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Houses of the Oireachtas

An Comhchoiste um Úsáid Drugaí

Tuarascáil Eatramhach

Deireadh Fómhair 2024

Joint Committee on Drugs Use

Interim Report

October 2024

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Contents

Related information

The Oireachtas Joint Committee on Drugs Use was established to consider the recommendations in the report of the Citizens' Assembly on Drugs Use and make a reasoned response to each recommendation.

Publications

All publications for this committee are available on the Oireachtas website.

Committee videos

Footage of Committee proceedings can be found on the Committee videos page.

Contact details

The contact details for the Committee can be found on the Committee page.

Terms of reference

Read the terms of reference for the Committee.

Committee Membership

Cathaoirleach

Gino Kenny TD, Solidarity - People Before Profit

Leas-Cathaoirleach

Senator Lynn Ruane, Independent

Members

Thomas Gould TD, Sinn Féin

Neasa Hourigan TD, Green Party

Josepha Madigan TD, Fine Gael

Paul McAuliffe TD, Fianna Fáil

Jennifer Murnane O'Connor TD, Fianna Fáil

Matt Shanahan TD, Independent

David Stanton TD, Fine Gael

Mark Ward TD, Sinn Féin

Senator Mary Fitzpatrick, Fianna Fáil

Senator Malachai O'Hara, Green Party

Senator Lynn Ruane, Independent

Senator Mary Seery Kearney, Fine Gael

Senator Marie Sherlock, Labour

Membership notes

- Deputy Kenny was elected Cathaoirleach of the Committee on 24 September 2024 by order of the Thirty- Second Report of the Committee of the Dáil and Seanad.
- Senator Ruane was appointed Leas Chathaoirleach in private session on 11 June 2024.
- Deputy McNamara was elected to the European Parliament on 7 June and resigned his position as TD and Cathaoirleach of the Committee on 11 July 2024.

Definitions

In private session, the Oireachtas Joint Committee on Drugs Use agreed that the following definitions be used in its debate and in the report.

Word or term	Definition
Prohibition	Prohibition refers to forbidding something by criminal law. In Ireland, the cultivation, possession, sale, and supply of controlled drugs is deemed illegal and is unlawful. Possession is prohibited under Section 3 of the Misuse of Drugs Act 1977. Sale and supply are prohibited under Section 15. The cultivation of cannabis and opium are prohibited by Section 17.
Criminalisation	Criminalisation refers to the act of determining in law that the commission of a specified illegal act constitutes a criminal offence.
Health-led responses	Health-led responses are those which focus on actions or interventions that address drug use and associated health and social harms, such as deaths, the spread of infectious diseases, dependency, mental health disorders and social exclusion. Health-led responses depend on State authorities, including the police, social services, and health authorities, having the legal powers necessary to implement diversion having the capacity to support diversion, so that a person found in possession of drugs for personal use, whether that be problematic or non-problematic drug use, will can be referred to the relevant health authority, dissuasion Committee etc. in the first instance. Health-led responses seek to strike an optimal balance between important policy objectives, including diversion measures away from prosecution towards health interventions, dissuasion measures, depenalisation measures and decriminalisation measures. The optimum legal framework to strike this balance will vary from jurisdiction to jurisdiction, depending on the provisions of their legal system and political will.
Depenalisation	Depenalisation generally refers to the policy of closing a criminal case without imposing punishment, for example because the case is considered ‘minor’ or if prosecution is not in the public interest.

Diversion	Diversion refers to any mechanism that supports a person who uses drugs away from the path of punishment by the criminal justice system and towards a health-oriented response such as counselling, treatment, or social reintegration.
Legalisation	Legalisation refers to the process of moving from prohibition to regulation, rendering lawful an act that was previously prohibited. With legalisation, regulations can be introduced to limit the extent of permissions involved, as is seen with restrictions for alcohol and tobacco, where regulations govern who can sell, purchase, and use these products. Within a legalised and regulated regime for drugs, it would remain illegal for non-regulated bodies to sell drugs. There are different ways to regulate the sale of currently controlled drugs, ranging from state monopolies to free market approaches. Penalties for breaching these regulations may be criminal or non-criminal.
Decriminalisation	Decriminalisation refers to the removal in law and in practice of criminal status from a certain behaviour or action. Within a decriminalised model, a person found to be in possession of a certain quantity of a substance or substances, in line with limits to be set in regulations, would not be breaking the law, and therefore would not receive a criminal sanction or criminal record

Legal Acts referred to
The Misuse of Drugs Act 1977 Section 3: Restriction on possession of controlled drugs (including personal use) Section 15: Possession of controlled drugs for unlawful sale or supply. Section 17: Prohibition of cultivation of opium poppy or cannabis plant.
The Criminal Justice (Engagement of Children in Criminal Activity) Act 2024 makes it an offence for an adult to compel, coerce, direct, or deceive a child for the purpose of committing crime, with those found guilty, potentially liable to face up to five years in prison.

Foreword

I am proud as Cathaoirleach of the Joint Committee on Drugs Use to introduce the Committee's interim report. The remit of the Committee is to consider the report of the Citizens' Assembly on Drugs Use and give a reasoned response to the thirty-six recommendations agreed by it in January 2024. The Committee was given a seven-month period to do this up to January 2025 but is publishing an interim report on 22nd October 2024 to record its work done to date. It regrets that it may not be able to complete its agreed plan of work and engage with other valuable contributors.

The Committee has considered all of the recommendations of the Citizens' Assembly on Drugs Use and provided a reasoned response to each one based on its work to date. The Committee has published additional recommendations. Those recommendations and the Committee's reasoned responses are a step along in targeting the urgent changes needed around drug policy and drugs use in Ireland. The Committee Members are alarmed by Ireland's high rate of drug deaths which has recently been the highest in Europe. The negative effects of drug use impacts all of society but disproportionately affects already disadvantaged groups and communities. The Committee Members know this from their own experiences, and this has been confirmed by the national and international witnesses who appeared before the Committee.

The work of the Committee was really helped by the input of all of witnesses who generously shared their time and expertise with it. It was very useful to hear how other countries have planned for and implemented decriminalisation. The testimony of people with lived experience of drugs use in Ireland as service users, service providers and those who live with drug use was very valuable to all the Committee Members. This report can't cover all of the issues and ideas put forward by the witnesses and I'd encourage people to look at the videos of the meetings or read the transcripts to see the range of topics discussed by the Committee.

I thank Leas-Chathaoirleach Senator Lynn Ruane and the former Cathaoirleach Michael McNamara for previously steering the Committee, and I sincerely thank the Committee Members for working cooperatively together.

The Joint Committee on Drugs Use requests that the issues raised in this interim report be the subject of a debate in both Houses of the Oireachtas.

Gino Kenny TD, Cathaoirleach

22 October 2024

Interim recommendations as agreed by the Committee

1. The Committee recognises that the stigmatisation of drug use and the shaming of drug users are a source of significant harm.

2. The Committee recommends that the Government introduce a health-led approach to the use and misuse of substances.

3. The Committee calls for the decriminalisation of the person in relation to the possession of all substances for personal use, in line with the recommendations of the Citizens' Assembly, and this highlights that the goal of drug policy should be to reduce harm and eliminate stigma, both, in large part, caused and exacerbated by the criminalisation of people who use drugs.

4. The Committee recommends that Section 3 of the Misuse of Drugs Act 1997 be repealed, to give effect to a comprehensive health led approach.

5. The Committee recommends, in line with the recommendations of the Citizens' Assembly on Drugs Use, that the decriminalisation of possession for personal use should apply equally to all illicit drugs.

6. The Committee recognises that issuing mandatory health referrals for those found in possession of drugs risks perpetuating existing, harmful stigma, and it will likely draw limited health resources away from those who need them most. With this in mind, the Committee recommends that people should be offered all supports and health resources that are required, but that no person should be criminalised for not availing of a supportive intervention.

7. The Committee stresses the importance of there being a strong, constructive working relationship between the community, voluntary and statutory services, and An Garda Síochána, to support the provision of compassionate and person-centred interventions where required, underpinned by a robust Memorandum of Understanding.

8. The Committee believes that the decriminalisation of the person for personal possession, should not result in an increase in consumption of drugs in a public area. Therefore, the Committee recommends that local authorities and An Garda Síochana are supported and empowered in strongly discouraging and reducing consumption

in public areas. This should be done in an appropriate and sensitive way which considers the complex inter-relationship between problematic use and extreme deprivation and homelessness.

9. The Committee recommends that specific trauma and harm reduction training be provided to An Garda Síochána and local authorities, to inform their work with individuals and communities affected by drug misuse and addiction.

10. The Committee calls for the development of clear guidelines for An Garda Síochána to operate within a decriminalised model.

11. The Committee recommends that the Government expand access to spent conviction legislation for persons convicted of possession of drugs for personal use.

12. The Committee recognises the role that poverty, inequality and trauma can play in the prevalence of problem drug use and addiction, and, accordingly, recommends the implementation of a poverty and trauma-informed approach in the development and delivery of our addiction services.

13. The Committee recognises the provision of stable and secure housing as being essential for recovery with appropriate supports and recommends that barriers to accessing housing for those in recovery be addressed at a local and national level.

14. The Committee stresses that previous offences for drug possession ought not to act as a barrier to an individual accessing stable, secure, and long-term accommodation.

15. The Committee recommends addressing the manifold barriers to recovery, including, inter alia, eliminating waiting lists for treatment, increasing the availability of detox beds, and the increased provision of family support and housing supply.

16. The Committee recommends that the Government invest nationally and locally in addiction services, including in supported housing within communities for people in recovery.

17. The Committee recommends the expansion of access to Opioid Substitution Therapy (OST), to address significant gaps which exist in the availability of methadone services and OST.

18. The Committee recommends expanding access to medical detox and the availability of all treatments along the continuum of care.

19. The Committee calls for the rapid expansion of residential drug treatment, and the pursuit of treatment which is diverse and adaptable to the changing nature of substance use and misuse.

20. The Committee recommends focused and targeted funding to address drug use amongst children and to move towards age-appropriate responses, both in the community and at a societal level.

21. The Committee recommends that the Department of Health develop a follow-on, health-led national strategy to “Reducing Harm, Supporting Recovery," which runs from 2017 to 2025. The Committee stresses the importance of a detailed multi-year plan being developed, which specifies the measures that the Government intends to take, in both the health and justice systems, to reduce drug-related harms and addiction.

22. The Committee calls for any new national drugs strategy to be fully resourced and underpinned by community development to ensure its efficacy.

23. The Committee calls for investment in gender-specific drug services, namely services that cater to the bespoke needs of women who use drugs, including in relation to childcare and the impact of menopause on recovery.

24. The Committee recommends that a national strategy for benzodiazepine detox be developed, so that individuals affected by addiction to benzodiazepines have access to GP led detox.

25. The Committee calls for the funding and resourcing of community-based drug projects and initiatives, so that they can provide individualised wraparound care and support who are accessing detox in the community.

26. The Committee calls for the urgent expansion of Supervised Injecting Facilities (SIF) across the country, especially in urban areas in order to support the reduction of public consumption.

27. The Committee recommends that the provisions of the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 be updated, to allow these facilities to cater to broader drug consumption, and to provide for the delivery of mobile consumption facilities and consumption sites.

28. The Committee recommends that patients have access to the full suite of Opioid Substitution Treatment (OST) and that full collaboration in the decision-making around these choices be consensual and human rights based.

29. The Committee echoes the recommendation from the 2022 report of the Oireachtas Joint Committee on Justice on an Examination of the Present Approach to Sanctions for Possession of Certain Amounts of Drugs for Personal Use and calls for support for the prescription of heroin assisted therapy (HAT) by suitably qualified medical practitioners, to reduce the risks and harms associated with the consumption of black-market heroin.

30. The Committee notes that the number of pharmacies that offer needle exchange is insufficient and therefore recommends an expansion of needle exchange nationally.

31. The Committee recommends that Naloxone become available over the counter, as opposed to being available only on prescription.

32. The Committee recommends that the Department of Health fully finance and resource the Naloxone programme, to include all necessary funding for level one and level two training, and the necessary CPR training.

33. The Committee stresses that there should be no burden or barrier to services, institutions, family members, or others accessing training for Naloxone provision.

34. The Committee recommends that pharmacists are reimbursed for the administration of Naloxone.

35. The Committee recommends that fact-based education and prevention programmes be appropriately resourced and supported at all levels of the education system, including adult education nationwide.

36. The Committee recommends that the Government run national harm-reduction campaigns on sensible drug use.

37. The Committee recommends that trauma training be integrated into the delivery of public services across society, the criminal justice system, and the development of public policy.

38. The Committee recommends an inter-departmental, all-of-Government approach to ending poverty in Ireland.

39. The Committee calls on the Government to undertake targeted investment in areas that are known to impact the development of substance dependency including poverty, social exclusion, low levels of educational attainment, the dearth of housing supply and the prevalence of homelessness, incorporating, amongst other things, significant investment in Family Resource Centres, Drug and Alcohol Task Forces and Community Development.

40. The Committee calls for the provision of suitable support for Irish Travellers and members of other minority communities, including the LGBTQ+ and migrant communities.

41. The Committee calls on the Government to undertake an analysis of adverse childhood experiences (ACE) and their impact on addiction in Ireland, with a view to developing a programme to reduce their prevalence, and to support individuals, families and communities affected by high numbers of ACEs.

42. The Committee recognises that drug-related violence and intimidation are prevalent in communities most acutely impacted by poverty and therefore recommends that the Government develop a strategy to address violence as a public health crisis.

43. The Committee calls on the Departments of Health and Justice to undertake a body of research into how a regulated drug market could operate in Ireland beginning with cannabis, and how Ireland can incorporate and implement the learnings of other jurisdictions that have taken positive steps in this regard.

44. In line with recommendations from the 2022 report of the Oireachtas Joint Committee on Justice on an Examination of the Present Approach to Sanctions for Possession of Certain Amounts of Drugs for Personal Use, the Committee recommends that steps are taken to introduce a regulatory model for certain drugs. The Committee recommends this should be considered with particular reference to

Spain, Malta, and Germany in the development of an Irish not for profit regulated cannabis market.

45. The Committee echoes the recommendation from the Joint Oireachtas Committee on Justice for the expansion of the Medical Cannabis Access Programme (MCAP), to ensure that more people affected by chronic illness can access cannabis in circumstances where other treatments have failed to relieve symptoms.

46. The Committee recommends that the Department of Justice invest more widely in support for people incarcerated in the Irish Prison System, including providing greater access to drug-free environments, reduced waiting lists for psycho-social interventions, and the provision of community drug workers and relapse intervention.

47. The Committee recognises that a regime of a health-led response to substance use and misuse, and support and prevention, is crucial to reducing stigma in prison settings, where punitive measures for drug use or relapse currently exist.

48. The Committee recommends that Naloxone be readily available in all Irish prisons.

49. The Committee recommends that prisoner officers receive training in addiction, trauma, ACEs, and how they impact peoples' lives and outcomes.

50. The Committee recommends that the Irish Prison Service explore the dual roles and competency of prison officers to ensure that their training and education are in line with a rehabilitative model.

51. The Committee recommends that the Department of Justice and the Irish Prison Service, along with the Departments of Health, Education and Social Protection, develop a comprehensive approach to the underlying causes and drivers of criminal behaviour and activity, to include trauma, poverty, intellectual disability, neurodivergence and addiction.

52. The Committee recommends a creative approach to testing at a community level where there is increased drug use. For example, if a supply of the 'fake benzos' is potentially harmful, these can be tested through community service without fear of arrest.

53. The Committee recommends swift and time-sensitive testing by statutory agencies of potent substances to save lives, especially in places of detention.

54. The Committee recommends that, in recognising drug addiction as a health issue that increased investment should be made into programmes, services and treatments which address addiction and the harms associated with it, paying particular attention to harm reduction, recovery, family support and improved social interventions and dual diagnosis services.

55. The Committee recommends that this increase and current core budgets, pilot initiatives and all new investment in addiction and community services are on a multi-annual basis.

56. The Committee recommends investing in a range of services to cover the full spectrum of needs that individuals or communities may experience, including, but not limited to, housing supply, education, employment supports, violence intervention initiatives, counselling and mental health supports, community development, drug and alcohol task forces, family support, and resource services, and psychology.

57. The Committee recommends that dual diagnosis services receive adequate funding to operate effectively across the country, to ensure that individuals who are affected by comorbidities can receive the support and interventions they require regardless of the service they choose to access.

58. The Committee recommends that the Department of Health recommit to the Drug and Alcohol Task Forces model and ensure that they are resourced and empowered in their functions, scope, and strategies. Furthermore, the Committee calls for increased investment in community and voluntary projects that support people who use drugs and their families.

59. The Committee recommends an evaluation of the State's oversight of community-based drug and addiction programmes, to support civil society participation, and to ensure that decision making, and autonomy are not undermined by overly centralised models of service delivery and community organising.

Table A: Recommendations of the Citizens' Assembly and the Committee's reasoned response

Number	Citizens' Assembly Recommendation	Committee's Response
1	The State should take urgent, decisive, and ambitious action to improve its response to the harmful impacts of drugs use, including implementing necessary legislative changes.	Agree The Committee would like to highlight the high levels of death and harm in Ireland as a reason for urgency for this recommendation. The Committee agrees that action taken should not involve a punitive approach to personal drug use, or the treatment of misuse. The State must ensure that people have health options, but they are not mandatory. The Committee recommends further scrutiny of laws and approaches to drugs in public spaces. We believe that decisive and urgent actions are crucial to ending the harmful impacts of drugs use in Ireland.
2	Government should prioritise drugs misuse as a policy priority, as part of an overall socio-economic strategy.	Agree The Committee agrees with this recommendation. The Committee hope there would be a strong emphasis on the relationship between socio-economic status, poverty, trauma, and drugs misuse. The Committee recommends that those in the prison service settings also have access to adequate support and services.
3	Government should give greater political priority and prominence to drugs policy and related issues. A dedicated Cabinet Committee chaired by the Taoiseach, supported by a	Agree. The Committee recommends the policies to address our recommendations are overseen and implemented by a super junior minister in the Department of Taoiseach. This should

	Senior Officials Group, should consider, and publish a detailed annual report on drug trends and emerging risks. The Department of Health must be supported in providing effective leadership and coordination of the work of the National Oversight Committee for the National Drugs Strategy.	include youth work, addiction, drugs policy, mental health, and community development in its brief. It should have its own Standing Oireachtas Joint Committee to deal with addiction issues. The Committee would like to see dedicated funding attached to this recommendation on a multi annual basis.
4	Government should recognise that an effective national response to drugs-related issues requires whole of government policy coherence, operational cohesion, and effective leadership.	Agree. The Committee recommends a cohesive approach with other Government Departments and recommends further insight and research into how other jurisdictions deal with the issues at a governmental level. The Committee recommends a specific inter-departmental group be established that meets on a regular basis that reports to a Joint Oireachtas Committee.
5	The Government must assign accountability, at the highest level, for the State's response to problematic drug use, including for the implementation and tracking of the progress of the Citizens' Assembly recommendations.	Agree. The Committee recommends that the role of the National Oversight Committee should be scrutinised by the inter-departmental group. The Committee recommends that the implementation and outcomes are reviewed on a quarterly basis. The Committee emphasises the importance of evidence-based policy and accountability.
6	The Government should introduce a 'Health in all Policies' approach to policy development.	Agree. The Committee strongly agrees that all policy should be evidence based; including prevention, improving the quality of one's conditions, ending poverty and advance a

		positive social environment that supports recovery and upholds the right to health and wellbeing. The Committee further agrees that 'Health in all Policies' must be intersectional with socio economic status and social justice issues.
7	Government should publish a new iteration of the National Drugs Strategy as a matter of urgency. A first draft should be published by June 2024 for consultation, with the recommendations of the Citizens' Assembly as a key input. The Strategy should contain annual action plans with measurable targets and objectives, clear designation of responsibilities, and regular reporting on implementation and expenditure.	Agree. The Committee expresses its deep concern that the timeline has passed. The Committee recommends that a new strategy should also include the work of the Citizens' Assembly and this Committee.
8	Government should ensure effective stakeholder involvement in implementing the National Drugs Strategy.	Agree. The Committee recommends that the widest possible definition of a stakeholder be taken into account when defining a stakeholder, as done by the Committee and Assembly.
9	Government should work with key stakeholders to build an effective whole of society response to drugs-related issues.	Agree. The Committee recommends further discussion on the definition of a stakeholder to ensure all voices are encapsulated.
10	Drugs policy design and implementation should be informed by service users and people who use drugs as well as family members of people affected by drugs, with	Agree. The Committee recognises the need to engage with all those affected by drugs misuse in order to develop of a 'Health in all policies' approach.

	provision of appropriate supports to enable this involvement.	
11	The State should formalise, adopt, and resource alternative, health-led options for people with a drug addiction within the criminal justice system.	Agree. The Committee recognises that treatment and support work best when someone is willing and ready to engage. We must ensure that the health-led option is always available when it is requested or offered and as many times as it is requested or offered. In addition to this, we must also consider congregated settings within the prison system. Access to health services in those contexts is entirely reliant on state funded treatment, with long waiting lists and limited-service availability.
12	The Government should allocate additional resources to fund community-based and residential treatment and recovery services as an alternative to custodial sentences for people with problematic drugs use.	Agree. The Committee recommends significantly improving funding for community-based services, and sufficiently resourced residential treatment and access to recovery at the level that it is requested. The Committee recommends that engagement with such services is not on a mandatory basis.
13	The Department of Justice and the Irish Prison Service should develop and fund enhanced prison-based addiction treatment services.	Agree. The Committee recommends that best practice treatment should be accessible if serving a custodial sentence. The Committee acknowledges that there are difficulties with prisoners accessing support if serving shorter sentences and this should be addressed and co-ordinated with and delivered by community-based services.

14	The Government should develop and expand the use of alternative pathways for young people engaged in low-level sale and distribution of drugs. The Assembly recommends that the criminal justice system adopts the widespread use of restorative justice and diversion initiatives in these cases, with enhanced investment in community-based youth work and community development projects and initiatives.	Agree. The Committee recommends supporting and expanding community-based initiatives, youth work and youth justice projects to divert young people from this path.
15	Drugs policy should prioritise the needs of vulnerable and marginalised groups and disadvantaged communities.	Agree. The Committee noted that the application of drugs policy and its implementation can vary from community to community and should be consistent across all communities. The Committee recommends that access to treatment is equitable and based on needs. The Committee is deeply concerned that service provision inadequately addresses current service user needs and differs geographically and there is not uniform access to treatment and supports. The Committee further recommends that service provision and improving people's conditions and environment should be addressed with a targeted strategic response that is person centred. The Committee recommends noting that the nature of marginalised groups in Ireland is changing as we experience significant demographic shifts.

16	The National Drugs Strategy should seek to optimise services to ensure continuity of care and joined-up care for all service users, including people with complex and/or specific needs.	Agree. At this point, the Committee recognises that they have not fully scrutinised this recommendation however, it advocates for detailed continuum of care plans. The Committee further recommends for greater dual diagnosis provision and supports.
17	The State should introduce a comprehensive health-led response to possession of drugs for personal use.	Agree. The Committee calls for the Minister to implement and make operational a health led response. The Committee recommends decriminalisation of the person in relation to possession for personal use. The Committee believes that healthcare must be voluntary and does not support mandated healthcare.
18	Government should allocate significant additional funding on a multi-annual basis to drugs services across the statutory, community and voluntary sectors, to address existing service gaps, including in the provision of community-based and residential treatment services, to support the implementation of the recommendations of the Citizens' Assembly. This funding should ensure geographic equitability in terms of access to statutory services, as well as providing for accountability, transparency, and traceability of allocations.	Agree. The Committee has heard from numerous witnesses and strongly agrees for funding to be provided on a multi annual basis. In order to address the recruitment and retention challenges, the Committee recommends improved pay and conditions for those who work in this essential sector.

19	The Government should examine the potential of novel funding sources to support increased drug services within the health and criminal justice systems, and in the community and voluntary sectors. Any novel funding should be secured, tracked and ringfenced for drug services expenditure	Agree. The Committee acknowledges that novel funding is not a substitute for increases to core budgets. Novel funding should only be viewed as a discretionary response that is reviewed at a six-monthly interval and incorporated into annual funding where positive outcomes are found. In the context of taskforces, the practice for obliging taskforces to compete in a tendering process against each other should be ended. The Committee recommends a review of the administrative burden of annual funding applications in community and voluntary sectors.
20	Key stakeholders should publish a joint report on an annual basis detailing total and disaggregated expenditure and channels of funding provided for drug-related services in Ireland, audited by the Comptroller and Auditor General.	At this point, the Committee has not yet considered this recommendation and thinks that this recommendation should be further scrutinised.
21	The Government should recognise, value, and adequately resource the role of family members and extended support network in supporting people affected by drugs use, and their children. Kinship carers and children should have the same rights as foster carers and foster children, and this should include legal rights and monetary rights on a non-means-tested basis.	Agree. The Committee recognises and supports the role of family and communities in supporting persons with addiction and their families. At this point, the Committee did not have time to adequately explore this but recognises the role of kinship carers and advocates for legal and monetary rights on a non-means-tested basis.

22	The National Drugs Strategy should include a strategic workforce development plan.	Agree. The Committee recognises the highly skilled nature of the workforce within the sector, and it is important that professional development options should be available across the sector and ensure pay and conditions parity.
23	A minimum, mandatory basic training should be implemented for personnel across education, health, criminal justice, prison, and social care services on trauma-informed and problem-solving responses to addiction, and health led response options for those presenting with problematic drug use or addiction.	Agree. The Committee agrees with the value and provision of trauma informed training. It suggests that is resourced and available to all those who work in this area.
24	The National Drugs Strategy should continue to prioritise the objective of reducing illicit drugs supply and associated structures, at international, national, and local level within communities.	Agree. The Committee recommends that a cross governmental strategy should be developed when tackling the illicit drug supply chain and their effect on our communities. The Committee heard of the detrimental effect of synthetics drugs, particularly new and emerging variations, and the need to prioritise prevention, education, and testing.
25	The National Drugs Strategy should focus on building resilient, sustainable communities though local partnerships in both urban and rural settings, and stronger community policing.	Agree. The Committee recommends that the National Drugs Strategy be rooted in the work of all community projects, partnerships and drug and alcohol taskforces.
26	The National Drugs Strategy should continue to prioritise the objective of	Agree.

	tackling the source and impact of drugs-related intimidation and violence and take a zero-tolerance approach.	The Committee strongly supports this recommendation and further recommends supporting the need to resource communities to develop long term responses that focus on violence prevention, reducing the harm and increased personal, public and community safety.
27	The National Drugs Strategy should include a detailed action plan to enhance Ireland's approach to prevention of drugs use.	Agree. The Committee agrees and advocates for the continued pursuit of evidence-based prevention methods and continual review against international best practice.
28	The Departments of Health and Education, in conjunction with the HSE, should design and implement a comprehensive, age-appropriate school-based drug prevention strategy for primary school children, junior and senior cycle secondary students, and wider community settings, as well as their parents/guardians and teachers. Prevention programmes should utilise external experts to deliver to classrooms, supporting teachers, with regular updating by the experts to the schools.	Agree. The Committee has not yet fully explored what an extensive age-appropriate drug strategy would look like.
29	The Department of Health should roll out regular national public health information campaigns, focusing on reducing shame and stigmatisation of people who use drugs, prevention, risk mitigation and advertising services.	Agree. The Committee supports evidence-based campaigns that reduce stigma around drug use and provides education on drug related harms.

30	The National Drugs Strategy should prioritise a systemic approach to recovery.	Agree. At this point, the Committee has not yet had the opportunity to explore this in detail. The Committee recognises that recovery looks different for each person.
31	The Department of Health should develop a strategy to enhance resilience, mental health, well-being, and prevention capital across the population, including a focus on providing therapeutic supports for children and young people, and for people dealing with trauma and adverse childhood experiences and dual diagnosis.	Agree. The Committee recommends that such a strategy is well resourced, and evidence based. It is important to note the lived experience of people who have used drugs and the input they can provide to developing this strategy.
32	The National Drugs Strategy should incentivise and promote evidence-based innovations in service design and delivery, prioritise the evaluation of pilot projects and emphasise the timely mainstreaming of best practice nationally and internationally.	Agree. The Committee recognises the difficulties services experience and recommend additional resources, supports to create accessible ways for services to implement their work. The Committee recognises the value of pilot projects and calls for an accelerated mainstreaming of successful pilot programmes
33	The National Drugs Strategy should include a plan to strengthen the national research and data collection systems for drugs to inform evidence-based decision-making.	Agree. The Committee recognises the value of data and evidence based resources and suggests the administrative burden for this data collection needs to be streamlined and minimised. The Committee notes that this should sit across all health service provision not just those in addiction etc.

34	Referral of submissions received by the Citizens' Assembly from the general public and stakeholders on Drugs Use to inform the development and implementation of the National Drugs Strategy.	Agree.
35	Referral of certain submissions received by the Citizens' Assembly on Drugs Use, in relation to the potential therapeutic benefits of certain substances, to the appropriate authorities for consideration.	Agree. The Committee has not yet fully scrutinised the potential benefits of certain substances but supports the referral of all materials by the Citizens' Assembly and the Oireachtas Joint Committee on Drugs Use.
36	The National Drugs Strategy should use evidence-based approaches to harm reduction and take measures to reduce the barriers to implementing harm-reduction approaches without undue delay.	Agree. The Committee emphasise the capacity of underfunded services and support all efforts to ensure effective, successful measures.

Remit

The Oireachtas Joint Committee on Drugs Use (the Committee) was established to consider the recommendations in the report of the Citizens' Assembly on Drugs Use and make a reasoned response to each recommendation.

The Committee was established by a motion agreed by Dáil Éireann on the 14th May 2024 and by Seanad Éireann on the 15th May 2024. The actions of the Committee are governed by its terms of reference.

Introduction

The Committee was established to consider the recommendations contained in the Report of the Citizens' Assembly on Drugs Use. The Committee must report to both Dáil Éireann and Seanad Éireann within seven months of its first public meeting. It can report sooner if necessary or appropriate.

The recommendations of the Citizens' Assembly on Drugs Use (the Assembly) make a valuable contribution to informing the Oireachtas and Government on possible approaches to drugs use in Ireland. The recommendations span a range of issues including the need for drugs policy to be prioritised by Government, how the State should deal with the possession of drugs for personal use, funding, resources for communities to respond to drugs use, a new National Drug Strategy and improving services for drug users.

The Committee held two meetings in private session to agree a work programme ahead of its first public session. The Committee has met seven times in public session to date to discuss the recommendations of the report of the Citizens' Assembly on Drugs Use across the first two modules. Its first public meeting was on 13 June 2024.

Recommendation 17 of the Citizens' Assembly which calls on the State to introduce a comprehensive health-led response (rather than a criminal response) to the possession of drugs for personal use is of particular interest to the Committee Members. Such a change in approach would have such an impact in a huge number of policy areas such as policing, the courts, public services, and public spaces etc.

Witnesses and Modules

Witnesses were suggested by Members of the Committee and the Committee Secretariat. As part of its work programme the Committee met twice in private session to agree a series of modules to examine the Assembly's recommendations through a series of themes, set out below. The interim report examines Modules 1 and 2.

- Module 1: Drugs Policy, the National Drugs Strategy and a whole of government approach
- Module 2: Engagement on Decriminalisation, Depenalisation, Diversion and Legalisation
- Module 3: Engagement on a Health Led Approach
- Module 4: Family and Community

Explanatory note on Modules

Module 1: Drugs Policy, the National Drugs Strategy and a whole of government approach

Examining parts of recommendations 1->5,7->10,16,20,22,23,27,30,32-36.

- These two meetings explored the pressing need for alternative approaches towards Ireland's drug policies be discussed, both in terms of the need to increase treatments and supports for drug addiction and in terms of the potential to discuss and change the current approach towards the regulation of drugs; and the nature of drug use in Ireland, current drugs policy, the national drugs strategy and legislative frameworks and the need for a cross government approach.

Module 2: Engagement on Decriminalisation, Depenalisation, Diversion and Legalisation

Examining parts of recommendations 11,13,17,19,23,24,28,29,31

These meetings explored comparative models in practice of:

- Depenalisation generally refers to the policy of closing a criminal case without imposing punishment, for example because the case is considered 'minor' or if prosecution is not in the public interest.

- Decriminalisation refers to the removal of criminal status from a certain behaviour or action. With decriminalisation, the likelihood of an offender receiving a criminal record and custodial sentence can be very significantly reduced (usually with de facto decriminalisation), or entirely eliminated (usually with de jure decriminalisation). In many EU jurisdictions, decriminalisation in the context of drug laws does not mean that the behaviour becomes legal, nor does it mean the elimination of sanctions or penalties for the commission of an offence.
- Diversion refers to any mechanism that moves an offender away from the path of punishment by the criminal justice system and towards a health-oriented response such as counselling, treatment, or social reintegration.
- Legalisation refers to the process of moving from prohibition to regulation, rendering lawful an act that was previously prohibited. With legalisation, regulations can be introduced to limit the extent of permissions involved, as is seen with restrictions for alcohol and tobacco, where regulations govern who can sell, purchase, and use these products.

Module 3: Engagement on a Health Led Approach

Examining parts of recommendations 6,17,23,36

- Health-led responses are those which focus on actions or interventions that address drug use and associated health and social harms, such as deaths, the spread of infectious diseases, dependency, mental health disorders and social exclusion.
- Health-led responses depend on State authorities, including the police, social services, and health authorities, having the capacity to support diversion, so that a person found in possession of drugs for personal use, whether that be problematic or non- problematic drug use, will be referred to the relevant health authority, dissuasion committee etc. in the first instance.

Module 4: Family and Community

Examining parts of recommendations: 7-10,12,14-16,18,19,21,23,24,25,26,28

- The importance of the family in supporting those in addiction, and the hidden trauma and harm experienced by the family, cannot be underestimated. Families and communities are often the first, and most, impacted by a person's addiction. This can often result in further harm to the family. The ways in which the various family

and community support services can help prevent these harms The concept of ‘family support’ is generally understood as the provision of services and interventions that support families in carrying out their ‘functions’ and a ‘whole family approach’ is an approach which recognises the intergenerational trauma and harm that can result in, and be caused by, addiction.

Module 1 meetings

Date	Module 1 meetings	Drugs Policy, the National Drugs Strategy and a whole of government approach
13 June 2024	Meeting 1 - Watch video transcript	**Engagement with Representatives from the Citizens Assembly** • Paul Reid, Chairperson • Cathal Regan, Secretary • Professor Jo-Hanna Ivers, Advisory support group • Brian Galvin, Advisory support group • Céire Moynihan, Member of the Assembly • Graham O'Neill, Member of the Assembly
20 June 2024	Meeting 2 - Watch video transcript	**Engagement with the HSE, Department of Justice and the Department of Health** Department of Health • Siobhán McArdle, Assistant Secretary • Tadhg Fallon, Assistant Principal • Brian Dowling, Assistant Principal • Mary-Jane Trimble, Higher Executive Officer Department of Justice • Ben Ryan, Head of policy for criminal justice Health Service Executive • Dr Eamon Keenan, National clinical lead in addiction services • Martina Queally, Regional executive officer, Dublin south and east

		• Joe Doyle, National lead in the national social inclusion office

Module 2 meetings

Date	Module 1 meetings	Engagement on Decriminalisation, Depenalisation, Diversion and Legalisation
27 June	Meeting 1 - Watch video transcript	• Professor Alex Stevens of the University of Kent • Dr Niamh Eastwood, executive director of Release • Ruby Lawlor, executive director of Youth RISE
4 July	Meeting 2 - Watch video transcript	• Dr Ricardo Baptista Leite, Founder and President UNITE • Beatrix Vas, drug policy co-ordinator UNITE • Marie Nougier, head of research and communications International Drug Policy Consortium • Dr Marta Pinto, assistant professor University of Porto • Dr Kasia Malinowska-Sempruch, programme director of drugs policy Open Society Foundations
9 July	Meeting 3 - Watch video transcript	**The International Comparative: Vancouver and Oregon** • Deputy Chief Constable Fiona Wilson of the Vancouver Police Department • Kellen Russoniello, Senior policy council with the Drug Policy Alliance in Oregon
11 July	Meeting 4 - Watch video transcript	• Dr Cian Ó Concubhair, assistant professor in criminal justice in Maynooth University • Nick Glynn, former policeman, senior programme officer at the Open Society Foundations and an acting board member of the UK's Independent

		Scrutiny and Oversight Board for the police plan of action on inclusion and race. • António Manuel Leitão da Silva, superintendent of the public security police and commander of the police of Porto
19 September	Meeting 4 - Watch video transcript	**Irish Pharmacy Union** • Tom Murray, President • Dr Denis O'Driscoll • Sinéad McCool, Head of Professional services **Irish College of General Practitioners** • Dr Diarmuid Quinlan, Medical Director • Dr Bernard Kenny, Director of the Addiction Management in Primary Care Programme • Professor Des Crowley, Academic Lead for Addiction Management in Primary Care

Consideration and Summary

Citizens' Assembly

1. The Committee's first public meeting was held with representatives of the Citizens' Assembly on Drugs Use (the Chair, the Secretary, two members of the advisory support group and two members of the Assembly). They presented the Citizens' Assembly (the Assembly) final report to the Committee, marking the completion of an extensive and inclusive deliberation on Ireland's drug policies. The Assembly of one hundred members representing diverse demographics, was tasked with proposing legislative, policy, and operational changes to reduce the harmful impacts of illicit drugs.

2. The Assembly engaged in extensive discussions, hearing from 130 presenters, including experts, stakeholders, and individuals with lived experiences. Over eight hundred public submissions were also considered.

3. The Committee members highlighted the severity of drug use in Ireland, citing alarming statistics such as 20% of young people using drugs and Ireland having the second-highest rate of MDMA use in the EU. Ireland has the highest rate of drug-induced deaths in the EU. The detrimental effects on communities were noted, highlighting the need for a comprehensive response.

4. The Assembly's work was praised, particularly its 36 recommendations, which are the foundation of the Committee's work. Its person-centred, victim-first, and health-led approach was endorsed.

5. There was a consensus that the Committee's response to the Assembly's recommendations must be holistic and not piecemeal. The Committee has a responsibility to address the issues around drug use thoroughly, incorporating the Assembly's recommendations into a broader all-of-government and all-of-State strategy.

6. The Assembly highlighted the link between drug use, poverty, and trauma. It is acknowledged that communities affected by poverty, and deprivation are disproportionately impacted by addiction. Addressing these underlying issues is seen as crucial.

7. The Assembly stressed the importance of not causing further harm, while focusing on reducing drug use, minimising damage, and supporting recovery and rehabilitation.

8. The problem of drug debt intimidation, particularly in marginalised communities, was discussed. There was a focus on the need for solutions to protect families and individuals from coercion by drug dealers.

9. There was concern about the effectiveness of existing community and health services, which are seen as under-resourced and unable to keep up with the growing demand. The need for stronger support systems within communities is highlighted.

10. The Members discussed the importance of focusing on prevention and education, as well as addressing the influence of criminal enterprises. There is a recognition that resources are limited, and prioritising actions that will yield the best outcomes is essential.

11. The Assembly's final report recorded the result of the vote of every question put to the Citizens' Assembly members. A large majority of Citizens' Assembly members supported most of the recommendations including that personal possession of all drugs should be decriminalised.

12. The vote on whether cannabis should be decriminalised (this was referred to as a health-led approach) or should be legalised was decided by a single vote, with a majority deciding against legalisation. This decision led to mixed reactions among members, with some expressing dissatisfaction and others believing the correct decision was made and further noting concern regarding the wording of the recommendation as voted on.

13. The Assembly stressed that whether cannabis is legalised or not will not resolve the matters in our society today in relation to drug policy, health, and socio-economic concerns.

14. The concerns expressed focus on the need for greater awareness and prevention regarding recreational drug use. The Assembly highlighted that many people, including the 99 members of the Assembly, were not initially well-informed about drugs but approached the issue with an open mind. They highlighted the significant

impact of drug use on communities, families, and individuals, particularly those in marginalised societies.

15. The Assembly was presented with five options ranging from maintaining the status quo to full decriminalisation and legalisation of drugs. The Assembly decided they wanted to avoid criminal convictions for personal drug use and instead promote diversion and support services, advocating for decriminalisation. However, they left unresolved complex legal issues, such as defining limits for personal use, handling repeat offences, and determining who would administer sanctions under a health-led approach.

16. The Assembly representatives stated that the decision not to legalise cannabis was not solely about rejecting a commercialised cannabis market. If the principle of legalisation had been approved, subsequent questions would have addressed the preferred supply models, such as state monopoly or social clubs. Arguments in favour of legalisation included benefits like reducing the criminal market and improving supply safety but concerns about increased prevalence and associated harms swayed the Assembly. Ultimately, both the vote for legalisation and the support for a health-led approach represented significant shifts from the current status quo.

17. Mr Paul Reid, Chairperson of the Citizens' Assembly, emphasised the urgent need for statutory bodies to embrace the recommended changes, particularly introducing legislation for decriminalisation. The status quo and the existing health-led approach from 2017 have been rejected by the Assembly. The appetite for these changes among statutory bodies is currently uncertain, and the Citizens' Assembly advocates for immediate action rather than delaying until 2025.

18. Ultimately, the Assembly's focus was on the broader goal of moving people out of the criminal justice system and handling drug use differently to avoid criminalisation. The Assembly was clear that a shift from the current system is necessary.

19. The Assembly was informed that access to drugs does not necessarily stop in the prison system; in some cases, it may even be easier to obtain drugs there, which does not help in addressing addiction. The focus was on removing people from the criminal system and providing appropriate health interventions instead.

20. The Assembly advocated for the paradigm shift of not treating an individual caught in possession of a substance for personal use through the criminal justice/court system but through a health-led one instead.

21. A majority of the Assembly members viewed drugs as harmful and oppose their legalisation. The goal was to address drug use as a health issue rather than a criminal one, similar to the approach taken with alcohol abuse, and to avoid stigmatising those affected.

22. Members of the Committee highlighted key takeaways, including the emphasis on decriminalisation for personal use, a health-led approach, and the need for increased political support and resources, particularly for recovery services and addiction treatment.

23. The Committee noted that cannabis has evolved significantly over the past 20-30 years, with increased addiction rates and psychiatric impacts, particularly among younger users.

24. The Committee also raised concerns about the push-and-pull factors influencing drug use in society, noting that drug issues are not solely tied to marginalisation or trauma but affect all tiers of society.

25. The Committee and the Assembly also challenged the stigmatising label of "disadvantaged" for communities, arguing that areas with less funding and support are more affected by drugs.

National Drugs Strategy

26. The Citizens' Assembly's recommendations on the National Drugs Strategy focused on transitioning to a health-led approach to drug issues, highlighting the need for a coordinated, whole-of-government effort. The Committee acknowledged the frustration of the Assembly members over the lack of progress in implementing the National Drug Strategy's proposals, stressing that drug problems arise from broader life issues. The Committee also underscored the importance of making progress on these recommendations for the sake of vulnerable children and communities.

27. The Assembly representatives commented on why June 2024 was recommended in their report as a deadline for a new national drugs strategy. Originally, a longer

timeline was considered, but the Assembly insisted on a faster pace to signal urgency. The Assembly expressed disappointment with Department of Health suggestions that the strategy might not be updated until 2025, which is when the current strategy expires. The Assembly criticised this delay, arguing that it lacks the necessary urgency and focus, which is resulting in loss of lives. Mr Paul Reid emphasised the critical need to meet the June 2024 deadline to prevent further harm.

28. The Assembly acknowledged the need for a comprehensive National Drugs Strategy with clear responsibilities, annual action plans, and involvement from those with lived experience and community groups. Key issues include addressing dual diagnosis, improving services for addiction within the criminal justice system, and providing specific support in prisons where a large proportion of inmates have addiction issues but lack adequate services. Additionally, it highlights the importance of social support networks in addressing addiction and calls for better, more equitable care nationwide.

29. The Committee welcomed discussion on the National Drugs Strategy from the Department of Health who acknowledge that the full implementation of the recommendations of the Assembly would require a major step-change in how the State responds to drug use.

30. The Department of Health gave an update to the Committee outlining Ireland's drug policy under the national strategy, "Reducing Harm, Supporting Recovery," which runs from 2017 to 2025. The strategy prioritises treating drug use as a public health issue rather than a criminal one, highlighting a compassionate approach. A mid-term review in 2021 identified six key priorities, including prevention, access to services, harm reduction, and alternatives to coercion. A two-year action plan is in place with increased funding, particularly for community services.

31. Key actions include improving access to treatment and implementing a health diversion scheme to redirect drug possession cases from the justice system to health services. The strategy is overseen by a national Committee and various implementation groups.

32. The Department of Health will draft a new strategy in early 2025, informed by evaluations and the Assembly on Drug Use. Ireland will also play a significant role in international drug policy discussions, including leading EU efforts in 2026.

33. HSE addiction services manage various treatment interventions across community health organisations and collaborate with the community and voluntary sectors. Their work aligns with the national strategy's priorities.

34. Ms McArdle from the HSE, stated that compassion is central to the National Drugs Strategy, focusing on reducing stigma and improving lives rather than punishment. A key priority is addressing the social determinants of health and supporting communities affected by drug use. One-third of the national drugs funding supports community-based services through 24 task forces and approximately 280 initiatives.

35. Ms McArdle attested to the ongoing work of the National Oversight Committee, involving various government departments, which ensures a cross-governmental approach, including efforts from the Departments of Education and Justice on harm reduction and community support. Local area boards also contribute to strengthening communities and addressing issues collaboratively.

36. The Committee questioned the ongoing work taking place by the Department of Health. The Department of Health stated that in 2024, they will evaluate the national drugs strategy by assessing its progress against its commitments and comparing its performance with European models, using available European data for reference.

37. The strategic priorities include prevention of drug use among children and young people; access to and delivery of drug services in the community; harm reduction responses and integrated care pathways for high-risk drug users; the social determinants and consequences of drugs use; alternatives to coercive sanctions for drug offences; and the performance of the strategy.

Drug Debt Intimidation

38. The Committee highlighted problem of drug debt intimidation particularly in marginalised communities across the second module. Drug debt intimidation, where families are terrorised by unscrupulous dealers demanding exaggerated repayments, can lead to desperate actions.

39. There was a focus on the need for solutions to protect families and individuals from coercion by drug dealers. There was a recognition that tackling drug-related intimidation and violence requires both strict measures and the development of alternative pathways for vulnerable youth to prevent their involvement in criminal activities.

40. The Committee expressed interest in solutions discussed by the Citizens' Assembly regarding this issue, particularly in relation to recommendation 26 The National Drugs Strategy should continue to prioritise the objective of tackling the source and impact of drugs-related intimidation and violence and take a zero-tolerance approach.

41. The DRIVE (Drug Related Intimidation & Violence Engagement) project and similar community-based services were praised for their work in supporting those affected by drug-related intimidation.

42. The Department of Justice and HSE stated that they are also working on the drug-related intimidation and violence programme, supported by An Garda Síochána's dedicated inspectors. Mr Ryan from the Department of Justice noted that tackling drug-related intimidation remains a significant challenge but assured that efforts are being made to embed support within communities.

43. The Committee also raised the issue of violence associated with drug dealing, noting that the real harm in communities often comes from the violence and intimidation rather than drug use itself.

Decriminalisation

44. The Committee noted the very powerful call by all witnesses with regard to dealing with the reality of drug use in our societies. The Committee further noted that drug use is an ongoing issue that has been poorly addressed by traditional criminalisation approaches. The key focus now of the Committee on Drugs Use, is to explore alternative models, such as decriminalisation and regulation, aimed at saving lives and enhancing safety for drug users.

45. Between 2019 and 2023, there was a 54% increase in charges for drug possession for personal use, with a 74% rise in Dublin. The Committee raised concerns about

the practicality of administrative sentences and the resources required for diversion programmes, noting that not all drug users need such interventions. The Committee stated that while decriminalisation won't necessarily reduce drug use, it should aim to avoid exacerbating harm and provide support for those affected by addiction.

46. Mr Paul Reid stressed that decriminalisation involves a fundamental shift from a criminal system to a health-led approach. It is a complete transition and requires support mechanisms for dissuasion and diversion where needed. The goal is to remove stigma and handle drug use in a fundamentally different, health-oriented manner.

47. Mr Brian Galvin, from the Assembly support group, stated that evaluating the effectiveness of decriminalisation is complex. Mr Galvin referred to insights from Portugal suggest that decriminalisation alone has limited impact unless accompanied by comprehensive services. Portugal's model initially reduced deaths but has faced challenges in recent years.

48. Mr Regan, Secretary to the Assembly, stated that stakeholders, including medical representatives and others opposed to drug legalisation, expressed concerns that some forms of decriminalisation might effectively amount to legalisation. He highlighted that decriminalisation should not equate to liberalising drug use but should instead shift the State's response to a more health-focused approach. There is broad consensus, including among those against legalisation, that criminalising individuals with drug issues is not effective.

49. Professor Stevens of the University of Kent referenced a 2018 report 'Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences' by Dr Caitlin Hughes for the Department of Justice and Equality, which examined alternatives to criminalising simple drug possession and identified four key alternatives: Depenalisation, Diversion, Decriminalisation, and Legalisation. The Committee explored these alternatives across a series of meetings for module 2.

50. The 2018 report highlighted the complexities within these alternatives, such as determining to whom they apply (adults, children, or both), which drugs are covered, and how to distinguish between possession and supply. Issues such as the type of diversion, funding, and consequences of non-compliance were also discussed.

51. Legalisation presents additional challenges, such as balancing the reduction of the illicit market with potential increases in drug use. Tight regulations might mitigate some risks but could fail to eliminate the illegal market entirely.

52. The report noted that experiences from over 50 countries suggest that reducing punishment for simple possession does not increase drug use, generally yielding positive outcomes. However, legalisation is more complex, with evidence suggesting potential increases in use among certain groups, like older adults in U.S. states where cannabis is legal.

53. Release UK highlighted that contrary to government fears, decriminalisation has not led to increased drug use, as evidenced by research from the European Monitoring Centre for Drugs and Drug Addiction and other experts.

54. Decriminalisation, when combined with harm reduction and treatment support, can lead to significant health, social, and economic benefits. This approach is endorsed by the United Nations and its agencies as a critical enabler of health services and rights protection for drug users. Portugal's decriminalisation model, implemented in 2001, has resulted in notable public health improvements, including reduced HIV transmission, lower injecting drug use, and increased treatment access. In contrast, countries like the U.S., which maintain a criminal justice approach, face much higher drug-related death rates and a decline in life expectancy due to a toxic drug supply and barriers to seeking help.

55. Ms Eastwood argued that criminalisation policies cause harm and deter individuals from seeking emergency help and treatment.

56. Ms Lawlor from YouthRise called on Ireland to decriminalise drug use and possession and to legalise and regulate all drugs. In her opinion, this approach, coupled with investment in communities, youth-friendly harm-reduction services, and evidence-based drug education, is necessary to disrupt the illicit drug market, reduce overdose rates, and ensure the safety and well-being of all, especially young people.

57. Ms Eastwood emphasised the importance of carefully designing decriminalisation schemes to avoid such unintended outcomes and prevent further criminalisation of people who already face complex challenges.

58. Ms Eastwood agreed with the need for the decriminalisation of all substances, highlighting that the goal of drug policy should be to reduce harm. The greatest harm, particularly in terms of health and overdose deaths, is linked to substances like opioids and crack cocaine. By not decriminalising these drugs, current policies fail to address this harm effectively. While decriminalisation itself may not directly reduce deaths, it creates an environment where people feel safer seeking treatment, something criminalisation often deters.

59. Professor Stevens stated that in Portugal, decriminalisation was part of a broader strategy that included increased support and treatment services. The policy allowed individuals to seek help without fear of legal repercussions, thus improving public health outcomes.

60. Professor Stevens further inferred that critics often misuse data to oppose decriminalisation. For example, an increase in drug-related deaths in Oregon post-decriminalisation is attributed to the opioid crisis and the pandemic rather than decriminalisation itself. Addressing concerns honestly and transparently is crucial. It is important to engage with the public's fears, provide accurate information, and counter misinformation to support informed decision-making about drug policy.

61. The Committee heard evidence that all witnesses support moving beyond decriminalisation particularly of the person to exploring a model of legalisation and regulation. The aim is to control drug substances, manage their quality, and reduce risks like overdosing. This approach is also intended to diminish the influence of criminal gangs involved in the drug trade.

62. Ms Nougier stated that not everyone needs drug treatment, but all individuals can benefit from support and harm reduction. Criminalisation negatively affects all drug users, whether they are dependent or not. Decriminalisation is crucial to prevent negative interactions with police, such as harassment and violence. Instead of involving the criminal legal system, drug users should access health and social services directly. For example, a woman who uses drugs occasionally might be

deterred from seeking necessary health services, which can harm her and her unborn child.

63. Deputy Chief Constable Wilson noted however, that decriminalisation in British Columbia which allowed for the possession of under 2.5 grams of illicit drugs, led to a significant negative change, officers lost the authority to address problematic public drug use, which they had previously managed by asking individuals to leave or warning them of potential consequences.

64. Mr Russoniello, an expert on drugs law from Oregon, stated that ideally, support systems should be established before implementing decriminalisation. However, decriminalisation is a form of harm reduction as it avoids the harms associated with arrest and incarceration, which have proven detrimental to both individuals and communities. The challenge is to balance advancing decriminalisation with the ongoing need to improve support services for drug users and the broader community.

65. The Committee accepted that it is crucial to understand that decriminalisation is not a cure-all for problems like the housing crisis or mental health issues but aims to avoid worsening these issues. The Committee also noted that decriminalisation alone leaves the issue of drug supply and trade largely unresolved.

66. Mr Leitão da Silva, a senior policeman from Porto that the decriminalisation of drugs has nothing to do with trafficking or the supply of drugs. The police still have the authority to break the trafficking system. A concern is that decriminalising drug use while removing sanctions might lead to increased drug consumption, as illegal suppliers may anticipate higher demand. Without effective measures to prevent this, society may struggle to control both the supply and consumption of drugs, potentially leading to uncontrolled growth in drug use over time.

67. Mr Leitão da Silva stated that Portugal's experience shows that decriminalisation did not lead to increased drug trafficking or higher drug use levels. Although drug trafficking has intensified recently, particularly in Porto, the approach has generally led to stable or reduced drug consumption. Effective policing and proper treatment of drug users have contributed to decreased demand and positive outcomes.

68. Mr Leitão da Silva stated that Portugal is experiencing increased visibility of drug use in public spaces, a situation not addressed by the 2001 decriminalisation law. The current law only criminalises the abandonment of syringes in public, with other forms of drug use not considered crimes or misdemeanours. There is political pressure to reconsider the law due to concerns about public visibility and insecurity.

69. Mr Leitão da Silva stated that if drug suppliers or traffickers are using drug users to distribute small amounts of drugs on a repeated basis then the police will target that drug user as he or she is considered a criminal.

70. Mr Glynn called for reform and advocates for a shift towards decriminalisation and legalisation, starting with cannabis, to remove drug supply from unregulated market. Reform could lead to better policing efficiency, reduced harm, improved community safety, potential tax revenue, and safer drug supplies, addressing issues related to addiction and drug use more effectively.

71. Dr Ó Concubhair's acknowledged that a cultural shift is needed within policing, particularly concerning stop and search practices. He emphasised that these powers should be used sparingly and only when legally justified. He suggested that decriminalisation could help police focus on more critical issues and highlights the need for political scrutiny and oversight of stop and search powers, which are currently lacking in Ireland. Without proper oversight and political commitment, there is a risk of these powers being overused, especially against marginalised communities, highlighting a need for better engagement and oversight in police-community relations. Ensuring police buy-in and understanding the benefits of decriminalisation can help address these challenges.

72. Dr Ó Concubhair highlighted the importance of managing public expectations and potential backlash when considering drug decriminalisation as happened with Oregon. He suggested that prohibiting public drug consumption through local authorities could be a prudent measure.

73. The Irish College of GPs (ICGP) supported a shift from focusing solely on legalising or decriminalising drug use towards a more holistic approach. The key is to focus on disadvantaged communities and ensure enough resources are available, recognising

that piecemeal solutions will fail, but a comprehensive approach can significantly improve both personal and public health.

74. The HSE is committed to a health-led strategy for managing drug use in Ireland, and well-supported GPs can play a key role in offering high-quality addiction care. Ireland has a serious drug problem, with 322 overdose deaths reported in 2020—the highest in the EU at 97 deaths per million people, compared to the EU average of 22 per million. In 2023, over 13,000 people sought treatment for drug issues, a record high. The evidence is clear, early detection and intervention can prevent drug use from escalating to dependence.

75. Mr Tom Murray for the Irish Pharmacy Union (IPU) stated that the issue at hand is focused on the decriminalisation of individuals who use drugs, rather than the decriminalisation of the drugs themselves. He advocated for a clear distinction between the user, seen as a patient in need of care, and the illegal product. Mr Murray stated that this is supported by international evidence suggesting that this approach effectively reduces harm, societal damage, and the negative impact on individual users. The goal is to provide patient-centred and patient-led care, aligning with the principles of Sláintecare.

76. The ICGP issued a statement last October asserting that cannabis is a dangerous drug and poses significant public health risks, leading them to discourage its use. They acknowledged the dangers associated with cannabis but suggest that criminalising individual drug users harms them, their families, and their communities, hindering their ability to seek help. While recognising the risks of cannabis use, the ICGP supports people who use drugs and believes that criminalising individuals, including patients within their community, undermines broader public health objectives.

Establishing limits for personal possession

77. Ms Eastwood explained that fixed weight drug thresholds in Portugal have been abolished due to enforcement challenges and the arbitrary nature of such limits. Different individuals have varying tolerances to drugs, making a fixed weight limit unfair. Additionally, police face difficulties in accurately assessing drug quantities.

As a result, a more effective approach may be to focus on proving intent to supply rather than relying on fixed weight limits.

78. The new Portuguese approach eliminates strict thresholds, treating them as a minimum rather than a maximum. Individuals caught with amounts below the threshold, without evidence of supply, are diverted to a dissuasion Committee. Those above the threshold are also diverted, provided there is no evidence of intent to supply. This approach allowed police discretion and aligned with international evidence showing the arbitrary nature of fixed thresholds, which vary widely between countries.

79. Professor Stevens suggested following the British approach, which places the burden of proof on the prosecution to demonstrate intent to supply rather than relying on an arbitrary weight limit. This method, which involves evidence such as scales or drug- related communications, is considered more reliable for distinguishing between possession and intent to supply. Dr Caitlin Hughes' research in 2018, highlighted the difficulty in defining a clear distinction between drug use/possession and drug sale/supply.

Societal impact

80. The Committee noted the witness testimony that without adequate services and support, decriminalisation alone is insufficient. However, if adopting a dissuasion model similar to Portugal's, it would involve developing comprehensive counselling, treatment, and education services tailored to varying levels of drug involvement.

81. Members referred to the European Drug Report 2024 which states that Ireland's drug death rate is four times the European average, indicating a severe failure in the government's drugs strategy. This high rate underscores the urgency of addressing the drug crisis in the country.

82. The Department of Health’s focus is on harm reduction and understanding the factors behind drug deaths. Addressing these factors is crucial for the Department of Health to implement evidence-based measures. Ireland's high drug-related death rate is concerning but comparing it with other countries requires consistent recording methods across Europe. Ireland is focusing on measures like supervised

injection facilities, naloxone distribution, and expanded treatment access to address the issue.

83. Dr Pinto stressed that drug use is a longstanding aspect of human behaviour and will likely persist. The key issue is not drug use itself, but the negative consequences resulting from poor drug policies, such as crime, black markets, and infection epidemics. The response advocates for evidence-based, rational drug policies combined with holistic and user-friendly services. It cites the example of drug consumption rooms, which, when designed with a user-friendly approach, have shown positive results.

84. The Committee acknowledged that a root cause of addiction is poverty and understood the need for investment at the same time in welfare supports to reduce poverty and prevent it.

85. Dr Pinto highlighted Portugal's significant investment in addressing the social disadvantages faced by people who use drugs. This investment includes various integration programmes aimed at mitigating these disadvantages. However, these efforts are also influenced by broader structural issues and crises within the country.

86. The ICGP viewed addiction not just as a health issue, but one deeply tied to social deprivation and childhood trauma. The negative effects of addiction extend beyond individuals to their families and communities, contributing to high rates of illness and death. It is important to see people who use drugs as patients and community members, not criminals.

87. GPs are on the frontlines, and each year, more individuals seek help for drug addiction. However, many face significant barriers—social stigma, fear of punishment, and the threat of criminal charges prevent many from seeking the help they need. Reducing these barriers, including through legislative changes, is crucial. GPs stated that they need to address the damaging effects of stigmatisation and criminalisation, which make it harder for people to get treatment, recover fully, and rebuild their lives, including accessing meaningful employment.

88. Mr Murray from the IPU, stressed that decriminalising individuals should not occur without implementing essential social supports for both the individuals and their

communities. They counter the misconception that decriminalisation would promote drug use, stressing that community supports must be established before decriminalisation to avoid potential social issues. The approach to this issue should be multifaceted, addressing various factors rather than relying on a single solution.

89. IPU stated, that we need to be working on education, harm reduction and reintegration for patients, because that is what they are, going through the addiction services. All these things are important. There is a whole tranche of social-economic and social-educational work that must also be done.

Rights based approach

90. Ms Nougier of the International Drug Policy Consortium (IDPC) highlighted the key points from their 2023 shadow report to the UN Commission on Narcotic Drugs. It finds that punitive drug policies have failed to reduce the illegal drug market and have led to a severe public health crisis, including 500,000 drug-related deaths annually and a global prison crisis with many incarcerated for drug offences. These policies also infringed on human rights, such as access to essential medicines and protection from discrimination.

91. Ms Nougier stressed the importance of involving a diverse range of drug users in the development and implementation of drug policies because drug use varies widely across different substances, contexts, and demographics. This includes casual users, those with major criminal records, and individuals with problematic use.

92. Ms Eastwood emphasised the importance of bodily autonomy, arguing that individuals should have the right to make decisions about their own bodies.

93. Mexico involved civil society in drug policy discussions before the 2016 UN General Citizens' Assembly special session on drugs. Ireland could benefit from a similar approach by reaching out to diverse civil society groups involved in drug policy and reform, such as Students for Sensible Drug Policy, Youth RISE, and the European Network of People who Use Drugs (EuroNPUD). Engaging with these organisations and networks could provide valuable perspectives from both casual and problematic drug users, helping to inform policy development.

94. The Committee was concerned that any dissuasion method involving sanctions might undermine a rights-based approach and asks for insights on how to ensure that support for drug misuse aligns with a rights-focused perspective.

95. Dr Pinto argued against mandatory treatment for drug users, citing its ineffectiveness and rejects the use of sanctions and the term "dissuasion," preferring harm reduction and non-judgmental support for those who seek help. Dr Pinto stresses that most drug users are not problematic users and should receive user-friendly, outreach- based services. She emphasises that dissuasion and penalties are not effective or aligned with health-based approaches, which should focus on harm reduction and understanding individuals' personal relationships with substances.

96. Dr Malinowska-Sempruch highlighted the importance of trusting people who use drugs to take care of themselves when given the right resources. Decriminalisation and harm reduction measures, like providing clean syringes, have proven effective in addressing health issues, such as the HIV epidemic. However, focusing solely on health indicators might neglect broader human rights concerns, leaving individuals feeling their lives are less meaningful. A human rights-based approach is essential.

97. Deputy Chief Constable Wilson noted the British Columbia provincial government was developing legislation to further restrict public drug use. However, the British Columbia Supreme Court ruled that the proposed restrictions might violate the rights of people who use drugs, as they could force individuals into more harmful situations by driving them indoors. The decision, based on a violation of Section 7 of the Charter of Rights and Freedoms, concluded that the legislation would likely cause more harm than benefit to those affected.

98. The Assembly discussed the deep connection between social deprivation, trauma, and drug addiction. They emphasised the vicious cycle where early life trauma leads to drug use, criminal convictions, and repeated incarceration. They stressed the importance of breaking this cycle through comprehensive recommendations that address both criminality and underlying issues like poverty.

99. The Citizens' Assembly stressed the importance of understanding that recreational drug use contributes to larger societal issues, including the struggles of children in disadvantaged areas.

100. The Committee expressed concern about the impact of drug use on disadvantaged communities, highlighting the significant challenges faced by these groups, particularly children and families. The Committee noted the need for a coordinated, all-of-government approach, including better resourcing and support from various departments such as Social Protection and Children.

Education concerns

101. The Assembly's discussion about education emphasised the importance of increasing awareness about drug issues at all levels of education, from primary to secondary and the importance of the input of people with lived experience of drug use. The Assembly also highlighted the need for stronger prevention strategies in Ireland, particularly within the education system as current prevention efforts are inadequate, with drug education in schools often starting too late, if at all. This lack of early and effective prevention education has contributed to the widespread drug use seen today. The Citizens' Assembly called for a significant increase in preventative strategies across all levels, from primary to tertiary prevention.

102. Witnesses recommended collaboration with educational institutions to encourage students to test their substances and provide harm reduction advice. Evidence indicates that when individuals are informed about the contents of their drugs, they are more likely to discard harmful substances, making drug testing a valuable harm reduction tool.

103. Ms Lawlor provided that drug reforms should be paired with effective educational campaigns that provide concrete information on drug risks and safer use such as the 'Safety First' curriculum from Stanford University, moving away from stigmatising and abstinence-only approaches. Ms Lawlor stressed that it is important to include parents, educators, and policymakers in these discussions, ensuring they understand and support evidence-based approaches to drug education and regulation.

104. Mr Russoniello highlighted that the most effective way to prevent fentanyl-related deaths through education and prevention efforts, such as school programmes, community centre initiatives, and collaborations between police and health services. The aim should be to ensure that young people never try the drug in the first place. The toxic nature of the illicit drug supply means that even small amounts can be fatal, affecting not just hardcore users but also first-time users, including children.

105. The IPU highlighted the importance of community education and preparedness regarding addiction services. Drawing from his personal experience working in a drug-dependency pharmacy in England, Mr Murray emphasises that treatment centres do not attract drug users from outside the community; rather, they serve local patients in need.

106. The IPU advocates for a proactive approach, stressing that community education should precede the establishment of these services, ensuring they are viewed as health resources provided by professionals rather than facilitators of drug use. The emphasis is on patient education and community involvement in addressing addiction.

Regulation and Legalisation

107. The Committee highlighted that despite alcohol and tobacco being regulated and legal, black markets for these substances persist.

108. Ms Eastwood stated that in the U.S., various states have implemented diverse models for cannabis legalisation. New York, Illinois, and Massachusetts: These states have adopted social equity approaches, aiming to repair harm from prohibition by granting licenses to individuals with cannabis-related criminal records and investing tax revenue into communities affected by the war on drugs. New York, for example, initially banned corporate participation to favour community-based organisations like HIV NGOs.

109. European countries face restrictions due to a 2004 EU law that limits drug production for commercial purposes. Germany's social club model is an example of

how EU member states are navigating these restrictions while reducing commercialisation risks.

110. Ms Eastwood stated that policy goals regarding drug regulation can vary widely. For instance, Canada has legalised cannabis but still penalises possession outside the legal market. Portugal recently updated its drug laws by including synthetic opioids like fentanyl in its decriminalisation model and removing drug quantity thresholds. This approach aimed to manage the risks associated with potent substances. Advocating for a regulated market can help mitigate harm from synthetic drugs and other new substances.

111. Ms Nougier noted that decriminalisation addresses personal drug use but does not regulate the illegal supply, which can be harmful. Legal regulation of substances like cannabis can improve supply safety and address market issues not covered by decriminalisation alone.

112. The Committee queried addressing the challenge of managing policies for drug users under different legal frameworks. Specifically, the difficulties in distinguishing between problematic and non-problematic users when dealing with criminalisation and decriminalisation systems. It notes that under legalisation, individuals self-identify for addiction support, but under criminalisation or decriminalisation, diversion programmes may complicate this distinction.

113. Dr Malinowska-Sempruch advocated for decriminalisation over diversion because decriminalisation removes police involvement in drug users' lives, whereas diversion maintains police engagement. Police, who are not trained to assess drug dependency, often end up making decisions about treatment, which is not ideal.

114. Examples from Switzerland, Czechia, and Portugal showed that people seek treatment when they are ready, making it more effective. Forcing people into treatment can waste public resources and is often counterproductive. Dr Malinowska-Sempruch believes that respecting individuals' readiness for treatment is both more resource- efficient and supportive of their autonomy.

115. Dr Malinowska-Sempruch shared insights on drug regulation, noting that cannabis is often the first drug to be regulated due to its widespread use. She

suggests looking at experiences from Canada, San Francisco, and Oregon rather than New York and proposes considering social clubs as an alternative to a fully regulated market.

Regulation of other Drugs

116. The Committee queried whether Ms Lawlor's proposal for regulating all drugs includes every substance and how this would be implemented practically. Specifically, how would the regulation process work in everyday scenarios, such as obtaining prescriptions from doctors and filling them at pharmacies.

117. Ms Lawlor noted that there are varied opinions on how drug regulation would work. According to one perspective, pharmacies would be the main distributors in a regulated market, with government-owned pharmacies handling distribution. Access would involve interaction with pharmacists, who would assess users' history and needs, offer support, and provide information on harm reduction. Age restrictions would generally be set at 18 and above, with a focus on ensuring that underage individuals are not criminalised for possession of prescription drugs.

118. Ms Lawlor stated that the availability of drugs with lower associated risks, like cannabis, MDMA, or psilocybin, might increase, while those deemed riskier could be less accessible.

119. Ms Eastwood stated that drug regulation can be a means to address the growing harms of the booming illicit market. She further noted that the Netherlands is exploring cocaine regulation through local trials, and models like cannabis social clubs might work for other drugs like MDMA and psychedelics. While immediate wholesale legalisation is not proposed, there is a push for decriminalisation and cannabis regulation as steps toward better managing drug-related harms.

120. Ms Eastwood stated that regulation should be approached differently for each drug for example heroin and cocaine, the focus should be on providing safer alternatives to illicit products, such as less harmful opium-based options and implementing measures like taxation and restricted access. The aim is to offer safe supplies and support for drug-dependent individuals, such as through diamorphine prescribing. The approach should be flexible, reflecting different needs for medical and consumer purposes rather than a one-size-fits-all solution.

121. Dr Leite suggested moving beyond decriminalisation, Portugal is considering regulated drug markets, starting with cannabis, as a potential strategy to reduce drug trafficking and increase state revenue. This approach aims to address drug market issues more effectively and support public health and safety initiatives.

122. Ms Nougier acknowledged the complexity of legalising and regulating drug markets and she stated that the goal of legal regulation is to shift control of drug markets from criminal gangs to governments, aiming to reduce illegal activities associated with these markets. Ms Nougier noted the need for realistic expectations, stating legal regulation will not entirely eliminate criminal activities. Criminal gangs may still operate, but the extent depends on how well the regulation is designed and implemented.

123. Dr Malinowska-Sempruch highlighted the importance of regulating heroin through medical prescriptions in countries like Switzerland and Germany due to its overdose risk. She cautioned that effective regulation requires careful planning. Simply transferring control to large cannabis businesses may not be ideal. Instead, it is important to consider how those affected by criminalisation can benefit from the legal market.

124. Dr Pinto referred to the historical and cultural context in regard to drug criminalisation which has often been driven more by social and cultural dynamics than by the actual dangers of the substances. For example, alcohol, despite its risks, has been less stigmatised compared to other substances.

125. Dr Malinowska-Sempruch emphasised that to effectively eliminate the illicit drug market, governments must take ownership and regulate drug markets. While no country has regulated all drugs, there are examples where specific drugs are regulated, such as coca in Bolivia, cannabis in several countries, and heroin in Switzerland. These instances are relatively new, but initial data is positive. Regulation is seen as the necessary approach to truly address the illicit drug trade.

126. Dr Ó Concubhair attested that decriminalisation or legalisation of drug use does not imply state endorsement or normalisation of the activity. Instead, the state can regulate and discourage it through other measures, as seen with tobacco regulation.

127. Dr Ó Concubhair provided that evidence shows no direct link between decriminalisation and increased drug use further stating that countries like Portugal with different drug policies do not necessarily have higher usage rates compared to Ireland.

128. Dr Ó Concubhair stated that the commercial model of drug sales, as seen in parts of the U.S., may increase consumption temporarily, while regulated models, such as in the Netherlands, show stable or lower usage rates compared to punitive approaches.

129. Dr Ó Concubhair suggested that if the State is serious about reducing the harm of illegal drug markets, it should regulate all substances according to their individual risks. He referenced categorisation of drugs based on harm, highlighting high-risk substances such as alcohol, opioids, and cocaine, which pose significant health and social risks in comparison to lower-risk substances such Psilocybin and MDMA, which have lower addiction risks and can be regulated more effectively.

130. Dr Ó Concubhair's stated that harm often comes from an unregulated market rather than the substances themselves. For MDMA, he notes its potential benefits in clinical settings and suggests examining models from other jurisdictions, like the Netherlands, which are exploring regulated access.

131. Dr Ó Concubhair advised that with regard to cannabis, he proposes the "social club model" as a potential solution, balancing regulation, and access to reduce criminal markets without encouraging problematic use. This model could provide a controlled, legal means for access while addressing concerns about drug market expansion and public health.

International Legislation

132. Ms Nougier noted that for a long time, governments have avoided legalising cannabis due to conflicts with international drug control treaties, which create major obstacles for regulation. Some countries that have already legalised cannabis are exploring ways to address these challenges, such as negotiating international agreements or seeking changes to the treaties.

133. The Committee questioned Dr Ó Concubhair about the implications of Ireland being bound by various international conventions and agreements related to drug policy, including the UN Single Convention on Narcotic Drugs. Specifically, what would be involved in de-ratifying these agreements and how it would impact efforts to decriminalise drugs, particularly in relation to the 1977 Act and repealing its section 3.

134. Dr Ó Concubhair's response provided a cautious overview of the implications of international law and treaties on drug policy, noting that while the UN Single Convention on Narcotic Drugs historically influenced global drug policies, changes in US and international attitudes may reduce the risk of sanctions for legalisation. He suggested that withdrawing from such treaties may not be necessary for legalisation efforts, citing recent developments in Germany and the EU. Germany’s approach, which has been cautious due to potential conflicts with EU law, might set a precedent, but specific details on how a state could withdraw from international treaties or the EU framework remain unclear.

Policing matters

135. The Department of Justice focuses on targeting criminal groups that exploit and coerce vulnerable individuals, especially youth. New legislation, the Criminal Justice (Engagement of Children in Criminal Activity) Act 2024, has been introduced to penalise adults who involve children in crime, with penalties up to five years in prison.

136. The Department is implementing a human rights-led approach to reduce negative impacts on people with addiction issues within the criminal justice system. This approach aligns with recommendations from the Assembly on Drug Use.

137. The Department of Justice aims to divert individuals, particularly youth, from criminal and drug-related activities. The Greentown programme, operating in two trial sites, supports young people and their families to move away from criminal networks. Additionally, funding for youth diversion programmes has significantly increased, with 2023's allocation being nearly €33 million.

138. Professor Stevens referenced that in Lambeth, South London, a shift in police focus from low-level drug possession to more serious crimes, like burglary, demonstrated that reallocating police resources away from minor drug offences could effectively address other community issues. This approach reduced minor offences and allowed for more significant crime prevention. Decriminalisation can enable a more strategic use of policing resources and support broader public health and social interventions.

Organised Crime

139. The Committee noted that the central issue is that controlled drugs like heroin, crack cocaine, and cannabis are effectively controlled by organised crime and not by any State body. Organised crime therefore regulates the distribution and profit from drug use, perpetuating the problem. The Committee noted the need for a paradigm shift to address who controls these drugs, recognising that demand will always exist regardless of our stance on drug use.

140. Mr Ryan from the Department of Justice stated the answer is complex. Criminal gangs manufacture and distribute illegal drugs, such as heroin and cocaine. Most heroin comes from Afghanistan, where production has been linked to the Taliban. Legalising drug production would require negotiating with countries and groups in drug-producing regions thus, it is not practical for the State to simply take over production.

141. The Committee stated that continuing the policy of criminalisation and lack of regulation will perpetuate the current issues with drug control and overcrowded prisons. A more effective approach would be to decriminalise drug use and consider legalisation and regulation. Addressing this fundamental issue is crucial to making progress and avoiding repeating the same debates in the future.

142. Dr Malinowska-Sempruch emphasised the failure and harm caused by the current criminal justice approach to drug control. Data shows increased drug use, and this approach has led to violence, corruption, and the criminalisation of low-level users rather than addressing powerful drug cartels.

143. Dr Pinto built on Dr Malinowska-Sempruch's point, suggesting that starting with decriminalisation is a more publicly acceptable approach that addresses many

issues related to drug use. However, for effective management and oversight of drug distribution, legal regulation is necessary. The response proposes starting with a single substance like cannabis, learning from its regulation, and then expanding controls to other drugs.

144. Mr Leitão da Silva emphasised the responsibility of policing to handle complex issues, such as drug users being exploited by drug dealers. He suggested that in Portugal, there is confidence in the police's ability to manage these challenges without resorting to criminalising drug users. In contrast, other regions might advocate for criminalisation as a way to enhance policing efficiency.

145. Mr Leitão da Silva's stance highlights his belief in the police's capacity to focus on drug trafficking and supply without compromising their effectiveness by involving drug users in their enforcement actions.

Local CAB

146. The current challenge is the visible disparity between the lifestyles of drug dealers and their reported means. The idea of a local-level criminal assets bureau (CAB) was suggested to tackle both lifestyles and assets of these criminals. The Committee asked the Department whether they have considered establishing such a local CAB to address this issue more effectively. Specifically, it inquired whether these authorities have the means to investigate how such individuals are funding their lifestyles.

147. The Department of Justice stated that the focus is on not criminalising individuals with addiction for simple possession, but rather on addressing organised crime and its impact, especially in disadvantaged areas.

148. The Department of Justice stated that there is a network of asset profilers within An Garda Síochána has been trained by CAB to target mid-tier drug dealers and their assets. The thresholds for seizing goods or cash have been reduced to €5,000 and €1,000, respectively.

149. Mr Ryan stated lifestyle evidence helps An Garda Síochána build a case against individuals, allowing them to identify and pursue those whose lifestyles

exceed their known income. This evidence is crucial for making applications to freeze assets and cash, as it supports claims that such assets are proceeds of crime.

Drug Supply/illicit market

150. The Committee also addressed the Department's stance on tackling drug supply and organised crime, noting issues such as the effect of drug prices on consumption and the lack of capacity to stop drug trafficking due to insufficient defence resources.

151. The Committee highlighted the need to consider the broader social context, acknowledging that drug dealers often come from disadvantaged backgrounds. It calls for realistic solutions and acknowledges the pleasure-seeking nature of drug use. Finally, it suggests revisiting the Citizens' Assembly's recommendation on decriminalising all drugs as a foundational step, independent of other complexities.

152. Members highlighted concerns about the increasing volume of drugs entering the country. Despite high-profile drug seizures, there is a worry that a significant number of drugs are destined for the Irish market, with some potentially transiting through to other countries. The Committee commented on the lack of discussion on the role of naval assets in intercepting drugs dumped at sea, suggesting that this gap in capability represents a significant policy issue that needs addressing.

153. The Department of Justice explained significant drug seizures have occurred, such as a €32.8 million seizure of synthetic opioids in County Cork. An Garda Síochána is achieving successes but faces recruitment challenges. The Department is supporting An Garda Síochána with a budget for recruitment despite these challenges.

154. Mr Ryan noted that international cooperation is ongoing to formalise extradition and mutual legal assistance treaties, although these processes are complex and time-consuming. The Department of Justice, An Garda Síochána, the Director of Public Prosecutions, and the Department of Foreign Affairs are working together on these issues.

155. The Committee listed concerns about decriminalisation which included the potential for uncontrolled supply chains and their impact on communities.

International evidence on decriminalisation without addressing supply chains shows varied effects, including challenges for policing, as it may limit their ability to follow drug distribution networks up to suppliers.

156. Professor Stevens stated that decriminalisation has not significantly impacted the size or harm of the illicit drug market, as it does not address the underlying high profits and violence associated with drug trafficking.

157. The Committee queried that if we transition from an illicit drug market to a controlled, nationalised drug policy, it implies a societal acceptance of drug use under regulated conditions. This shift would suggest that society is now more accepting of drug-taking, rather than attempting to eliminate it altogether.

158. The Committee heard from all witnesses that multiple actions need to occur simultaneously to address drug issues effectively, without one being overly dependent on the other. It stressed that decriminalisation is crucial for addressing problems like poverty, drug trade, and education, but it alone will not solve all issues. Regulation is often mistakenly seen as a solution to intercept drug trafficking, but it must be paired with practical alternatives for those involved in the drug trade.

159. Professor Stevens countered that while criminal law signals societal norms, the example of tobacco shows that dramatic reductions in smoking, including among youth, were achieved through effective public health education and restrictions, not through criminalisation. Similar approaches—focusing on education and regulation—could be applied to other substances if they were legally available.

160. The Committee noted the sociological or criminological perspective highlights that decriminalising drugs without legalising them could inadvertently support illegal drug markets and cartels. The question is whether regulation alone is sufficient or if legalising drugs is necessary to address these issues.

161. Ms Eastwood argued that to effectively reduce harms from the illicit drug market, regulation is necessary. Without it, efforts will be futile and may worsen, especially with issues like synthetic opioids. The current approach, which primarily targets low-level offenders, fails to impact major drug cartels, or address the

broader market issues. Policymakers need to ensure that their strategies effectively reduce harm and address market control.

162. Ms Eastwood noted that decriminalisation alone will not eliminate the illicit drug trade or protect young people from being coerced into drug gangs. Addressing this issue requires more than just legal changes; it necessitates targeted efforts to prevent youth from being drawn into these criminal activities and to support those in disadvantaged communities.

163. The Committee queried that when decriminalisation was introduced, it aimed to free up police resources by reducing arrests for small amounts of drugs used personally. This shift was intended to allow law enforcement to focus more on serious criminals, such as traffickers and suppliers. The question is whether this change led to a noticeable benefit in terms of policing effectiveness and resource allocation.

164. The Committee complimented Portugal's more progressive approach compared to Ireland, and queried who controls the illicit drug market. Mr Leitão da Silva stated that in Portugal, the illicit drug market is often controlled by families or gangs, but not to the same extent as in Ireland. In Porto, drug dealing is particularly prevalent in certain social neighbourhoods, making police actions more challenging.

Policing in Ireland

165. The Committee sought to explore whether Ireland has unique strengths in its policing model, particularly in fostering cooperation and support, and how these strengths could be enhanced despite challenges with police resources and numbers. The goal is to ensure that the positive aspects of Ireland's model, where police are seen as "guardians of the peace" and generally do not carry arms, are not overlooked, and are developed further.

166. Ms Nougier noted that training police officers on harm reduction and drug use is valuable, but police should not be the first point of contact for people who use drugs as it can be more harmful than helpful. People should seek help from specialised services rather than from law enforcement.

167. Dr Malinowska-Sempruch underscored that when individuals choose to engage with police, especially those affected by drug use, officers should be trained to provide non-punitive, supportive assistance. In cases of overdose, police should have naloxone and be prepared to intervene. The aim is for police to be well-informed about drug issues and to help individuals effectively and constructively. This means removing criminal sanctions for drug possession.

168. Mr Russoniello noted that police resistance to Measure 110 in Oregon included claims that decriminalisation stripped them of tools to manage public intoxication. However, possession remained unlawful, and police had the authority to issue citations and seize drugs. The issue seems to be more about the police not effectively using the tools available rather than the absence of legal authority.

Policing

169. Ms Eastwood highlighted concerns about police discretion in diversion schemes, which often perpetuates the inequities of criminalisation. For example, in New South Wales, Indigenous youths were found to be twice as likely to receive a court summons rather than be diverted, showing how discretion can reinforce existing harms rather than mitigate them.

170. The Committee heard evidence to the problematic nature of police discretion in diversion schemes and the risks associated with escalated approaches. In schemes where penalties increase with repeated offences (e.g., a warning first, then a fine, and finally prosecution), individuals with drug dependencies are more likely to be criminalised. This approach effectively criminalises drug dependency, which should be avoided to better address the underlying issues of addiction and support those in need.

171. Deputy Chief Constable Wilson advised that in British Columbia, the lack of regulation on public drug use led many who initially supported decriminalisation to oppose it once it was implemented. Public concern over drug use in visible areas, especially near children, became a major issue. Any region considering decriminalisation should include clear rules about public consumption to maintain community support and address these concerns effectively.

172. Temporary arrests for public disturbances were seen as inadequate and risky, especially for those in drug crises. The aim was to address public consumption directly through new laws rather than relying on existing, insufficient provisions.

173. Mr Russoniello noted that before Measure 110 was passed, there were some discussions with police departments, but they were limited. Since Measure 110 was a voter ballot initiative rather than a legislative process, it did not undergo extensive political deliberation. The law was implemented as drafted without substantial input from the police.

174. Mr Russoniello attested that developing decriminalisation policies should involve all relevant partners, including police, given their key role in implementation. Measure 110, however, may not have been drafted optimally for this, as it heavily relied on police involvement, which led to challenges. Many police departments would prefer health professionals handle these situations, highlighting the need for better stakeholder engagement and planning.

175. Mr Leitão da Silva noted that since decriminalisation, Portuguese police have developed better relationships with both drug users and the broader community. This improved rapport has allowed police to focus more on community policing and other criminal activities. The shift from a focus on criminalising drug use to a more nuanced approach has enhanced their effectiveness and community interactions.

176. The Committee sought Mr Glynn's opinion on whether British police would support a shift to drug decriminalisation, given their current training and focus on the war on drugs. Mr Glynn highlighted a mix of attitudes within British policing regarding drug decriminalisation. While many officers viewed policing the drug war, especially focusing on cannabis, as exciting and a key part of their role, others find it a less engaging task. Some officers supported changing laws to allow focus on more critical issues, while more conservative members may prefer continuing the war on drugs. Younger officers might be more open to decriminalisation.

Minors

177. The Committee raised concerns about the role of poverty and environment in grooming and questions whether legislation allows an 18-year-old to be charged with grooming a 15-year-old.

178. Mr Ryan from the Department of Justice confirmed that 16-year-olds and 17-year-olds have been conditioned and are grooming younger children, The Criminal Justice (Engagement of Children in Criminal Activity) Bill will not apply to them. However, for those aged 18 and upwards, it is possible.

179. The Department of Justice stated the youngest children being coerced into the drug trade for activities such as look-out duties were seven or eight years old.

180. Members expressed concern regarding the complexities of grooming and community dynamics, noting concerns about how young people are targeted within their communities.

181. Youthrise Director, Ms Lawlor, highlighted that punitive drug policies, intended to protect young people, have instead led to systemic health and human rights violations. These policies push young people away from vital support systems, increase their vulnerability to criminal records and incarceration, and disproportionately affect marginalised communities.

182. Reports from organisations like the OHCHR, the UN, and Amnesty International highlight the disproportionate impact of punitive drug policies on young people, leading to stigma, reduced access to education and housing, and diminished future prospects. While diversion programmes like the Garda youth diversion scheme show that investing in personal development can reduce reoffending, Ms Lawlor argued that these efforts do not address the root causes of harm from current drug policies.

183. Professor Stevens referenced the Edinburgh Study of Youth Transitions and Crime by Professors Susan McVie and Lesley McAra that 14-year-olds involved in low-level offending, including drug offences, often have worse reoffending outcomes if the police catch them. The study suggested that diversion programmes, which still involve police contact, may not fully mitigate these negative effects. The Scottish

Government has embraced the lesson that minimising the involvement of criminal justice agencies in young people's lives is crucial to preventing poor outcomes and reducing recidivism.

184. Professor Stevens noted that effective measures to reduce risk-taking among youth include accurate information, whole-school approaches, and life skills training. Investment in these areas, rather than cuts to services, can help address drug use and associated risks among young people.

185. Professor Stevens noted that much of the resistance to new drug policies is driven by longstanding beliefs that drugs are inherently dangerous and concerns about children's safety. Evidence indicates that decriminalisation does not necessarily increase drug use among children. However, there are concerns about potential increases if marketing practices, like those in some US states, target young people.

186. Deputy Chief Constable Wilson explained that in British Columbia, the exemption for decriminalisation applied only to adults aged 18 and over. Possession of illicit drugs remains illegal for those under 18. In such cases, police may pursue charges or use diversion principles under the Youth Criminal Justice Act, enforcing the law for youth.

187. The Committee was interested about whether similar issues of young people being exploited by older gangs, as observed in Ireland occurs in Vancouver. Deputy Chief Constable Wilson explained that young people are exploited to carry or traffic drugs. Dealing and trafficking in illicit drugs is and has always been illegal in British Columbia and Canada, and this was never going to be exempted. The exemption was simply for personal possession for personal use. The Controlled Drugs and Substances Act would apply to youth just like it did prior to the exemption.

Vaping

188. The Committee commented on the rise in vaping among teenagers, who are using it despite never having smoked, highlighting concern about commercialising substances once they are accepted by society.

189. Ms Eastwood commented that the rise of vaping illustrates a common issue where regulation lags behind market trends and highlights the need for regulators to anticipate and address emerging trends before they become widespread. Effective regulation should precede the development of new markets, as seen with vaping in the UK.

190. The Committee raised the alarming rise in vape use among children, which may include substances like THC. This trend presents significant challenges, including mental health issues like psychosis. The Committee stressed that while discussions around drug policy are necessary, they must also address the potential unintended consequences and complexities that arise as policies are implemented.

Community & Family

191. The importance of community support networks in both urban and rural areas was highlighted, as these networks help families dealing with addiction challenges. Despite the presence of some effective community groups, the issue of addiction and its effects on families was described as under-resourced and not sufficiently addressed it unfortunately remain largely unnoticed by broader statutory services.

192. The Committee noted the importance of engaging people who use drugs, their communities, and families. There is a call from stakeholders for a community development approach, which may differ from current practices. Effective engagement should reach marginalised and less visible groups. Existing engagement often involves state-controlled entities, which may limit genuine community and family involvement.

193. The Citizens' Assembly recommendations, particularly 12 and 15, emphasise the importance of stakeholder engagement with people who use drugs, their communities, community projects, and families. Effective community engagement should focus on service provision, social and cultural capital, and recovery capital.

194. Dr Ivers and Dr Leite noted that community-based organisations are vital in reaching vulnerable populations who may not engage with formal institutions.

195. Mr Reid stated that presentations to the Citizens' Assembly highlighted the significant and widespread impact of addiction on families from diverse backgrounds. Family members shared powerful personal experiences, highlighting the severe damage addiction can cause within families. Presentations also addressed kinship care and the challenges of supporting families with children. A major concern was the disparity in financial support between kinship carers and foster carers, with a call for equalising this support to provide better access to necessary psychological and other supports for families.

196. Members questioned how community resources will be enhanced to counteract widespread criminal activity and expressed concerns that communities feel unsupported and isolated in their efforts to combat drug-related problem.

197. Regarding community efficacy, Mr Ryan highlighted the development of a local leadership programme in collaboration with the University of Limerick. This programme, piloted in Longford, Waterford, and north inner-city Dublin, aims to build local leadership capacity to better address organised criminality. Successful feedback has been received from Longford, and similar support may be extended to other areas, including north inner-city Dublin.

198. The Committee highlighted the "postcode lottery" of care, where access to addiction services and harm reduction varies significantly based on location, creating inequalities for patients. Concerns are raised about the adequacy of current funding for the Integrated Primary Care Unit.

199. The IPU stated that moving towards models like harm reduction or decriminalisation would require significant changes, including increased funding and resources, a comprehensive support system, and strategies to ensure equitable access to care across all regions.

200. Mr Murray stated that current funding for their services is inadequate, noting that pharmacists are struggling to maintain operations despite being a key point of healthcare, with over 50% of the population visiting them weekly. They expressed a desire to align with government policy and expand service offerings, reflecting public demand. However, they highlight disparities in addiction care services, influenced by varying levels of demand—particularly in rural areas, where patient numbers are low.

201. Mr Murray advocated for the need for a comprehensive funding model that considers the overall support for community pharmacies to enable the equal provision of additional services.

202. Dr Crowley attested that patient treatment for drug dependence includes the need for a safe, non-judgmental environment to facilitate open communication about substance use, accurate diagnosis to differentiate between drug use, misuse, and dependence, and the timely implementation of evidence-based treatments. However, comprehensive assessments are often hindered by time constraints, and local treatment services are frequently lacking or poorly coordinated, leading to disparities in access to care. While there are well-funded organisations providing support, the overall recovery framework remains fragmented, with some regions having duplicated services while others lack any treatment options entirely.

Marginalised communities

203. The Committee noted that shifting to a health-driven approach to drug issues represents a significant cultural and societal change. Marginalised communities are disproportionately affected by criminal justice approaches to drug use, which often exacerbate existing issues within these communities. Research shows drug use rates are similar across all communities, but marginalised groups experience more severe impacts. While current systems are inadequate, there is a need for broader societal support, including youth services and poverty alleviation, to address underlying issues. Focusing on these supports first might be crucial before implementing larger cultural changes.

204. Professor Stevens advocated for "progressive decriminalisation," aligning with the Committee’s view that drug issues are deeply rooted social problems. Solving these issues requires more than just altering drug laws; it involves addressing the broader social context, such as improving youth services, reducing poverty, and combating homelessness, which all contribute to problematic drug use.

205. Ms Lawlor stated that without investing in communities alongside policy reforms, such as legalising and regulating drugs, these reforms will not achieve their intended goals. Efforts to improve socioeconomic conditions and employability in marginalised communities are undermined by punitive and prohibitionist policies,

which allow gangs to thrive and overshadow the positive impacts of community investment.

206. Ms Eastwood stated that drug policy is often driven by economic deprivation and social exclusion rather than the drugs themselves. The UK spends £1.6 billion annually on drug law enforcement with minimal impact on drug availability; redirecting this funding to community investment could be more effective.

207. The Committee addressed the misconception that addressing drug addiction through a health-focused approach implies condoning addiction or that policing can solve addiction problems. The Committee questioned how to separate addiction from criminal justice responses and highlight that addiction often disproportionately affects marginalised communities.

208. Dr Ó Concubhair acknowledged the complex issue of drug addiction stigma and state responses. He notes that different substances and communities are treated differently by the law, with historical roots in targeting specific populations, such as Black, Mexican American, and Chinese American communities. The response explains that politicians often resort to bans as a solution to problems even if such measures are not evidence-based. This tendency to criminalise rather than address the root causes of addiction reflects broader systemic issues.

209. Mr Glynn suggested that police are not ideally suited to handle addiction issues and that resources should be shifted from law enforcement to addiction and harm reduction services. He argues for reallocating funds from drug war efforts to support these services, highlighting the need for patience and long-term investment in addressing addiction, which often involves deep-rooted and generational challenges. The response also highlights the importance of political support and adequate resources for these approaches to be effective.

210. The Committee referenced the concerning trend of intergenerational addiction, noting that children today are less able to seek support from family members, such as grandparents, compared to the past. This shift underscores the need for increased support services to assist individuals facing addiction issues. Members highlighted the absence of comprehensive "wraparound services," which integrate various forms of support for those in need.

211. The ICGP recognised that adverse events as part of the journey of addiction are very significant. That is clearly documented. There is an onus on any system to try to stop that intergenerational addiction because experience of addiction is in itself an adverse childhood event for the child of the parent who is addicted.

212. The IPU stated greater education is required to address perceptions of drug misuse and abuse, highlighting a societal snobbery that differentiates between types of drug use. For instance, using heroin is often viewed negatively, while cocaine use among affluent individuals is sometimes dismissed as harmless. This called for a broader educational approach to recognise and address all forms of drug misuse and abuse, ensuring services are targeted effectively rather than focusing narrowly on certain substances.

213. GPs have foundational knowledge from their training and can identify patients in need but are not equipped to provide specialised care for all conditions. Dr Quinlan advocated for the importance of GPs directing patients to appropriate services and specialists, ensuring timely and equitable access to the necessary level of care. They highlighted that with over 500 medical conditions, it is unrealistic for GPs to prescribe for every condition, underscoring the need for collaboration with specialised Colleagues.

Community Health Supports

Primary Care

214. The Irish Pharmacy Union (IPU) advocated for a greater role for community pharmacists in any future drug policy related to decriminalisation, de-penalisation, diversion, or legalisation. They believe community pharmacists are essential in providing harm reduction services, such as opioid substitution treatment (OST), needle exchange, and supplying naloxone for suspected opioid overdoses. Additionally, pharmacists can offer patient care, health screening, and targeted interventions, as well as educate local communities about drug-related harms and direct them to appropriate services.

215. The Irish College of General Practitioners (IGCP) attested that they witness firsthand the devastation that drug-related overdose deaths cause for families and loved ones. They understand the pain and stigma that come with addiction and

believe that, together, we can break this cycle. However, addressing drug misuse and addiction requires significant resources. Legislative reform must come with strong financial investment to make a real impact.

216. Addiction is discussed in 10-20% of GP appointments, making it crucial for doctors to have the proper training to identify and treat both substance and behavioural addictions. In Ireland, GP trainees receive education on addiction medicine, preparing them to handle various types of drug use, whether it's alcohol, prescription medications like sleeping tablets or painkillers, or illicit drugs such as cannabis and cocaine. GPs have a unique role in addressing addiction based on the substance involved, and they are vital in the fight against drug misuse and its harmful effects.

217. Over 350 GPs in Ireland, have received specialised training in addiction treatment, primarily focusing on opioid use disorder. However, drug use patterns are changing, and the ICGP believes there needs to be expanded access to a broader range of treatments through HSE specialist clinics. This expansion should include evidence-based care for both chemical and behavioural addictions to meet the growing demand for addiction treatment.

218. Managing addiction—through assessment, intervention, and ongoing care—is both time-consuming and resource-intensive. Unfortunately, there is limited access to public clinical psychology, counselling, and inpatient recovery beds, which, along with insufficient GP resources, reduces the quality of care and limits treatment options available to patients.

219. ICGP attested that criminalising drug use further isolates people in these communities, and challenges like housing insecurity and homelessness make substance use disorders even more severe. Supportive housing programmes, combined with addiction treatment, can significantly improve recovery for individuals, their families, and communities.

220. While both the IPU and ICGP supported a health-led strategy, the Committee noted their concerns about the need for substantial resources and community-targeted support. They emphasised the urgency of addressing the addiction crisis and questioned how to identify when critical levels of service have been achieved.

The Committee supported the need for clear indicators and metrics, such as waiting lists, to determine when sufficient progress has been made, urging for prompt action rather than waiting for an indeterminate future.

221. The ICGP highlighted that they are practicing clinical physicians who spend most of their time seeing patients. They emphasised the direct harm caused by drug use, noting that the death rate from drug overdoses in their region is significantly higher than the EU average. They believed the situation has reached a critical stage and assert that individuals who are addicted to drugs should not face penalties for their addiction.

Needle exchange

222. Dr O'Driscoll outlined that in establishing the pharmacy needle exchange programme, which was designed to supplement existing services in areas of significant need, particularly for individuals seeking opiate substitution therapy. Initially considered the lowest tier of needle exchanges, the programme aimed to provide specific needle types while also signposting users to additional support services. Although 100 pharmacies were selected, which may seem small, they were vital in regions lacking any needle exchange options. The programme has shown adaptability, modifying needle exchange packs to accommodate emerging demands, such as those from users seeking melanotan and steroids, thereby addressing the diverse needs of various user groups.

Stop and Search

223. The Committee stressed that the issue with decriminalisation models, including the Portuguese model, is that while they decriminalise personal drug use, they still criminalise addiction. This created a disparity: recreational users may face fewer issues with sanctions and repeated searches, while those struggling with addiction could be repeatedly stopped and searched, complicating their path to recovery, and potentially interfering with treatment.

224. The Committee queried whether the 2017 proposal for an adult caution system, which the Department of Justice claims is nearing its end, truly represents decriminalisation. The witnesses questioned if this system merely temporarily treats drug use as a health issue while ultimately continuing to view it as a criminal matter.

225. The Committee stated that legislators should address the issue of stop-and-search practices, which currently may use addiction and drug use as a means to uncover other crimes. Removing Section 3 from the Misuse of Drugs Act 1977 could reduce this broader search capability. Decriminalisation proposals should not be discarded due to concerns about law enforcement's ability to pursue other crimes without using section 3.

226. Additionally, addiction often overlaps with mental health issues, and mandating criminal sanctions before offering health interventions is problematic. The threat of criminalisation does not effectively address addiction and may not lead to meaningful health outcomes. It is necessary for the Committee to explore the medical rationale and evidence for maintaining criminal sanctions against individuals caught with drugs for personal use, and to consider the health impacts of such sanctions.

227. The Committee asked whether the Department of Justice has assessed the impact of removing Section 3, specifically how it would affect An Garda Síochána's approach to drug enforcement and support if simple possession were no longer criminalised.

228. Mr Ryan responded that regarding Section 3, that the Department of Justice has reviewed approaches from other jurisdictions, as outlined in a report by Mr Justice Sheehan. This report discusses the pros and cons of removing Section 3 and its implications for Ireland.

229. Ms Eastwood referenced that in the UK, research shows that Black people are disproportionately targeted by stop and search for drugs, despite similar drug usage rates as white people. This practice is traumatic and damaging, especially for young people navigating these encounters daily.

230. Efforts to mitigate this, such as new guidance restricting stop and searches based solely on the smell of cannabis, have faced resistance from police forces and numbers have risen again as officers seek alternative methods to demonstrate effectiveness. The evidence suggested that legislative reform, rather than incremental changes, is needed to address these issues. Decriminalisation and

regulation in the US have been shown to reduce police contact with communities, indicating a potential path forward.

231. Mr Leitão da Silva stated that the decriminalisation of drugs in Portugal did not eliminate the police's authority to stop and search individuals. If drugs are found during a search, the police can still seize them and refer the individual to the Commission for the Dissuasion of Drug Addiction. The power to stop and search remains in place.

Prohibition

War on drugs

232. The Committee heard testimony that reflects on the historical context of drug criminalisation in Ireland, noting that early debates and recommendations largely opposed criminalising drug possession. Despite this, the state pursued criminalisation primarily to meet UN treaty obligations rather than addressing drug issues. The Committee remained concerned that the ongoing issues with the war on drugs, which have led to this Committee and similar discussions, reflect its failure.

233. The Committee agreed prohibition is not working, and punitive policies are causing further harms, often fatal. The Committee queried what, if any, intermediary policy options are appropriate in an Irish context today and has anything changed since the report Mr Justice Sheehan produced in 2018 and what legal steps may be required.

234. The Committee further noted that the current "war on drugs" approach, which focuses on cutting supply, has been ineffective, as evidenced by increasing drug use despite educational efforts.

235. Dr Ó Concubhair stated that drug prohibition negatively affects police-community relations and undermines human rights-based policing. Excessive use of stop-and-search practices and other coercive measures harms community trust and is often targeted at socioeconomically or ethnically marginalised groups.

236. Mr Glynn provided that drug use is a longstanding and inevitable part of human behaviour; prohibition and the war on drugs have not succeeded in eliminating drug use and often cause more harm than the substances themselves.

237. Mr Glynn attested that drug prohibition leads to overdose deaths, violence, and increased criminalisation. The focus on drug-related offences diverts police resources from addressing more pressing crimes.

238. The Committee noted a theme across all recent discussions that the current war on drugs is unachievable and recreational drug use is a persistent reality. They express concern about the potential consequences of expanding access to a broader range of drugs and lifting current criminal sanctions.

239. The Committee queried a hypothetical scenario of alcohol being suddenly made illegal, similar to current drug policies. This was to explore the potential consequences of such a drastic policy shift, including the impact on public health, societal behaviour, and the effectiveness of enforcement, given that alcohol is widely accepted, marketed, and has significant health implications.

240. Mr Glynn highlighted that historical evidence from U.S. Prohibition shows that banning alcohol does not work. The era led to the creation of cocktails to mask alcohol content and did not effectively curb alcohol use.

241. Similarly, Dr Ó Concubhair's response outlined that there was a significant increase in deaths due to toxic alcohol as a consequences of alcohol prohibition in the U.S Prohibition led to a surge in organised crime as illegal markets flourished. Alcohol consumption dropped by about 20%, but not dramatically. Higher-strength alcohol became more common, as it was easier to transport and avoid detection. Similar dynamics are observed with substances like fentanyl, where higher potency becomes more prevalent in unregulated markets.

242. Dr Ó Concubhair noted that while black markets for cannabis do exist even after legalisation, evidence shows they have significantly declined. The transition from an illegal to a legal market takes time and may not eliminate illicit production entirely. However, the key factors influencing the presence of a black market include cost, regulatory barriers, and market accessibility.

Possession

243. The Committee noted that innovative, health-led, and human rights-compliant approaches to drug policy may be constrained by the Misuse of Drugs Act.

International evidence suggests that this legislation limits certain progressive strategies that could be implemented.

244. Mr Reid stated that the Assembly was clear in its intent to remove drug possession from the criminal justice system without fully legalising it. Other recommendations addressed the whole issue of stigma and public stop and search leads to significant stigma.

245. Since 1977, there has been a policy shift within the HSE and Department of Health towards a health-led approach to drug issues, focusing on harm reduction rather than criminalisation. The discussion suggests that relying solely on policing to manage drug issues is ineffective, and that alternative strategies such as revising the Misuse of Drugs Act, exploring regulation, legalisation, and decriminalisation should be considered.

246. The Committee focused on the issue of possession offences. They sought clarification on whether individuals prosecuted for other charges are excluded from the adult caution scheme for cannabis offences. They questioned why possession and other charges are not considered separately in this context.

247. Mr Ryan stated that the eligibility for the adult caution scheme depends on the nature of other offences. Gardaí may use discretion for low-level offences, allowing someone to receive a caution for possession. However, more serious offences, such as intent to supply, are considered ineligible for the scheme. The adult caution is not intended for individuals involved in more significant criminal activities.

248. Professor Stevens referenced research from the United States indicating that decriminalising drug possession effectively reduces arrests, criminal records, and fines related to drug possession. However, the impact on stop-and-search activities is less clear. While decriminalisation is likely to reduce these activities—benefiting marginalised and working-class communities over-policed for drug use—it may not eliminate stop-and-search practices entirely, as police may still find reasons to conduct them. In England, over half of stop-and-searches are for drug possession, highlighting this ongoing issue.

249. Professor Stevens noted that currently, no place in the world has fully legalised all drugs, though there are medical markets for some substances like heroin. Most legalisation have focused on cannabis, with varying models in place:

250. Germany allows possession, production, and sale under specific conditions, including personal cultivation and sharing through cannabis social clubs. Belgium and Spain, implement self-producing cooperative models where people grow and share cannabis within groups. Uruguay features a system of licensed sellers and buyers with regulated access to cannabis. California, USA has a more liberal market with a wide range of cannabis products, though it suffers from a lack of federal regulation, leading to extensive advertising.

251. Professor Stevens stated that while legalisation can be linked to increased use, especially in free market models, restrictive approaches can also provide legal access without promoting widespread use.

252. He goes on to argue that for many, drug use is not seen as inherently wrong, especially compared to offences like sexual assault. If we accept personal autonomy over drug use, deterrence becomes the primary argument for its criminalisation.

253. Deputy Chief Constable Wilson stated that currently, if someone is stopped by police for another reason and found with less than 2.5 grams of drugs, they are unlikely to be charged with possession. If the person were jailed, the drugs would be seized and destroyed, but under decriminalisation, the drugs would be returned upon release, acknowledging the risks of seizing drugs from individuals with substance use disorders.

254. Dr Ó Concubhair stated that the Misuse of Drugs Act 1977 was enacted in Ireland to align with the UN Single Convention on Narcotic Drugs, which the U.S. heavily influenced to fight the U.S. "war on drugs". Historically, many substances now banned such as cocaine and heroin, were once legal in Ireland, suggesting that prohibition is a relatively recent phenomenon.

255. Dr Ó Concubhair argued that the Misuse of Drugs Act 1977, enforces criminalisation that harms communities and strains police-community relations. He advocates for decriminalising drug use in Ireland, which must involve repealing

section 3 of the 1977 Act to avoid continued criminalisation and punishment of drug users. He critiqued the current system's impact on human rights and policing, noting that drug prohibition leads to excessive and harmful police practices.

256. He provided that the criminal justice response to drug use under the 1977 Act is highly intrusive, coercive, and punitive, causing significant harm to communities and raising human rights concerns. Policing practices related to drug enforcement, such as intelligence-gathering and stop-and-search tactics, are degrading and dehumanising, particularly for marginalised groups.

257. The Committee asked Mr Glynn to elaborate on his observations regarding how police powers under the Misuse of Drugs Act in the UK are used, abused, and misused by police officers. The question sought details on the specifics of these issues as they relate to the UK legislation and police practices.

258. Mr Glynn explained that police powers under drug legislation are frequently misused across various countries, including the UK and others like the Netherlands, Belgium, France, and Spain. Misuse examples include, using stop-and-search powers as a means of controlling areas or engaging with people, often leading to coercive actions or escalation to violence. Officers employing dubious tactics, such as claiming to smell cannabis, to justify searches and meet numerical targets, even when no drugs are found. Overuse of stop-and-search powers, result in minimal finds but significant use of resources.

259. Mr Glynn argued that despite having ample powers, the police have not effectively addressed drug-related issues, suggesting that alternative approaches beyond expanding police powers are necessary.

260. Dr Ó Concubhair's response highlighted his significant concerns about the misuse of drug search powers by An Garda Síochána, particularly outside the Dublin metropolitan area. Academic research on Garda practices is difficult due to limited access to data, making comparisons with UK practices challenging. Dr Ó Concubhair notes that Gardaí, lacking stop-and-search powers under the Criminal Justice (Theft and Fraud Offences) Act 2001, often resort to drug search powers, leading to potentially unlawful searches.

261. Research has identified significant unlawful use of drug search powers, with anecdotal evidence suggesting extensive and sometimes unjustified use in certain communities, there is concern that the misuse in Ireland may be as pronounced as in the UK or Scotland, though precise data is lacking.

Health led approach

262. Professor Ivers of the Citizens' Assembly highlighted evidence supporting the effectiveness of brief interventions, which can lead to positive behavioural changes for the majority of individuals. While 90% of people may use drugs without serious consequences, there is a hidden population, possibly up to 30%, who use drugs in a harmful or hazardous way. Screening these individuals can help identify those who need more specialised care. This underscored the importance of the health-led approach, even for those who might not initially seek help or recognise their own risk.

263. Dr Malinowska-Sempruch viewed drug use primarily as a public health issue rather than a criminal one. The criminalisation of drug use infringes on individual rights and hampers public safety as individuals are less likely to seek help, report overdoses, or access treatment due to fear of legal repercussions.

264. Dr Malinowska-Sempruch stated that criminalisation has not only been ineffective but has also contributed to the overdose epidemic and other global harms. She called for countries to adopt brave, new strategies to address drug issues more effectively and compassionately.

265. The Committee appreciated the witnesses' insights and reflects on societal changes in Ireland, such as the legalisation of same-sex couple parenting rights. They draw parallels between this progress and the potential for change in drug policy, recognising a need for decriminalisation and a shift towards health-focused approaches.

Recovery

266. Professor Ivers highlighted that the current treatment system works well for individuals with fewer complex needs—those who have stable housing, positive relationships, employment history, and some level of education. These factors,

referred to as "capital," help sustain recovery. However, she points out that the system is "stacked against" those with more complex needs, such as co-occurring mental health issues or unstable living conditions. She stressed the need for a cross-government approach, political will, and systemic support to better assist the more vulnerable population and ensure a societal shift in addressing addiction recovery.

267. The Department of Health supports effective recovery and believes that it is crucial to have appropriate recovery supports and involve individuals with lived experience. They further stated that, new funding will focus on enhancing recovery efforts. Recovery should be guided by the recommendations of the Assembly and new strategies. While transitioning off methadone is a goal for some, remaining on methadone can still be beneficial, as it ensures access to treatment and care and helps individuals stay alive.

268. Dr Caitlin Hughes' research in 2018, highlighted the difficulty in defining a clear distinction between drug use/possession and drug sale/supply. Professor Stevens suggests following the British approach, which places the burden of proof on the prosecution to demonstrate intent to supply rather than relying on an arbitrary weight limit. This method, which involves evidence such as scales or drug-related communications, is considered more reliable for distinguishing between possession and intent to supply.

269. Ms Lawlor advocated that drug treatment for young people is voluntary, informed, and tailored to their needs. Recovery varies for each individual, and while abstinence is one goal, reducing chaotic drug use is another valid approach.

270. The ICGP emphasised that criminalising individuals leads to significant harm and negatively impacts their recovery from addiction. Key aspects of recovery include fostering hope, accessing meaningful employment, and opportunities for education, free from societal stigma. The ICGP viewed criminalisation as a barrier to sustained recovery, reinforcing their position against penalising those with addiction.

271. Mr Crowley emphasised the need to address treatment deficits, particularly for addictions beyond opioids, such as cocaine, which currently lacks a national treatment programme. It highlighted that most individuals who experience fatal overdoses are not in treatment and stresses the importance of removing barriers to

access. He advocated for a comprehensive approach to all behavioural and chemical addictions, focusing on evidence-based solutions. Additionally, they encouraged the committee to consider primary care settings as key locations for delivering treatment without stigma or discrimination.

272. Dr O'Driscoll advocated for the importance of providing equal care for all substance users, not just those using opioids, and emphasises a patient-centred approach in supporting individuals in their recovery journey.

Residential beds

273. The Committee highlighted a concern with the number of rehabilitation beds and services. Dr Crowley responded that there is a significant gap in the availability of residential treatment options for individuals struggling with drug use, particularly regarding stabilisation and residential beds, which are largely limited to detox facilities. Only a couple of centres exist nationally for those needing to stabilise rather than become drug-free.

274. Consequently, patients are often referred to detox services that may not suit their needs due to the lack of appropriate options. Additionally, many patients face long waiting times—ranging from six to twelve months—for residential treatment, during which their circumstances and motivation can change drastically, making timely access to care critical.

275. The Committee sought clarity on whether there is progress towards a strategy that would enable better access to detox services for those in need particularly for those requiring access to benzodiazepine detox.

276. Dr O'Driscoll reflected on his experience in addiction services, highlighting the importance of patient-driven approaches to benzodiazepine detoxification. He explained that automatic dose reductions are ineffective and that detox protocols should be tailored to individual needs. A community project involving local GPs and pharmacies aimed to develop effective benzodiazepine detox strategies, but challenges remain in managing prescriptions and interventions outside of structured addiction services.

277. Dr O'Driscoll also noted that the duration of detox should be determined by the patient's needs, rather than a fixed timeline. They pointed out that while adjustments can be made more easily within addiction services, the community setting complicates the process. They also mentioned the establishment of a benzodiazepine subcommittee in 2000, indicating ongoing discussions around this issue for many years.

278. Dr Crowley stated that GPs might participate in benzodiazepine detoxification if proper support structures were in place. Many GPs are reluctant to prescribe these medications due to fears of managing dependent patients and the potential for overprescribing. However, it is noted that prescribing benzodiazepines to dependent individuals can be considered good practice, highlighting the need for better support to assist GPs in these situations.

Relapse

279. Dr Crowley voiced the concern that society needs to view addiction as a chronic relapsing disease that warrants compassion and understanding, rather than stigma. It calls for general practitioners to be trained to recognise signs of addiction, such as absenteeism, and to adopt a non-judgmental approach when addressing these issues during consultations. This attitude is particularly important during relapse, as individuals often struggle to re-engage with support services due to the stigma associated with addiction. Encouraging re-engagement is vital to preventing fatal overdoses, but stigma frequently obstructs this critical process.

Spent Conviction Legislation

280. The Committee noted that it is important to recognise that a criminal conviction for drug possession can severely limit recovery options. Such convictions remain on vetting forms, potentially excluding individuals from educational and employment opportunities, and hindering their recovery process.

281. Decriminalisation could improve this but there seems to be no significant push within the Irish police force for such reform, unlike in other countries where some police officers have advocated for less punitive approaches.

282. Dr Malinowska-Sempruch noted that in the U.S., there are examples where small cannabis businesses have created job opportunities for individuals with

criminal records. This approach helps integrate people who might otherwise struggle to find employment and reduces their likelihood of returning to illicit activities. Dr Pinto states that in Latin America, coca can be sold with minimal regulation, such as in tea or powder form.

283. Ms Nougier commented that there is a variety of jurisdictions that have allowed for the expungement of criminal records of people who have been previously convicted of drug use-related activities to support recovery and reintegration with the labour market.

284. Dr O'Driscoll stressed that the challenges faced by individuals with criminal records in moving forward in their lives, advocating for the decriminalisation of drug users as a crucial step.

Status Quo

285. The Committee further noted the opposition to change and resistance to new models often stems from a belief in maintaining the status quo or advocating for harsher penalties. In many places, including Ireland, public opinion is shifting towards exploring alternatives due to dissatisfaction with the ineffective results of past approaches and the high levels of drug deaths in Ireland in comparison to other European counterparts. The debate on drug policy will likely continue to face opposition from entrenched beliefs and vested interests, but increasing public awareness and demand for change may drive progress towards more rational and effective drug policies over the next decade.

286. The Committee asked witnesses if they agree that despite recent discussions about a health-led and diversion approach to drug policy in Ireland, there is a tendency among the Department of Justice, the police, and political figures to maintain the status quo rather than pursuing decriminalisation.

287. Dr Ó Concubhair acknowledges significant political anxiety and opposition to decriminalisation from An Garda Síochána, reflecting a broader reluctance to change. Dr Ó Concubhair explains that criminalisation effectively imposes stigma, which affects people's lives and opportunities, but it has not been successful in deterring drug use or changing attitudes toward it. While stigmatisation can have some deterrent effects, it primarily functions as a retributive measure, focusing on

punishment rather than prevention or harm reduction. The core issue is whether the state should continue to stigmatise drug use if it fails to achieve its other aims, such as deterrence or reducing harm.

288. He noted that removing stigma requires more than just superficial changes; criminal offences inherently perpetuate stigma. He cites England's mixed experience with diversionary measures, highlighting that while some police leaders support reducing stigma, many on the ground resist these changes. This resistance is evident in the limited uptake of diversionary measures for cannabis and the continued prosecution of those caught with it. The response suggests that similar cultural and institutional challenges would likely impede progress in Ireland.

289. Mr Glynn stated that changing legislation is crucial for altering policing practices, to ensure consistency and compliance at all levels of the police force. While senior leaders can advocate for new approaches, such as limiting stop-and-search practices based on cannabis smell, without legal changes, front-line officers may not fully adopt these practices. The example from Durham, England, illustrates that some police leaders may choose to prioritise other issues over minor drug offences, but without legislative change, such efforts lack permanence and can be easily reversed.

290. The Committee agreed that in order to make a meaningful difference, bold and radical changes are necessary. The impact of these changes could be profound, because as highlighted altering policy could potentially save lives, making all efforts worthwhile.

Consumption

291. Professor Ivers told the Committee that since the early 1990s, significant progress has been made in addressing heroin use and opioid addiction, building on the foundation laid by the Rabbitte report. The introduction of methadone programmes, needle exchanges, and soon-to-open supervised injection facilities have helped keep opioid users alive and well, despite the persistent high number of deaths. The number of opioid users, particularly heroin users, remains close to 20,000, similar to 2006 levels, but services have become more sophisticated.

292. Professor Stevens stated that if there is no strong evidence that criminalising drug use reduces usage or improves public health, then the justification for such measures is questionable. Repeated studies across multiple countries across multiple offence categories show that increasing the lengths of sentences for offences does not necessarily deter or reduce the occurrence of an offence, including drug offences.

Supervised Injection Facilities

293. The Committee questioned the delay in establishing medically supervised injecting facilities in Ireland, particularly regarding Merchant's Quay.

294. Dr Keenan from the HSE stated that the delay at Merchant's Quay is due to a lengthy planning process and increased construction costs. Despite existing evidence from similar facilities in Europe and North America showing benefits like reduced drug-related litter, improved access to services, and fewer overdoses, the facility is still awaiting final approval. The plan included a six-month evaluation to inform the continuation of the project and an impact assessment on local children.

295. The Committee supported the opening of Dublin's first injection facility but advocates for expanding it into a broader consumption facility and seek insights on how broader consumption facilities could better support marginalised groups facing drug-related issues and criminalisation.

296. Ms Nougier stated that it is crucial to tailor the facility to the evolving needs of local communities. Drug use patterns and preferences change over time, so flexibility is key. Safe injection rooms often become more than just places to use drugs; they serve as vital community hubs where people seek additional support.

297. Ms Nougier provided that incorporating feedback from users will help adapt services effectively. For women and marginalised groups, it is beneficial to create spaces within harm reduction services that cater specifically to their needs, such as women-only hours or specialized services. This approach can reduce stigma and encourage engagement.

298. Dr Pinto noted that drug consumption rooms should integrate multiple harm reduction approaches, such as connecting people with their families, social inclusion, and labour opportunities.

299. It is vital to involve people who use drugs, as well as diverse groups, in shaping and assessing these services to ensure they meet their needs effectively. Personal testimonials from users of drug consumption rooms in Porto highlight the value of these services in providing community and support, suggesting that well-designed harm reduction services can be more effective than mandatory responses.

300. Mr Russoniello attested that Oregon currently lacks supervised consumption facilities or overdose prevention centres, despite advocacy efforts. This absence has been a significant issue, particularly for addressing public drug use. Additionally, the state has insufficient sobering centres to manage intoxicated individuals found on the streets. Although Measure 110 was intended to fund these services, there were delays in the disbursement of funds, which hindered the establishment of necessary support.

301. Mr Leitão da Silva highlighted the importance of adapting policing strategies and maintaining a supportive approach, as exemplified by recent initiatives like the drug consumption room in Porto. However, concerns about rising drug volumes in Europe and the need for increased enforcement were also highlighted.

Public Consumption

302. Professor Stevens noted that the issue of criminalising drug use in public spaces, while decriminalising possession, can disproportionately impact homeless individuals who lack private spaces to use drugs. This approach creates inequalities between those with access to private spaces and those without. Although public drug use is generally disliked, it can be managed through measures such as park by-laws and police intervention, rather than resorting to criminalisation. This avoids further penalising vulnerable populations.

303. Deputy Chief Constable Fiona Wilson stated that with decriminalisation, the possession of drugs became legal, and public consumption of these drugs was permitted with only a few exceptions. This contrasted sharply with the strict regulations on public alcohol consumption that remained strictly regulated and

largely prohibited. As a result, after decriminalisation, it became possible for individuals to use drugs, like heroin, in public spaces like transit bus stops, even though consuming alcohol in such locations remained illegal.

304. Deputy Chief Constable Wilson noted that from a policing perspective, the ideal scenario would be to regulate open-air drug use similarly to how alcohol use is managed, with specific restrictions and controls in place. This would help balance public safety with the need to provide support for those using drugs. The current situation, which involves rolling back decriminalisation, is seen as problematic and not preferred. The aim would be to establish a clear and practical framework for managing drug use in public spaces, avoiding the legal and practical issues faced under the existing system.

305. Deputy Chief Constable Wilson recognised that the proposed public use legislation was seen as a compassionate approach, allowing police to ask individuals using drugs in problematic public areas to leave without criminal penalties. If they refused, it would be considered a criminal matter under obstruction laws, thus avoiding criminalising drug use itself.

306. Mr Russoniello advised that in order to address these challenges, two additional measures that could have helped are expanding harm reduction services, such as safe consumption sites and ensuring timely and adequate funding for services alongside decriminalisation efforts to meet the increased demand for support and prevent the problems associated with unmanaged public drug use.

307. Mr Russoniello noted that local police defunding may have affected the enforcement of public safety measures, and it is important to assess if safe consumption sites or similar facilities were introduced to offer care settings for drug users experiencing homelessness or institutionalisation.

308. The witnesses were asked that if Ireland were to consider decriminalising drugs, should the legislation include specific provisions to prohibit public drug use from the outset and also address public consumption rules for individuals who lack access to private spaces for drug use.

309. Deputy Chief Constable Wilson advised that in British Columbia, the lack of regulation on public drug use led many who initially supported decriminalisation to oppose it once it was implemented. Public concern over drug use in visible areas, especially near children, became a major issue. Any region considering decriminalisation should include clear rules about public consumption to maintain community support and address these concerns effectively.

310. Deputy Chief Constable Wilson highlighted several key issues encountered with decriminalisation in British Columbia seen an increased public drug use noting a rise in public drug use, with people congregating outside businesses, parks, and other public spaces. This led to complaints from business owners and the public. She further noted the challenges for law enforcement, attesting that before decriminalisation, police could respond to drug use by asking individuals to move along. However, after decriminalisation, police had limited authority to address public drug use, leading to decreased public complaints because people learned that calling 911 was ineffective. This complicated efforts to gauge the true impact on communities.

311. Deputy Chief Constable Wilson advised that in British Columbia, the consensus is to avoid incarcerating individuals due to substance use disorders. However, there is a strong emphasis on ensuring that police officers retain the authority to manage public drug consumption. The experience in British Columbia showed that without this authority, public drug use can become problematic. The response suggests that police should have tools, whether through legislation, ticketing, or creative diversion methods, to address public consumption issues effectively. This is crucial to avoid the negative consequences observed in British Columbia, where unchecked public drug use led to significant challenges.

312. Deputy Chief Constable Wilson explained that while Vancouver has sufficient overdose prevention sites, many remote communities in British Columbia lack adequate facilities.

313. Deputy Chief Constable Wilson noted an increase in outdoor drug use following decriminalisation, which led to more overdose deaths in outdoor spaces. Although one goal of decriminalisation was to reduce the risk of overdose by

encouraging outdoor use, the increase in outdoor deaths suggests that this assumption needs further research. Ms. Wilson highlighted the need for more harm reduction resources and a broader range of care services across the province.

314. The Committee asked if Deputy Chief Constable Wilson thinks that Vancouver's approach might have been rushed, possibly putting the "cart before the horse" in response to the overdose crisis during COVID-19, where overdose deaths outnumbered COVID-related deaths. The question seeks to clarify whether addressing issues like public consumption, licensed establishments, semi-public spaces, and driving concerns—similar to public order laws related to alcohol—could have mitigated some of the challenges Vancouver faced.

315. Deputy Chief Constable Wilson highlighted that British Columbia did not see a required increase in resources following decriminalisation, contrary to initial expectations. The lack of resource escalation, combined with insufficient parameters around public consumption, created challenges. For instance, the federal exemption allowed 18-year-olds to use drugs in licensed establishments, even though the drinking age was 19, leading to unintended situations like drug use in such venues. Despite no increase in overall drug use, the way drug use was managed became problematic and complex, impacting communities in ways that were not anticipated.

316. Mr Leitão da Silva stated that Portugal is experiencing increased visibility of drug use in public spaces, a situation not addressed by the 2001 decriminalisation law. The current law only criminalises the abandonment of syringes in public, with other forms of drug use not considered crimes or misdemeanours.

317. Mr Leitão da Silva would recommend that if Ireland were to bring in decriminalisation it would be treated in a similar way to alcohol, meaning the use of drugs in a public place, would not be permitted.

318. The Committee asked if witnesses had concerns regarding the potential for public backlash if drug decriminalisation leads to unrestricted public use, as seen in places like British Columbia and parts of the US.

319. Dr Ó Concubhair suggested that if drug decriminalisation were pursued, it would be wise for local authorities to implement measures to restrict public drug use, similar to existing restrictions on public alcohol consumption. This could help prevent public backlash and address security concerns. He notes is practical to grant local authorities and police the power to manage drug use in sensitive areas such as near schools.

320. Mr Glynn agreed with the idea of limiting public drug use through local authority measures rather than increasing police powers. He supports context-specific measures like exclusion zones around schools but emphasises that drug policy should focus on health and education rather than criminal justice.

Opioids, Synthetic Drugs and Potency

321. While opioid use remains a major issue, newer problems have emerged, such as the rise in cocaine use, which has overtaken cannabis as the most common drug for treatment. Cocaine-related deaths are increasing, making it a significant new challenge. Professor Ivers stated that fentanyl has not yet become a major issue in Europe, unlike in North America, where opioid overdose deaths are far higher. Despite the challenges, many lives have been saved, and there is recognition that while much has been achieved, more work is needed, particularly in terms of recovery.

322. Dr Keenan acknowledged the growing presence of synthetic opioids, MDMA, crystal meth, and fentanyl. While these drugs are not yet widely manufactured in Ireland, their potential emergence poses significant challenges. The increasing use of such potent substances could put more pressure on the addiction treatment system, affecting the availability of services for detoxification, maintenance, and recovery.

323. Synthetic opioids are becoming a major concern across Europe. In Ireland, there is no known production of these opioids. However, there is a troubling increase in drug potency, including MDMA and cocaine. Recent incidents, such as overdose clusters in Dublin and Cork and cases involving counterfeit benzodiazepines containing nitazene drugs, highlight the growing issue and the associated risks across the country.

324. The Committee heard about concerns regarding the increased potency of drugs, including a significant rise in cannabis potency over recent decades, and the addition of psychoactive substances leading to polysubstance use. It is noted that Oregon's reversal of drug decriminalisation was partly due to a thirteenfold increase in fentanyl-related overdoses and challenges with homelessness, as the system struggled to manage these issues without relying on drug possession laws.

325. The Committee sought to understand how the Gardaí approach the issue of drug potency during standard possession searches and how they collaborate with the HSE, which monitors drug potency. Specifically, it asked about the methods for documenting and communicating information about the potency of substances between law enforcement and health services.

326. The Department of Justice explained that when Gardaí seize drugs, they are sent to Forensic Science Ireland for analysis, and Forensic Science Ireland then reports back on the findings. Currently there is no regulations regarding potency specifically.

327. Dr Keenan noted that higher-potency substances, especially cannabis, are leading to more referrals to the HSE, with cannabis being the most common referral among those under 25. This increase in potency impacts health and requires a response from treatment providers.

328. Dr Keenan attested with regard to drug analysis, the national red alert group has brought together labs, An Garda Síochána, HSE emergency management, the ambulance service, and emergency departments to collaboratively address emerging trends like nitazenes. This group focuses on analysing drug potency and contaminants, moving beyond prosecution-based analysis to better understand new substances and their effects.

329. Dr O'Driscoll expressed concern about the evolving landscape of drug substances, particularly focusing on fentanyls and nitazenes. Stimulant-style drugs and synthetic cannabinoids are gaining traction in Europe. He also highlights the potential for opium production to shift to Southeast Asia, indicating a changing global market influenced by players like the Taliban. Recent incidents, such as overdoses that resembled opioid crises but were caused by novel benzodiazepines,

underscore the unpredictability of emerging substances. Dr O'Driscoll noted that the dark web allows for easier access to various drugs, complicating efforts to predict which substances may become prominent next.

330. Dr Crowley agreed with Dr O'Driscoll on the importance of ensuring access to treatment for opioid dependence, as this can provide protection against overdoses. Dr Crowley expressed the need to engage individuals using opioids with treatment services and highlight the critical role of naloxone in reversing overdoses if the new opioid becomes prevalent. The ICGP calls for coordinated efforts to manage the situation effectively.

331. The Committed noted concern with the rising issue of addiction to prescription medications like tramadol and oxycodone, particularly among individuals who appear to be functioning normally in society (e.g., working adults). Members noted that some individuals have only been offered methadone programmes, which may not be suitable for their lifestyle, as they are not part of traditional drug-using communities. There is a need for more understanding and options for people with these types of addictions, and the members sought insight into how prevalent this issue is and what solutions are being considered by health professionals.

332. Dr Crowley addressed concerns regarding codeine dependence, acknowledging that while it is similar to opioid dependence, it involves a distinct group of individuals with specific needs. In their practice, the first-line treatment for this population is buprenorphine, and they are also advancing the use of depot buprenorphine, a monthly injection that significantly improves the lives of patients by reducing the frequency of visits required for treatment.

333. Dr Crowley emphasised the importance of primary care in providing these services, highlighting the need for general practitioners with specialised skills to assess and treat patients effectively. The ICGP advocates for enhanced support and services in primary care to address the stigma and discrimination faced by these individuals.

Harm Reduction

Opioid Substitution Treatment (OST) / Opioid Agonist Treatment (OAT)

334. The Committee queried the current state of opioid substitution programmes. Statutory methadone clinics provide medication with minimal wraparound services, often resulting in a maintenance-focused approach. In contrast, community-based services, despite limited resources, offer a more holistic support system. The Committee further queried the challenges with methadone maintenance programmes that can feel restrictive. Patients face bureaucratic hurdles that can hinder their progress and personal agency. Failures or lapses in the system can lead to punitive measures, which further alienate individuals from support.

335. The HSE provides opioid agonist treatment (OAT) to over 11,000 individuals, including new treatments like injectable buprenorphine. There are numerous clinics and pharmacies involved in this scheme.

336. The HSE has expanded naloxone availability and training, saving an estimated 18 lives in 2023. New cocaine and crack services are in place, and a medically supervised injecting facility will soon open as a pilot programme.

337. The Department of Health stated that there are about 20,000 opioid-dependent individuals in the country, with approximately 11,500 receiving opioid substitution or agonist treatment, which is favourable compared to other European countries.

338. Methadone treatment is used to stabilise individuals who often come from chaotic backgrounds with various personal and health issues. The addiction services also provide support for related conditions, like hepatitis C.

339. Recovery requires a comprehensive societal approach, including job opportunities, education, and family support. Rapid detoxification can be detrimental if individuals lack these supports, potentially leading to relapse. Methadone can be part of a stabilising strategy that helps individuals maintain jobs and family responsibilities.

340. The Committee asked for an update on nurse-prescribing of opioid agonist treatments (OAT), initiative. While the target numbers for nurse-prescribing have

been met, some individuals face challenges due to their GP not being part of the scheme or concerns about confidentiality.

341. While it is not seen as a major solution to current problems, nurses play a crucial role in addiction services. The HSE is working to enhance nurses' roles, including creating career pathways for them to become clinical specialists and advanced practitioners, who may then prescribe various medications, though legislative changes are needed for prescribing OAT specifically.

342. Professor Stevens stated that effective provision of OAT shows success in engaging and retaining individuals in treatment and saving lives. Given the rise in drug-related deaths in the UK, there is a strong push to expand and enhance the availability and quality of OAT. This should include increasing access to methadone, buprenorphine, depot buprenorphine (Buvidal), and also offering heroin-assisted treatment and diamorphine for those who do not respond to other treatments.

343. The Committee discussed the concept of a "human-rights-based" approach in healthcare, specifically regarding opioid substitution therapy (OST). It highlights the expectation that patients should have the choice between treatment options like methadone and suboxone. However, it raised concerns about the lack of actual choice available to patients, questioning whether methadone is favoured due to cost or availability, thereby limiting patients' autonomy and agency in their treatment decisions.

344. The ICGP explained that medical practitioners prioritise the most appropriate treatment for patients without considering cost. They advocated for shared decision-making, moving away from a paternalistic model where treatments are imposed. Practitioners consider individual circumstances, such as substance interactions or coexisting health issues, to determine the best opioid agonist therapy (methadone or Suboxone). Treatment should be based on informed consent and patient comfort, with ICGP supporting this approach.

345. The Committed raised further questions about the allocation of patients to GPs providing opioid treatment, particularly in counties outside Dublin. While some doctors who have completed the necessary training express frustration at not receiving any patients, others are overwhelmed with patients. Members sought

clarification on who decides patient assignments and the decision-making process involved when a GP joins the list to provide care. They highlighted issues of accessibility, as patients may prefer to see a local doctor, yet it appears that external decisions are directing them to other providers, leading to inequities in patient distribution among GPs in nearby communities.

346. Dr Kenny outlined the process for GPs to specialise in addiction medicine through training provided by the ICGP. After completing the training and meeting required standards, GPs can apply for a contract with the HSE. Depending on their training level, they may inherit existing patients on OAT or conduct full assessments and manage new patients independently. The response acknowledges that community-based treatment is preferable for patients.

347. Dr Kenny highlighted the existing funding model that support GPs in providing OAT through an agreement with the Health Service HSE, which has been effective. Currently, 350 members are actively prescribing OAT, and the college aims to expand this program to better serve the community. While training includes addressing various addictions, the HSE lacks a funding program for therapies related to substances other than opioids. Given that addiction is often a chronic disease with potential for relapse, there is a call to extend the program to encompass other substances, such as cocaine and cannabis use disorders.

Drug related harms

348. In responding to a query regarding data, Department of Health officials stated that the Health Research Board (HRB) effectively gathers data on suspicious deaths and collaborates closely with coroners to provide accurate information on drug-related harms. Despite Ireland's generally lower mortality rates compared to other countries, the HRB's work reveals the significant impact of poly-substance abuse on drug- related deaths.

349. The Department of Health stated that Ireland's drug-related services budget is about €160 million, with recent increases for expanded addiction services, community support, and naloxone distribution. The focus includes enhancing treatment and support interventions based on specific drug-related harms.

350. Department of Health officials stated that harm reduction initiatives include widespread naloxone distribution, with over 6,000 doses delivered last year and more than 400 uses recorded. A supervised injection facility is under construction and expected to open by year-end, supported by both the Departments of Justice and Health. Additionally, a pilot programme with An Garda Síochána is being developed to train officers in overdose identification and naloxone administration. Back-of-house drug testing at festivals, supported by An Garda Síochána, is another safety measure in place.

Naloxone

351. Dr Keenan stated that the naloxone training programme focuses on service providers, including those in homeless shelters and front-line services, as well as peers and family members. The "Circle Programme" has trained 128 peers nationwide to identify overdoses and administer naloxone. This initiative aims to ensure that both professionals and family members are equipped to respond effectively to overdoses. Dr Keenan stated that An Garda Síochána is supportive of developing two naloxone pilot programmes in Dublin.

352. The HSE is authorised to provide naloxone training and can apply to the Health Products Regulatory Authority (HPRA) to stock naloxone. This process involves training organisations like the Simon Community and other emergency accommodation providers, who can then obtain licenses from the HPRA to keep naloxone on their premises. The Committee welcomed the availability of naloxone, particularly in public settings, could be crucial for immediate intervention.

Access to Naloxone in emergencies

353. The Committee was concerned about the accessibility of naloxone for emergencies and queried that needing to obtain a prescription from a GP every time naloxone is used can hinder timely response in overdose situations. This requirement seems impractical since naloxone has no adverse effects on individuals who are not overdosing, making it difficult to effectively address emergencies. The Committee advocate for a more streamlined process that allows easier access to naloxone without the need for repeated prescriptions.

354. Dr O'Driscoll explained that prior to the UK's departure from the EU, it introduced a measure whereby persons could walk into a pharmacy and get the drug without a prescription. Anyone could access it that way. Ideally, that is the way the product would be able to be accessed, but here is a stepwise process due to legal constraints. The ICGP stated that this is within the territory of the Irish Medicines Board, the HPRA and the organisations that have the product license on the market because they have to go through a stepwise certain process to have that happen.

355. The ICGP would support greater access to naloxone particularly for family or loved ones of a person who uses drugs and the removal prescription requirements.

Prescribing practices

356. The Committee questioned whether some doctors might be too quick to prescribe medication rather than trying other approaches such as thorough counselling. This could be because of fear of litigation. It advocates for a focus on equipping individuals with skills for independent living rather than relying solely on prescriptions.

Harm reduction services

357. Ms Lawlor highlighted that decriminalisation alone will not disrupt the drug market but improves access to harm-reduction services, particularly for young people, by reducing barriers and stigma. It also supports systems that lower the age for accessing these services.

358. Deputy Chief Constable Fiona Wilson stated that in British Columbia, the police had long been supportive of harm reduction approaches, such as safe injection sites and treatment on demand. This supportive culture meant that the transition to decriminalisation was smoother compared to Oregon. For instance, Vancouver's police had rarely pursued charges for simple possession before decriminalisation. In 2022, there were only five or six such charges despite handling 700 to 800 service calls daily.

359. Mr Leitão da Silva stated that if there is greater investment in harm reduction, there is more likely to have people leave drug use. It is not just harm reduction; it is harm reduction plus other programmes that stop people from using drugs. If it works this way, there will be a lower number of drug users. If the focus is solely on

harm reduction, there will definitely be a positive impact on public and individual health.

360. The Committee queried if Mr Leitão da Silva agrees that decriminalisation is itself a harm reduction strategy and is integral to achieving effective harm reduction. The question suggests that decriminalisation should be viewed as a fundamental component of a broader harm reduction approach, rather than a separate or standalone measure.

361. Mr Leitão da Silva described a specialised police team in Portugal that works alongside municipal teams to manage drug use areas, focusing on harm reduction by cleaning up paraphernalia like syringes. He emphasised that decriminalisation is not directly tied to changes in drug use rates but highlights the need for effective police strategies. He noted that police often deal with social and mental health issues related to drug use, but stresses that while police play a role in these situations, they should not replace the work of dedicated social workers who are better suited to handle such cases.

Pharmacists' role in harm reduction

362. Currently, pharmacists in Ireland offer harm reduction services through OST, naloxone distribution, and a limited needle exchange program. However, these services are restricted by funding and a shortage of trained personnel, leading to unequal access for patients with addiction issues. While there has been a decline in HIV infections related to injecting drug use across the EU, recent increases since the COVID-19 pandemic highlight the need for further action.

363. The IPU also pointed out the lack of provision for health education, screenings, and drug-related harm interventions in community pharmacies. In summary, the IPU called for greater involvement of community pharmacists in shaping drug policies to address harm reduction and improve access to services, which will contribute to wider public health goals like reducing HIV and viral hepatitis rates.

364. Dr Crowley stated that the critical link between HIV prevention and harm reduction services for people who use or inject drugs. They highlight the success of their STI services over the past 20 years in effectively eliminating new HIV infections

in this population, with no new cases reported for 10 to 15 years in their area, aside from a few occasional infections. He stresses the importance of ensuring unhindered access to safe needle and injecting equipment to combat not only HIV but also hepatitis C, which spreads more easily.

365. Dr Crowley mentioned substantial investments in hepatitis C treatment programs, now integrated into community healthcare and involving GPs. However, the risk of reinfection remains high for those who continue to inject drugs. Therefore, they advocate for legislation that removes barriers to accessing harm reduction services, allowing individuals to obtain clean needles at pharmacies, opioid substitution disorder clinics, or standalone needle exchange programs without obstacles.

366. The Committee noted that the Dublin's drug-related death rates are alarmingly high, with 147 overdoses reported in 2020 alone, which is double the number of road traffic fatalities that year. It stresses the lack of resources and adequate funding for organisations working on drug issues, leading to severe waiting lists for treatment.

367. In light of these challenges, the Committee posed questions to witnesses about the potential concerns related to immediate decriminalisation of drugs and the necessary resources to manage such a change. Additionally, it inquired whether GPs are adequately prepared to handle drug-related issues and ask the IPU for statistics on needle exchange programs available in pharmacies.

368. From a GP perspective, the ICGP highlighted the societal stigma surrounding drug addiction, often perceived as a moral failing rather than a medical issue. The ICGP advocates for a medical understanding of addiction, offering education and training in addiction medicine for GPs. While there are effective services for opioid substitution therapy, there is a call to expand treatment options for other substances, such as rising cocaine and crack cocaine use, as well as benzodiazepines.

369. ICGP stressed the need for more resources and funded treatments for these substances. Additionally, it notes the long wait times for residential treatment and the scarcity of clinical psychology in addiction services. The GP community supports

the piloting of dual-diagnosis clinics to address the significant overlap between mental health disorders and substance misuse, advocating for better referral options for patients.

370. The IPU concern is that only about 100 out of 1,800 pharmacies currently offer needle exchange services, which is seen as insufficient given the high number of annual pharmacy visits (over 78 million). The availability of methadone services and opioid substitution therapy (OST) is also variable and dependent on patient demand.

371. To better support individuals with addiction issues, pharmacies require increased resources and training in recognising symptoms of drug addiction, enabling them to effectively direct individuals to appropriate services. In addition to funding, IPU needs additional secondary consultation rooms and enhancing community education in a broader conversation regarding mental health and drug addiction issues.

Local taskforces

372. The Committee noted the absence of pharmacists and doctors in drug taskforce meetings, suggesting that including these professionals could enhance community responses to addiction trends and improve health outcomes. They advocated for a more structured health response that addresses addiction comprehensively.

Diversion and Dissuasion

Adult caution scheme for cannabis possession

373. The Committee highlighted its concern about the current adult caution scheme for cannabis possession. Data shows that between December 2020 and February 2024, 5,139 people received cautions for simple possession, while 17,125 were prosecuted. This disparity highlights the arbitrary nature of police discretion. There is worry that decriminalisation efforts may not go far enough and could rely on ineffective measures like the caution scheme, rather than implementing comprehensive legislative changes.

374. Mr Regan of the Citizens' Assembly clarified that the planned health diversion model applies for first, second or maybe third time offences but after that, the process reverts to the status quo, the criminal justice system. The comprehensive health-led approach calls for either complete or extensive opportunities for people to engage with a health-led system. It is a different order of magnitude.

375. The HSE supported various diversion and residential treatment programmes, including the SAOR model and increased funding for treatment episodes.

376. The Department of Justice worked with the Department of Health, which leads on drug policy, to advance the "health diversion scheme" (formerly known as the health diversion programme. This scheme aims to offer individuals caught in possession of drugs alternatives to entering the criminal justice system, complementing existing initiatives like the adult caution scheme.

377. The Department of Justice further noted that they are providing additional opportunities for individuals to access health services rather than face the criminal justice system. The goal is to avoid imprisoning people for minor offences, as short prison sentences are not rehabilitative and do not benefit them.

378. The Committee questioned, if the Department is planning to incorporate the Assembly's suggestions into its strategy, or will it continue with the 2017 adult caution framework until new decisions are made.

379. The Department of Justice noted that it is aware of the Citizens' Assembly's recommendations, though they are not yet official government policy. The health diversion scheme aligns with the Assembly's direction but is not as extensive. The scheme will be evaluated after 12 months. The Committee's report and recommendations will be reviewed by the Government, and if the scheme proves effective, there will be evidence to support its expansion.

380. The Committee asks the Department of Health how criminal justice measures, like arresting individuals for drug possession, fit into a health-led approach to addiction. Specifically, it questions how such measures align with evidence-based health initiatives given the complexity of addiction, even if health diversion options are provided.

381. Mr Fallon at the Department of Health, stated that a working group under the national drugs strategy explored alternative approaches to personal drug possession, including policy debates, research, and public consultation. Based on their recommendations, the Government chose to implement a health diversion scheme, reflecting a health-led approach to addressing drug possession.

382. The Department of Health stated that the health benefit of arresting individuals for drug possession lies in the potential referral to health services, which could address issues like dual diagnosis and homelessness. However, engagement with these services is not mandatory. Evidence supporting this approach will need to be reviewed further.

383. The Committee queried the broader issue of decriminalisation versus diversion. The Assembly has recommended focusing on decriminalising all drugs, highlighting that the conversation should be about the individuals affected rather than the substances themselves. This approach is particularly important for vulnerable communities that use drugs like crack cocaine and heroin, as isolating these substances from the decriminalisation debate could further marginalise these groups.

384. The Committee noted a common misconception that diversion is a more compassionate option, as it offers individuals a chance to recover. However, it highlights that when people examine the evidence, they often realize that decriminalisation has more significant benefits from both health and policing perspectives.

385. Regarding diversion, Ms Eastwood highlighted the risk of "net widening," where providing police with alternative sanctions, such as fines instead of arrests, could increase criminal justice interventions. This can lead to unintended consequences, such as criminalising people for not complying with fines or other penalties, even if the original intent was to avoid punishing drug possession.

386. Regarding diversion schemes, Ms Eastwood notes that there is evidence from the U.S. showing a reluctance among people to participate, largely due to distrust of schemes associated with policing. She notes that most drug users do not have

problematic use, according to UN data and do not need health interventions. This could place an unnecessary burden on already stretched treatment services.

Garda diversion scheme

387. The Committee heard evidence that Ireland's Garda diversion scheme effectively keeps many young people from reoffending. The scheme focuses on personal development rather than punishment, and it shows promising results, with most participants not reoffending. The Committee invited Ms Lawlor to provide more details and insights into her findings on the effectiveness of this approach.

388. Ms Lawlor referenced her research which highlights the benefits of the diversion scheme, which focuses on personal development and family connections to reduce reoffending among under-18s. This approach is effective but limited in scope, as criminal markets still exert strong influence, particularly in lower socioeconomic communities. While decriminalisation is crucial, it must be accompanied by measures to disrupt criminal gangs and protect children from being coerced into these markets. A regulated market is essential to fully safeguard young people and prevent long-term criminal consequences.

389. Professor Stevens cited research on diversion schemes in England involving over 60 police officers. Some officers support reduced criminalisation, seeing it as beneficial for addressing drug users problems and reducing wasted time. They believed that repeated criminalisation is ineffective. Conversely, other officers view reduced powers to search and arrest as a limitation on their effectiveness.

390. Professor Steven noted that the evidence, including from Portugal, does not strongly support this view. For successful diversion or decriminalisation policies, it is crucial to involve police in policy discussions and provide thorough training on their roles, limits, and community expectations. Community accountability mechanisms are also essential to ensure police practices align with community needs.

Sanctions

391. Ms Eastwood stated that evidence on the effectiveness of sanctions for drug dependency is unclear. If drug dependency is considered a health issue, imposing sanctions seems counterproductive and burdensome. Most people do not have

dependency issues, so adding sanctions only increases the state's management challenges.

392. The Committee raised concerns about preventing recreational drug users from progressing to more addictive substances, particularly opioids. It drew an analogy to vaping, which has evolved and expanded in its market, suggesting a similar risk in the drug trade. The key issue highlighted is not just the recreational use of drugs but the potential for individuals to become exposed to and dependent on highly addictive substances, creating significant challenges for overcoming addiction.

393. The Committee sought Dr Ó Concubhair's opinion on whether Ireland's current approach to drug policy, characterised by criminal sanctions, plays a role in signalling disapproval of drug use to youth. It expressed concern that removing these sanctions and opening up the drug marketplace could lead to increased drug use and potentially uncontrolled issues similar to those seen in parts of the western United States, where there is widespread drug use and significant societal dysfunction due to heavy drug dependence.

394. Dr Ó Concubhair advocated for legalising certain drugs, like opioids, but envisions a highly regulated system controlled by medical professionals, not an open commercial market.

395. Professor Stevens provided that there is insufficient evidence to support the effectiveness of escalating sanctions as a deterrent. From a philosophical perspective, if there is no solid evidence that a punishment achieves its intended goals, it should not be used. Punishments inherently cause harm, and without clear justification based on evidence, imposing them is not warranted.

396. Ms Lawlor attested that more young people around the world are using drugs than ever before in places where punishments are in place for drug use and possession. It is not working, and it is not something that we should continue to promote.

Dissuasion

397. The Committee acknowledged that while many people may have positive experiences with dissuasion, it is important to note that these experiences often occur in the absence of sanctions, with support systems facilitating engagement.

398. Deputy Chief Constable Wilson highlighted that illicit drug use should be treated as a health issue and recommended that if diversion to health pathways is considered, there should be a reporting mechanism to ensure these pathways are effective, accessible, and properly utilised.

Funding

399. A key issue is the lack of multi-annual funding for frontline drug services, which hampers their ability to proactively respond to emerging drug trends. These services are often reactive and constrained by short-term funding, affecting their effectiveness. In the community and voluntary sectors, the instability caused by annual contracts makes it difficult to retain staff, who face job uncertainty and may leave due to the lack of long-term job security. The Committee noted that many staff go on to other placements in the public service that provide more security and better conditions of employment.

400. Mr Reid stated that the challenge with multi-annual funding ultimately stems from the Department of Public Expenditure and the annual budget approvals by the government. The HSE and similar bodies lack the authority to commit to such long-term funding and this is rooted in the broader budgeting approach and how estimates are managed.

401. The Committee criticised the lack of long-term, adequate funding for drug task forces and the disconnect between funding decisions and on-the-ground needs. The Committee called for a cultural shift in how society views individuals with drug addiction, advocating for more immediate action and support rather than just discussions and pilot programmes.

402. The HSE stated that the HSE funds the community and voluntary sector, which plays a crucial role in delivering services and supporting local communities.

Ms Queally of the HSE also stated that Drug Task Forces are also vital in mobilising support for the national drugs strategy.

403. Ms Queally also highlighted the importance of multiannual and sustained funding. The HSE emphasise that to effectively nurture and strengthen programmes, consistent and long-term financial support is crucial.

404. Ms Mc Ardle, from the Department of Health, confirmed that access to drug services is not limited to referrals from An Garda Síochána. People can self-refer through various channels, including online resources like drugs.ie, the HSE website, healthcare professionals, and family members. The publication of a service map aims to make these resources easily accessible. It is highlighted that there are multiple ways to access help for drug or alcohol issues, and individuals are encouraged to use these community resources.

405. The Committee referred to an earlier discussion where the Assembly highlighted the need for increased funding for drug services, recovery, community services, and education. The sector is critically underfunded, with inadequate support for drug and alcohol task forces, which lack multi-annual funding. Effective implementation of a new drugs strategy requires addressing these fundamental issues.

406. The Department of Health stated that in 2022, drug service expenditure was allocated as follows: 45% to HSE addiction services, 39-40% to community, and voluntary sector services, and 15% to GPs and pharmacies. The Health Research Board received about 1% of the funding. Since 2022, funding for drug services has increased by 12%. Despite this, there is significant stigma around accessing services, and awareness needs to be improved, as indicated by the lack of long waiting lists for many services. The Citizens' Assembly's focus on this issue is seen as crucial.

407. Ms McArdle further expanded that when areas experience higher demand, increased funding is directed towards those needs. For example, this year, funding has been increased for dual diagnosis services to address the gap in care for individuals with both addiction and mental health issues. A new model of care is being implemented to improve services for both adults and adolescents across

various hubs. Funding decisions are based on evidence of increased demand or growing needs. The proposal to increase funding is welcomed by all Departments.

408. Ms Eastwood noted that Ireland already has substantial investment in its treatment system. Advocating for increased funding for treatment and harm reduction remains crucial, but with the existing structure in place, decriminalisation could further enhance outcomes.

409. Mr Glynn suggested that resources should be shifted from law enforcement to addiction and harm reduction services. He highlighted the need for patience and long-term investment in addressing addiction, which often involves deep-rooted and generational challenges.

410. Dr Quinlan stated that while primary care providers are equipped to manage chronic diseases like asthma and diabetes, there is a lack of funding and support for treating mental health conditions such as depression, anxiety, and psychosis. This absence of resources leads to competition for limited GP time and space, hindering the ability to provide adequate mental health care. He argues that enhanced mental health services in primary care are possible, but require proper resourcing, contrasting this with the recent focus on contraceptive services, which also lacks sufficient funding for mental health support.

411. Dr Crowley stated that there is a need for increasing the skillset of the GP so that involves training. It involves resourcing the GP practice to have the time to do the work. The final bit is the referral pathway to other support services like talking therapies, psychosocial case workers and key workers dealing with all of the other aspects that are connected to the addiction.

Supports

412. The Committee agreed with the concerns of the Assembly, that addressing housing is essential for recovery, as lack of housing worsens drug issues. Drug possession is currently classified with serious crimes, and such convictions stay on records indefinitely. The focus should be on both harm reduction and abstinence models, removing barriers to seeking help. People in the drug trade often come from

disadvantaged backgrounds similar to those with addiction problems. Sensitivity in discussing these issues is crucial, as drug use often stems from trauma and poverty.

413. Dr Keenan noted that crack cocaine-specific programmes for women have been introduced in Tallaght and the south inner city to address issues related to this drug. Funded by the Department of Health, these initiatives aim to support those struggling with crack cocaine. The number of people accessing cocaine treatment has been increasing annually, and new treatment figures expected next week will reveal the impact of recent funding on these numbers.

414. The Committee expressed concern at the support framework for individuals recovering from addiction, particularly in relation to the Housing First strategy. It asked about the communication and coordination between Approved Housing Bodies (AHBs) and their respective organisations, like the Department of Health and the HSE, to ensure that people in Housing First placements receive appropriate support. Concerns were raised about the management of placements, especially when they become chaotic due to the presence of others with similar issues. It also asks if the Department of Health tracks and manages the distribution and impact of such housing provisions across various regions, including high-pressure areas like Dublin 1, to address the burden on different communities.

415. Ms Nougier indicated that problematic drug use is often higher among those in poverty, as they face challenging circumstances exacerbated by criminalisation. The impact of drug policies on vulnerability and harm should not be underestimated. Harm reduction strategies are increasingly recognised for addressing not only health issues related to drug use but also broader social issues, such as housing, food, and gender-based violence.

416. Dr Malinowska-Sempruch acknowledged that drug use among unhoused individuals often arises as a coping mechanism for their dire circumstances. It also highlights the additional challenges that criminalisation creates, making it harder for individuals to reintegrate into society. In the U.S., for instance, those with criminal records face barriers such as ineligibility for public housing and limited job opportunities.

417. Dr Pinto described a successful programme in Portugal that aimed to improve the employability of people undergoing drug treatment by collaborating with the labour market. The government incentivised businesses with tax benefits to hire these individuals, which yielded positive results. However, this programme was discontinued due to austerity measures. The response notes that user-friendly measures are being reintroduced, highlighting the importance of involving people who use drugs in designing effective responses.

418. Mr Kellen Russoniello, noted that before Measure 110, Oregon had one of the lowest rankings in the U.S. for access to substance use disorder treatment and mental health services. The measure marked a significant improvement by providing ongoing state funding for harm reduction and ensuring services were available in each county. This shift was crucial as harm reduction efforts typically relied on unstable grant funding.

419. Mr Russoniello noted that while comprehensive data on the overall transformation of the behavioural healthcare system is still lacking, Measure 110 has led to notable increases in service access. For example, health screenings rose by 298%, substance use disorder treatments by 143%, and housing and employment services by nearly 300%. These services have become more systematically available rather than relying on sporadic grants.

420. Mr Russoniello noted that despite the recent rollback of decriminalisation, the legislature-maintained funding for health services remains due to its positive impact on people's lives.

421. Deputy Wilson advised there was a significant need for increased resources for individuals with substance use disorders. This includes enhanced education, prevention, and harm reduction services, as well as immediate and accessible treatment on demand to support and protect those in need.

422. Deputy Chief Constable Wilson stated that Vancouver has 12 overdose prevention sites, including those offering inhalation services. While urban areas have good resources, remote communities lack adequate services. Despite police involvement and expectations of a dramatic increase in health resources during decriminalisation, there was only a modest increase. Resources for education,

prevention, and treatment, as well as harm reduction in rural areas, were insufficient. Deputy Chief Constable Wilson recommended that decriminalisation should be accompanied by a significant boost in health resources which is maintained. She cites examples from Vancouver and Oregon, as well as Portugal, where increased resources initially helped but subsequent reductions led to problematic outcomes.

423. Mr Russoniello noted that problems such as worsening public drug use, exacerbated by factors like Covid-19, fentanyl, and the housing crisis, were wrongly attributed to Measure 110. This misattribution led to the rollback of the measure, which was seen as a solution rather than addressing underlying issues like housing and healthcare.

424. Mr Russoniello highlighted that while decriminalisation is a crucial element of a public health approach, it must be accompanied by an increase in services to be effective. Services should be developed alongside decriminalisation to ensure a comprehensive approach. He also noted political and policing resistance to decriminalisation and highlighted the importance of integrating all aspects—decriminalisation, policing, health-led approaches, and services—into a cohesive strategy.

425. Dr O'Driscoll advocates for a comprehensive primary care strategy that fosters collaboration among pharmacists, GPs, and other disciplines to create a multidisciplinary support network based on a psycho-social model. It highlights a significant gap in support systems, noting that individuals are often discharged without adequate psycho-social assistance. The upcoming review of the national drugs strategy should address how professionals can work together and actively involve patients and their families in their care.

Nightlife, Testing and Data

426. The Committee queried how the HSE's safer nightlife programme addresses social inclusion and the Citizens' Assembly's recommendations on this issue. It also masks for specifics on the funding and expansion needs of the HSE to improve the programme's effectiveness.

427. Dr Keenan stated that a gas chromatography-mass spectrometry (GC-MS) machine was used to analyse new drugs, such as a synthetic opioid found in a tablet from Limerick. This analysis allowed for an immediate alert to be issued, highlighting the machine's importance in drug monitoring and safety. The rapid emergence of new drugs is concerning, and additional resources are needed to monitor these trends effectively.

428. The HSE is involved in the safe nightlife programme at festivals to educate and assist individuals who may experience adverse effects from drug use. There is concern that the presence of such programmes at festivals might inadvertently normalise or endorse informal drug use as part of the festival experience.

429. Dr Keenan stated that HSE's approach at festivals is pragmatic, acknowledging that drug use occurs despite efforts to prevent it. They provide harm reduction through on-site volunteers, who will engage with attendees, and by offering pre-event information on drug risks. The programme includes drug testing, communication of potential harms, and practical advice for users, such as staying with friends and informing medics if drugs are used. Festival promoters support this initiative to enhance safety and awareness.

430. Ms Eastwood stated that drug testing initiatives like the Loop in the UK and Australia, and WEDINOS in Wales, are crucial for harm reduction. WEDINOS has been operational for ten years, allowing people to send in drug samples and receive results within a week, which helps users understand what is in their drugs. In the UK, restrictions on drug testing are related to Home Office licenses. It is recommended that Ireland’s Department of Health make licensing as flexible as possible to enable drug testing in youth and community centres, and drug treatment facilities. Basic on-site equipment can be used alongside more sophisticated lab testing, making the process cost-effective and widely accessible.

431. Ms Lawlor commented that drug checking or testing is crucial and should be implemented immediately to address the overdose crisis and prevent deaths. It can be effective under the current drug model in Ireland and would be even more beneficial if people felt safe from criminalisation.

432. Ms Lawlor stated that promoting drug testing and harm reduction services within communities, especially through a peer-based approach (with young people under 30) is highly effective as it is seen as supportive rather than as traps for legal enforcement.

433. Professor Stevens stated that checking services should target two key vulnerable populations People in the Night-Time Economy, this includes individuals using drugs at nightclubs and festivals. Drug checking services, like those provided by the Loop charity in the UK and in the Netherlands, are crucial here to address issues such as the increased potency of MDMA and dangerous adulterants in party drugs.

434. Drug checking is also essential for individuals using opioids, especially in overdose prevention centres or drug consumption rooms. These services are vital to protect against the risks posed by substances like fentanyl and metazene, which can be fatal if not identified.

435. Ms Eastwood said that harm reduction strategies should focus on, accessible testing centres to establish drug checking services where people frequently access drugs, such as in overdose prevention centres.

436. Deputy Chief Constable Wilson noted that drug testing was more useful when people were trying to avoid fentanyl in their drugs, as it allowed individuals to detect its presence and use drugs more safely. However now many entrenched drug users are actively seeking fentanyl and benzodiazepines, which are prevalent in almost all street drugs. As a result, drug testing to detect fentanyl is less helpful. There are limited drug checking sites available, and while police support these and safe supply programmes, they emphasise that such initiatives need to be lawful.

437. Dr O' Driscoll commented on the complexities of testing street benzodiazepines, emphasising that true understanding often only comes from examining samples. The process can feel like searching for a "needle in a haystack" due to the numerous variations present, including etizolam, flubromazolam, and mixtures with tramadol or paracetamol. Most information is derived from the European Drug Agency and data from health authorities, which helps identify these substances. The potency of different benzodiazepines varies, with etizolam noted for

its stronger effects compared to prescribed options, contributing to its unavailability for human use.

Data on Addiction Services

438. Dr Keenan stated that the Health Research Board (HRB) service captures data on individuals starting treatment, including their substance use, family backgrounds, and ethnicity, feeding this information into the national drug reporting system managed by the HRB. This data helps identify marginalised groups and prioritise their access to treatment. Dr Keenan further stated that they also track methadone treatment through a central list. Addiction services fall under the HSE's social inclusion sector, which collaborates with departments focused on migrant, Traveller, LGBTI health, and domestic violence, ensuring that these factors are considered in treatment.

439. Ms McArdle attested that the national oversight Committee monitors data and conducts targeted research on migrant and vulnerable groups. Recently, research on the impact of drug use on women led to investments through the women's health action fund, increasing funding to improve access to services tailored to women and their families dealing with problematic drug use.

International Experience

440. The Committee can drive significant domestic change by drawing on international experiences and expert evidence, especially since Ireland lacks a robust body of research on drug policy. Given Ireland's unique context, it is essential to consider what has been done in other countries.

441. The Department of Justice stated that Oregon and Canada are reconsidering their approaches to drug policy due to unintended consequences. For instance, Mexican cartels continue to produce significant amounts of cannabis despite regulatory changes. Licensed cannabis purchases tend to be made by more affluent individuals, while cartels still dominate the market.

Portugal

442. Professor Stevens stated that over the past 20 years, drug use rates in Portugal have fluctuated, with advocates and critics of decriminalisation using these variations to support their positions. Comparisons between drug use trends in

Poland and Portugal, as well as a 2019 study involving over 115,000 young people in 38 countries, suggest that drug policy changes have little impact on youth drug use. While young people's drug use tends to fluctuate more than adults', decriminalisation is not shown to increase it.

443. Dr Ricardo Baptista Leite attested that in the 1990s, Portugal faced a severe heroin epidemic causing widespread social and economic issues. In response, the Portuguese Parliament took a bold step by decriminalising drug use, shifting the focus from criminalisation to treating drug use as a health issue. This change did not legalise drug use but eliminated the criminal penalties for personal use while maintaining penalties for drug trafficking.

444. Portugal's decriminalisation model involves a comprehensive five-pillar approach: prevention, dissuasion, harm reduction, treatment, and reintegration. This approach has led to significant positive outcomes, including a dramatic decrease in HIV infections related to drug use (from over 50% to less than 2% of new infections) did not lead to increased drug tourism or higher drug consumption, which remains below the EU average.

445. Dr Ricardo Baptista Leite noted that the success of Portugal's model underscores that decriminalisation alone is insufficient. Effective drug policy requires an integrated approach that includes community-based support, harm reduction services, and social programmes.

446. Dr Pinto provided key aspects of the reform included that drug use rates among adults and adolescents decreased, with a reduction in blood-borne infections and stigma. Portugal's drug use rates remain below the European average.

447. Dr Pinto referenced several studies, including a 2020 review, which showed that decriminalisation did not increase drug use prevalence or market size but saved money on law enforcement, reduced drug-related crimes, and increased public support for health-focused approaches.

448. Dr Pinto notes that overall, Portugal's experience demonstrates that while decriminalisation alone is not a panacea, it contributes significantly to improved drug policy outcomes when paired with comprehensive, humanistic interventions.

449. Dr Malinowska-Sempruch supported that Portugal's experience demonstrates that decriminalising drug use encourages people to seek help and engage with services, reducing prison populations and increasing treatment uptake. In contrast, in places like China, where drug use remains criminalised, methadone programme struggles with low participation due to fear of arrest.

450. Dr Malinowska-Sempruch referenced that in the U.S., women are hesitant to access harm reduction services due to the risk of losing custody of their children if they are charged with drug possession. Conversely, Switzerland's decriminalisation and harm reduction measures, including heroin maintenance programme and safe injection sites, have successfully reduced drug-related deaths and HIV infections.

451. Ms Vas from Unite outlined recent reforms in Portugal's drug decriminalisation system. Portugal has recently updated its decriminalisation model to address issues that arose over the past two decades, including the rise of novel psychoactive substances not initially covered by the original framework.

452. Reforms focused on removing possession thresholds and shifting towards evaluating intent to supply. This approach aims to reduce the overlap between users and those involved in drug dealing and better manage complex medical emergencies related to drug use.

453. Dr Pinto stated that in the history of these reforms, which began 20 years ago, and how they initially addressed common substances but did not cover newer psychoactive and synthetic drugs. As a result, people using these newer substances faced legal challenges and were more likely to be arrested. The Portuguese Parliament recognised this issue and acknowledged the difficulty in distinguishing between drug users and dealers based on possession amounts.

454. Dr Malinowska-Sempruch explained that Good Samaritan laws in the U.S. protect individuals from being charged with possession or even murder when they seek help for someone who has overdosed, highlighting the importance of such laws in a criminalised environment. They emphasise that these laws are necessary due to the punitive nature of the U.S. drug system.

455. Ms Vas stated that Portugal initially focused on addressing severe substance abuse issues rather than regulating cannabis. However, as the system is continually reviewed, there have been ongoing discussions for over a decade about managing cannabis-related harms, due to its illegal status. The current motivation for revisiting cannabis regulation is to improve harm reduction and address factors not considered two decades ago.

456. Dr Malinowska-Sempruch mentioned an example from Newark, New Jersey, where a community safety initiative focuses on violence reduction rather than controlling drug availability. She suggested that a similar approach, integrating public health and safety, could be beneficial. Clear messaging from law enforcement is essential—petty drug sales should be deprioritised while addressing violence remains a top focus. This approach helps ensure that law enforcement efforts are consistent and effective in reducing harm.

457. The Committee asked whether Portugal's approach to drug policy, which treats drug use as a societal issue rather than a criminal one, reflects a belief that drug use is an inevitable part of society that cannot be fully controlled. It seeks to understand if the rising rates of recreational drug use, despite decriminalisation, are viewed as a societal problem and questions how the Portuguese police perceive this trend in the context of their broader drug policy and societal impacts.

458. Mr Leitão da Silva noted that in Portugal, since 1996, legislation has helped police monitor drug consumption patterns, though addiction cannot be precisely quantified. The rise in recreational drug use presents new challenges, requiring adjustments in policing philosophy. Despite decriminalisation, police still play a role in providing information and referring individuals to dissuasion commissions. However, he argues that managing drug users is more suited to social work than to traditional policing, suggesting that while police involvement is necessary, these roles should not be their primary focus.

459. A key challenge remains changing the police mindset from viewing drug users as criminals to seeing them as individuals with social and health issues. This shift, which aligns with human rights and public health perspectives, requires a long-term effort and generational change within the police force.

460. The Committee queried Portugal's decriminalisation and the approach addresses the societal desire to discourage recreational drug use, particularly as it may lead to harder addictions like opioids. It questioned the effectiveness of Portuguese policing measures in curbing the uptake of recreational drugs and whether decriminalisation has impacted the state's ability to control the supply of illegal drugs entering the country.

461. Portugal faces a dual challenge: a rising influx of drugs into Europe, with Portugal as a primary entry point, and decreased investment in drug harm reduction programmes since 2010 such as the dismantling of the Institute for Drugs and Drug Addiction. Current overdose death rates are relatively low compared to other European countries, but they have increased from past lows. The combination of increased drug availability and diminished investment in social, medical, and policing strategies has led to higher visibility of drug use.

462. Mr Leitão da Silva noted it is not possible to record the number of drugs any drug user takes daily. It is because the law established the number of drugs people can take with them for consumption during a ten-day period. The figures from drug consumption facilities show there are people whose average daily consumption is eight times per day and goes as high as 20 times per day. He states a requirement to self-identify would be against human rights.

463. The Committee drew a parallel between Ireland's cultural acceptance of alcohol and the changing attitudes towards drug use in other cultures, as described by Mr Leitão da Silva. The Committee asked for details on how Portuguese police manage the operational challenges of distinguishing between modest drug users, who use drugs for personal use, and those involved in illegal drug supply and distribution. It sought to understand how policing is handled given that drug sales and distribution remain illegal in Portugal, despite the shift towards a more humane, non-criminalising approach for users.

464. Mr Leitão da Silva provided that the challenge for Portuguese police lies in managing the grey area between drug users and suppliers. The legislation allows users to carry a ten-day supply, which drug dealers exploit by supplying small amounts to users who then resell them. This complicates police investigations as

drug dealers use users for trafficking. Despite this, the police maintain operational effectiveness and have successfully seized drugs. The current focus is on disrupting how drug dealers use users to traffic small quantities of drugs. The approach has improved information sharing and policing, but the issue remains significant.

IPU engagement with Pharmaceutical Group of the European Union (PGEU)

465. The IPU stated that the Portuguese model supported the decriminalisation of the patient. They were actively involved from the start of this and viewed it as a very successful model. Key to it was that the pharmacy union was integrated at the start and very well supported.

466. The OST program was highly effective, well-supported, and resourceful, achieving its goals to the extent that opioid substitution programs were temporarily paused. Although it was reinstated after COVID-19 due to pandemic-related issues, its earlier success was notable. The leadership of a pharmacist played a crucial role in adapting the model for community pharmacy use.

467. IPU discussions with Portuguese colleagues in PGEU, highlighted their belief that decriminalising drugs alone is insufficient; it requires an integrated, holistic approach. Portugal has lower drug use rates than many European countries, attributed to their successful five-pillar strategy: prevention, discussion on use, harm reduction, treatment, and reintegration. They emphasised that these structures must be established in society before decriminalisation to avoid serious issues.

468. The IPU leaned that during the COVID-19 pandemic, HIV notifications and testing through the Health Protection Surveillance Centre (HPSC) decreased. However, there has since been an increase in cases due to improved reporting and more individuals seeking treatment, particularly among men who have sex with men (MSM) and chemsex groups. The 2015 decriminalisation of headshops led to a spike in HIV cases linked to mephedrone use.

469. A critical issue identified is the need for education among migrant populations, especially non-English speakers using steroids for bodybuilding. Research from Liverpool John Moores University showed that these groups lack understanding of harm reduction practices, such as the risks of sharing needles,

which could contribute to rising incidences of HIV and other viral infections like hepatitis C.

470. Ms McCool explained that the pharmacy perspective, the IPU meeting with Portuguese pharmacist colleagues through the Pharmaceutical Group of the European Union (PGEU) revealed positive experiences with Portugal's rapid response to opioid misuse, which became a significant issue in the late 1990s. The Portuguese government quickly established a structured approach within 12 to 18 months, implementing resources such as needle exchange and opioid substitution programs. This swift action facilitated community engagement and education, benefiting families and individuals affected by addiction.

471. While the outcomes were generally favourable, there was a sense of complacency among Portuguese pharmacists, as they became accustomed to the successful programs and the support available. They noted that any arising issues were typically referred to commissions for resolution, promoting patient decriminalisation and access to care. Although the opioid substitution program was eventually discontinued due to its success, needle exchanges remained operational as outreach services to help individuals consider engaging with addiction support resources.

472. Overall, the experience underscored the importance of timely resource allocation and community-focused initiatives in addressing substance misuse. Mr Murray stated that the role of pharmacists in Ireland can significantly enhance patient access to addiction services through screening, recognition, and referral. With adequate resources, pharmacists could increase the availability of needle exchange programs, opioid substitution therapy, and harm reduction services, similar to the successful model in Portugal. Given the 78 million visits to pharmacies annually, pharmacists are well-positioned to fulfil this role, provided they receive proper training and resources.

Drug Policy in Vancouver

473. On January 31, 2023, Health Canada issued a decriminalisation exemption under the Controlled Drugs and Substances Act as part of a three-year pilot programme. The exemption allowed personal possession of up to 2.5 grams of

various illicit drugs, including opioids, cocaine, MDMA, and methamphetamines This initiative aimed to address substance use through a health-focused approach rather than criminal justice. However, trafficking, production, and possession in certain places, like schools and vehicles operated by minors, remained illegal.

474. This programme was initially supported by police in British Columbia due to the province's severe toxic drug crisis, which has led to over 14,000 overdose deaths since April 2016. Police had concerns about potential negative consequences, including issues with public consumption and driving safety. Despite the intention to reduce harm, there were problems with drug use in public spaces and its impact on businesses.

475. As a result, less than 15 months after implementation, personal drug possession in public spaces was again prohibited. The experience highlights that decriminalisation alone is insufficient and must be part of a broader strategy that includes education, prevention, treatment, and enhanced health services. The case underscores the need to balance public health initiatives with community safety and well-being.

Vancouver – The Three Exemptions

476. Deputy Chief Constable Wilson explained that initially, the decriminalisation exemption had six exceptions, including K-12 schools and certain locations like Canadian Coast Guard vessels. To address concerns about public drug consumption, three additional exceptions were later added; playgrounds, splash pads/ public swimming pools, and recreational centres—areas where children and youths are commonly present. Consequently, possession of 2.5 grams or less of illicit drugs was not permitted in these locations.

477. Deputy Chief Constable Wilson stated that in Canada, cannabis is largely legalised, with regulations similar to those for alcohol. There are rules governing public use and government-regulated stores that sell cannabis and related products. British Columbia has focused more on decriminalisation of illicit drugs rather than cannabis legislation. Vancouver figures show that Indigenous people in this province, in particular, are much more likely to be impacted by the illicit drug crisis, evidenced by the number of overdose deaths.

478. Deputy Chief Constable Wilson elaborated that 2.5 g limit for various drugs for personal possession was established after negotiations, rather than a 4.5 g non-cumulative limit. This cumulative 2.5 g limit covers opioids, cocaine, MDMA, and other major drugs, but excluding benzodiazepines. Training for police involved using visual references rather than scales, allowing officers to use their discretion when assessing quantities.

Drug Policy in Oregon

479. The Drug Policy Alliance (DPA) is a leading U.S. organisation dedicated to ending the drug war and promoting a non-punitive, equitable, and regulated drug market. DPA played a pivotal role in authoring and campaigning for Oregon's Measure 110, which in 2020 made Oregon the first state to decriminalise the possession of small amounts of all drugs. This measure significantly reduced drug possession arrests and criminal records, improved access to health and social services, and saved money that was redirected to expand services.

480. However, despite these achievements, implementation faced challenges. The COVID-19 pandemic, rising fentanyl use, and increased homelessness complicated the process. Additionally, opposition from police and delayed funding hindered the measure's effectiveness. Critics, influenced by misinformation, led to a decision to recriminalise drug possession.

481. Drug Policy Alliance stated that research shows that Measure 110 did not increase fatal overdoses or crime rates, which are more closely linked to broader issues like the opioid crisis and housing instability. Recriminalisation is expected to exacerbate problems rather than solve them, particularly affecting marginalised communities. It is a failure in political commitment rather than a failure of the policy itself.

482. The DPA argued that while decriminalisation is crucial, it must be part of a broader approach that includes housing, crisis response services, and overdose prevention. The movement towards drug decriminalisation and health-focused approaches continues in Oregon and other parts of the U.S.

483. Mr Russoniello provided that in Oregon, while marijuana is classified as a Schedule 1 substance under federal law and remains illegal, state law permits

possession of cannabis up to a certain amount and allows access through state-regulated dispensaries. Public use of cannabis is treated as a civil violation, not a criminal one, with fines up to $1,000, but Measure 110 did not address this separately as possession was already unlawful.

Fentanyl

484. Deputy Chief Constable Wilson stated that in British Columbia, fentanyl has been a major factor in the high number of toxic drug deaths with an average of seven deaths per day. Fentanyl was included in the decriminalisation exemption, and she would not change this decision. Excluding it would have been very inconsistent with the objectives of decriminalisation as the aim was to address the overdose crisis and fentanyl was responsible for a large number of those deaths.

485. However, she stressed the need for significant improvements in how the exemption is implemented. DCC Wilson urges the Committee to prioritise robust enforcement measures to prevent fentanyl from spreading to Ireland, including efforts to control importation, detection, and dismantling of production facilities.

486. Mr Russoniello would advise that including fentanyl in decriminalisation is crucial, as it dominates the drug market in the US and is widely used. Excluding fentanyl would undermine the effectiveness of decriminalisation, as most users would still fall outside its protection. Decriminalising fentanyl aligns with a public health approach, aiming to connect users with health services rather than criminalising them.

487. Mr Russoniello noted that if Oregon had implemented decriminalisation without the simultaneous challenges of fentanyl and Covid, the outcome might have been more positive. Decriminalisation would likely have been given more time to succeed. The current situation is unfortunate, but the goal is to integrate all elements of decriminalisation and support services as we move forward.

488. The Committee acknowledged that while Oregon is often cited as a cautionary tale, there are valuable lessons to be learned from British Columbia's experiences. The impact of Covid and fentanyl created a severe crisis, making the situation particularly challenging and tragic. The response expresses sympathy for those on the front lines dealing with the crisis.

489. Mr Kellen Russoniello stated that cannabis laws remain as they were. Possession of any of the other controlled substances is now a misdemeanour offence, punishable by up to six months in jail. The new law envisions counties creating their own types of diversion programmes. However, it is still very much up in the air what those diversion programmes will.

490. Dr Leite attested that drug trafficking remains illegal and is a criminal offence in Portugal, Decriminalisation focuses on treating drug use as a health issue rather than a criminal one. This approach aims to improve individual and societal well-being by reducing problematic drug use.

491. Dr Leite provided that the phenomenon of drugs being offered on the streets, including fake or synthetic drugs, is a known issue in Lisbon and other cities. This issue is partly due to the rise of new drug types and scams. Continuous community awareness and effective police enforcement are crucial.

Appendix 1

Meetings of the Committee following modules that were agreed for the Interim Report

Date	Module 3 meetings	Engagement on a Health-Led Approach
26 September	Watch video transcript	• Anna Quigley, Project Lead, Citywide Drugs Crisis Campaign • Caron McCaffrey, Director General, Irish Prison Service • Dr David Joyce, Acting Executive Clinical Lead, Irish Prison Service • Sarah Hume, Acting Head of Psychology, Irish Prison Service • Anne Collins, National Clinical Lead for Mental Health and Addiction, Irish Prison Service • David Treacy, Governor, Irish Prison Service
3 October	Watch video transcript	• Paula Kearney, BRIO Coordinator SAOL Project • Gary Broderick, Director SAOL Project • Eddie Mullins, CEO, Merchants Quay Ireland • Geoffrey Corcoran, Head of Operations and Delivery Merchants Quay Ireland • Dr Sharon Lambert, School of Applied Psychology University of Cork • Dr Barry Cullen, Youth work and Community Development Retired Coordinator of a Local Drugs and Alcohol Taskforce • Dr Richard Healy, Research and Policy Officer AHEAD
10 October	Watch video transcript	• Nina Brennan, Assistant Secretary, District Court Operations Dublin Drugs Treatment Court • Fiona Wright, Principal Officer, Head of Dublin Combined Court Office, Dublin Drugs Treatment Court

		• Maeve Foley, Assistant Principal Officer, Drug Treatment Court Co-Ordinator, Dublin Drugs Treatment Court • Mr. Tony Duffin, CEO, Ana Liffey Drugs Project
17 October	Watch video transcript	**09:30-11:30 - Trinity School of Nursing & Midwifery** • Barry McBrien, Assistant Professor • Professor Catherine Comiskey, Professor in Healthcare Modelling and Statistics • Dr Peter Kelly, Assistant Professor in Mental Health Nursing **11:30-12:30 - An Garda Síochána** • Deputy Commissioner Mr. Justin Kelly • Seamus Boland, Superintendent, Garda National Drugs and Organised Crime Bureau.