points of their submission. There will be a question and answer session with members, who may be coming and going as there is so much going on today. This will be an interesting session. Members will not make speeches - they should keep them for the Dáil and the Seanad.

Before we begin, witnesses should note that by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to 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 witnesses are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable. Members are reminded that under the rulings of the Chair, they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable. I invite Mr. Carroll from BeLonG To to make his presentation.

Mr. David Carroll: I thank the Chairman, Deputies and Senators. I am the executive director of BeLonG To youth service. BeLonG To is Ireland's national lesbian, gay, bisexual and transgender, LGBT, youth organisation. We aim to support and resource LGBT young people through a range of different services and supports around the country.

Our drug service is unique in that it is the only service in the country which works with LGBT populations around their drug use. The service is a long lasting service, set up in 2007 on foot of research which showed some complexity of drug uses in LGBT populations. It is

funded since 2007 through the North Inner City Drugs Task Force, support for which we are very grateful. To explain the rationale behind our submission, I am delighted to welcome my colleague, Mr. Gerard Roe, BeLonG To's drugs and alcohol education and outreach worker.

Mr. Gerard Roe: I thank the committee for accepting our submission and for inviting us here today. BeLonG To's submission advocates in favour of altering the current approach to sanctions for the possession of a certain amount of drugs for personal use. We believe it is in the best interests of LGBT young people, and indeed all young people, that legislative change is needed to address how we treat those who are found in possession of drugs for their personal use.

Studies have revealed that drug use is widespread among LGBT young people and is more prevalent than in the general youth population. Findings from our research indicate that LGBT young people are two to five times more likely to consume drugs than their heterosexual counterparts.

Many LGBT young people experience different forms of discrimination and social exclusion, most visibly in the form of homophobic and transphobic bullying. As a result, LGBT young people are often likely to suffer from poor mental health and experience high levels of suicide ideation, self-harm and problems with alcohol and drugs use. Statistics also illustrate a correlation between mental health and drug use. With such high levels of drug use and mental health issues among this population, surely the response needs to be dealt with as a health issue rather than one of criminal justice.

From my unique position as the sole drugs worker for the LGBT community, I have seen how current practice and legislation impacts negatively on my target audience. BeLonG To is not geographically bound. The young people who seek support through our services come from all different cultural and socio-economic backgrounds. In my experience, it is mostly working class young people who come into contact with the criminal justice system. They are more likely to be stopped and searched and to be found in possession of drugs for personal use and therefore most likely to be criminalised. The criminalisation of drug use often lends itself to the stigma that surrounds it. We believe that decriminalising drugs for personal use will lift the barriers and stigma surrounding drugs and drug use. The resources used to criminalise the possession and use of drugs could then be redirected into good evidence-based education, harm reduction treatment and smart campaigns.

The intention of current legislation is to outlaw and prevent people from using drugs but, as the research shows, it has not achieved this. Drug use and the availability of drugs is widespread across all sections of society. It is realistic to think that with drug use at such high levels it has now become a public health issue and should be treated as such. My local expertise is backed up by international evidence. Portugal, reacting to having one of the highest rates of drug use in Europe, decriminalised all drugs in 2001. The report of the Irish delegation to Portugal has shown that there has been significant societal impact since decriminalisation.

While it is still illegal to possess and sell drugs in Portugal, there has been a significant decrease in drug related crime, overdose, HIV and drug use, especially among the youth population. It is of no surprise that other countries are now following suit, treating drug use as a public health issue instead of one of criminal justice. International bodies such as the World Health Organisation and the European Convention on Human Rights also call for the decriminalisation.

I will conclude by saying that BeLonG To is in favour of altering Ireland's current approach to the possession of limited quantities of certain drugs. In our experience, current legislation actually prevents LGBT young people from seeking support for their drug use for fear of criminal sanction. LGBT young people are also less inclined to disclose or discuss their drug use due to the stigma that surrounds criminality, drugs and addiction. We believe that while the current legislation has been set up to outlaw and prevent drug use it has not achieved this in Ireland. International evidence has shown that the stated aims and objectives of prohibition of illegal drugs have not been successful.

We now have a unique opportunity to learn from the approach taken in Portugal and move towards a future that treats drugs users in a more humane and dignified way by addressing drug use and addiction as primarily a health issue. We need to have an effective drugs strategy that complements a new and effective drugs policy or we run the risk of continuing to fail. To quote the delegation report on the visit to Portugal, "It takes a lot to make an honest person to become a criminal".

Chairman: I thank Mr. Roe. We will now move on to the Dublin North East Drugs and Alcohol Taskforce. I invite Mr. Pat Carey to make his opening remarks.

Mr. Pat Carey: I thank the Chairman and the committee for this opportunity to present our ideas and thoughts. I thank the members for their attention to what we are trying to promote. Our task force covers the area from Clontarf, Howth, Darndale, parts of Baldoyle and some of the Dublin 3 and Dublin 5 areas. At local level we are mandated to implement, in as far as we can, the National Substance Misuse Strategy.

I have been involved in this work for some time. The argument I would put forward at this stage is that it is time for society to look in new ways at the how addiction is seen and treated. This is something I have come to slowly, but now is the time to place this whole debate into the health space.

When I was in the Department this issue arose on two occasions. There was extreme reluctance to go down that route and the war on drugs was constantly mentioned, in here and elsewhere. I never believed in the war on drugs. There is a huge complexity attached to that whole debate and we need to mediate it. The Houses of the Oireachtas have a key role in that regard. Addiction should be treated as a public health issue and I believe there are the beginnings of acceptance for that argument. I compliment the Minister of State, Deputy Aodhán Ó Ríordáin for helping to open up the debate and we will gladly contribute to it.

Criminality stems from addiction, it is not the other way around. Anybody who represents a community which is in any way disadvantaged will be aware that the incidence of criminality and disadvantage are all closely linked together. Any changes in the law on decriminalising drugs for personal use should be part of a broad public health review. We are probably ready at this stage to hold that debate in Ireland but it needs to be careful and thoughtful. Something introduced in another jurisdiction is not the strongest argument going for introducing it in Ireland but there is sufficient evidence available that it helps the person likely to be a victim of substance misuse if there is another approach to their treatment and the criminal justice system is not strictly part of it. In the same way that we have managed to devise sanctions for the overuse and misuse of alcohol, I have no doubt that the same approach can be adopted in tackling abuse and misuse of substances such as cannabis and others.

To allay public fears, we must make the distinction between decriminalisation and legalisa-

tion as these are two very separate arguments. It would be futile for us to try fighting in public on the merits of one over the other. Strategies have been developed in Ireland for some time and some people in this room were pioneers in how the process was driven through the years. They know that the best routes forward are enlightened ones.

I will use the task force we represent as an example. The most recent figures available from the Garda indicate that 79% of detections are for simple possession, with 80% of detections in the most disadvantaged parts of the task force area. The total number of detections were 557, with 445 from the parts of the constituency that would be regarded as most disadvantaged. There is no point in decriminalising certain categories of drugs unless that is done in conjunction with other changes in tackling addiction. That is down to resourcing, and there must be a serious increase in the level of resourcing across the board. It is very easy to trot this out but evidence can be made available. The Health Research Board and other research bodies have much evidence accumulated over ten or 15 years to demonstrate that any point we make can be backed up.

Resources need to be found to change the culture that facilitates and normalises addiction. Certain parts of large urban areas in this city and others see, regrettably, very young children introduced to substances that lead rapidly to addiction at a very young age. Programmes grounded in the primary sector, for example, must be implemented seriously and in a widespread fashion. I urge this committee to encourage the educational sector to be much more proactive in the way it approaches the implementation of the strategy, both at a local and a national level. There is a wide variety of programmes.

In future, we can learn from other countries and particularly what has been done when they have gone down the decriminalisation route. We must adopt a humane and health-focused approach for people apprehended with cannabis for personal consumption and treat those people as patients rather than criminals. Law enforcement resources must be targeted at drug suppliers and gangland crime. Task forces are well positioned to identify needs and engage communities but, ideally, policy changes are needed to support those in addiction and punish those engaged in criminality.

Mr. Graham de Barra: I thank the Chairman and members of the committee for inviting us to appear before it today. I am the founder of Students for Sensible Drug Policy, SSDP, in University College, Cork, and the National University of Ireland, Galway. I co-authored today's submission to the committee. My professional experience working in drug policy includes five years working with youth non-governmental organisations, four months with the Pompidou group at the Council of Europe, of which Ireland is a member state, and several consultations in the United Nations. Currently, I am an adviser to SSDP and the director of Help Not Harm. Our current approach to drug policy in Ireland is a failure. This point is indisputable. There is, on average, one drug-related overdose in Ireland every day, which is almost twice the number of fatal road crash incidents. The national student drug survey indicates that one in two third level students have consumed cannabis in the past 12 months alone. Drugs have never been easier and cheaper to obtain in every town, village and city in the country, from Donegal to Cork. In Ireland, we have arrested 140,000 people for drug possession over the past ten years, making up 75% of all drug arrests. That is 40 arrests every day for possessing small amounts of drugs. A conviction has serious ramifications for a young person's life and the lives of those living in poverty, as the committee well knows. A conviction may restrict education, work and travel. Research from the University of Essex indicates that people with cannabis convictions have 19% lower average lifetime earnings than those who do not. Criminalisation therefore con-

tributes to poverty, stigmatises one in two students and it is not saving lives. A case we came across as recently as last night, through our own members, is that of a young person convicted for possessing cannabis worth €2.

Insanity, as defined by Albert Einstein, is doing the same thing over and over again and expecting different results. It is time for Ireland to bring its drug policy into the 21st century. At SSDP, we recommend the decriminalisation of personal drug possession in a holistic approach that includes education and treatment, in light of the committee's report on its trip to Lisbon last June. Many countries have taken this approach already and I commend the committee for investigating the Portuguese example. Ireland has 15 times as many drug-related deaths as Portugal, which has the lowest incidence among all European Union countries. As a result of decriminalising drugs in Portugal in 2001, HIV rates have halved and there has been a reduction in injecting drug use and drug use by minors.

With austerity, a number of Garda stations in the country have closed but somehow we are actively investing scarce resources into arresting 40 people per day on non-violent personal drug possession charges. We do not arrest 40 people per day for hard, violent crime, and the excuse given is that there are not enough resources. We must redistribute Garda resources and determine who is a bigger threat to society. Is it the college student smoking cannabis in his bedroom or the gangs roaming our streets? If a politician wants to be seen as tough on crime, this is the perfect opportunity. We will vote for anybody who comes forward to support decriminalisation.

All drug use, including alcohol consumption, is only problematic for approximately 10% of people, according to Columbus State University. We do not criminalise people who consume alcohol in a harmful way and instead we help them. We should do the same with all drugs. Current drug policy does not prevent drug use but it does prevent people getting help. If our goal is to minimise harm and save lives, the evidence from Portugal indicates that a more balanced, social and just approach with decriminalisation is the minimum solution. With the national drugs strategy due for renewal, we hope the committee will consider our proposals. I thank the committee for listening.

Mr. Daniel Kirby: I am a PhD student of biomedical physics at Dublin City University. As we outlined in our submission, decriminalisation of personal possession is certainly a very positive step to take towards battling the problems associated with drugs in our country today. However, it is important to be honest about the shortcomings of decriminalisation and seriously explore the possibility of legalisation and strict regulation of drugs.

The knee-jerk response to any mention of legalisation of drugs is fear that it would increase availability. This is not true. Drugs are incredibly easy to find in any town in this country, despite their illegality. What we currently have is an entirely unregulated black market for drugs. It is precisely because drug use is risky that we want to explore a regulated market.

It is essential to accept that large sections of our society engage in illegal drug use. This will always be the case, whether it is a nurse smoking a joint after a stressful day, a student taking ecstasy at a party, an artist taking LSD because he or she is curious about the perceptions of reality or a homeless heroin user trying to forget the pain of his or her early life. We can shake our heads and wonder why people engage in activities that seem irresponsible and pointless to some of us or we can accept that some people will always engage in risky behaviour. We should allow them to do so without being branded criminals or greatly increasing that risk by the fact that the only drugs available are of unknown origin and purity.

We have a chance to create a correctly regulated drug market, learning from the mistakes made with alcohol and cigarettes. There should be strictly regulated marketing, with no pushing of products or sponsoring of sporting events.

Many countries around the world have realised that the war on drugs is not working, and governments are starting to take action. From Portugal to Uruguay and from Colorado to Washington, Governments are investigating new approaches. It is time for us to seriously consider moving the control of drugs from criminal gangs to the governments who are supposed to have our best interests at heart. Legalisation and regulation are the only way to do this.

Ms Maura Butler: The Association for Criminal Justice Research has a broad membership, some of which are of the view that decriminalisation is not a good idea, while others are in favour. Second, it is important to indicate that the views expressed in this submission are those of the ACJRD in its independent capacity and are not those of the ACJRD members' organisations or their employers. I propose to present a résumé as required, but before doing so I wish to state that I am very obliged to both Professor Catherine Comiskey and Denis Murray for assisting the ACJRD in compiling this submission. Mr. Murray is a family therapist. Ms Comiskey is a professor who has kindly agreed to attend today to assist the committee with her very broad research knowledge and statistics on this area, for which I thank her.

Initially, in the ACJRD submission, we raised some queries about the Lisbon document. We pointed out that it might be useful to the discussion to have the following: more data on the less positive or negative results of the Portuguese policy; empirical evidence to support the contention that the criminalisation of addicts was counterproductive and prevented them from seeking help; the metrics that determine what "personal use" quantities might be; the resource implications in Portugal of reporting to the Commission for Addiction Dissuasion; information on whether the Portuguese State has power to require treatment, the type of follow-up treatment and how it might work; data showing that users gained full-time employment and did not go back to drugs, which was mentioned in the report, but without supporting data; and statistical analysis of the outcome in Portugal over the past 15 years.

In relation to literature reviews in this area, ACJRD would like to point to its 2013 annual conference paper, entitled Preventable Harm: Criminal Justice, Communities & Civil Society, which examined the matter before today's committee. On a previous occasion we made presentations on the relationship between gangland crime and drugs, which we feel ought to influence this particular discussion.

With regard to research, I am obliged to Professor Comiskey, who will elucidate this matter later on. Research conducted by the National Advisory Committee on Drugs and Alcohol has indicated that the use of illegal drugs is widespread and spans all age groups in Irish society. A NACDA report in 2009 demonstrates that in 2006, the number of persons who used opiates in this country was over 20,000, which means 7.2 persons per 1,000 of population. International research has shown that treatment for opiate use works, but more is needed in terms of rehabilitation and recovery. It also demonstrates that access to drug treatment reduced levels of crime and improved social functioning. The ROSIE Study, which was conducted in Ireland by Professor Comiskey, is indicative of a similar position in this jurisdiction.

In terms of the promotion of health and well-being, we support what Mr. Carey said a few moments ago about the necessity for a health framework. A study carried out by Youth Work Ireland in Cork in 2011 indicated that social interventions, rather than a medical or legal approach, offered the best outcomes. Also, family therapists reporting on the outcomes of regular

contact with the Garda by young people with regard to purchasing alcohol, around which there is a lack of regulation, have suggested that there is a need to promote health and well-being if a policy of decriminalisation of certain drugs is to be pursued. Family therapists also suggested, in terms of adolescent addiction services, that they had a preference for putting resources into early intervention and protective or preventative measures. Furthermore, statistics from the HSE for 2013, which are in the submission, show that a high and increasing level of contact with young people who have multiple addiction support needs must involve the child and adolescent mental health services, CAMHS, and child protection services. Issues of self-esteem, indebtedness, poor school attendance, lack of motivation, memory loss and mental health concerns are often minimised by young people as separate from their substance use. The changing profile of drug use presents challenges to services in terms of establishing a broad range of treatment responses. A study by the Family Support Network of Ireland highlights that intimidation and threats of violence are increasing among families whose members have drug-related debts. A study comparing various therapeutic responses revealed that multi-dimensional family therapy, MDFT, produced better outcomes for young people.

In conclusion, we suggest that we need more empirical data on how the Portuguese experience worked out. We need to learn from literature review and research, both nationally and internationally. Primarily, treatment is key for drug addiction, and there is a correlation between treatment and reduced crime rates. Plus, any proposed decriminalisation must be done within a health and well-being promotion framework. Adolescents are already a particularly vulnerable group with respect to addiction, requiring early intervention and protective or preventative measures. They require a singular focus in the context of any proposed decriminalisation of the use of certain drugs. All of those matters have huge resource implications, as previous speakers have mentioned, and that is a view that we support.

Chairman: I thank Ms Butler. So far, everyone has stuck to the time allocated, which is appreciated.

Ms Deirdre Malone: The Irish Penal Reform Trust warmly welcomes the invitation by the committee to comment on Ireland's approach to the possession of limited quantities of certain drugs. As the committee will be aware, the IPRT is not a drug treatment service organisation, but we support progressive reform of the penal system, with imprisonment used as a last resort. Over the years we have observed, in research, the intimate connections between drug use and offending behaviour. It is important to point out that the IPRT understands decriminalisation, as opposed to legalisation, to be a reform of the law that would abolish criminal sanctions in respect of the act of possession, but would continue to enforce a prohibitionist regime by shifting the response to a civil or administrative or, ideally, a health-based response.

IPRT firmly holds four views on the issue. First, a focus on addressing the root causes of personal drug misuse would be more cost-effective and socially effective than continuing to expend enormous resources on criminalisation and, in some cases, imprisonment. Second, low-risk offenders, including those found in possession of drugs, could be safely and efficiently removed from the criminal justice system, which would reduce some of the pressure on prison places and resources. Third, and crucially, moves to decriminalise certain drug-related offences must be met with investment in evidence-informed substance misuse services, treatments and interventions in the community, because decriminalisation cannot happen in isolation. The last point, which is very dear to our hearts, and which I do not think will be raised by other witnesses, is that securing employment or training and the ability to rebuild one's life after committing an offence, after conviction or after addiction is crucial to breaking the cycle of offending. With

the Portuguese model, no conviction was recorded when somebody came into contact with the committee on dissuasion. Along with enacting effective spent convictions legislation, we would see that aspect as essential in any model designated for decriminalisation.

To adopt decriminalisation as an approach does not imply that drug use or abuse is not a serious issue or one that does not demand a response. Instead, it recognises that drug use is an issue that demands an effective response. Using a criminal justice response, which includes prison, to tackle a chronic relapsing condition such as drug addiction is counterproductive for the individual and the community. Criminalising possession is not supported by strong evidence of effectiveness in reducing the number of repeat possession offences, and it compounds the cycle of disadvantage.

It is important to note the consensus with regard to international research. One finding by many major national and international bodies is that there is no link between the severity of punishment and the level of drug use in society. In 2012, the Release centre launched a report analysing 21 jurisdictions that had decriminalised possession of all or some drugs and found no increase in the prevalence of drug use. That finding has been echoed and amplified by the World Health Organization, the United Nations Development Programme and, most recently, by the UK Home Office in its 2014 policy paper. There is consensus that decriminalisation has no impact on drug use, but it would have an impact on the wastage of resources within the Irish criminal justice system in terms of Garda time, court time and prison resources. When the committee considers this issue it must look not only at the offence position but at that first interaction with the criminal justice system. Addiction or the use of drugs can contribute to other drug-related offences, such as theft and shoplifting, which often arise in relation to drug use. A very common sanction in regard to drug possession would be a court ordered fine. We are aware that in 2014 more than 9,000 people were imprisoned for failure to pay a court ordered fine. That flow of entries into and out of the prison system not only has an impact on admissions and accommodation for the Irish prison system but also has an impact on such things as security. Transience in the prison population, caused by high rates of committal on short sentences, increases the risk of illegal drugs entering the system and creates an unstable environment in which it is more difficult to maintain good order.

We know from the Release report that the Portuguese experience was that while in 1994, 44% of prisoners were incarcerated for drug related offences, in less than ten years that number had halved to 21%. This resulted in a major reduction in prison overcrowding in Portuguese prisons. In our view, decriminalisation would reduce some of the strains on the prison system but also reduce the number of drug users circulating within that system.

The cost of prison is enormous - €70,000 per year per prisoner, not including education, court time or prison time. To use the full force of the criminal justice apparatus is an expensive and ineffective response to personal drug possession and it potentially diverts resources away from services and supports and Garda time that could be used much more effectively to address the more serious offences and offending.

I mentioned the impact of the Portuguese approach and the fact that no criminal conviction was recorded in those cases. We would simply reiterate that along with effective spent convictions legislation, which we still do not have, this would be a crucial part of the system of decriminalisation. The Irish Penal Reform Trust views the introduction of this model, if properly researched, properly resourced and properly operationalised, as one which has very strong potential to represent an innovative and cost-effective response to drug misuse and related offending.

Chairman: I thank Ms Malone for her presentation and for keeping within the time limit. I appreciate that. I invite Ms Martina McGovern to make her presentation.

Ms Martina McGovern: I thank the Chairman, Deputy David Stanton, and members of the committee for the invitation to address it. We welcome this opportunity to draw attention to a few points which we ask the committee to consider when drafting any strategy in this area.

The Irish Association of Social Workers, IASW, founded in 1971, is the national organisation of professional social workers in the Republic with more than 1,000 members. As social workers we work in partnership with individuals, families and groups experiencing marginalisation, disadvantage, social and emotional difficulties. We view the client in the context of the society or system in which they exist and not solely as an individual.

Our key recommendations are that drug treatment services actively prioritise adults who are parents for treatment, both outpatient and inpatient. Effective treatment of the parent can and does have positive impacts on the health, welfare and safety of the child. The Hidden Harm report in Northern Ireland highlighted that parental problem drug misuse can and does cause serious harm to children at every age from conception to adulthood. Children are at higher risk of emotional and physical neglect or abuse, poverty and material deprivation and poor physical and mental health in adulthood.

We recommend that part of the existing homeless services provide accommodation and associated services exclusively to pregnant women and their partners or to parents who are in treatment and are caring for new-borns. The Child Care Act 1991 highlights that the welfare of the child should be of paramount consideration. A commitment from homeless services to allocate, provide and prioritise accommodation specifically for families would be welcomed.

Our association recommends that the number of short-term beds which are set aside for stabilisation purposes be increased. We recommend that domestic violence services offering emergency accommodation offer placement to those with drug issues who are engaged in treatment. A number of the services which provide emergency accommodation request that those who are offered placement are "stable in drug treatment". Imposing such a condition continues to leave women who are often already vulnerable, further isolated and without access to a service which we firmly believe would be of huge benefit. While the progress of those attending treatment obviously varies in the level of stability they are achieving, the fact that individuals have committed to a programme is a clear indication of motivation towards rehabilitation. We recommend that homeless services set aside a residential service or services admitting those who have entered into drug treatment residential programmes and have successfully completed them. Many former drug users find themselves homeless after completing rehabilitation.

I thank the committee for the opportunity to voice our views. I welcome any comments which members may have.

Chairman: The final submission in this session is from Merchants Quay Ireland, represented by Mr. Tony Geoghegan and Ms Denisa Casement.

Mr. Tony Geoghegan: I thank the Chairman and committee members. Merchants Quay Ireland welcomes the opportunity to make an input into this debate. We appreciate it is a topical debate and one that engenders a large range of emotional and ideological responses. Merchants Quay Ireland is a national drug treatment service and provides services across the spectrum of drug misuse from crisis intervention services through to detox, community detox, residential

detox, residential rehabilitation, aftercare and some social housing. As such, any input we have into the debate is specifically from a drug treatment perspective as this is where our experience and expertise lie.

Merchants Quay Ireland views addiction as primarily a health and social issue and as such believes that it is best dealt with in the health and social care system. It is our firm belief, based on our many years of experience, that diverting drug users from the criminal justice system into drug treatment services is by far and away the most effective way of addressing the drugs problem. In this regard, as a number of the earlier presenters have mentioned, there is strong evidence, both from Irish and international research, that engagement in drug treatment leads to significant and sustained reductions in drug use, drug related crime and anti-social behaviour. Professor Catherine Comiskey can speak much more fully about the ROSIE study on drug treatment outcomes which was conducted in Ireland under the auspices of the national advisory committee on drugs. It showed that where there was engagement in drug treatment, regardless of what type of modality people engaged in, whether crisis services, day services, residential services, and regardless of whether it was a harm reduction approach or a total abstinence approach, there were still significant gains right across the spectrum in terms of health, social functioning, relationships and reductions in crime. Ms Deirdre Malone mentioned the British Home Office. Its cost-benefit analysis on drug treatment provision estimated that for every £1 spent on treatment there was a £3 saving in terms of criminal justice costs and that saving increased significantly when health and social costs were taken into account.

We see the decriminalisation of the possession of a limited amount of certain drugs as a positive mechanism for diverting people from the criminal justice system into the health and social care services. I reiterate some of the other points. The fact that possession of a limited amount of certain drugs for personal use would not be a criminal offence does not mean there would not be intervention with the person. It simply means that rather than a criminal justice sanction being made, a public health intervention would be made with the person. It is important to realise that. In this way, decriminalisation has the potential to impact positively in a number of ways, first, by diverting people into drug treatment and support services at a much earlier stage in their using career. It is important to remember in terms of drugs and drug use that it is not a one-size-fits-all approach. There is a plethora of drugs and people use them in all different ways. In terms of engaging with people, the earlier this can be done, the better the outcomes.

The second element, post-drug treatment, is something on which a number of people have touched. Decriminalisation has the potential to remove one of the most significant barriers to reintegration for those in recovery. We know, unfortunately, that during the course of their drug use so many drug users come in contact with the criminal justice system and often acquire convictions, either for drug use or related matters. There is no facility in Ireland to enable these convictions to become spent, which is contrary to the Government's policy on drugs. The national drugs strategy has a specific rehabilitation pillar which places emphasis on reintegration into society. It is universally accepted that the best outcome for drug users, including those engaged in crime, is rehabilitation and reintegration into society. However, the rehabilitation process is severely hampered. It is nonsense to invest huge amounts of money in trying to engage people in drug treatment, as well as encouraging them to reintegrate into society, when there is such a significant barrier which repeatedly knocks them back in terms of employment, insurance, travel, their own self-esteem and how they feel. That matter is really important.

In summary, I would like to highlight a couple of points. Decriminalisation has the potential to direct drug users out of the criminal justice system and into drug treatment. In its own

way, that would relieve the burden on the criminal justice system, including in overcrowded prisons, the courts which are run ragged and, to some extent, the Garda. Equally important, for people who are experiencing problems or using drugs, it would increase their access to and contact with drug treatment services. Other significant public health gains would come out of this, including a reduction in the spread of hepatitis and HIV. Our experiences during the years have shown us that the criminalisation of drug use does not act as a deterrent when somebody decides to start using drugs. It does, however, impact significantly on them when they try to stop using them. From a treatment perspective, therefore, we would welcome this initiative.

Chairman: I thank Mr. Geoghegan.

Earlier we thought we would not have enough seats for everybody in attendance, but we do now. I have, therefore, invited the other groups present to join us. I propose that we continue with the presentations and take questions afterwards. I am pleased, therefore, to welcome the representatives of the Irish Hospital Consultants Association who include Mr. Martin Varley, secretary general; Dr. Eamon Keenan, consultant psychiatrist - adult education; and Dr. Gerry McCarney, consultant psychiatrist - children and adolescents. The Ana Liffey Drug Project is represented by Mr. Tony Duffin, director, and Mr. Marcus Keane, head of policy and advocacy. They are all welcome. I also wish to welcome back Ms Anna Quigley, co-ordinator of the City-wide Drugs Crisis Campaign.

Earlier Deputy Finian McGrath initiated a debate on gangland crime in Dublin. When we debated the matter, we discovered that we did not have a Minister of State with responsibility for dealing with the drugs problem. When we subsequently wrote to the Taoiseach, Deputy Aodhán Ó Ríordáin was appointed as a result. I know that the former Minister, Mr. Pat Carey, did great work in this role. We also travelled to Portugal to assess what was happening there; therefore, all of this flowing from that work.

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 it to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to 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 asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable.

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 Houses or an official either by name or in such a way as to make him or her identifiable.

We will start with the Irish Hospital Consultants Association. I call on Mr. Varley to make its presentation.

Mr. Martin Varley: I thank the Chairman and members for the invitation to appear here today. I will just make a few introductory comments. The Irish Hospital Consultants' Association represents 85% of consultants working in acute hospitals and mental health services. Our submission, which members of the committee have probably seen, has been prepared with the assistance of consultants working in the HSE's addiction services in Dublin.

At this point I would like to hand over to Dr. Eamon Keenan on my right-hand side. He will

give the committee a summary of our position.

Dr. Eamon Keenan: I thank the Chairman and members for inviting us here to talk about this very important topic. The IHCA has decided to make a submission on this issue because we were concerned about a lack of balance in the debate to date. The public discussion on drug decriminalisation or legalisation appears to have looked at the positive results of liberalisation as opposed to perceived negative consequences.

We fully accept that obtaining a criminal record for the use of a drug brings with it significant adverse consequences which would be removed with decriminalisation. However, the risk of a criminal record may act as a deterrent to drug use for some people. It has been noted that decriminalisation is a risk factor for future use and a concern exists that decriminalisation is simply one step along the way to the legalisation and production of drugs.

Increased use of any drug is likely to result in increased need for accessible treatment and there has been little planning or resourcing for this. Any treatment should be readily available prior to changing a law to facilitate increased drug usage.

We are concerned that the debate focuses on rights without offering adequate consideration of the harmful effects of drug use. Many drugs have specific harms, but taken as a whole, they generally do affect one's capacity to function normally when intoxicated. The emergence of the new psychoactive substances has been noted with concern by many clinicians in Ireland and abroad. One of the major selling points of these substances is the fact that they can be marketed as legal for some time until legislation can be put in place to deal with their distribution and use. The fact that they are legal has been reported as one of the factors that people consider when they use the substance. We feel it is important that the negative effects of substance use, as well as perceived positive effects, are discussed in the public domain.

In the Netherlands, prevalence data on use of cannabis and other drugs concluded that the policy of depenalisation did not increase the prevalence of cannabis use. However, they did detect a significant escalation in use of cannabis following the commercialisation of cannabis via coffee shops.

Much has been said about Portugal. In 2001, Portugal introduced a new law which significantly changed the legal response to drug users. They ended criminal sanctions for drug possession for personal use but developed commissions for the dissuasion of drug addiction to direct drug users into treatment. At the same time, they also developed a drug strategy, similar to our own national drugs strategy, which is likely to have had an impact on the current situation in Portugal. The Portuguese model is viewed by some as an unqualified success but there are divergent views on this. For example, the Cato report said it was a resounding success, while the APLD report considered it a failure. Both reports have been objectively reviewed and both appear to be very selective in the data which they chose to report. It has also been argued that the policy of decriminalisation may result in more people entering treatment. Two other factors need to be considered in relation to this. First, the commissions for the dissuasion of drug addiction, CEDTs, in Portugal mandated that approximately one third of the people referred to them had to enter treatment because they were deemed to be addicted to the possessed substance. Second, it has also been suggested that the decriminalisation of drug use made people more willing to seek help from health professionals. There is evidence that some measures of the level of drug-related harm deteriorated after the new policy was introduced in Portugal. There was an escalation in deaths linked to substances other than heroin. There was also an escalation in cannabis use among teenagers. Our point here is that people can reach different

conclusions based on which data they choose to interpret.

There is a constantly evolving picture in the United States concerning drugs, specifically cannabis. Different states having differing approaches to cannabis in relation to decriminalisation, medicinal use only, full legalisation or prohibition. Future research from this area will give us an opportunity to examine how these approaches impact on rates of drug use and attitudes among people over time. This is why we feel we should not rush into this decision but take the opportunity presented by the change in legislation in other countries to assess the impact on drug trends, population health and society in general.

In the past, the Government has utilised the National Advisory Committee on Drugs - now the National Advisory Committee on Drugs and Alcohol - to provide scholarly reports on various contentious topics, including harm reduction approaches and dual diagnosis. There is an opportunity now to commission a piece of independent, evidence-based research to inform legislators of the intricacies of the proposed approach in this area. The probability that decriminalisation will result in increased treatment entry is to be welcomed. However, decriminalising any substance gives some tacit consent to its use and, by extension, the State has a moral responsibility to manage the potential negative health impact for at least some of the people who use those drugs. This requires proactive planning by treatment commissioners and treatment providers, which has not occurred to date.

As the National Drugs Strategy 2009-2016 draws to a close, we are strongly of the view that these factors should be taken into account in developing any new national strategy for 2016 onwards. We very much welcome being at the table for these discussions because treatment provision for people with drug-related problems has gone off the agenda in recent times.

Chairman: I thank Dr. Keenan for giving of his time and expertise in putting together his presentation for the committee. We really appreciate it. The next speaker is Mr. Tony Duffin from the Ana Liffey Drug Project.

Mr. Tony Duffin: Thank you, Chairman. I am the director of the Ana Liffey Drug Project. For anyone unfamiliar with the project, it is an non-governmental organisation whose core work is providing direct social and medical services, mostly to active drug users. We work within a harm reduction ethos, in line with the overall objective of our current national drugs strategy, by seeking to tackle the harm caused by drug use. We are almost entirely funded by the State or statutory agencies and we are very grateful for that support. I am accompanied today by my colleague, Mr. Marcus Keane, who is head of policy and advocacy.

I thank the committee for the opportunity to appear before it to discuss this important topic. Having worked in addiction or related services for more than 20 years, I believe the prevailing sentiment regarding drug policy among those who deliver services in Ireland is more positive than I have ever seen. There is a widespread and honest recognition that our current approach is not as effective as it could or should be, accompanied by a willingness to consider other approaches. That this committee is discussing the issue of decriminalisation of possession offences is indicative of the current mood and is to be both commended and welcomed. The fact that possession of certain drugs is a criminal offence makes this committee an appropriate forum for the current discussion, but the evidence internationally is overwhelmingly in favour of drug policy in general shifting from a criminal justice footing to a health footing. The simple fact is that criminalising people who use drugs enjoys the twin distinctions of being both expensive and ineffective.

This is a useful starting point for a discussion on decriminalisation. As a policy response, what does criminalisation of possession of small amounts of drugs for personal use achieve? The objective, presumably, is that should be a deterrent, intended to reduce demand. However, there is no evidence it is effective in that goal. The committee has seen this at first hand in the case of the Portuguese experience. Contrary to predictions, the sky has not fallen in there and that country is not overrun with drug addicts and drug tourists. As the European Monitoring Centre for Drugs and Drug Addiction, EMCDDA, notes, drug prevalence rates in Portugal have not confirmed the theory that decriminalisation, or a less punitive approach, leads to increased use. Indeed, it seems that criminalisation - or decriminalisation, for that matter - is not significantly linked to demand.

Given that this is the case, the question becomes one of whether criminalisation is the best policy response to the problems associated with possession of drugs for personal use. The answer to that must be "No". In fact, criminalisation does nothing to address the issues citizens face which have led them to be in possession of drugs in the first place, nor does it serve to protect society at large. All it does is simply punish a behaviour. While it should and must be acknowledged that judges and other officers of court are all too aware of the issues surrounding drug use and do what they can to approach personal drug use from a humane perspective, it must equally be acknowledged that this is not their role. The criminal justice system is simply not the appropriate system to deal with what is undeniably a health and social issue.

This leads me to my second point, which is to tell the committee about the people we work with at Ana Liffey. In general, they are problematic drug users, many of whom are also dealing with comorbid issues such as homelessness, mental health diagnoses and physical health diagnoses. It is a group with complex needs and the fact that possession of drugs is not criminalised does nothing to discourage these people's drug use. Criminalisation, however, further stigmatises them unnecessarily. Although people are not dissuaded from their drug use by the existence of the law, they are afraid of the consequences of breaking the law. I have met people who were scared to seek help because of the fear of criminalisation. Whether or not they are correct in these beliefs is immaterial; the fact is their beliefs are honestly held and real and act as a barrier to their getting help.

Thus, the question for me is not whether the *status quo* of criminalisation for possession should be maintained – it is ineffective at best and damaging at worst – but what should replace it. Drugs can be harmful and drug use can cause great hardship to individuals, families and societies. It is correct that we as a society have a response for people who are in possession of drugs. The question is what it should be. Ana Liffey is an organisation which is committed to reducing harm. Consistent with that view, we support the implementation of policies that minimise harm. The committee will be aware that the evidence from Portugal indicates reductions in problematic use, drug-related harms and criminal justice overcrowding. As such, the Portuguese experience is instructive in terms of the general framing of any policy response.

However, we must look at the issues we face here and develop our own response to suit. There are many factors to consider when deciding what such a policy might look like in practice. The Ana Liffey Drug Project is happy to make further submissions to the committee on those possibilities if it would be of assistance. I am satisfied, in general terms, that a one-size-fits-all approach will not work. Complex problems require tailored solutions. A person in possession of cannabis may require a different response from that which should apply to a person in possession of cocaine. A person found in possession for the third time may require a different response from what should happen when a person is found in possession for the first

time. A problematic drug user may require a different approach from what is appropriate for an occasional drug user.

The important thing is that the approach is person-centred, rooted in health and directed towards realistic and helpful outcomes. This is true not just of decriminalisation but of drugs policy as a whole. Drugs policy has traditionally been driven by fear, morality and ideology. This is no firm grounding, and we have reaped the results. Instead, we need a drugs policy that is rooted in health and based on evidence, pragmatism and respect for every individual in society. The criminalisation of simple possession meets none of those standards.

Chairman: Thank you, Mr. Duffin. The final speaker is Ms Anna Quigley of the CityWide Drugs Crisis Campaign.

Ms Anna Quigley: I thank the Chairman for the opportunity to take part in this discussion. I am pleased to say that I am in a position to make my contribution shorter because much of what I intended to say has already been covered.

Chairman: Excellent.

Ms Anna Quigley: It is great to find one's self in a room with people who are in agreement with oneself and making all the same points. It makes life a lot simpler. As Mr. Pat Carey said earlier, this discussion would not have happened a few years ago. I am here on behalf of the CityWide Drugs Crisis Campaign, which is a network of community-based organisations involved in dealing with the drugs issue, initially across Dublin but now across the country. We have not yet got around to changing our name. Twenty years ago, when we started working in communities, people locally were looking for a law and order approach to this issue. They were very clear about that. Even three or four years ago, we in CityWide would not have been debating the issue of decriminalisation and we certainly would not have had the vast majority of our groups in favour of it, which we do now.

There are two key changes that have taken place. First, there is now a clarity about what we mean by "decriminalisation," which is to say there is a very clear distinction between decriminalisation and legalisation. It is interesting to look back to what was happening 20 years ago. Anyone who was around then will remember the street campaign whose slogan was "Addicts, we care; pushers beware." Even 20 years ago, people were saying that. We find that when we ask people, "Do you think a person should be deemed a criminal because he or she uses a drug?", the vast majority say, "No, we do not." That is what we mean by decriminalisation - that we do not make a person a criminal because of his or her use of a drug. It is not about drugs becoming legal; that clear distinction is well understood.

The other thing that has had a huge impact in changing people's minds is, as other speakers referred to, greater awareness about the impact of decriminalisation. As part of our role nationally, we represent the Family Support Network and service users' network on national committees, as they do not have their own representation. They report very clearly to us the stigma that is involved in being a criminal because of one's drug use, along with all the other things that go along with that. Other speakers today referred to issues around employment and the barriers to work for people with a drug conviction. One particular issue that is very relevant to the community sector is the increase in the prevalence of Garda vetting. One cannot get a job of any description across social services, community services or voluntary services unless one receives Garda vetting clearance. A lot of people we deal with will not even bother applying for clearance because they are convinced that if they have drug possession on their form, their

application will not even be considered. That is a very significant issue.

Several speakers referred to the concern many people have that decriminalising drug users will mean more people are more likely to use drugs. However, evidence from the close to 30 countries that have introduced some form of decriminalisation does not back up that concern. These countries have decriminalised drug use for very different reasons. In Germany a case was brought to the federal court and the position was found to be unconstitutional under privacy laws. In the Czech Republic they have done it for cost-efficiency reasons. There are various different systems, but across the board no significant increase in drug use has been shown as a result. It is important to make that point.

Portugal has been discussed a good deal. The best thing about the Portuguese model is that those responsible do not over-claim for it. They do not say decriminalisation is going to solve the drug problem. What they say is that decriminalisation is one element of the drug policy. That is crucial. One of the issues raised by people who are concerned about decriminalisation is that the change would send a message, particularly to young people, that it is okay to misuse drugs. In fact, the Portuguese system does not do that. There is a clear intervention. The key point is that the intervention is now taking place in the public health area rather than the criminal justice area.

There is another key aspect relating to Portugal. Decriminalisation is not an answer of itself and it is not going to address all the issues we have discussed. Some key points identified in Portugal chime with what we already know from the Irish experience. They are worth reiterating because to some extent they have been forgotten. First, services have been mentioned and they are crucial. In the Portuguese set-up there is access to social work, social services and psychologists. These are services we can only dream about. Our level of services is a major issue. That point has been made already.

Another point relates to inter-agency working. We cannot provide a range of services without inter-agency co-operation. We know that. Indeed, our whole drug strategy is based on that. We have said in a number of forums recently that inter-agency working is no longer supported in our system. It is occurring less and less, and we are going back to silo thinking. This will be an essential part of the package if we are going to decriminalise drug use. The services must be organised on an inter-agency basis.

Another key aspect of the set-up in Portugal is the leadership. I can never remember the title, but they have a director whose job is to ensure co-ordination and co-operation. There has been a lack of leadership in Ireland in recent times. You mentioned earlier, Chairman, about the new Minister of State. We have a Minister of State who is leading strongly on the matter, but we do not have someone in a position on a day-to-day basis to follow up on inter-agency co-operation. There is a major gap and it needs to be addressed.

The final aspect from Portugal is another thing we already know but have forgotten. It relates to the connection between drug use, disadvantage and poverty, and the point that the underlying issues need to be addressed. We should look at introducing decriminalisation and we should use the opportunity to effectively reinvigorate the drug strategy. We already have all the principles in our strategy, but in recent years we have not seen them operating. This would be a great opportunity to try to invigorate and return to the principles that have been effective in the past.

Chairman: Thank you very much. That concludes the contributions of our speakers. Thank

you all for staying within the time and for being concise, brief and most interesting. Four members have indicated that they have questions. We will ask a question and then get an answer and so on. I call on members to confine themselves initially to three questions. Then we will move around until we run out of questions. Senator Bacik is first.

Senator Ivana Bacik: My apologies, Chairman, I was caught at another meeting. I thank all the speakers and groups who have contributed. It is refreshing and important for us to hear their varied and wide experience and expertise in the area and to hear so many contributions. I realise it is not universal and that there is a divergence of views, but many have spoken of the merits of moving to a health-based model as opposed to a purely criminal justice or penal model.

One question struck me following the intervention from the Irish Hospital Consultants Association and Ms Quigley relating to the Portuguese experience. I was not on our delegation that went to Portugal, but we got the impression that it was regarded as successful in terms of harm reduction and better outcomes for persons with chronic addiction. Is that a fair assessment? Someone raised the point that there was an alternative perspective on the Portuguese model. I am keen to hear the views on that.

Chairman: Who are you directing that question to?

Senator Ivana Bacik: The Irish Hospital Consultants Association and Ms Quigley, or anyone else who has knowledge of the Portuguese model.

Chairman: We will give the consultants an opportunity to respond first, followed by Ms Quigley. Who wants to respond?

Dr. Gerry McCarney: I suppose it is fair to say that there has been considerable good press about the Portuguese model, and it merits further observation and investigation to see how it would fit with the Irish perspective. I have examined the figures relating to young people in particular. We should keep in mind some of the relevant surveys, such as the health behaviour in school-age children surveys. In Portugal there has been a gradual but consistent increase in cannabis use in particular. It is now the most used drug among the young population there. The change has arisen since 1999, when it first came in. Indeed, the rate of cannabis use in Portugal has increased to the extent that it is now only a little below the rate for Ireland. Therefore, we have an increasing pattern of drug use among young people in Portugal, whereas the Irish statistics for school-age children are on the way down.

There is a good deal about the Portuguese model that might be worth considering. That is for sure and I think we need to do that. However, we have spoken about ideology. We should not rush in. We need to stand back. People have various views. Not everyone is happy with the Portuguese model and not everyone is happy with the changes in the United States. Certainly, there is a need to develop services in this country. If we were to change the legal status of drugs without spending time developing the services then we would be in a difficult position. If more people are using, then, as a percentage, we are going to have more people with difficulties and hence more treatment needs.

It is not clear-cut. Depending on what they choose to pick out, people can use various data to support their argument. It depends on ideology. It is time for an independent assessment of the data and the studies available, not only those relating to Portugal but from other countries as well, because many jurisdictions are considering this.

Dr. Eamon Keenan: Portugal is taking a very interesting approach. Some elements of the drug-related harm-reduction approach are impressive and they certainly warrant examination. However, to put it all down to a decision in 2001 to decriminalise drugs takes away from the fact that there has been major investment in treatment services in that country. The Portuguese national drug policy was published in 1999. It was amended in 2002 subsequent to the legislative change regarding the decriminalisation of drugs. It is now the case that if a person has a problem with drugs in Portugal, he can get access to treatment at an early stage. It is more than a question of one legislative change; it is an entire package of care. As Dr. McCarney has said, people can pick out certain research to suit their arguments. One of the major criticisms from inside Portugal in respect of the Cato report - the report that is most widely cited to show the benefits of Portugal's approach around decriminalisation - is to the effect that someone was brought in from America and stayed in the country for three weeks and then went back to America. He then wrote a report of 36 pages and got himself into *The Economist* and onto the front page of *Time* magazine. The argument is that he did not really reflect the nuances of what was going on in Portugal at the time. It is very interesting and some elements of it are important and laudable, but we need to look at the evidence properly.

Ms Anna Quigley: I will pick up on what Dr. Keenan said. The statistics are clear in respect of problematic and injecting drug users and drug-related harm such as HIV, hepatitis C, and hepatitis E. All of those have clearly gone down. I do not think there is any dispute on that point. Therefore, for the most marginalised group of drug users, the evidence is clear.

I repeat the point that no one has ever claimed that decriminalisation alone is going to solve the problem. We have to keep coming back to that point. If we do not put in place the services then we will not see any difference. It should be noted that Portugal is similar to Ireland in that the country has gone through a major recession. The people there are honest about saying that the level of services they have now is not at the level of services they had previously. All these factors need to be taken on board. No one is claiming that decriminalisation on its own is going to be the change that makes all the difference. However, the overall shift in the approach to policy is the key. That is what decriminalisation is about. It is about shifting from criminal to public health. It does not hold that we will solve all the problems but simply that we will deal with the problems in a different framework.

Deputy Finian McGrath: I thank all the groups for coming in and making their submissions and sensible proposals. I was beginning to get concerned that there was a little too much consensus for a while because I was agreeing with everyone.

Deputy Alan Farrell: It is a little like the Technical Group.

Deputy Finian McGrath: A red light goes on in my head when I hear the word "consensus". A point was raised by Ms Quigley and the hospital consultants. When we were in Portugal we met people working in front-line services. They said straight out that they could do with more services. At the same time, they had services and they were impressive.

Another point was made about independent research. The Oireachtas Joint Committee on Justice, Defence and Equality will always make decisions based on quality research and independent assessment. We are interested not in good press, but in what works on the ground. It is important to say that.

Mr. Roe's submission hit the nail on the head in relation to young people and LGBT. He mentioned a figure that I need to ask him about. Did he say drug addiction was two and a half

times higher among the LGBT community than the rest of society?

Mr. Gerard Roe: Yes. Research carried out in 2007, which in effect laid the opportunity for the drug service to exist, showed that young adult LGBT people in Ireland were two to five times more likely to consume drugs than their heterosexual counterparts. This comes from an array of factors. There is the experiential or curiosity factor, as we know, but also psychological and other societal factors. As I said in my submission, LGBT young people experience forms of discrimination and social exclusion and that could be one of the reasons for their drug use.

Deputy Finian McGrath: My second question is to Mr. Pat Carey and Mr. Shane Brennan. Mr. Carey touched on the need for a careful and thoughtful approach in Ireland. On the resource issue, Mr. Carey said there is an important role for the education sector. Can a programme or the education sector prevent a young child who is living in a very negative situation and who has very low self-esteem at age ten, 11, 12 or 13 years going down the road of drug addiction? Is there such a successful programme nationally or internationally?

Mr. Pat Carey: Not on its own, to be honest. It would be futile to suggest that any one intervention could. As a general criticism of the education sector, and it happened when I was in charge of the strategy also, it has never fully engaged in the full implementation of the national drugs strategy. Whether it is because of caution or some other reason, I am not really sure. Apart from initiatives like our own, such as strengthening families programmes, some of our work is going into classrooms on invitation. However, the engagement of the education sector is marginal, which is unfortunate. The pressures at second level seem to almost preclude any engagement at all apart, from time to time, in transition year. Unless there is a joined-up inter-agency approach, the strategy will never have a chance to work. It is getting ever more complex by the day. It depends on resources. A good deal of fresh new thinking needs to be embarked on. That is why I welcome the debate on criminalisation. It is not the panacea anywhere and we need to come to the best possible solution for the best possible number of people in addiction, but no one agency or Department can make significant or meaningful contribution to the complexities of substance misuse, whether it is alcohol cannabis or benzos.

Ms Anna Quigley: The role of youth services should be emphasised. It is absolutely crucial. BeLonG To is here and I was at a meeting earlier in one of the youth services in the north inner city. They have a crucial role to play, particularly in more disadvantaged areas to support young people who may be at risk or who are already using drugs. It is one of the reasons we continue to argue that the young people's facilities services fund must be maintained as part of the national drugs strategy. I emphasise that point.

Dr. Gerry McCarney: One of the key things on education and prevention is to get it in early. Many of the young people we see begin to experiment with drugs and alcohol between the ages of eight and ten. Research on the appreciation of alcohol as a positive thing between the ages of nine and 13 in an American city would suggest that is when it happens. It ties in with a change in one's capacity to think in the abstract.

The influence of family and community has a big impact on how people think. If they are exposed, we need to get in at a very early stage. According to the statistics, 9% of females and 13% of males under the age of 13 admit to having been drunk at least once in the previous month. They are alarming statistics. If we are going to talk about education, it has to come in early.

Professor Catherine Comiskey: One way to address the education issue is to look at par-

ents. That is certainly where one might get some early intervention. We are now on our third generation of substance abusers in this country. The NACDA has commissioned a study to look at the number of children living with substance abuse. The ROSIE study showed that for every person in treatment, there was at least one child. If we have 10,000 or more opiate users on methadone, it is guaranteed that there are at least 10,000 children living with substance abuse. That is one way to look at it.

Mr. Daniel Kirby: There needs to be a strong distinction between problematic drug use and non-problematic drug use. If one wants to connect with teenagers and young people, one has to acknowledge the fact that some people will use drugs sensibly without seeing negative consequences, while others will have such consequences. It is important to be realistic about it in order to connect with people and not to say "Just say no".

Chairman: What is coming out so far is that the Portuguese model is worth exploring and investigating and we need more research and facts and figures, which I think we got anyway when we were there. It is not a panacea or the only thing, however. There are many other things that need to happen around this area. That is what is emerging from the meeting so far. Deputy McGrath has a third question.

Deputy Finian McGrath: Mr. Tony Geoghegan referred to the Merchants Quay project. After years of working to provide front-line services, does Mr. Geoghegan consider that the health and social care system is good for society and the broader State and community? Are we taking it seriously enough in terms of the provision of resources for these services?

Mr. Tony Geoghegan: The short answer is "No". Dr. Eamon Keenan is involved in drug treatment from the HSE perspective and would say that waiting lists still exist for treatment. Access to treatment in different parts of the country is highly problematic. We do not have the resources to provide the treatment that is necessary. Agencies like ours have to fund-raise in order to provide our detox services. Ours is one of the few residential detox services in the State. My overall view, based on my years of experience, is that addiction is part of the human condition. There are certainly many arguments within the field as to whether it is a disease or a socially-learned behaviour. I do not think it makes that much difference given that we are not going to find a magic cure whereby one will give someone a tablet which will instantly cure his or her addiction. It is about how we as a society manage it. If one is engaged with people and can try to deal with them on a human level in a health and social care setting, one will have more success than by criminalising people, which is unhelpful. That is not to condone drug use. I recognise like everybody that some people use drugs without gaining problems in the same way as some people have an occasional cigarette. All drugs have the potential for harm, however. It is better to deal with them within a support and social care setting rather than in a criminal justice setting.

Chairman: I thank Mr. Geoghegan for bringing us back to the centre of our debate today, which is the Portuguese approach. They have moved from criminlisation to the health system. In fact, they recommend that we do not even talk about decriminalisation. They talk about moving to health rather than the criminal justice system. Dr. Keenan wanted to come back in.

Dr. Eamon Keenan: I agree with Mr. Geoghegan that the issue of resources is vital. It is all very well having laudable documents and producing strategies - for example, the 2009 strategy - saying that alcohol is now part of an overall substance misuse strategy. The reality is that the resources did not come with that laudable statement. Therefore, there has not been any shift in respect of alcohol services across the country, apart from a few isolated pockets which have

gone out of the way and, as Mr. Geoghegan says, may be involved in fund raising. Resources are key. This requires money and needs to be properly resourced for people to access treatment. We have a very good methadone delivery service in this country but there is much to be desired in respect of resources relating to cannabis, cocaine, the new psychoactive substances and alcohol.

Senator Martin Conway: Deputy Finian McGrath covered a couple of the questions I was going to ask. I would have had a different view until I went to Portugal. For all of the flaws that were pointed out to us in Portugal by the different people who presented to us, the general theme overall was that moving it into health was the appropriate thing to do. We are now in an election cycle so we need to look at initiating the debate, as Mr. Carey quite rightly said. The time is right. Drug use is a nationwide phenomenon, not just an urban phenomenon. I come from a rural part of a mainly rural constituency and I know that many of my neighbours use drugs on a recreational basis and I certainly would not consider them criminals. I embrace the debate and think a mature and sensible approach will come out of our discussions as a committee. When the national debate takes off, hopefully, we will adopt a sensible approach to dealing with the misuse of drugs.

Deputy Alan Farrell: I went to Portugal with the committee recently and it was an eye-opening experience. Like Senator Conway, I had a very firm view about drugs and their use in the public domain, which has changed slightly. I very much welcome the various groups coming in and, in particular, their submissions, which I read yesterday. The only outstanding question I have, which was touched on by Senator Conway, concerns what we do next. Clearly, there is a great deal of research that needs to be done. I am conscious of Ms Butler's contribution. I am also conscious of the fact that our report is not empirical. It is based on the observations of the committee members and the clerk to the committee who were present and on a number of documents that were provided to us. The bottom line is that I believe either the Department of Health or the Department of Justice and Equality needs to have a full debate with the Portuguese authorities regarding how we can learn more from their model and put in the services that are there. The only question I have, which is not directed at any one individual, relates to what we do next, aside from promoting or insisting that the Minister for Justice and Equality initiates some kind of cross-departmental approach to this with the Department of Health with a view to compiling more information so that we can take this matter further.

Ms Anna Quigley: In respect of what to do next, the timing is really good in a way in that the consultation around the next national drugs strategy is starting. It will run through 2016. What would be really useful in respect of the terms of reference would be an oversight committee for developing it and putting the issue of decriminalisation on the agenda. The terms of reference for these kinds of committees and processes can sometimes be quite conservative and based on the way we have done it before, so it would be really useful if the issue of decriminalisation was put on the agenda as part of the development of the new strategy with all the other issues we have talked about here.

Professor Catherine Comiskey: As a researcher, my opinion is that we need more independent research, but I would not wait until the strategy was written, because we have a strategy. In that strategy, one of the actions is conducting more research, and part of that research is a national rehabilitation study. We could look at the decriminalisation and do some research on that. We have already said we are going to look at the question of where we send people if we do decriminalise drugs. We do not know which forms of rehabilitation work and which do not work, because that study, which is in the current strategy, was never acted upon. It needs to be

acted upon as a matter of urgency. I suggest that the committee's next step is to do independent research on decriminalisation involving a longitudinal study and include the question of where we send these people if we do adopt this health model. We know treatment works. What about rehabilitation?

Dr. Gerry McCarney: I agree with the previous speakers. What I think would work well would be to use the time to do a piece of independent research looking at what models are out there and what best fits Ireland while simultaneously integrating the services around the country and conducting a gap analysis to see what is not there. We can then go forward to put that together. The independent research would need to have a time limit so that we have an endpoint at which we say that we will now make a decision about what to do.

Mr. Marcus Keane: To build on what other people were saying, it is important to make a broad policy decision about whether criminalisation of simple possession is the correct way to continue or whether it should be dealt with under a health framework. That broad decision to move from one policy area to another would be the starting point. Obviously, we are very much in favour of moving it to health. In doing that, it is important to consider what the legal position in Ireland currently is: the possession of drugs that are scheduled under the Misuse of Drugs Act 1977 is a criminal offence. The 2010 Act relating to new psychoactive substances does not criminalise simple possession of those substances, so it is not as if it is a major shift in that regard. The simple possession of certain substances is not criminalised.

Chairman: Could Mr. Keane tell us what these substances are?

Mr. Marcus Keane: Anything that is not scheduled under the 1977 Act will fall within the ambit of the 2010 Act dealing with psychoactive substances.

Mr. Pat Carey: I strongly support the call for further research, which should be ongoing anyway. Whatever the outcome, policy makers need to go back to 2007, when the NDRIC report was published. The recommendations in that report need to be implemented. They were not implemented, which has probably landed us where we are at this stage. We need targeted resources and more professionalisation of this sector as quickly as resources permit.

Deputy Alan Farrell: Could Mr. Carey repeat the name of that report?

Mr. Pat Carey: It was the NDRIC report - the national rehabilitation integration framework. It was published before I took over as Minister of State in 2007. Professor Comiskey knows more about it.

Chairman: Deputy O'Brien has three questions.

Deputy Jonathan O'Brien: I will only ask one because most of them have been asked. The biggest issue here is that the legislators are far behind society. We must face up to this issue. The legislators need to get up to speed. I firmly believe decriminalisation is the right way to go, but it is not the solution in itself. If there is a focused policy shift towards decriminalisation, it then forces legislators and Governments of the day to look at the other policy issues that need to be implemented, such as the provision of treatment centres and rehabilitation. That is where we need to go. We need a broad opinion about where we would like to go and policies then need to follow that. The national drugs strategy is contradictory in that it has a rehabilitation pillar but also a criminal justice element. The policy, as it stands, does not lend itself to moving towards a decriminalisation scenario.

The Irish Hospital Consultants Association said in its statement that it accepts that obtaining a criminal record for drug use brings about adverse consequences which would be removed with decriminalisation but that the risk of a criminal record can also act as a deterrent. That may be the case with a very small number of people but there are other deterrents which we need to be considering and focusing on. One is educating people, about which we have already spoken. If we educate people on the dangers of consistent, harmful drug use, that can act as a deterrent. I do not think the argument that the risk of a criminal record is a deterrent is good enough or should prevent us from moving to decriminalise drug use. Indeed, I believe it is counter-productive. It is not the case that one approach fits all. We have been talking about the Portuguese, Dutch and Australian models but what we need is an Irish model. We need an Irish model that works for us. We can look at all of the models out there and take the best parts from each, but unless we develop an Irish model that deals with the Irish problem, we are not going to address it in any meaningful way.

When we talk about criminalisation, we are not just talking about people's inability to get a visa or a job. I met a person at my office last week who had a minor conviction for drug use. That person had received a letter from the local authority to the effect that he would not be considered for local authority housing for a period of two years because of that conviction. That is crazy, particularly in the context of the current homeless crisis. Criminalisation is one of the elements that leads to homelessness and mental health problems, as well as putting people at risk of becoming homeless. Unless we move to a policy of decriminalisation, we are not forcing legislators or policy makers to look at anything other than the system that currently operates.

Chairman: I thank the Deputy and I ask Ms Malone to respond.

Ms Deirdre Malone: On the issue of the impact of convictions, it is a national disgrace that Ireland is the last country in the EU to introduce spent convictions legislation. Spent convictions legislation was first debated and considered in 2006-2007. It is now 2015 and we still have a Bill which has not been seen in over a year and a half. That is a disgrace. This is something we have campaigned on for many years. In the absence of moving forward on decriminalisation, the spent convictions legislation must be enacted. We get calls daily from people with convictions for minor offences who cannot move on with their lives and who, as Ms Quigley said, do not even try. That obstacle relating to the jobs market is entirely at odds with the policy of this Government on rehabilitation. The passage of that legislation must happen in the coming months.

There was a suggestion from Dr. Eamon Keenan that there may be some evidence that retaining criminalisation acts as a deterrent. If criminalisation of drug possession was a deterrent, we would have far fewer people in our courts every day facing drug possession charges. A study carried out by Release in respect of the position in 21 jurisdictions indicates that decriminalisation of possession of some or all drugs resulted in no increase in the prevalence of drug use. Indeed, the World Health Organisation, WHO, agreed that there was no clear link between punitive enforcement and lower levels of drug use and that moves towards decriminalisation were not associated with increased drug use. A British Home Office paper found that, looking across different countries, there was no apparent correlation between the toughness of a country's approach and the prevalence of adult drug use. The idea that criminalisation has ever acted as a deterrent to possession is simply incorrect.

Dr. Gerry McCarney: This is why we are asking for a period of time for independent research on the various models that exist in order to determine which one might fit an Irish situation.

Regarding decriminalisation, the suggestion that the potential for having a criminal record might act as a deterrent is, as indicated in our submission, based on research from California. The latter is as valid as any other research. We are not philosophically opposed to the idea of decriminalisation but there is a need for a balanced approach. Any Irish model deserves to have some research done to see what would be the best approach here.

Having worked for quite a few years in St. Patrick's Institution, I rarely met a young person who was in there just because of possession of drugs. There were other behaviours - including acquisitive crime and public order offences - associated with their drug use and often this was why they were in the criminal justice system. Decriminalisation is not going to necessarily wipe the slate clean for everyone and that must be borne in mind. It all comes down to providing services which can help people and there is across-the-board agreement on that here. That common ground should be our focus.

On the issue of the jobs market and employment, we cannot run away from the fact that if a person is using a drug that impacts upon memory, concentration, motivation, drive and application, that will have an impact on how well he or she might do in the pursuit of a job. That is the reality of the situation. However, if we have proper services to help people, to get them back into education and to motivate them to change their behaviour, that will be beneficial and we are all in agreement on that point.

Ms Maura Butler: I do not want us to lose sight of the fact that the adolescent population is particularly vulnerable. Any policy that is developed must focus on that and must be informed by the work that is being done by adolescent addiction service providers and by their recommendation that education should focus on early intervention and preventative measures. Some of the policies relating to restorative justice could be moved into that space. Adolescents, as a particularly vulnerable group, must be a primary focus in the development and implementation of any policy.

Chairman: I have a question on resources. Ms Malone and others spoke about the cost of keeping people in prison and a figure of €69,000 per annum was mentioned. It must be noted that unless we close down a prison, we do not make massive savings. One must also take into account the costs associated with court cases, with gardaí being tied up waiting for cases to be called, the work of the probation services and so forth, as well as those relating to the Prison Service. In a decriminalisation scenario, we could move those resources into treatment, as has been suggested by many of today's witnesses but is there any way of quantifying that? Could we say that if we move to this new model, a great deal of resources will be freed up which can be used for treatment, rehabilitation and prevention?

Professor Catherine Comiskey: Mr. Geoghegan mentioned figures and I also have some data on that. Work was done in the UK which showed that for every £1 spent on treatment, £3 is saved further down the line. Research has been done on that question but how much more research do we do? While I agree that we need to do some more, there is a lot of research already done from which we can benefit.

Deputy Jonathan O'Brien: On that point, it cannot all be just about money either. Let us not get caught up in figures. If we can keep people out of the criminal justice system and divert that money into rehabilitation and treatment services, that is all well and good. However, we must also realise that at the centre of all of this is an individual who may have a chronic addiction and that addiction could actually lead to a loss of life. We should not just focus on how much it costs, in terms of treatment programmes and so forth. We must look at it from a

humane perspective as well. That is why we must move to a public health focus rather than a criminal justice focus.

Chairman: Yes, but obviously this committee is concerned with matters of justice, which is why we are looking at the issue from that point of view. Other Oireachtas committees can look at this issue from a health point of view. Our concern is with the justice system.

Mr. Daniel Kirby: On the Chairman's question about cost savings, a document was published by the UK Treasury a few days ago. Its focus is on cannabis and legalisation or regularisation. Its focus is on the legalisation and regulation of cannabis, as well as referring to its decriminalisation. It highlighted that up to 672,000 hours of police time are spent on possession offences each year. It also goes into the savings from a financial perspective. It only came out several days ago, so I have not had a chance to ingest it fully.

Chairman: If Mr. Kirby gives the reference to the clerk to the committee, we can get a copy of it. One of the messages I am picking up from this session is hasten slowly and not to rush into this, that more research and a wider debate is needed. I hope this is the start of the debate. All submissions to, and the transcript of, this meeting will be sent to the Minister of State for his consideration. We will publish an interim report on this subject later in the year.

The joint committee adjourned at 3.55 p.m. *until 10.00 a.m. on Wednesday, 21 October 2015.*