

Irish Drug Policy and Reform

**A research report by Trinity FLAC,
in association with the Irish Council for
Civil Liberties**



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Legal
Advice
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Trinity FLAC Irish Drug Policy and Reform Research Report

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Introduction

Trinity FLAC Legal Research Officer: Celia Reynolds

In 1998, the UN set its goal to achieve a ‘drug free world’ by 2008, under the vainglorious slogan ‘we can do it’¹. In the decades past and since, countries across the world have sought to enforce prohibitionist oriented policies, often at the expense of more effective approaches that incorporate broader reference to public health and poverty. This perpetuation of unsuccessful, unrealistic strategies has led to the criminalisation of millions in lieu of rehabilitation, further destabilised drug transit nations and funded global spending on drug law enforcement in excess of \$100bn annually². Conversely, the main beneficiaries of prohibitive drug legislation have been criminal organisations, who have gained control of a global market with a turnover of more than \$32bn a year³. Since its declaration in 2008, the UN has come to the conclusion that “global drug control efforts have had a dramatic unintended consequence: a criminal black market of staggering proportions”⁴.

Consequently, in recent years the consensus that underpinned the prohibitionist frame of thinking has been dismantled and a revolution of international drug policies is on the horizon. The overall aim of this report is to argue that Ireland should follow this trend by re-evaluating and reforming its current drug policy. Admittedly, this research project will advocate for a general policy of decriminalisation, seeking to have the offence of possession removed from Irish legislation and a reallocation of resources away from counterproductive and damaging policies. This argument will be advanced on two fronts, the first being that the current system of criminalisation is harmful to the public, both in terms of its costs and its ineffectiveness controlling drug abuse; and the second being that an administrative and health led response will more accurately address the issues at hand.

The damaging nature of the current system of criminalisation harms the Irish public and disproportionately affects the disadvantaged groups of society. Policy makers will find that drug abuse pervades a multitude of Ireland’s most pressing social issues, intertwining itself with challenges surrounding homelessness, poverty and mental health. Imprisonment should be used as a sanction of last resort and not as a punitive response to a symptom of social breakdown. As the IPRT reports, even short periods of imprisonment can have long-term, damaging effects, including disruption to family life, loss of employment and access to services, and an increased risk of institutionalisation as

¹ UN Resolution A/RES/S-20/2 (General Assembly, Twentieth Special Session, 21 October 1998).

² Count the Costs, ‘The Alternative World Drug Report: counting the costs of the war on drugs’ (2012) <<https://www.opensocietyfoundations.org/reports/alternative-world-drug-report-counting-costs-war-drugs>> accessed 30 January 2019.

³ Jamie Doward, ‘The UN’s war on drugs is a failure. Is it time for a different approach?’ *The Guardian* (2 April 2016) < <https://www.theguardian.com/world/2016/apr/02/un-war-on-drugs-failure-prohibition-united-nations>> accessed 30 January 2019.

⁴ *ibid.*

a result of the prison environment⁵. Since the passing of the Misuse of Drugs Act 1977, the poor governmental response to the Irish drug crisis has exacerbated the harm felt by the underprivileged, without any meaningful decrease in drug use or supply. This paper intends to show that ‘A Drug Free-World’ and the suggestion that we can attain it is a harmful fallacy.

This report first begins with an analysis of the various models of thought that underpin drug policy. The intention of Part I will be to frame the debate, underline the flaws in the traditional prohibitive approach and critically analyse the philosophical approaches that support a policy of decriminalisation. Part II will summarise Irish drug jurisprudence, offering an analysis of the Misuse of Drugs Act 1977 and the penalties contained therein. Part III will identify the issues that must be addressed in any new formulation of policy. Part IV will provide a comparative analysis of other jurisdictions, with a particular focus upon Portugal and the U.S. in Part IV.I and IV.II respectively. The purpose of this is to identify aspects of other jurisdictions that tackle drug use more effectively and to provide examples of where prohibitive policies have failed. A broader perspective of the global drug trade will be given in Part V, identifying new challenges in the modern drug market. Contemporary drug trade has been characterised by two key developments, the rise of global crypto markets and the manufacturing of synthetic drugs. As these changes become ever more apparent, Ireland will need to figure out where it will fit in the global response. Part VI will provide an in depth analysis of drug treatment and abuse in Irish prisons, advocating for greater investment in current rehabilitative practices. Following from this, Part VII will discuss the harm reduction policies used on a wider scale for all of society. A criticism will be given of measures such as the Drug Treatment Court and a move away from punitive practices will be put forward. Finally, Part VIII will look to the future, discussing upcoming reformations and informing the overall conclusions and recommendations for this research paper.

As a preliminary note, I would like to thank all the researchers for their hard work, patience and cooperation when putting this paper together, without them this project would not have been possible. I would further like to thank Mary Hastings, Chair of Trinity FLAC, and Mary Murphy, Secretary of Trinity FLAC, for their invaluable guidance and support.

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⁵ IPRT, ‘IPRT Submission to inform the role and priorities of the Probation Service’s Strategic Plan 2018-2020’ (16 February 2018) 2.

I: Models for Drug Control

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This section intends to analyse the different models for drug control that exist across legal systems. The aim of Part I is to create an overview of the various approaches to drug policy that exist across the world and to frame the discussion of national policies throughout this paper. It will first look the 'Harm Principle', a liberal theory first enunciated by Mill. Three approaches to harm reduction will be identified and discussed in relation to models for drug policy. Following this, the paternalistic reasoning that underpins many national drug policies will be discussed. A spectrum of paternalism will be identified and an attempt will be made to place Irish drug policy somewhere along it. Lastly, the final section of Part I will utilise an economic analysis to discuss drug control policies. It will be argued that a pivot away from supply-centric towards demand-centric policies is more beneficial for drug policy.

The 'Harm' Principle and Moralism

The harm principle was first made famous by John Stuart Mill as a liberty limiting principle which posits that because criminal law has the power to restrict our liberty, it should be used sparingly to prevent harm to others⁶. This principle informs the criminalisation of drugs and underpins much legislative choice regarding drugs policy in Ireland. This section will explore the different perspectives of the harm principle to investigate how the harm principle might impact policy reform in Ireland. There are three perspectives associated with the harm principle: the prohibitionist approach, the individual approach and the harm reduction approach; they will each be discussed in turn.

The prohibitionist approach is based on the idea that by prohibiting drugs we will reduce and prevent harm incurred to society. Under this theory, the drugs trade harms society by destroying the lives of drug abusers, destabilising communities and increasing instances of drug-related crime. Traditionally this prohibitionist approach has been applied through drug policies worldwide, most notably in the US with the war on drugs, but also in Ireland through the Misuse of Drugs Act 1977. One of the key issues with the 'Harm Principle' is that it bases its premise on an indeterminate theory of harm. What level of harmful activity is within the remit of a person's liberty that they may no longer be justly punished for it? While more tangible harms, such as drug-related crime, may be agreeably controlled, more remote

⁶ Joel Feinberg, *The Moral Limits of The Criminal Law* (1st edition, Oxford University Press 1985) 27.

situations, such as the possession of drugs for personal use are contentious. In the latter case, the individual could be described as confining any alleged harm to themselves or as indirectly contributing to an illegal drug trade. Indeed, while some advocates believe criminalisation prevents harm to an individual in society, others believe that prohibitive laws may cause more harm than good. These commentators point towards the US 'war on drugs', a policy which has skyrocketed prison populations and costs, with no meaningful decrease in drug activity. This will be discussed in greater detail in Part IV.II.

The individualist approach sees the Harm Principle as giving political priority to the 'individual freedom from coercion rather than individual or collective goods such as morality or welfare'⁷. It argues that criminalisation creates more harms than it addresses. Individual drug use does not pose a significant enough threat to others and thus does not require the elimination of drugs to reduce harms⁸. Furthermore the harms of drug use should be balanced with the harms of criminalisation and punishment⁹. This is because the costs of imprisonment and a criminal record are an indirect harm on the person as they are impaired later on in life when it comes to reintegrating themselves into society. This interpretation may also be seen as problematic by being too narrow to meet society's needs. Minimal state intervention ignores the way in which individual interest can be compromised in drug addiction¹⁰.

The third perspective of harm reduction combines these two approaches in order to strike a balance between the positive and negative view of the Harm Principle. O'Mahony endorses such an approach which he denotes as 'harm reductionism'. Under this approach the primary aim of policy is the minimization of the diverse harms associated with illegal drug use, even if this process involves accepting continued use¹¹. This harm reductionism takes many different forms, such as 'strict medical rationale' harm reductionism. O'Mahony

⁷ William Wilson *Criminal Law* (Pearson, 5th edn, June 2014) 35.

⁸ *ibid* 17.

⁹ Lucas, Kyle J. Mr. (2014) 'Does the Harm Principle Justify Criminal Drug Statutes Against Drug Use?' (2014) 7(1) *The Hilltop Review*, <<http://scholarworks.wmich.edu/hilltopreview/vol7/iss1/6>> accessed 29 January 2019.

¹⁰ William Wilson *Criminal Law* (5th edn, Pearson June 2014) 19.

¹¹ Tim Murphy 'A Review of O'Mahony, "The Irish War on Drugs: The Seductive Folly of Prohibition"' (2009) 49(3) *British Journal of Criminology* 425 <https://www.researchgate.net/publication/249284896_A_Review_of_O'Mahony_The_Irish_War_on_Drugs_The_Seductive_Folly_of_Prohibition> accessed Nov 05 2018.

convincingly argues that it is ‘a reactive, countermovement within global and local prohibitionist systems, or at any rate, a movement essentially defined and driven by the existence of drug prohibition’¹². A version of this in action can be seen in the new National Drugs Strategy in Ireland which focuses on harm reduction through a relaxing of criminal laws. This policy will be discussed in greater detail in Part VII and VIII. The National Drugs Strategy sees some drugs as ‘softer’ than others and concentrates on regulation that discourages the use of the hardest drugs¹³. As per harm reductionism this might increase drug taking but overall harm would be reduced. This approach also closely mirrors Mill’s philosophy because it balances the need for individual freedom with the role of the state to look after public welfare. Although this approach is less problematic than the other two interpretations of the Harm Principle, whether harm reductionism provides a conclusive argument that drug users should face sanctions is yet to be determined.

Related to the concept of the harm principle is the idea of Moralism. Moralism asserts that it can be morally permissible for the government to restrict behaviours that cause neither harm nor offense on the basis that such actions would constitute evils of another kind. This proposes that law can enforce morality without a social benefit. It is rarely used as a justification for criminalisation unless wider public interest is at stake¹⁴. Contemporary defenders of enforcing morality have also emphasised that a threshold of seriousness be satisfied before criminalisation is appropriate¹⁵. In the case of drugs, moralism would contend that drugs threatens to destroy the community. This is because drugs are seen as a fixed element of the criminal underworld that enables other illicit activity, such as prostitution, because it is a form of income for criminal gangs. Also for expensive drugs, such as heroin, an addict needs a lot of money to fuel the addiction and often turns to crime to fund it. The problem with this approach is the moral inconsistency that it promotes¹⁶. Alcohol can also threaten the social structure due to the violent activity that comes about following intoxication, yet possession of a cellar of wine is accepted in society and not condemned. Critics would also claim that it is in fact morally wrong to continue criminalizing approaches to control of drug use when these strategies ‘fail to achieve the goals for which they were

¹² Joel Feinberg, *The Moral Limits of The Criminal Law* (1st edition, Oxford University Press 1985) 27.

¹³ *ibid.*

¹⁴ William Wilson *Criminal Law* (5th edn, Pearson June 2014) 38.

¹⁵ *ibid* 19.

¹⁶ Joel Feinberg, *The Moral Limits of The Criminal Law* (1st edition, Oxford University Press 1985) 27.

designed; create evils equal to or greater than those they purport to prevent; intensify the marginalization of vulnerable people; and stimulate the rise to power of socially destructive and violent empires'¹⁷.

To conclude, both the harm principle and moralism play a key role in justifying drug policy and they are both equally problematic. The harm principle is open to interpretation, with three dominant perspectives: prohibitionist approach, the individual approach and harm reductionism. The prohibitionist approach has been criticised as being too strict, the individual approach is seen as too liberal, with the combined approach of harm reductionism seeming to strike a happy medium. Moralism on the other hand promotes a moral inconsistency that could be argued as being too unstable to be the foundation for law (in relation to drugs at least). Clearly no approach is perfect, but each has its own merits.

Paternalism

Paternalism is defined as "the policy or practice on the part of people in authority of restricting the freedom and responsibilities of those subordinate to or otherwise dependent on them in their supposed interest"¹⁸. Paternalism is a practice that has been prevalent in the majority of legal systems, where legislation operates to prevent the public from causing themselves harm. While the criminalisation of drugs is not solely based on paternalism, it still constitutes a large factor for why most drugs are illegal.

There are three main degrees of paternalism that will be discussed; hard paternalism, soft paternalism and anti-paternalism. The former is commonly associated with drug control and justifies complete prohibition of an activity or substance, in order to discourage this behaviour that could cause harm. Hard paternalism "accepts as a reason for criminal legislation that it is necessary to protect competent adults, against their will, from harmful consequences even of their full voluntary choices and undertakings"¹⁹. We see this form of paternalism outlined clearly in some aspects of Irish legislation, a key example being

¹⁷ Peter Reuter & Alex Steven, 'Injection Drug Use and HIV/AIDS: Legal and Ethical Issues' (Canadian HIV/AIDS Legal Network, 24 November 1999); Peter Reuter & Alex Steven, 'An Analysis of UK Drug Policy: A Monograph Prepared for the UK Drug Policy Commission' (2007).

¹⁸ Unknown contributor, 'Paternalism' (Oxford English Dictionary Online) <<https://en.oxforddictionaries.com/definition/paternalism>> accessed 26 January 2019.

¹⁹ Joel Feinberg, *The Moral Limits of The Criminal Law Vol. 3 Harm to Self* (Oxford University Press Inc 1986).

controlled and banned substances under the Misuse of Drugs Act 1977²⁰. The main argument in favour of this model of drug control is that “drug use is sufficiently irrational conduct that there is moral title to interfere with it”²¹. It suggests that drugs must be made illegal so that the public may not be influenced into making immoral choices. The United States has taken a similar approach to drug policy through the ‘War on Drugs’ that has been waged for decades; this will be analysed in Part IV.II.

A drug policy utilising softer paternalistic policies has been advocated recently by academics such as Cass Sunstein and Richard Thaler. ‘Soft-Paternalism’ or ‘Libertarian Paternalism’ accepts the premise that in general, people should be free to do what they like and be ‘free to choose’. On the other hand, it also argues that it is legitimate for ‘choice architects’, like the government, to influence these decisions so that people may be better, healthier and live longer lives²². Moreover, because individuals often make mistakes, the government should push individuals to make the ‘right’ choices; whether it is through education, tax or a variety of other subtle tactics²³. By putting individuals in the position “to make more informed, and presumably better choices” the government can maximise opportunity to choose while protecting the public²⁴. A moderate form of libertarian paternalism is often applied to legal drugs, through the use of higher taxes, laws around the purchasing and consumption of the drugs, and government funded ad campaigns. A more drastic measure involves legalising all drugs and leaving the individual to make informed decisions. Such a policy will be discussed in Part IV.I; where Portuguese drug reforms will be discussed.

This model of ‘libertarian paternalism’ is still open to criticism. Thaler and Sunstein define a ‘nudge’ as any aspect of the choice architecture that alters people’s behaviour in a predictable way without forbidding any options or significantly changing their economic incentives²⁵. While innocent nudges like warning labels and cancer warnings on cigarette packets are no cause for concern, issues arise where the methods used to influence people are more

²⁰ Section 2, Misuse of Drugs Act 1977.

²¹ David A. J. Richards, ‘Drug Use and the Rights of the Person’ (1982) Rutgers Law Review 3, 178.

²² Richard Thaler & Cass Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness* (2nd edition, Penguin Books 2009) 5.

²³ One of the more subtle nudges detailed by Thaler and Sunstein included the use of happy or sad faces on energy consumption reports for three-hundred households in San Marcos, California; *ibid*, 74-75.

²⁴ Hill CA, ‘Anti-Anti-Anti-Paternalism.’ (2007) 2(3) NYU JL & Liberty 444.

²⁵ Richard Thaler & Cass Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness* (2nd edition, Penguin Books 2009) 6.

innocuous and coercive, like subliminal messaging. Some commentators argue that there is something inherently invasive in utilising a position of power to influence the way people think, especially without the public realising that this influence is occurring. As well as this, choice architects may also be subject to error themselves, as Hill points out; “if people subject to law make mistakes, so, too, do people who make the law”²⁶. Hill further questions whether it is possible for the government to accurately know what mistakes people will regret, “how do *we* know what people really want?”²⁷. If the effects of a well-chosen default option are as powerful as Thaler and Sunstein suggest, the public may only be able hope that the choice architect is using a nudge with benevolent intentions and not for their own agenda,

Finally, there is anti-paternalism, which is applied in a handful of jurisdictions for drug control, such the Netherlands (which will be examined in Part IV of this paper). This view is that paternalism is “not only objectionable, it is a violation of human rights”²⁸. Any paternalistic model for drug control clearly conflicts with a model based on the ‘Harm Principle’, as discussed earlier. The philosopher Huask makes the argument that the criminal law and state punishment should only be used, and are only fully justified when used, against harms that makes victims of others²⁹. If an individual’s possession or consumption of drugs causes no harm to others, the government has no place to intervene. Szasz, a critic of paternalistic policies, argues that, ‘if we take drugs and conduct ourselves as responsible and law-abiding citizens, should we have a right to remain unmolested by the government?’³⁰. Nadelman further argues that “enforcement of drug laws makes a mockery of an essential principle of a free society, that those who do no harm to others should not be harmed by others, and particularly not by the state”³¹.

Some academics argue for a ‘right to use drugs’, stemming from the fundamental human right to liberty³². In his 2008 book, *The Irish War on Drugs*, Paul O’Mahony argues that society would make substantial gains from accepting the libertarian view that there is a right

²⁶ibid.

²⁷ ibid.

²⁸ David A. J. Richards, ‘Drug Use and the Rights of the Person’ (1982) *Rutgers Law Review* 3, 178.

²⁹ O’Mahony, *The Irish War on Drugs: The Seductive Folly of Prohibition* (Manchester University Press 2008).

³⁰ Szasz, *Drugs and Drug use in Society* (Greenwich University Press 1994).

³¹ Ethan A. Nadelmann, ‘Drug Prohibition in the United States: Costs, Consequences, and Alternatives’ [1991] 5 *Notre Dame J.L. Ethics & Pub Policy* 783.

³² Paul O’ Mahony, *The Irish War on Drugs* (1st edn, Manchester University Press 2008)

to use drugs so long as others' rights are not infringed'³³. Use of drugs does not need to be seen as an illogical activity and can be explained as being entirely rational, even considering the risks they pose to the individual.³⁴ If the government is justified in criminalising dangerous drugs, it could also be compelled to criminalise other 'risky' activities that individuals engage in voluntarily, such as sky-diving or unhealthy diets. De Marneffe, who opposes the legalisation of heroin, still holds that "no one wrongs anyone by simply using heroin and no one morally deserves to be punished for doing so"³⁵.

The anti-paternalism view, like all other degrees of paternalism, remains open to critique. It is easy to argue that the harm caused by drug use, particularly continued drug use, is not limited to the individual but to families and communities. The harmful effects of drug use on the individual and community at large will be examined in full in Part III.

Economic Model of Drug Control

While most jurisdictions base their drug policies off paternalistic or harm prevention theories, many academics have begun to suggest a more economic analysis. Structural characteristics of the 'drug market' may in fact have more to do with drug consumption and abuse than the actions of governmental and law enforcement agencies.³⁶ Economists, such as Tom Wainwright³⁷, argue that the immediate task for international policymakers is to accept that a focus on reducing demand or at least a more rational approach to reducing supply is required. This section will look at the effect of prohibition on the drug market, and how the implementation of this type of strategy is being employed in an Irish context.

Effect of Prohibition

The addictive nature of drugs and its pervasiveness in modern society has made drugs a relatively inelastic product, such that it does not respond in a typical manner to the market forces of supply and demand. Demand for some goods is 'elastic', meaning that it drops dramatically following even a small increase in price. Demand for other products is

³³ *ibid.*

³⁴ David. Richards, 'Drug Use and the Rights of the Person' (1982) *Rutgers Law Review* 3, 178.

³⁵ Doug Husak and Peter de Maneffe, *The Legalisation of Drugs: For and Against* (Cambridge University Press 2006).

³⁶ Reuter, Peter, and Mark A. R. Kleiman. "Risks and Prices: An Economic Analysis of Drug Enforcement." *Crime and Justice*, vol. 7, 1986, pp. 289–340. JSTOR, JSTOR, www.jstor.org/stable/1147520.

³⁷ Tom Wainwright, *Narconomics* (Ebury Press 2016).

‘inelastic’, meaning that consumers will keep buying more or less the same amount as before, even in the face of big-price rises³⁸. Intuitively, the effect of this inelasticity is most acute for addictive substances. Consequently while policies of seizing illegal drugs and stamping out drug crime may decrease supply, the effect is only to increase the price for which consumers pay, not decrease their demand. If prohibition is to be insisted upon, care must be taken to ensure that enforcement is resourced *only* up to the point of drastically raising marginal prices to the point where consumption is measurably reduced³⁹.

Wainwright comes to two worrying conclusions as to the effects of a policy that focuses purely on supply. The first is that, “Governments are condemned to invest large amounts of resources in return for only meagre gains.”⁴⁰ One survey of the United States suggests that even if government expenditure on the ‘war on drugs’ could be used to increase the price of drugs by 10%, this could at most lead to a 3.3% drop in demand⁴¹. As well as this, cartels may easily use their buying power to force farmers and manufacturers to absorb any cost increases. This is due to their position as monopsonies; in the same way a monopoly can dictate the price to buyers, a monopsony may dictate the price to sellers⁴². Consequently, supply-side policies will also have a limited effect on their manufacturing cost.⁴³ Secondly, large increases in price, coupled with only small decreases in demand mean that with every enforcement ‘success’, the value of the market only increases⁴⁴. Rather than deterring cartels from manufacturing drugs, supply-side policies actually make the drug market more profitable. The LSE Expert Group on the Economics of Drug Policy notes another effect of these supply side policies on countries that namely produce rather than consume; ‘producer and transit countries’ have ended up paying a much higher cost “in terms of violence, corruption and the loss of legitimacy of state institutions”⁴⁵.

³⁸ Tom Wainwright, *Narconomics* (Ebury Press 2016) 272.

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⁴⁰ *ibid*, 273.

⁴¹ Peter Reuter, ‘Understanding the Demand for Illegal Drugs’ (Washington DC: National Academies Press), accessed online 26th January 2019 <<http://www.nap.edu/catalog/12976/understanding-the-demand-for-illegal-drugs>>.

⁴² Tom Wainwright, *Narconomics* (Ebury Press 2016) 17.

⁴³ Tom Wainwright, *Narconomics* (Ebury Press 2016) 271-272.

⁴⁴ Tom Wainwright, *Narconomics* (Ebury Press 2016) 273.

⁴⁵ LSE Expert Group on the Economics on Drug Policy, ‘Ending the Drug Wars’ (May 2014) 26, <https://www.researchgate.net/publication/302997226_Addressing_the_costs_of_prohibition_Internally_displaced_populations_in_Colombia_and_Mexico> accessed 26th January.

A far more effective policy would be to focus on decreasing demand from consumers.⁴⁶ This can be explained through a variety of reasons. Firstly, demand leads to supply, so to disrupt the demand side of equation will be more effective. Secondly, using scarce funds to disrupt supply chains, destroy coca fields etc., are problems the cartels will quickly and easily resolve given their vast resources. Concentrating on educational programmes, such as rehabilitating drug offenders, educating poorer communities with skills to find alternative work or funding drug prevention programmes in schools might be far more effective in the long run. Some studies have shown that the cost of treatment for a drug offender is actually ten times more cost effective than enforcement⁴⁷. The somewhat obvious conclusion from this is that the taxpayer faces less costs putting someone into a job than it does paying enforcement agencies to chase them down for a drug related crime.

Irish Economic Viewpoint:

It is useful at this point to look at the effect that the Irish prohibition on drugs has had on Ireland. The Irish approach may be appropriately characterised as more supply rather than demand-centric. As Ireland often acts as a port of entry to the European market, law enforcement has been concentrated on seizing drugs at the border; as well as patrolling neighbourhoods and performing searches and seizures. However, changes to policies in recent years have moved towards a focus on reducing demand; these changes will be outlined briefly in this section but discussed in greater detail in Part VII and VIII.

Supply Centric Policies

As the National Advisory Committee on Drugs and Alcohol (NACDA) noted, “the public demand for illegal drugs and the profits which can be earned from drug-dealing ensure that Irish drug markets, like those elsewhere, remain resilient and adaptable to law-enforcement interventions”⁴⁸. Over the past decade, more than 120,000 people have received criminal

⁴⁶ Wainwright, *How economists would wage the war on drugs*, Wall Street Journal, 20/02/2016

⁴⁷ Beau Kilmer et al, ‘Reducing Drug Trafficking Revenues and Violence in Mexico’ (RAND Corporation 2010) 19
<https://www.rand.org/content/dam/rand/pubs/occasional_papers/.../RAND_OP325.pdf> accessed online 26 January 2019.

⁴⁸ Johnny Connolly and Anne Marie Donovan, ‘Illicit Drug Markets in Ireland’ (NACDA 2014) 260 <<https://www.nacda.ie/index.php/press-releases/174-nacda-illicit-drug-markets-in-ireland.html>> accessed online 27 January 2019.

convictions for drugs possession, or supply, and Garda continue to prosecute around 1,000 individuals a month in order to meet Garda performance indicators in its efforts to 'reduce supply'⁴⁹. Unfortunately, the evidence suggests that Garda drug enforcement activity has been misplaced, with the vast majority of seizures being of drugs for personal possession or use, rather than supply. 90 % of the seizures at the Irish border were of cannabis herb or resin and the vast majority (90%) of these seizures weighed less than 28g⁵⁰. Between 70% and 90% of arrests in the four district areas studied were of people aged under 24, who were prosecuted for possessing cannabis with a value of €10 or less.⁵¹ The actual effect of these seizures, in terms of reducing supply, raising street prices and reducing demand through deterrence must be seriously questioned.

Moreover, where law enforcement is successful in seizing large amounts of drugs, the effect on the local community can be drastic. NACDA concluded that one of the unintended or adverse consequences of effective Irish supply reduction activities was the indirect contribution to greater levels of drug-related violence⁵². The feud between the Kinahan and Hutch gangs which erupted in February 2016 and led to 12 murders and the murder of Gary Hutch in Spain in September 2015 was caused by a seizure of €2m worth of drugs. There have been over 200 drug gang related murders in Ireland in the past decade and only around 10% have resulted in convictions⁵³. It might be noteworthy in an economic analysis of the drug trade to consider the pragmatic reflection of Irish economist, David McWilliams;

‘Standing back, we need to accept that the war on drugs is not working at all. It is creating, not stopping, criminality. How many more innocent people will have to be gunned down before we begin this conversation? The economics of this debate are straightforward — so

⁴⁹ ‘Research Shows Ireland has lost War on Drugs’ *Irish Independent* (Dublin, November 12 2016) <<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.134>> accessed 8 November 2018.

⁵⁰ Johnny Connolly and Anne Marie Donovan, ‘Illicit Drug Markets in Ireland’ (NACDA) 261 <<https://www.nacda.ie/index.php/press-releases/174-nacda-illicit-drug-markets-in-ireland.html>> accessed online 27 January 2019.

⁵¹ ‘Research Shows Ireland has lost War on Drugs’ *Irish Independent* (Dublin, November 12 2016) <<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.134>> accessed 8 November 2018.

⁵² Johnny Connolly and Anne Marie Donovan, ‘Illicit Drug Markets in Ireland’ (NACDA) 263 <<https://www.nacda.ie/index.php/press-releases/174-nacda-illicit-drug-markets-in-ireland.html>> accessed online 27 January 2019.

⁵³ ‘Research Shows Ireland has lost War on Drugs’ *Irish Independent* (Dublin, November 12 2016) <<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.134>> accessed 8 November 2018.

why not start the discussion?’⁵⁴

Demand Side Policies

The most recent publication by the Irish government concerning drug policy suggests that that discussion has begun. The paper, ‘Reducing Harm, Supporting Recovery’, marked a pivot towards demand-side policies. The policy intends to address the harm caused by substance misuse in Ireland and create a new focus on reducing demand to drugs.⁵⁵ Among many initiatives, the government has pledged to improve the delivery of substance use education across all sectors, including youth services, services for people using substances and other relevant sectors⁵⁶. The movement towards reform, away from supply-centric policies, towards a concentration on reducing demand, will be discussed in full under Part VIII of this paper.

Conclusion

This section has examined the theoretical underpinnings of drug policies around the world. Paternalistic ideas justify state intervention in order to protect the individual from themselves. However, in analysing drug policy, it should be recognised that simplistic solutions from a purely ideological perspective will be counterproductive. A consequentialist approach, one that looks at the effects on communities and drug markets must be taken, in order to have an effective drug policy.

⁵⁴ David McWilliams, ‘The war on drugs has failed, we must end this drain on resources’, (davidmcwilliams.ie, September 3rd 2017) <<http://www.davidmcwilliams.ie/the-war-on-drugs-has-failed-we-must-end-this-drain-on-resources/>> accessed 7 November 2018.

⁵⁵ Department of Health, ‘Reducing Harm, Supporting Recovery’, (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

⁵⁶ *ibid* 82.

Irish Legislation and Case Law

Elizabeth Ring, Yvonne McDonagh, Serena Oster

Introduction

As Anne Quigley, co-ordinator of Citywide, has stated: “the evidence shows that our current approach of criminalising people for possession of drugs does not reduce the overall level of drug-use in society. What it does do is increase the difficulties and challenges for a person trying to address their drug use.”⁵⁷ Indeed, in recent years, Irish drug legislation has come under increasing scrutiny by the courts and the media, due to lobbying by drug reform groups, such as Citywide, and the success of other European models for drug control. Much attention has been paid as to how Ireland criminalises possession and the case law has been plagued by the difficulty of being unable to clearly define key elements of the offence, particularly in relation to knowledge of the possession. Over time, however, clearer stances on criminalisation under the Misuse of Drugs Act 1977 Act have emerged.

This section will focus on the Misuse of Drugs Act 1977, and how it criminalises possession in comparison to the intention to distribute. The sentencing of those convicted under the Acts will then be examined, along with what discretion is afforded to judges when imposing such sentences. Finally, through the prism of Irish case law, the construction of possession will be analysed and whether this is reflected within the legislation.

General Introduction to the Misuse of Drugs Act 1977

The Misuse of Drugs Act 1977 is the primary legislation used to criminalise drug offences. This part will focus on how the Act deals with the criminalisation of possession in comparison to the criminalisation of intention to distribute.

Section 3 of the Misuse of drugs Act states that;

⁵⁷ Kitty Holland, ‘Almost 75% of drugs offences last year were ‘possession for personal use’ *The Irish Times* (Dublin, 24th of June 2018) <<https://www.irishtimes.com/news/social-affairs/almost-75-of-drugs-offences-last-year-were-possession-for-personal-use-1.3542251?mode=sample&auth-failed=1&pw-origin=https%3A%2F%2Fwww.irishtimes.com%2Fnews%2Fsocial-affairs%2Falmost-75-of-drugs-offences-last-year-were-possession-for-personal-use-1.3542251>> Accessed 24 October 2018.

“(1) Subject to subsection (3) of this section and section 4 (3) of this Act, a person shall not have a controlled drug in his possession.”⁵⁸

Section 15 of the Misuse of Drugs Act states that;

“(1) Any person who has in his possession, whether lawfully or not, a controlled drug for the purpose of selling or otherwise supplying it to another in contravention of regulations under section 5 of this Act, shall be guilty of an offence.”

“(2) Subject to section 29 (3) of this Act, in any proceedings for an offence under subsection (1) of this section, where it is proved that a person was in possession of a controlled drug and the court, having regard to the quantity of the controlled drug which the person possessed or to such other matter as the court considers relevant, is satisfied that it is reasonable to assume that the controlled drug was not intended for the immediate personal use of the person, he shall be presumed, until the court is satisfied to the contrary, to have been in possession of the controlled drug for the purpose of selling or otherwise supplying it to another in contravention of regulations under section 5 of this Act.”⁵⁹

Intention to Distribute

Possession, in layman’s terms, relates to a person having control of certain unlawful things, in this case controlled substances under Section 2 of the Misuse of Drugs Act 1977. No definition of ‘possession’ is contained in the Act, and thus the Courts have been left to fill the legislative lacuna. This will be expanded upon later.

Under Section 15 of the Act, once the court establishes that a person has over a certain quantity of a drug in their possession, it is presumed “until the court is satisfied to the contrary” that the drug was in their possession for the purpose of distribution. The onus, therefore, is on the defence to prove that the accused did not intend the drugs for sale or supply. Although this presumption can be rebutted by various defences, the burden of proof that is placed on the defendant hampers their case, and therefore makes it easier to convict.

⁵⁸ Misuses of Drugs Act 1977.

⁵⁹ *ibid.*

Section 29 of the Act states a number of defences which may be employed in order to prove this. S. 29(3) state that the accused may rebut the presumption under S.15 of the Act by proving that they were in lawful possession of the drug. S. 29(2)(a) of the Act provides that it is a defence for the accused to prove that he did not know and had no reasonable grounds for suspecting that what he had in his possession was a controlled drug or that he was in possession of a controlled drug. The defence may also argue under S.29(2)(b) that they believed the substance to be a controlled drug, and had the drug in fact been a controlled drug, they would not have been committing an offence at the time. Finally, under S.29(2)(c) they may argue that suspecting the substance was a drug, they retained the drug in their possession in order to prevent the commission of a crime, or to place the drug in the possession of a person who is lawfully entitled to take custody of it.

Introduction to Penalties and Sentencing

When comparing the criminalisation of the possession of drugs and the intention to distribute under S. 27 of the Misuse of Drugs Act, the penalties for each are of varying length and imposition. If one is found in possession of drugs *not* for distribution, the penalties range from a monetary fine and/or imprisonment for a maximum of one year on summary conviction, and a maximum of seven years for a conviction on indictment. Contrastingly, the penalties for the possession of drugs for the intention of distribution induce harsher penalties, reflecting the nature of the offence. These penalties range from imprisonment for one year and/or a fine on summary conviction, to life imprisonment and/or an unlimited fine for conviction on indictment.⁶⁰

Although these penalties may appear to be harsh, it is true that in reality, “the legal system has for a long time dealt with these cases, and for an equally long time has recognised that harsh punitive measures are neither a desirable nor effective use of the law insofar as simple possession is concerned.”⁶¹

The DPP usually elects for summary disposal in all cases. This means that “the courts are given powers to provide outcomes that are more reminiscent of healthcare than criminal justice. This

⁶⁰ ‘The Law in Ireland’, *Citywide Drugs Crisis Campaign*, <<https://www.citywide.ie/decriminalisation/ireland/the-law-in-ireland.html>> Accessed 23 October 2018.

⁶¹ LSE and Ana Liffey Drug Project, ‘Not Criminals: Underpinning a Health-Lead Approach to Drug Use’ (2018) 31 <<http://www.lse.ac.uk/united-states/Assets/Documents/IDPU-Not-Criminals-Report.pdf>> accessed January 2 2019.

hardly seems desirable— it is, in essence, a delivery mechanism for healthcare which is routed through the criminal justice system, complete with all the expense, time and stress for the individual that this approach brings. If this approach is merited, it must be supported by the evidence – there must be strong public policy reasons for criminalising simple possession.”⁶² It appears that from a defendant’s perspective, the emphasis on the possession of drugs, as opposed to the intention to distribute, has a negative effect on the cases under the Misuse of Drugs Act, and further legislation. Furthermore, the reality of the implementation of the legislation is that the attempt to carry out a form of healthcare through the courts system is ineffectual and outdated.

Sentencing

The Misuse of Drugs Act 1977 is the primary legislation used to criminalise drug offences in Ireland. Section 27 of the Act deals with the penalties imposed in relation to offences created under the Act. This part will focus on the various sentences imposed under the 1977 Act and the judicial discretion afforded to judges when carrying out sentencing.

Section 27 of the Misuse of Drugs Act provides for the imposition of both monetary fines and/or imprisonment sentences as penalties for the offences outlined in the Misuse of Drugs Act 1977. The imposition of sentences following a conviction under the Misuse of Drugs Act usually involves the exercise of very wide judicial discretion⁶³. This includes the power to impose any sentence deemed appropriate ranging from a suspended term of imprisonment and/or a fine up to the every maximum penalty permitted by law. This judicial discretion is however, subject to guidelines and limitations such as statutory requirements to impose a mandatory penalty.

The range of penalties available under section 27 of the Act vary according to the circumstances of the particular offence and offender. Judges when determining sentences if and when an accused is convicted are required to consider these circumstances as well as the type of drug and value and quantity of the drug.

⁶² *ibid* 32.

⁶³ Martin McDonnell and Paul McDermott, “Misuse of Drugs: Criminal Offences and Penalties” (Bloomsbury 2010).

Section 3 of the Misuse of Drugs Act 1977 prohibits the simple possession of a controlled drug. Any person being tried under the offence created by section 3 can be tried either summarily or on indictment. For the purpose of penalty provision, a distinction is drawn between the possession of cannabis or cannabis resin for personal use and the possession of any controlled drug, including cannabis or cannabis resin, where the possession is deemed to be for some purpose other than personal use.⁶⁴

The penal provision for the offence created under s 3(2) is found at s 27(1) of the 1977 Act:

“(1) Subject to section 28 of this Act, every person guilty of an offence under section 3 of this Act shall be liable –

(a) where the relevant controlled drug is cannabis or cannabis resin and the court is satisfied that the person was in possession of such drug for his personal use:

(i) in the case of a first offence, to a fine on summary conviction not exceeding fifty pounds,

(ii) in the case of a second offence, to a fine on summary conviction not exceeding one hundred pounds,

(iii) in the case of a third or subsequent offence, to a fine on summary conviction not exceeding two hundred and fifty pounds or, at the discretion of the court, to imprisonment for a term not exceeding twelve months, or to both the fine and the imprisonment;

(b) in any other case—

(i) on summary conviction, to a fine not exceeding two hundred and fifty pounds or, at the discretion of the court, to imprisonment for a term not exceeding twelve months, or to both the fine and the imprisonment, or

⁶⁴ Martin McDonnell and Paul McDermott, “Misuse of Drugs: Criminal Offences and Penalties” (Bloomsbury 2010).

- (ii) on conviction on indictment, to a fine not exceeding fifteen hundred pounds or, at the discretion of the court, to imprisonment for a term not exceeding seven years, or to both the fine and the imprisonment.”⁶⁵

Although the above penalty provision differentiates between the type of drug and the purpose for which it is possessed, ss 3 and 27 do not create two separate offences. Rather, a distinction is drawn because the statute requires the courts to consider the type of drug and the purpose for which it is possessed when determining the appropriate sentence. The Supreme Court summed up the effect of s.27 in *State (Gleeson) v District Justice Connellan*⁶⁶:

“The question of use of the drug is not an ingredient of the offence under the section...The question of use only arises in relation to the penalties to be imposed if and when the accused person is convicted of the offence.”

The possession of a controlled drug for supply is treated as a serious offence, as is reflected in the sentence available - conviction on indictment provides for a maximum sentence of life imprisonment.⁶⁷ However, the penalty on summary conviction is much less severe – a fine not exceeding €1,269.74 and/or a maximum term of 12 months’ imprisonment.

The penal provision for both the possession of a controlled drug with a value of €13,000 or more for unlawful sale or supply contrary to S 15A(1) of the 1977 act and the importation of a controlled drug with a value of €13,000 or more contrary to S 15B(1) of the 1977 act is found at s 27 (3A). Both offences may only be tried on indictment and carry a maximum sentence of life imprisonment – a sentence which is commensurate with the gravity of the crime. The court can however exercise judicial discretion by declining to impose a life sentence, in which case s 27 (3C) stipulated that a minimum period of 10 years is to be served by the convicted offender. A deviation from the mandatory minimum sentence is however, provided for under s 27(3D) (a) and (b) where the judge believes there to be “exceptional and specific circumstances” exist in respect of the offence or the person convicted of the offence.

⁶⁵ As substituted by the Misuse of Drugs Act 1984, s 6.

⁶⁶ [1988] I IR 559 at 561.

⁶⁷ See *People (DPP) v Gethins* (23 November 2001, unreported) CCA

Section 21(1) effectively contains three separate offences: (i) attempting to commit an offence, (ii) aiding, abetting, counselling or procuring the commission of an offence, (iii) soliciting or inciting a person to commit an offence. Section 27 (9) of the Act states that any person found guilty of any of the above crimes is liable to be punished with the same sentences as if he/she were themselves guilty of the substantive offence.

The imposition of a sentence, custodial or otherwise, in criminal proceedings is normally required to accord with the overriding principle of proportionality⁶⁸. *State (Healy) v Donoghue*⁶⁹ states that a convicted person must receive a sentence which is appropriate to his degree of culpability and relevant personal circumstances in order to vindicate his personal rights. Additionally, Denham J in *People (DPP) v M* stated that

“Sentences must be proportionate. Firstly, they must be proportionate to the crime. Thus, a grave offence is reflected by a severe sentence... However, these sentences must be proportionate to the personal circumstances of the appellant. The essence of the discretionary nature of sentencing is that the personal circumstances of the appellant must be taken into consideration by the court.”⁷⁰

The Law Reform Commission’s *Report on Mandatory Sentences* reaffirms the value of judicial discretion but notes “deficiencies” and a “level of inconsistency” in Ireland’s largely unstructured sentencing system⁷¹. For this reason, the Commission supports previous recommendations that a Judicial Council should be able to develop and publish suitable guidance or guidelines on sentencing.⁷²

Possession under Irish Case Law

The peculiarity of possession as an offence was noted in *DPP v Ebbs*⁷³, where the Court stated that the knowledge required to establish possession related to the *actus reus* rather than the *mens rea* of the offence. In simpler terms, what is criminalised is a mental state rather than an activity. It is for this reason that possession is considered by some academics to be a strict

⁶⁸ McDonnell and McDermott, “Misuse of Drugs: Criminal Offences and Penalties” (n.1).

⁶⁹ [1976] IR 325.

⁷⁰ [1994] 3 IR 306 at 316.

⁷¹ Ruadhan Mac Cormaic, “Judges Need Guidance in Sentencing, says Law Reform Report” *The Irish Times* (Dublin, 11 June 2013).

⁷² Law Reform Commission, *Report on Mandatory Sentences* (LRC 108 - 2013)

⁷³ [2011] 1 IR 778.

liability offence, the prosecution need to only prove knowledge⁷⁴. The difficulty in satisfactorily establishing possession is noted by Coffey, "...in the absence of proof that the defendant was aware of the existence of the prohibited objects or substance, there is no proof of the physical element of possession"⁷⁵. As a result of this, the law has sought to infer the requisite knowledge from objective facts. Consequently, as Shartel notes, the definition of 'possession' has become "one of the most elusive and ambiguous of legal concepts."⁷⁶

As mentioned above, possession of controlled drugs is the basic offence under the Misuse of Drugs Act 1977 governed under section 3 of the Act which sets out that a person,⁷⁷ who has in their possession a controlled drug, will be guilty of an offence.⁷⁸ In its simplest conception, the offence of possession involves knowingly having a prohibited item under one's control. The most authoritative definition of 'possession' arose in Davitt P.'s statement in *Minister for Posts and Telegraphs v Campbell*⁷⁹, where he described two forms of possession: actual and constructive;⁸⁰

"In my opinion a person cannot, in the context of a criminal case, be properly said to have possession of an article unless he has control of it either personally or by someone else. He cannot be said to have actual possession of it unless he personally can exercise physical control over it; and he cannot be said to have constructive possession of it unless it is in the actual possession of some other person over whom he has control so that it would be available to him if and when he wanted it".⁸¹

If the offending item is under the direct control of a person, they have actual possession of the item. Contrastingly, if a person is acting under the direction of another, they merely have constructive possession.⁸² Davitt P stated that the most important element of possession was

⁷⁴ Gerard Coffey, 'An Evaluation of "Possession" in the Construction of Criminal Liability' (2016) 26(4) ICLJ 108, 109.

⁷⁵ Gerard Coffey, 'An Evaluation of "Possession" in the Construction of Criminal Liability' (2016) 26(4) ICLJ 108, 109.

⁷⁶ Cf Burke Shartel, 'Meanings of Possession' (1931-1932) 16 Minnesota Law Review 611.

⁷⁷ Peter Charleton, *Controlled Drugs and the Criminal Law* (An Cló Liúir, 1986) 91

⁷⁸ see also Misuse of Drugs Act 1977 (MDA 1977), ss. 1(2), 4(3), 15 and 29(1 and 2)

⁷⁹ [1966] IR 69.

⁸⁰ Martin MacDonnell and Paul McDermott, "Misuse of Drugs; Offences and Penalties" (Bloomsbury, 2010).

⁸¹ *ibid* 73.

⁸² Conor Hanley, *An Introduction to Irish Criminal Law* (Gill Education 2015) 53.

control. As Barnes comments; “[t]he control required for the external element of the offence to be satisfied must be in combination with an intention to control the said item.”⁸³ This judgment was later cited with approval in the more recent case of *The People (DPP) v Gallagher*,⁸⁴ and seems to represent the treatment of possession in Ireland.⁸⁵

An analysis of the practicalities and meaning of possession in relation to its legislative context and its application within the case law of this and neighbouring jurisdictions, would, at this juncture, be appropriate. As illustrated by the sentiments of Davitt P. above, it is well settled that the fundamental ingredients pertaining to the law of possession are the exercise of some sort of control over the objects by the accused, along with an awareness as to their existence.⁸⁶ Control, which constitutes the external element of the offence of possession, may either be actual or constructive as suggested in *Campbell*. This was affirmed, along with the importance of control as part of possession, by Kearns J. in judgment in *People v Tanner*,⁸⁷ in which the learned judge articulated that control need not necessarily be confined to the physical custody of the accused, but may also be extended to include various types of constructive possession.

As noted by McAuley and McCutcheon, control may also be acquired passively and without any physical conduct, such as manual delivery or physical proximity, on the accused’s part.⁸⁸ The issue of physical proximity was considered in *People v Foley*,⁸⁹ where the Court of Criminal Appeal found that, while mere proximity to a prohibited article does not automatically equate to possession, on the facts of the case, the proximity of the applicants to the objects, i.e. that they were sitting directly beside the firearms which were on open display, was sufficient to support an inference of possession.⁹⁰ There is also some support for the proposition that control may be inferred where the ~~con~~ item in question is not actually found on

⁸³ Ronan Barnes, *Joint Enterprise, Section 15 (A) of the Misuse of Drugs Act 1977 and the Meaning of ‘Possession’* 23(3) ICLJ 70, 74.

⁸⁴ [2006] IECCA 110.

⁸⁵ Ronan Barnes, *‘Joint Enterprise, Section 15(A) of the Misuse of Drugs Act 1977 and the meaning of “Possession”* (2013) 23(3) ICLJ 70, 72.

⁸⁶ Finbarr McAuley and J. Paul McCutcheon, *Criminal Liability* (Round hall 2000) 208.

⁸⁷ *The People (DPP) v Tanner* [2006] IECCA 151.

⁸⁸ Finbarr McAuley and J. Paul McCutcheon, *Criminal Liability* (Round hall 2000) 229.

⁸⁹ *The People (DPP) v Foley* [1995] 1 IR 267

⁹⁰ Conor Hanley, *An Introduction to Criminal Liability* (3rd edn., Gill & McMillan 2015) 54. See also *R v Whelan* [1972] NI 153 which was distinguished from *Foley* on an evidentiary basis that the applicants had no knowledge of the concealed weapons, though they were in the same room as them, and that no such inference could be drawn.

anyone's person.⁹¹ For instance, an inference of possession may be drawn where a prohibited item is found within a person's dwelling.⁹² Similarly, the owner of a car will be assumed to possess the items within said car.⁹³

Knowledge is the second element relevant to possession. The law on this matter seems to be well settled. Where a person is unaware that a substance is under his dominion then he cannot, in the legal sense, be said to possess it. This eliminates the culpability, for example, of someone who has an illicit substance planted on them. In *People v Nugent and Byrne*,⁹⁴ the Court allowed an appeal on the basis that the onus was on the prosecution to prove that the defendants knew about the stolen money located within the vehicle. This judgment was then applied in the later case of *Minister for Posts and Telegraphs v Campbell*,⁹⁵ where Davitt P. concluded that the evidence before the court was consistent with the proposition that the unlicensed television was placed in the cottage without the defendant's knowledge. Hanly notes that the view that has emerged over time is that the prosecution must prove that the accused knew of the existence of the substance in order to establish possession, but this knowledge is not necessary to establish the *actus reus* of possession.⁹⁶

Proof of knowledge was also pivotal in the determining of *R v Whelan* and *People v Foley*.⁹⁷ In *Whelan*, the Court could not conclusively determine which of the three appellants, though it was highly likely that it belonged to at least one of them, possessed the gun and ammunition which had been discovered concealed on top of a cupboard during a police raid. Some additional evidence would have been required to make such a determination. *Foley* was distinguished from *Whelan* on the basis that, when the police discovered the defendants, the guns were in plain sight and that, in those circumstances, it was open to the court to draw an inference that the occupants were in possession of the items.

⁹¹ *ibid* 54.

⁹² *Minister v Campbell* [1966] IR 69; it is worth noting that on the facts of the case, there was insufficient evidence to conclude that the cottage in question was indeed the defendant's dwelling, and so no inference of possession for the unlicensed television could be adduced.

⁹³ *The People (Attorney General) v Nugent and Byrne* [1964] 98 ILTR 139.

⁹⁴ *ibid*.

⁹⁵ *Minister v Campbell* [1966] IR 69.

⁹⁶ Conor Hanley, *An Introduction to Irish Criminal Law* (Gill Education 2015) 56.

⁹⁷ *R v Whelan* [1972] NI 153; *The People (DPP) v Foley* [1995] 1 IR 267.

A more contentious issue, however, is whether the prosecution needs to show that the accused knew, not only of the object's existence, but also the nature of it.⁹⁸ Though the line has become apt to being blurred, particularly within the Irish jurisprudence, it seems to be settled that only knowledge of existence is necessary to prove possession.⁹⁹ Lord Pearce summarised the majority view in *Warner v Metropolitan Police Commissioner* in the following classic statement:

“Though I reasonably believe the tablets I possess to be aspirin, yet if they turn out to be heroin I am in possession of heroin tablets. This would be so I think even if I believed them to be sweets”.¹⁰⁰

These sentiments were reiterated in *R v McNamara*, in which the court determined that it was not necessary for the prosecution to prove that the defendant knew the nature of what was in the container in his possession- he knew the box contained something, even if he did not realise that it was cannabis.¹⁰¹

Within Irish case law the issue is somewhat more unclear. As averted to above, in *Tanner*,¹⁰² the Criminal Court of Appeal defined possession as requiring “awareness on the part of the accused of the nature of the substance or recklessness as to what the object is”.¹⁰³ However, the decision in *DPP v Healy, Byrne and Kelleher* seems to endorse the positions in *Warner* and *McNamara*.¹⁰⁴ Furthermore, the Court approved of McAuley and McCutcheon's statement that only knowledge of existence is required in *The People (DPP) v Ebbs*.¹⁰⁵ It may therefore be suggested, in order to establish possession, that the prosecution must prove knowledge of the existence of the container or substance, and while proof that the defendant was aware of the contents of the container or nature of the substance may be required for a conviction of the particular offence, such knowledge is not, however, necessary in

⁹⁸ Finbarr McAuley and J. Paul McCutcheon, *Criminal Liability* (Round hall 2000) 215; Gerard Coffey, 'An Evaluation of "Possession" in the Construction of Criminal Liability' (2016) 26(4) ICLJ 108,111; Conor Hanley, *An Introduction to Irish Criminal Law* (Gill Education 2015) 55.

⁹⁹ *ibid* 21.

¹⁰⁰ [1969] 2 AC 256, 305.

¹⁰¹ [1988] 87 Cr. App. R. 246.

¹⁰² *The People (DPP) v O'Shea* [1983] ILRM 549; *The People (DPP) v Kelly* (CCA, 11 July 1996)

¹⁰³ *ibid*.

¹⁰⁴ *The People (DPP) v Healy, Byrne and Kelleher* [1998] 2 IR 417

¹⁰⁵ [2011] 1 IR 778, 786-87.

establishing the physical element of possession.¹⁰⁶ This view, however, seems to be somewhat convoluted, and although it may find some resolution in s. 15 of the 1977 Act, it would benefit from more precise judicial clarification regarding which circumstances require what proof. This would mitigate some of the confusion and conflicting precedents that have arisen with regards to possession and containers within Irish law.

Conclusion

The Misuse of Drugs Act 1977 is an important legislative instrument in the criminalisation of drug related offences, particularly with regards to possession and intent to distribute. To this end, such criminalisation also serves a more pragmatic function in that proof of, say, possession, is far easier to ascertain than that of use.¹⁰⁷ The Courts have shown a dynamic approach in their interpretation of possession and the specific elements thereof, which is also reflective of the provisions laid out in statute. This may also be extended to the judicial reasoning given to the sentencing of such offences. A wide range of penalties are available under section 27 of the Misuse of Drugs Act. This range provides broad guidelines for sentencing while also allowing judges to exercise their judicial discretion and impose an appropriate and just sentence with due regard to the gravity of the offence and the personal circumstances of the offender. On the surface, the law in this jurisdiction appears to set out a comprehensive framework, both through legislative and judicial means, with respect to the offence of possession, intent to distribute and other drug related offences, along with the sentencing of these offences, that serves to expedite enforcement.

The end effect of this comprehensive framework, however, appears to evoke a pro-prosecution based system which, it may be argued, perhaps reflects the moral standpoint in relation to drugs and their use which has historically been prevalent in this jurisdiction. Possession is very much seen as an offence and is treated as such under the law, requiring punitive or rehabilitative sanctions. This is not to say that the system entirely does not seek to

¹⁰⁶Conor Hanley, *An Introduction to Irish Criminal Law* (Gill Education 2015) 56; the distinction between knowledge of the nature of the substance in one's possession and the nature of a substance contained within a container or box is worth noting. With regards to nature, the Courts seem to have settled that every physical aspect of the substance must be distinct in order to avoid criminal liability. With respect to containers, it is generally accepted that the defendant will be in possession of the contents of a container if he knew, or reasonably ought to have known, that there was indeed something in it. No criminal liability will be attached to a person who believed the container to be empty. See also *R v Hehir* [1895] 2 IR 709; *R v Wright* [1976] 62 Cr. App. R. 169

¹⁰⁷ Charles H. Whitbread and Ronald Stevens, "*Constructive Possession in Narcotics Cases: To Have or Have Not*" (1972) 58 Va. L. Rev. 751, 753-54

find a balanced approach, as seen with the legislative provision of defences and with the drive for proportionate sentencing, as well as clear criteria set out in order to establish the offence of possession. Yet, as with many aspects of the law, the provisions governing possession and particularly the system in place which works to implement these provisions, could benefit from reform.

III: Analysis of Key Issues in Ireland

Ellen Hennessy

For the purpose of providing a comprehensive and multi-faceted analysis of current drug policy it is important to focus on the key issues faced in Ireland. Focusing on a community perspective highlights the different ways the drug problem in Ireland manifests itself due to certain economic and social factors that are characteristic of different areas. This report will cover the recent report of the Illicit Drug Markets in Ireland 2014, previously referred to in Part I, commenting on the report and its findings, deducing fundamentally where, why and how the drug problem has presented itself.

Drug Problem in Communities

Drug use is a societal issue which affects countless communities across Ireland. Strong socio-economic links can be drawn between poverty, deprivation, inequality and drug use.¹⁰⁸ It has been found that drug use is statistically more common in early school leavers, early school leaving being a problem strongly linked to under privileged, impoverished areas.¹⁰⁹ The Risk and Protection Factors for Substance Use Among Young People Report¹¹⁰ conducted by NACDA found that 1% of early school leavers had taken other drugs (such as psychedelics, cocaine, heroin) compared to 11% of school goers.¹¹¹ Unemployment rates, troubled family bonds, lack of community resources and educational opportunities weaken the social fabric of communities resulting in the marginalization of people in society. Low levels of further education are often associated with problem drug use.¹¹² Educational disadvantage can worsen existing problems of social exclusion adding to a society that encourages drug use

¹⁰⁸ Johnny Connolly and Anne Marie Donovan, 'Illicit Drug Markets in Ireland' (NACDA 2014) 260 <<https://www.nacda.ie/index.php/press-releases/174-nacda-illicit-drug-markets-in-ireland.html>> accessed online 27 January 2019.

¹⁰⁹ Luke Cassidy, 'Drug abuse higher for early school leavers' *The Irish Times* (29 October 2010) <<https://www.irishtimes.com/news/drug-abuse-higher-for-early-school-leavers-1.669543>> accessed online 27 January 2019.

¹¹⁰ Trutz Haase and Dr. Jonathan Pratschke, Risk and Protection Factors for Substance Use Among Young People 2010 <www.drugs.ie/resourcesfiles/research/2010/RiskYoungPeopleSchool.pdf> accessed 27 January 2019>.

¹¹¹ *ibid* 12.

¹¹² Flynn S, 'Literacy and numeracy crisis in disadvantaged schools' *The Irish Times* (28 March 2005).

rather than discourages it. These people who are at the margins of society are most at risk of developing a drug problem.¹¹³

Illicit Drug Markets in Ireland 2014 Report

In Ireland today, drug use is widespread across many different communities. A 2014 report, the first of its kind in Ireland, sought to analyze the growing drug problem by investigating different drug markets.¹¹⁴ The report sought to investigate various social factors that lead to the development of a drug market and visible drug use in a community. The four sites selected for the study were areas across Ireland lacking in various community facilities and infrastructure. The report lends itself to the common assumption that areas most prone to drug abuse seemed to fall along poverty lines due to a number of social problems in disadvantaged areas. It demonstrates clearly the types of communities commonly afflicted by drug use. The report identifies key features in these communities on how the drug markets operate and the problems that arise from drug use. The markets were selected based on geographical and economic factors culminating in a comprehensive report on the nationwide drug problem. The four sites were selected labelled A to D offer an insight into the drug problem facing four different communities in Ireland. The findings of the report are as follows.

Site A

- Site A was a suburban town with a population of approximately 40,000 people. Of the residents in site A more than one in ten were unemployed and 29% of the whole areas housing was owned by the local authority. 90% of residents surveyed were concerned about the drug abuse problem in their area.
- The residents found that the lack of amenities for young people was a factor in the widespread drug presence in their area. Unemployment and easy availability of drugs was found to add to the drug problem in the area.
- The report concluded that the main drugs sold and used in site A were heroin, cocaine, crack cocaine and cannabis.

¹¹³ Shaw, Egan, Gillespie et al, 'Drugs and Poverty: A Literature Review' (Scottish Drugs Forum, Scottish Association of Alcohol and Drug Action, March 2007).

¹¹⁴ Johnny Connolly and Anne Marie Donovan, 'Illicit Drug Markets in Ireland' (NACDA 2014) 260 <<https://www.nacda.ie/index.php/press-releases/174-nacda-illicit-drug-markets-in-ireland.html>> accessed online 27 January 2019.

- Site A shows the drug problem in Ireland from a disadvantaged, disservice community experiencing high unemployment and anti-social behavior.

Site B

- Site B represented two electoral districts, a small rural town with a population of 2,000 and a rural hinterland with a population close to 10,000.
- The commonly available drugs in site B were cocaine, cannabis, ecstasy and heroin. - Crack cocaine, in contrast to site A was not readily available.
- Site B's drug market emerged when supply and demand for heroin began to rise upon the release of criminals to the town having served prison sentences and had developed heroin addictions.
- Poor parental supervision, boredom and levels of unemployment were cited as a reasons for drug use in site B.

Site C

- Site C was an urban area with the deprivation ranking of the community ranking in the highest figures.
- The market of site C has existed for over 20 years operating primarily on the sale of cannabis and ecstasy.
- A black market also existed with selling of prescription medications such as benzodiazepine with forged prescriptions.
- Local residents cited unemployment, boredom and inadequate social amenities as reasons for drug use in their area.
- No type of illegal drug was openly sold at street level in any of the communities in the area. Transactions were arranged using mobile phones and drugs were exchanged at various locations convenient for buyers and sellers.

Site D

- Site D had a long history of drug use. The market and use in this area dated back to the 1970's.
- According to the findings of the survey the most widely available drug was found to be heroin.
- Crack cocaine and cocaine were commonly used drugs in the area also.

- Consistent with the findings of the previous sites investigated unemployment and low job opportunities ranked highest as the primary reasons for drug use in this area.
- This site had a sophisticated distribution chain often three or four levels to provide heroin, cannabis and cocaine to buyers in the market.

The findings of each site in the report are very consistent with one another. From the study there is a common thread of drug markets and drug problems emerging in deprived communities. Reasons such as unemployment, disenfranchised youth and lack of facilities are among the main reasons leading to the creation of drug problems across varying communities in Ireland. The 2014 report confirms the thinking that there is a correlation to be found between drug use and poverty. From a sociological and conceptual stand-point there are many reasons for this; social environment is highly influential on health and social behaviors of individuals.¹¹⁵ Factors such as governmental policies, taxation and employment are all closely linked to these social outcomes.¹¹⁶ The strong connection between poverty and drug use is compounded by a strong factor of social exclusion in communities similar to the sites surveyed across Ireland. The report helps inform the key factors leading to drug use in communities. It addresses key problems that need to be addressed in these areas and focuses on how the drug problem in Ireland should be addressed by identifying the problems faced.

Following from the 2010 report¹¹⁷, the National Advisory Committee on Drugs and Alcohol chairman drew on the strong links between rehabilitation and community based programmes to tackle problems directly in the community. He cited the importance of the National Educational Welfare Board, which works to counteract early school leaving and subsequent early drug use.¹¹⁸ Fundamentally the correlation between poverty and lack of education in future drug use has offered significant support in favour of a system of education and rehabilitation as opposed to criminalisation to tackle the drug problem in Ireland. Mr

¹¹⁵ Luke Cassidy, 'Drug abuse higher for early school leavers' *The Irish Times* (29 October 2010) <<https://www.irishtimes.com/news/drug-abuse-higher-for-early-school-leavers-1.669543>> accessed online 27 January 2019.

¹¹⁶ *ibid.*

¹¹⁷ Trutz Haase and Dr. Jonathan Pratschke, *Risk and Protection Factors for Substance Use Among Young People 2010* <www.drugs.ie/resourcesfiles/research/2010/RiskYoungPeopleSchool.pdf> accessed 27 January 2019>.

¹¹⁸ Deborah Condon, 'More Drug Use Among Early School Leavers' *Irish Health* (30 October 2010), <<http://www.irishhealth.com/article.html?id=18130>> accessed 27 January 2019.

Corrigan, the chairman, stated that it is imperative that substance use education should be delivered in all secondary schools, youth reach and community training centres.¹¹⁹

Rural and Urban Divide

A 2017 report published highlighted problems identified by people across Ireland who were consulted on their views about the problems that should be addressed to inform the new National Drugs Strategy¹²⁰.

The issue of rural and urban communities was identified by participants. It was conceded that drug use is not a city problem focused primarily on the capital. It was overwhelmingly reported that drug use is widely prevalent across towns and villages in rural areas of Ireland. The problems faced in relation to these areas in tackling the burgeoning drug problem is the lack of treatment, information and rehabilitation services that are available to drug users. The services were found to be mostly city based and did not reach these rural areas affected. People were expected to travel long distances mostly to the city to avail of these services lacking in their own areas.

There were widespread calls to tackle the drug problem in rural Ireland by funding services that are commonly available in city locations.¹²¹ People seeking harm reduction services in the country are faced with additional costs incurred by travelling far distances. Rural isolation and poor transport infrastructure are major obstacles for those seeking help.¹²²

Drug Problems amongst the Homeless Community

The Simon Communities Snapshot Study Report found that over 50% of homeless individuals surveyed reported that they were current alcohol users, while 31% reported that they were current drug users¹²³. Given the prevalence of abuse amongst this particular group, it is imperative that any new drug policy include the homeless population as a specific target group to help. The highest level of drug use was found among people sleeping rough and

¹¹⁹ *ibid.*

¹²⁰ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

¹²¹ *ibid.*

¹²² Simon Community, 'Simon Communities Submission to Inform National Drug Strategy' (October 2016) 12.

¹²³ *ibid* 8.

those using emergency accommodation. Heroin is most frequently used amongst the homeless population, with more than 58% of survey participants reporting that they had used it before¹²⁴. Perhaps even more worrying, of the drug users who reported themselves as being currently using, 76% were using more than one¹²⁵. Drug abuse issues amongst the homeless community are often more complex to solve, as many in this population experience complex needs, including a dual diagnosis of mental health and problematic drug and/or alcohol use due to environmental factors, in particular a lack of supported housing¹²⁶.

Conclusion

In order to craft an effective drug policy, it is necessary that the government address the twin issues of poverty and drug abuse together. It must be recognised that drug abuse can arise due to a multitude of issues, including lack of facilities, unemployment, mental health issues, poor home environments, socialization and homelessness. This section has identified these factors as being some of the key issues in Ireland that must be addressed.

¹²⁴ *ibid.*

¹²⁵ *ibid* 9.

¹²⁶ *ibid.*

IV: Drug Policy in the EU

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This section will examine the approaches taken towards drug policy across Europe. It will consider the EU measures which are endorsed by member states such as Spain, the Netherlands and the Czech Republic as well as the deviations and alternative policy strategies adopted by EU member states as well as other European countries (Switzerland).

EU Legislation

Only around half of all countries in Europe specify drug use or consumption as an offence¹²⁷. For example in Italy there is no law explicitly making the use of drugs an offence and in Ireland and the United Kingdom it is only the use of prepared opium that is prohibited by law¹²⁸. However, all countries specify that the possession of drugs for any form of personal use is an offence, though there are varied ways in which this is defined¹²⁹. Furthermore all countries have laws prohibiting the production, trafficking, or selling with intent to distribute or supply.

The European Union (EU) Drugs Strategy (2013-20) is the ninth document on illegal drugs which has been endorsed by EU member states since 1990¹³⁰. The European Commission has been studying the drug phenomena across the EU for several years as the use of drugs, especially among young people, is at a historically high level¹³¹. The plan aims to direct collective action in the field of drugs within the European Union and at international level without imposing any legal obligations on EU Member States¹³². It sets out defined priorities,

¹²⁷ European Monitoring Centre for Drugs and Drug Addiction, 'Penalties for drug law offences in Europe' (22 September 2015).

<<http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance>> accessed 31 October 2018.

¹²⁸ *ibid.*

¹²⁹ *ibid.*

¹³⁰ EMCDDA, 'Perspectives on Drugs, The EU drugs strategy (2013–20) and its action plan (2013–16)' (May 2015).

<https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31 October 2018.

¹³¹ Survey coordinated by Directorate-General Communication, 'Youth attitudes on drugs, Analytical Report' (July 2011)

Available at <http://ec.europa.eu/commfrontoffice/publicopinion/flash/fl_330_en.pdf> accessed 31 October 2018.

¹³² EMCDDA, 'Perspectives on Drugs, The EU drugs strategy (2013–20) and its action plan (2013–16)' (May 2015)

<https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31 October 2018.

objectives and actions for the countries involved giving the Member States the freedom to develop their own national policies so they can place emphasis on their national priorities¹³³

The current Strategy aims to reduce both the drug demand and drug supply within the EU¹³⁴. It intends to do so through a range of new methods which include rehabilitation, social integration and recovery, whilst aiming to also reduce drug supply through the disruption of illicit drug trafficking and the dismantling of organised crime groups involved in drug production and trafficking. Unfortunately, “drug trafficking and drug production remain among the most profitable criminal activities for organised crime groups active in the EU¹³⁵.” The most popular drug in the EU is cannabis, with estimates that the total use of cannabis amounts to 2,000 tonnes per year and 682,000 seizures of cannabis reported in the EU in 2014¹³⁶. Cocaine is currently the second most widely used drug in the EU with member states seizing more than 61 tonnes of it in 2014 alone¹³⁷.

The Strategy is progressive in multiple ways. This is the first time, alongside the traditional drug policy aims of reducing supply and demand, that an EU Drugs Strategy has included the aim of the “reduction of the health and social risks and harms caused by drugs¹³⁸.” In order to achieve this, the Strategy has placed an increased importance on the social integration and recovery of previous drug users into communities; an issue of importance outlined in Part III. The expected increased emphasis on the care of drug users who are imprisoned will also help to achieve this aim. The Strategy aims to ensure that prisoners receive care that would be equivalent to the services provided by the health services within their own communities¹³⁹.

¹³³ *ibid.*

¹³⁴ EU Drugs Strategy (2013-20) OJ C 402. <<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:C:2012:402:FULL&from=EN>> accessed 30 November 2018.

¹³⁵ “Drugs Policy” (European Commission, Migration and Home Affairs, October 2018). <https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31 October 2018.

¹³⁶ *ibid.*

¹³⁷ *ibid.*

¹³⁸ “Perspectives on Drugs the EU drugs strategy (2013–20) and its action plan (2013–16)” (European Monitoring Centre for Drugs and Addiction, May 2015) <https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31 October 2018.

¹³⁹ EU Drugs Strategy (2013-20) OJ C 402, <<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:C:2012:402:FULL&from=EN>> accessed 30 November 2018, para. 19.6.

Furthermore, the Strategy calls for alternative approaches to traditional law enforcement methods to be used to combat drug crime¹⁴⁰. In a meeting in Brussels, Fay Watson (EURAD) stressed the need to consult with all parties active in the drugs field, including civil society, in order to achieve the aim of providing a “balanced and broad response to the issues presented by drug use¹⁴¹.” He emphasised the need for a range of responses to be developed to meet the needs of different target groups.

There is also the proposition that special attention is to be paid to communication technologies, which are playing an increasing significant role in the spread of drugs, as in the last few years the internet has been an online market for the sale of illegal drugs¹⁴².

Country Profiles

Spain

Drug consumption and possession for personal use in private are formally unlawful in Spain¹⁴³, yet have never been criminalised¹⁴⁴. Although Spain has adopted the 1961 UN Single Convention on Narcotic Drugs¹⁴⁵, the Spanish Criminal Code only criminalises drug supply activities such as cultivation, preparation and trafficking of scheduled drugs as well as possession of illicit drugs to facilitate the consumption of others¹⁴⁶. As consumption and possession for personal use fall outside the scope of this Act, they are not criminalised¹⁴⁷. However, possession for personal use or consumption in public areas, while not criminalised, can attract serious administrative sanctions for violating public order, ranging from €300 to

¹⁴⁰ “Perspectives on Drugs the EU drugs strategy (2013–20) and its action plan (2013–16)” (European Monitoring Centre for Drugs and Addiction, May 2015)
<https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31-October-2018

¹⁴¹ Jeff Lee, (2013) “The European Union Drugs Strategy 2013-2020” (European drug prevention quality standards Phase 2, September 2013)

¹⁴² “Drugs Policy” (European Commission, Migration and Home Affairs, October 2018).
<https://ec.europa.eu/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control_en> accessed 31 October 2018

¹⁴³ José Luis de la Cuesta and Isidoro Blanco, ‘Spain: Non-Criminalisation on Possession, Graduated Penalties on Supply’ in Nicolas Dorn and Alison Jamieson (eds.) *European Drug Laws: The Room for Manoeuvre* (Drug Scope, 2001)

¹⁴⁴ Delegación del Gobierno para el Plan Nacional sobre Drogas, *Plan Nacional Sobre Drogas: Memoria 1986* (Ministerio de Sanidad y Consumo 1986)

¹⁴⁵ 1967 Ley de Estupefacientes

¹⁴⁶ Article 368 of the Spanish Criminal Code

¹⁴⁷ Amber Marks ‘The Legal and Socio-Political Landscape for Cannabis Social Clubs in Spain’ (2015) Observatorio Civil De Drogas. <<https://www.qmul.ac.uk/law/media/law/docs/research/148791.pdf>> accessed 28-11-2018.

€30,000. These fines can be suspended if the charged individual agrees to attend a detoxification programme¹⁴⁸. In order to distinguish between possession for personal use (an administrative matter) and possession for sale or supply (a criminal offence), the standard of the average quantity required for individual consumption for 5 days, as set by the Spanish National Toxicological Institute, has been used by the Spanish Constitutional Court as a threshold for ‘personal use’.¹⁴⁹

An area of current controversy in Spanish drug policy is the legality of so-called ‘Cannabis Social Clubs’ or CSCs. Until 2015, the jurisprudence from the Spanish Constitutional Court suggested that CSCs, which cultivate cannabis non-profit for the use solely of members, were not unlawful, adopting an expansive view of ‘personal use’ that encompassed social supply in a ‘closed-circle setting’, especially as the closed nature of such clubs meant that the diffusion of cannabis to the general public was prevented. However, in the *Pannagh*¹⁵⁰ case, the Spanish Constitutional Court ruled that a Bilbao CSC had exceeded the philosophy of shared consumption due to its structure and presence of 300 members, thereby not having criminal immunity under the closed-circle doctrine. This ruling has currently left CSCs in Spain in a legal grey area, filled with uncertainty about their legal standing while awaiting legislative regulation. The prosecution of CSCs is largely based on political considerations, with some sympathetic prosecutors refusing to bring cases against CSCs while prosecutors in other regions continue to do so, even though the ‘overwhelming majority’¹⁵¹ do not result in convictions or penalties.

The Spanish drug policy contains a number of potential lessons to inform the future direction of Irish drug policy. Its treatment of drug possession for personal use as an administrative rather than criminal matter allows drug dependence and addiction to be viewed through a healthcare lens rather than a punitive lens. Defining drug quantities for ‘personal use’ in conjunction with

¹⁴⁸ Ley Organica 1/1992, de 21 de febrero, Sobre Protección de la Seguridad Ciudadana. See also Martín Barriuso Alonso, ‘Cannabis Social Clubs in Spain: A Normalizing Alternative Underway’ (2011) Series on Legislative Reform of Drug Policies Nr 9, 1.

¹⁴⁹ EMCDDA, (2015) ‘Threshold Quantities for Drug Offences’.
<<http://www.emcdda.europa.eu/html.cfm/index99321EN.html>> accessed 08-10-2018. See also Genevieve Harris, ‘Conviction by Numbers: Threshold Quantities for Drug Policy’ (2011) Series on Legislative Reform of Drug Policies Nr 14, 1.

¹⁵⁰ Judgment nr. 788/2015 of the 2nd Chamber of the Spanish Supreme Court

¹⁵¹ Amber Marks ‘The Legal and Socio-Political Landscape for Cannabis Social Clubs in Spain’ (2015) Observatorio Civil De Drogas. <<https://www.qmul.ac.uk/law/media/law/docs/research/148791.pdf>> accessed 28 November 2018.

the national toxicology body also makes charges more consistent but its lack of a contextual basis could be exploited by drug traffickers. Irish law, when considering whether possession of drugs in closed clubs like CSCs should be treated as ‘personal use’ under any future developments, should be clear and consistent to avoid the current uncertainty that exists in Spanish law in this area.

The Netherlands

Dutch drug abuse policies in The Netherlands include the rejection of law enforcement as the primary method of drug abuse deterrence, with exception made only to higher levels of trafficking of hard drugs. Drug policy in the Netherlands can be described as normalising, pragmatic and non-moralistic in its aims and falls in line with the anti-paternalistic theories discussed in Part I. The primary legislation giving rise to Dutch drug policy is the revised Opium Act 1976. The strategy of a separation of the markets and social contexts of soft and hard drugs is directed at reducing social and personal harms.¹⁵² Schedules I and II of the Act outline the divisions of substances presenting unacceptable risks (including among others opiates, cocaine, cannabis oil; codeine; amphetamines and LSD) and other substances (including tranquilizers and barbiturates; includes cannabis (without the qualification of unacceptability))¹⁵³ The tolerance principle (gedoogbeleid) set out in the Act provides for “non-conforming lifestyles, risk reduction in regard to the harmful health and social consequences of drug taking, and penal measure directed against illicit trafficking in hard drugs.”¹⁵⁴ Measures in the Penal Code can be implemented regarding the confiscation of illegal assets and the deterrence and prosecution of money laundering activities.¹⁵⁵

“Coffeeshops” sell cannabis for personal use and are considered compatible with the principle of tolerance: the aim is that the availability of small quantities of cannabis (sold in line with the criteria issued by the Prosecutor General) will deter experimentation with more dangerous

¹⁵² Ed Leuw, “Drugs and Drug Policy in the Netherlands” (1991) 14 *Crime and Justice: a review of research* 229.

¹⁵³ European Monitoring Centre for Drugs and Drug Addiction – Country Profiles: Netherlands <[¹⁵⁴ Ed Leuw, “Drugs and Drug Policy in the Netherlands” \(1991\) *Crime and Justice: a review of research* Vol 14 229.](http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=N>L accessed 11 October 2018.</p></div><div data-bbox=)

¹⁵⁵ European Monitoring Centre for Drugs and Drug Addiction – Country Profiles: Netherlands <<http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=NL>> accessed 11 October 2018.

drugs.¹⁵⁶ A surge in criminal activity surrounding coffeeshops in the 1980s and 1990s engendered an increase in regulation of these coffeeshops. Local authorities were convinced of the necessity to exercise more stringent control over them and to screen owners for potential criminal backgrounds.¹⁵⁷ A licensing system was first utilised as a means to regulate coffeeshops and cannabis sales in 1993.

Some observers have commented that attempts to eradicate drugs in society can isolate certain groups or individuals, and is more likely to cause social damage instead of preventing or curing it.¹⁵⁸ The Dutch system of regulation has a number of benefits. Customers can turn to legal providers, which would have the effect of reducing the market share for illegal operators. Regulation can enable the authorities to assess and gain more control of the risk of the product such as addiction or exploitation¹⁵⁹. The Dutch drug abuse policy exemplifies a system which has attempted to tolerate drug use within certain parameters and to implement initiatives which aim at preventing drug abuse, rather than criminalising it.

Switzerland

The revised 1951 Federal Law on Narcotics is the legal basis of Swiss drug abuse policy. The obligation to implement this law lies with the 26 cantons (member states of the Swiss federation). The methods of combating drug abuse are concretised in the four pillars of approach; prevention, therapy, damage limitation and repression.¹⁶⁰

A call for reform emerged in the 1980s stemming from widespread drug abuse which was linked to a huge increase in HIV cases.¹⁶¹ A 1994 extensive pilot programme in heroine-assisted therapy (HAT) was endorsed by the Swiss people in 1999 with a 54 % majority.¹⁶² The results of a research project which was carried out in the initial stages of the programme proved the benefits of HAT. The core elements carried out in the programme included on-site

¹⁵⁶ *ibid.*

¹⁵⁷ Toine Spapens, Thaddeus Muller, Henk van de Bunt, "The Dutch Drug Policy from a Regulatory Perspective" (2014) Springer Science + Business Media Dordrecht 196.

¹⁵⁸ Ed Leuw, "Drugs and Drug Policy in the Netherlands" (1991) 14 *Crime and Justice: a review of research* 230.

¹⁵⁹ Toine Spapens, Thaddeus Muller, Henk van de Bunt, "The Dutch Drug Policy from a Regulatory Perspective" (2014) Springer Science + Business Media Dordrecht 201.

¹⁶⁰ Martin Buechi, Ueli Minder "Swiss Drug Policy, Harm Reduction and Heroin-supported Therapy" (2011) Fraser Institute Digital Publication 3.

¹⁶¹ Joanne Csete, Peter Grob, "Switzerland, HIV and the Power of Pragmatism: Lesson for Drug Policy Development" (2012) 23(1) *International Journal of Drug Policy* 82.

¹⁶² *ibid* 83.

controlled injections, comprehensive medical, psychiatric, and social assessment and a comprehensive care programme.¹⁶³ The results of the programme of a group of 800 volunteer patients indicated general improvements to both somatic and psychological health. Homelessness reduced from 12% to 1%, permanent employment rate improved from 14% to 32%. Illicit use of heroin and cocaine quickly regressed although the use of cannabis and alcohol reduced only minimally.¹⁶⁴ Over time, 60% of patients that had left the programme chose to pursue further treatment which was either abstinence oriented or methadone-maintenance based.¹⁶⁵ There were 20 treatment centres with a total of 1194 treatment slots as of October 2000.¹⁶⁶

Despite UN-supported International Narcotics Control Board's criticism of the HAT trials and strong recommendation for verification and review from WHO, the EMCDDA has praised the Swiss efforts of combating drug abuse with an alternative strategy to law enforcement.¹⁶⁷

The Czech Republic

The Czech Republic is the only Eastern-European country to emerge from communist rule without inheriting a heavy-handed drug policy.¹⁶⁸ Following the establishment of democracy in the Czech Republic and a subsequent amendment to the country's Criminal Code in July 1990, the possession of narcotic drugs and psychotropic substances ceased to be a criminal offence, and this remained the law until 1998. Due to the country's growing drug scene and subsequent political pressure for the implementation of stricter drug laws, the government amended the Criminal Code, introducing penalties for drug possession in undefined "amounts bigger than small"¹⁶⁹, effective from 1999. A study conducted from 1999 to 2001 found that the new stricter law did not deter drug use, had no health benefits for society and was economically expensive for the country.¹⁷⁰

¹⁶³ Martin Buechi, Ueli Minder "Swiss Drug Policy, Harm Reduction and Heroin-supported Therapy" (2011) Fraser Institute Digital Publication 10.

¹⁶⁴ *ibid.*

¹⁶⁵ *ibid.*

¹⁶⁶ *ibid* 11.

¹⁶⁷ Joanne Csete, Peter Grob, 'Switzerland, HIV and the Power of Pragmatism: Lesson for Drug Policy Development' (2012) International Journal of Drug Policy, Vol 23 Issue 1 86.

¹⁶⁸ Joanne Csete, 'A Balancing Act: Policymaking on Illicit Drugs in the Czech Republic', Open Society Foundations.

¹⁶⁹ Zákon č. 112/1998 [Act No. 112/1998], 1998, Ref. No. 39/1998.

¹⁷⁰ T. Zábranský, V. Miovský, H. Gajdošíková, & M. Mravčík, 'Impact Analysis Project of New Drugs Legislation' (PAD) 2001.

In 2010 the country adopted a new Penal Code, which made possession of small quantities for personal use a non-criminal offence under the Act on Violations (Act No 200/1990), punishable by a fine of up to CZK 15 000. The Criminal Code has introduced a distinction between cannabis and other drugs for criminal personal possession offences: possession of a quantity of cannabis ‘greater than small’ attracts a prison sentence of up to one year while possession of other substances is punishable by up to two years’ imprisonment.

The country’s ‘National Drug Policy Strategy 2010-18’ is made up of four pillars: prevention; treatment and reintegration; harm reduction; and supply reduction.¹⁷¹ Since the introduction of the Criminal Code in January 2010, drug use among young adults and school children has reduced.¹⁷² Illicit drug use in the Czech Republic is primarily concentrated among young adults, with cannabis being the most commonly used substance. Prevalence of cannabis use amongst young adults in the Czech Republic is one of the highest in the EU, at 19.4%, compared to the EU maximum figure held by France of 21.5%.¹⁷³ One of the main problems associated with cannabis use in the Czech Republic is that because of its use, growth and supply are not legal, grow shop owners have been targeted in recent years by police raids despite having ran their businesses for years without their legality being disputed. As a result, many political parties are calling for a more liberal and state-regulated cannabis trade.

Despite criticism regarding high levels of cannabis use, the figures for problem drug use in the country are relatively low compared with other EU countries.¹⁷⁴ Almost 25% of approximately 37,500 problem drug users receive high-quality medical treatment, and when considering those receiving sterile injection equipment and blood testing, the figure is closer to 70%. As a result, the Czech Republic has been effective in minimising the real health, social and economic costs

¹⁷¹ European Monitoring Centre for Drugs and Drug Addiction (2018) ‘Czech Republic - Country Drug Report 2018’ <<http://www.emcdda.europa.eu/system/files/publications/8893/czech-republic-cdr-2018-with-numbers.pdf>> accessed 30 November 2018.

¹⁷² Ladislav Csémy & Pavla Chomynová, ‘An overview of the main results in the Czech Republic in 2011’, *Zaostřeno na drogy*, 10(1), 1–12.

¹⁷³ EMCDDA, ‘Key Statistics’ in ‘Czech Republic - Country Drug Report 2018’. <<http://www.emcdda.europa.eu/system/files/publications/8893/czech-republic-cdr-2018-with-numbers.pdf>> accessed 30 November 2018.

¹⁷⁴ EMCDDA, ‘Czech Republic - Country Drug Report 2018’. <<http://www.emcdda.europa.eu/system/files/publications/8893/czech-republic-cdr-2018-with-numbers.pdf>> accessed 30 November 2018.

that drug use can cause to society. This is an example of very cheap intervention leading to extremely successful and cost effective results.¹⁷⁵

Conclusion

The alternate models for drug policy across Europe could be sources of inspiration for further development of drug policy in Ireland. It is observed that the EU's current drug policy strategy emphasises the need for reducing health and social risks caused by harmful drugs as well as controlling circulation of illegal drugs. The EU's strategy has also indicated the significance of ensuring social integration and recovery of drug users. It identifies the contemporary challenge of rapid circulation of drugs and drug trafficking due to modern communication technologies. This strategy allows for a certain amount of deference to develop drug policy at a national level to ensure accordance with cultural differences and attitudes towards drug use in each member state.

Spain has seen a shift in policy to permit "personal use" of certain drugs. The concept of Cannabis Social Clubs initially enjoyed relative success although the uncertainty of regulation and political strife surrounding the "clubs" has left CSCs in a position of somewhat legal limbo. The Dutch policy of the separation of the markets and social contexts of soft and hard drugs is directed at reducing social and personal harm. The "tolerance principle" permits the provision of small quantities of cannabis in regulated institutions such as "coffeeshops". The legal provision of soft drugs strives to reduce the use of more harmful drugs. The Swiss drug policy aims at reducing harm through the "four pillars" approach. Heroin-assisted therapy treatment is considered in line with the "four pillars", enjoyed much success and was praised by the EMCDDA. The drug policy implemented by the Czech Republic has seen success with regards to the treatment of new and long-term high-risk drug users, and endorsement by major political parties of legalization of cannabis sees the country moving towards fairer laws regarding both its use and trade.

It must be considered whether the aforementioned measures could also be implemented within Irish drug policy in the future. The certain amount of deference afforded to EU member states as provided for in the EU Drug Strategy could enable such future developments in Ireland. The measures taken in certain European countries have shown to be successful in different ways,

¹⁷⁵ Pavel Bém, 'Drug Policy in the Czech Republic', The Beckley Foundation. <<http://beckleyfoundation.org/wp-content/uploads/2016/04/Dr-Pavel-B%C3%A9m.pdf>> accessed 30 November 2018.

although it must also be considered whether the steps taken in other countries would be compatible with Irish attitudes and legal structure.

IV.I Case Study: Portugal

Adam Elebert, Rory Gavigan, Ross Malervy

The Portuguese model of drug policy is radically different to that in Ireland. Yet progressive Irish legislators such as Lynne Ruane and the Social Democrats have pointed towards Portugal as being a model we should follow. In 2001, Portugal was in the midst of a heroin crisis and so undertook the challenge of solving this. In order to do this, the Portuguese state decriminalised all illicit drugs and heavily invested in both treatment for addicts and healthcare. Since that time, the heroin problem in Portugal has eased off dramatically and the drug policy has been hailed as a success by almost all commentators. In this section, we will examine the background to the approach taken by Portugal; the new sentencing measures in Portugal; and the possible administrative difficulties of implementing the policy into Irish law.

Drug Policy in Portugal pre-2001:

In order to fully understand the broad impact of the implementation of Portugal's policy of decriminalisation it is important to examine the pre-existing policy of criminalisation. Before the introduction of the radical policy, Portugal maintained a policy of criminalisation much the same as Ireland i.e. criminalisation of possession of drugs be that for personal use or for commercial purposes. Portugal developed a severe drug problem in the 1980s as a result of a brutal regime under Antonio Salazar which left the country thoroughly underprepared for the "drugs boom" that swept across Europe in the 1980s.¹⁷⁶ The approach of successive governments was prohibitive in nature and Portugal aligned itself with other countries by denouncing drugs as evil and sacrilege. Governments approached the problem with a quasi-religious approach, using national campaigns with slogans like "Drugs are Satan", "Just say no". These approaches had little impact and the country's problem lurched from bad to worse.¹⁷⁷

Context

¹⁷⁶ Tiago S Cabral, 'The 15th Anniversary of Portuguese Drug Policy: It's history, its success and its future' (2017) 3(0) *Drug Science, Policy and Law* 1, 3
<<https://journals.sagepub.com/doi/10.1177/2050324516683640>> accessed 7 January 2019.

¹⁷⁷ Susana Ferreira, 'Portugal's Radical drugs policy is working' *The Guardian* (5 Dec 2017) (<<https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it>> accessed 20th October 2018.

Portugal had a drugs history aligned with the rest of the world, having spearheaded a war on drugs approach until the turn of the century. In 1974, the dictatorship under Antonio Salazar ended and a newfound freedom swept into Portugal, with under this new found freedom a drug market was cultivated. In the interests of context, it is important to note that Salazar's policies and leadership were in accordance with traditional Catholic values which closeted any freedom of expression in Portugal. Salazar's values were enforced through a tough regime of censorship and imprisonment.¹⁷⁸ The disbanding of the colonies and ending of imperialism ushered in returning emigrants, bringing new drugs and different cultures to Portugal. The drugs revolution that followed was comparable to the drugs craze that swept the world in the mid 20th century.

In the 1980s, a shocking 1 in 100 were addicted to heroin.¹⁷⁹ Successive administrations took a particularly hard-line approach to drug dealers and introduced the now infamous mandatory minimum sentences which is associated with the malfunctioning U.S. drug policy.¹⁸⁰

Portugal followed a largely conventional narrative, taking a hard-line approach of outright criminalisation largely lead by a conservative majority with harsh punitive penalties. The government was vehemently against the commercialisation of drugs and policies were constructed with the intention of deterring drugs business. However, when the drug problem continued to press into the late 1990s, a more effective and radical approach had to be taken.

Portugal's New Approach To Sentencing:

Since 2001, the Portuguese approach to drug policy has been decriminalisation. All drugs, without exception, are now decriminalised. In Article 2(1) of the relevant legislation, it is laid out thus:

‘The consumption, acquisition and possession for one's own consumption of plants, substances or preparations listed in the tables referred to in the preceding article constitute an administrative offence.’¹⁸¹

¹⁷⁸ Hugh Kay, *Salazar and Modern Portugal* (1970 New York Hawthorn Books).

¹⁷⁹ Danna Harman, 'Portugal: when heroin was king' *Huffington Post* <https://www.huffingtonpost.com/danna-harman/when-heroin-was-king-ten-_b_897474.html> Accessed 17th October 2018.

¹⁸⁰ Caroline E. Sapp, 'Rehabilitate or incarcerate? A new comparative analysis of The United States' sentencing laws on low-level drug offenders and Portugal's decriminalisation of low-level drug offenses' [2014] 23 *Cardozo Journal of International and Comparative Law* 63.

¹⁸¹ Art. 2, Lei n. 0 30/2000 de 29 de November.

This is not to say that all drugs are therefore legal; illicit substances are still unlawful. Rather, the Portuguese legal system does not impose the same criminal sanctions on people found to be in possession of drugs for personal use as it once did. Instead of being a criminal offence, it is now simply an administrative violation. Instead of being subject to harsh fines and sentences of imprisonment, perpetrators are now given a mere warning, a small fine, or are referred to an administrative panel which is set up to deal with low level drug violations and decide on sanctions.¹⁸²

Supply centric political concerns might be mitigated by the fact that decriminalisation does not apply to the sale or trafficking of drugs. The measures of decriminalisation apply only “to the purchase, possession, and consumption of all drugs for personal use (defined as the average individual quantity sufficient for 10 days’ usage for one person).”¹⁸³ In keeping with the pragmatic and context-based approach to sanctions, Portuguese law also differentiates between users and addicts. A key example is Article 15, where it states “non-addicted consumers may be sentenced to payment of a fine or, alternatively, to a nonpecuniary penalty.” As well as this, if the user has no evidence of addiction or of repeated violations, the fine is suspended. Addicted persons are subjected to the slightly harsher sentences such as restriction on being in certain areas, and are strongly encouraged to attend addiction programmes which aim to help addicts in overcoming their substance abuse, while reporting back to the commission for progress reports.

While the possession of drugs is no longer a criminal offence, it is a mistake to assume that citizens now enjoy complete freedom in using illicit substances; the police are still expected to intervene in drug usage by confiscating the substances and issuing a citation. The question of sanctions, however, is left to what are called ‘Dissuasion Commissions’. The commissions are “comprised of three members: two representatives from the medical and social service sectors (e.g., physicians, psychologists, psychiatrists, or social workers) and one representative from the legal sector (e.g., lawyers)”¹⁸⁴. These commissions look at the amount of drugs that the user was found to be in possession of, and if that amount exceeds the 10 day personal use limit, they will refer the case to a criminal court for drug trafficking charges.

¹⁸² Lei n. º 30/2000, de 29 de November

¹⁸³Greenwald, ‘Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies’, (2009) Cato Institute.

¹⁸⁴ Jordan Blair Woods, ‘A Decade After Drug Decriminalization: What Can the United States Learn from The Portuguese Model?’, (2001) 15(1) University of the District of Columbia Law Review.

Otherwise, the Dissuasion Commissions deal with the sanctions themselves. Penalties include both fines and non-pecuniary penalties. Greenwald sums up the fines well: “[i]n theory, offenders can be fined an amount between 25 euros and the minimum national wage. But such fines are expressly declared to be a last resort. Indeed, in the absence of evidence of addiction or repeated violations, the imposition of a fine is to be suspended.”¹⁸⁵ While there are legal guidelines for the commissions to follow, which concern the nature of the drug usage before them and even the type of substance that the person was caught with, the commissions themselves enjoy a wide degree of discretion.

Penalties can include a ban on being in certain places which may be deemed ‘high-risk’ such as nightclubs, bans on interacting with certain people, warnings, suspensions of professional licenses, restrictions on travel and seizure of personal possessions.¹⁸⁶ The commissions look closely at the specific circumstances of the user in front of them and accordingly decide on the severity of the sanction. As well as this, commissions regularly engage in the practice of reducing or suspending sanctions if the user engages in drug treatment programmes of their own volition. While they have no specific power to force people to these programmes, in practice the suspension of sentences serves as an incentive for many to attend.

In summation, the Portuguese approach to sentencing in drug offences is one of administrative, rather than criminal nature. If one is caught with illicit substances, the drugs are confiscated and police issue a citation for a dissuasion commission. The commissions are non-judicial bodies of a non-criminal nature and have extraordinarily wide discretion to decide on sanctions. The purpose of these sanctions is not to inflict punishment on the drug-users, but rather to encourage them to reconsider their drug usage and, if needed, to attend addiction programmes.

Administrative Implementation of the Portuguese Drug Policy:

In July 2001, The socialist prime minister of Portugal Antonio Guterres introduced Law 30/2000, which decriminalised the consumption and personal possession of drugs.¹⁸⁷ Under this law, if a person is found with a small quantity of drugs, they will be examined by the

¹⁸⁵ Lei n.º 30/2000, de 29 de Novembro

¹⁸⁶ Arts. 15-18, Lei n. 0 30/2000 de 29 de Novembro.

¹⁸⁷ EMCDDA, ‘Portugal Drug Report 2018’ (2018)

<<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019.

local commission for dissuasion of drugs to see if they are in need of rehabilitative treatment.¹⁸⁸ Advocates for this law within the administration have emphasised that the law helps drug users to kick their habits, while freeing up police time to combat drug dealers.¹⁸⁹ Drug use is therefore not legalised *per se*, rather drug users are seen as having committed an administrative offence.¹⁹⁰

The main administrative body for controlling drug use in Portugal is the General-directorate for Intervention on addictive behaviours and dependencies (SICAD).¹⁹¹ SICAD is responsible for implementing the national drug policy of Portugal alongside disseminating information for drug users about safe practices. SICAD supports, plans and evaluates the Drug policy devised by the Inter-ministerial¹⁹² council for Drugs, Drug Addiction and Alcohol-related problems.¹⁹³ The Council and SICAD are quite symbiotic, as the Director general for SICAD is also the national co-ordinator for Drugs, Drug addiction and Alcohol related problems¹⁹⁴.

The Director general for SICAD is João Goulão who has been head of SICAD since its inception in 2012. Goulao has had a pivotal role in drug decriminalisation in Portugal, having previously been the head of the Institute of Drugs and Drug Addiction (IDT) before that body was merged into the wider National Health Service, forming SICAD.¹⁹⁵ Goulao was also the chairman of the European monitoring centre for Drugs and Drug addiction (EMCDDA) from

¹⁸⁸ *ibid.*

¹⁸⁹ Andrei Khalip, 'Once a model, crisis imperils Portugal's drug programme' *Reuters* (Davos, August 13 2012) <<https://www.reuters.com/article/us-portugal-drugs/once-a-model-crisis-imperils-portugals-drug-program-idUSBRE87C0N120120813>> accessed 2 November 2018.

¹⁹⁰ Nicholas Kristof, 'How to Win a War on Drugs' *The New York Times* (New York, 22 September 2017) <<https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html>> accessed 2 November 2018.

¹⁹¹ EMCDDA, 'Portugal Drug Report 2018' (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019, 13.

¹⁹² 'Minister' in most European states is synonymous with an upper level civil servant, subordinate to an elected member of the executive.

¹⁹³ EMCDDA, 'Portugal Drug Report 2018' (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019, 3.

¹⁹⁴ *ibid.*

¹⁹⁵ Andrei Khalip, 'Once a model, crisis imperils Portugal's drug programme' *Reuters* (Davos, August 13 2012) <<https://www.reuters.com/article/us-portugal-drugs/once-a-model-crisis-imperils-portugals-drug-program-idUSBRE87C0N120120813>> accessed 2 November 2018.

2010 to 2015.¹⁹⁶ SICAD is thus partners with its European counterpart EMCDDA, who are also based in Lisbon.

The National drug policy of Portugal can be devised into four stages. The original strategy was called the ‘National Strategy for the fight against Drugs 1999’ however this has been replaced by the ‘National plan for the reduction of Addictive behaviours and dependencies 2013-20’¹⁹⁷. The national plan is divided into ‘action plans’ of four years, one from 2013-2016 and the second from 2017-2020.¹⁹⁸ This new strategy was devised as the Council believed the 1999 strategy was confined exclusively to drugs and wished to combat all addictive behaviours and promote general health and wellbeing.¹⁹⁹ The action plans have numerous goals, such as decreasing new HIV infections and overall drug related mortality rates by 2016 , with further decreases projected for 2020.²⁰⁰

The results have been mixed. There has been a general downward trend of new HIV rates since 2000, and now only one in ten new HIV patients are drug users.²⁰¹ This may be attributed to the steps made by the National Health Service of Portugal to provide free Syringes for drug users, who have distributed over 54 million syringes from 1993 to December 2015.²⁰² Other measures have been less successful. A stated goal of the 2013 plan is to reduce drug overdoses by 10% by 2016 and by 30% in 2020.²⁰³ Unfortunately, drug

¹⁹⁶ Nicholas Kristof, ‘How to Win a War on Drugs’ *The New York Times* (New York, 22 September 2017) <<https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html>> accessed 2 November 2018.

¹⁹⁷ EMCDDA, ‘Portugal Drug Report 2018’ (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019.

¹⁹⁸ Portuguese Ministry of Health, ‘National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020’ (Executive Summary, June 2014) 8 <http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf > accessed 8 November 2018.

¹⁹⁹ *ibid* 9.

²⁰⁰ *ibid* 16.

²⁰¹ EMCDDA, ‘Portugal Drug Report 2018’ (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019, 10.

²⁰² *ibid*.

²⁰³ Portuguese Ministry of Health, ‘National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020’ (Executive Summary, June 2014) 16 <http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf > accessed 8 November 2018.

overdoses increased in both 2015 and 2016 rising to 5.8 per million population.²⁰⁴ This number however is still far below the European average of 20.3 deaths due to drug overdoses per million population.²⁰⁵ The visions of the 2013 plan which include lofty ambitions such as ‘humanism and pragmatism’ also include strategically important goals such as ‘territoriality’.²⁰⁶ Territoriality focuses on combatting addiction and dependency by going to areas where users congregate, distributing needles, testing drugs and providing medical and psychiatric help for those who desire it.²⁰⁷ This strategy, concomitant with existing drug decriminalisation and Public health initiatives means that drug users no longer fear arrest.²⁰⁸

A key problem for the administration is the strength of the commission for Dissuasion of drugs. When a drug user is apprehended, they are brought before a local commission composed of three members; one legal expert and two medical staff, often composing doctors, psychologists and social workers.²⁰⁹ The commission has very little power except that they may fine drug users or recommend them on for further treatment. The commissions sessions usually only last 15 minutes.²¹⁰ The commission attempts to combat drug addiction by seeing drug use as a medical problem, usually eschewing from punitive measures.

Conclusion:

The purpose of this section was to illuminate the situation in Portugal before the change, the current regime, and also to foresee any potential barriers to a smooth implementation of the system. As can be seen above, the approach has obvious benefits but is not a quick fix to the

²⁰⁴EMCDDA, ‘Portugal Drug Report 2018’ (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019, 9.

²⁰⁵ *ibid.*

²⁰⁶ Portuguese Ministry of Health, ‘National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020’ (Executive Summary, June 2014) 8 <http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf > accessed 8 November 2018.

²⁰⁷ Nicholas Kristof, ‘How to Win a War on Drugs’ *The New York Times* (New York, 22 September 2017) <<https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html>> accessed 2 November 2018.

²⁰⁸ *ibid.*

²⁰⁹ EMCDDA, ‘Portugal Drug Report 2018’ (2018) <<http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf>> accessed 27 January 2019, 4.

²¹⁰ Nicholas Kristof, ‘How to Win a War on Drugs’ *The New York Times* (New York, 22 September 2017) <<https://www.nytimes.com/2017/09/22/opinion/sunday/portugal-drug-decriminalization.html>> accessed 2 November 2018.

problems associated with drug abuse in Ireland today. Ultimately, however, there is little to prevent or dissuade a similar approach being implemented.

IV.II: Drug Policy in the US

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Within U.S. politics exists an established criminalisation culture in which policing and incarceration are the default tools used to deal with social issues. The ‘War on Drugs’ is the prime example. While Portugal decriminalized all drugs in 2001²¹¹, the U.S. continued to enforce its hard-paternalistic policy, maintaining tough mandatory minimums, long sentences and hefty fines. As a result of this approach, the United States now has the largest incarcerated population in the world²¹². Hundreds of thousands continue to struggle with health consequences of substance abuse, which thereby affects their overall economic, social and emotional well-being. While there has been a move towards decriminalisation and legalisation in US drug reform, past mistakes and current issues will offer a useful lesson to Ireland in drafting new drug reform policy. This section will comment on the U.S approach to the drug crisis by looking at the history of the ‘War on Drugs’, its costs and international reactions. Particular attention will be paid to the impacts of mandatory minimum sentencing, a measure which has been incorporated partially into the Misuse of Drugs Act 1977 in Ireland. As a preliminary note, the limitations of this paper must be recognised; this section does not intend to address *all* issues within the U.S. approach to criminalisation, rather it intends to provide an overview of the problems at hand.

History of ‘The War on Drugs’

The Prohibitionist Era

The War on Drugs movement can be traced all the way back to the Prohibition era, when ‘prohibitionists’ led by a Protestant movement, sought to end the alcoholic beverage trade in order to protect public safety, health and morals. The “dry” period began with the ratification of the 18th Amendment to the U.S. Constitution—which banned the manufacture, transportation and sale of intoxicating liquors²¹³. People took to different, alternative, and illegal routes to gain access to alcohol and criminal gangs seized control of the beer and liquor supply for many cities. Opposition mobilized nationwide, with organised groups arguing that prohibition had

²¹¹ Nicholas Kristof, ‘How to Win a War on Drugs: Portugal treats addiction as a disease, not a crime’ *The New York Times* (New York, 22 September 2017).

²¹² Jim Parsons, ‘Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis.’ (2017) The Vera Institute of Justice.

²¹³ History Editors, ‘Prohibition’ (A&E Television Networks, October 29, 2009) <<https://www.history.com/topics/roaring-twenties/prohibition>> accessed 29 October 2018.

led to crime, lowering of local revenues and improperly imposed “rural” Protestant religious values on “urban” United States²¹⁴. Prohibition ended with the dawn of the Great Depression when Franklin D. Roosevelt recognized the untapped market of alcohol production that could provide jobs and therefore spike the declining market²¹⁵.

The lessons learned from the Prohibition era in the United States refer closely to the faulty principle that exists behind criminalisation, the idea that prohibition and punishment will completely deter use of an illegal substance. The complete ban of alcohol allowed organised crime to seize control of a commodity and use it to fund their nefarious activities and grow in power- much in the same way the illegal drug trade has prospered in regions such as South America, where cartels have crippled local economies and allowed corruption to seep into the political process.

Drug Control 1950s-200s

A few decades after the Prohibition era, the country was focused on a civil rights movement led by men such as Martin Luther King Jr. During this politically disruptive period, a fear arose from the mainstream media and public of ‘Black Crime’ and the riots that had sprouted from the fight for equal rights. In 1964, the presidential candidate Barry Goldwater, laid the foundation for the “get tough on crime” movement in response. The U.S. failed to view Prohibition as a lesson in criminalisation, and instead began criminalising drugs at an accelerated rate. Consequently, incarceration disproportionately affected the African American communities, who were often profiled and targeted by law enforcement.

The Controlled Substances Act was passed in 1970 and by 1971, President Nixon became the first president to officially declare a “War on Drugs”²¹⁶, stating that illegal drugs were “public enemy number one”.²¹⁷ Nixon increased the presence and budget of federal drug control agencies and was a prominent advocate for mandatory sentencing. He further placed marijuana in Schedule One, the most restrictive category for drugs, interrupted attempts by state

²¹⁴ Margaret Sands Orchowski, *The Law that Changes the Face of America* (Rowman & Littlefield 2015) 32.

²¹⁵ History Editors, ‘Prohibition’ (A&E Television Networks, October 29, 2009) accessed 29 October 2018. <<https://www.history.com/topics/roaring-twenties/prohibition>>

²¹⁶ Peter Reuter, ‘Why Has US Drug Policy Changed So Little over 30 Years?’ (2013), *The University of Chicago Press Journals*, Vol. 42, No. 1

²¹⁷ Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. (New Press 2016) 48

governments to decriminalise marijuana.²¹⁸ Once elected, President Ronald Reagan continued to propose the policies on drug criminalisation. During his first term, he gave major speeches announcing new initiatives against drugs. Through the 1986 Anti-Drug Abuse Act, Reagan specifically targeted crack cocaine, initiating extremely harsh sentences. The Administration wanted to highlight the alleged “crack baby epidemic” in inner-city neighbourhoods, fraught with unemployment and deindustrialisation. These were the city’s poorest neighbourhoods, which were made up almost completely by racial minorities. Two years later, the 1988 Anti-Drug Abuse Act authorized public housing officials to evict any tenant who allowed any form of drug-related criminal activity to occur on or near the housing premises. This also eliminated federal benefits such as student loans. During this same time, FBI anti-drug funding increased “from \$8 million to \$95 million” and DEA anti-drug spending went from \$86 million to \$1,026 million.²¹⁹

With increasingly aggressive investigative and prosecutorial efforts, there was a sharp increase in the number and length of federal prison sentences served for drug offences. “By 1992 the average time served for drug offences in federal prison had risen to more than 6 years, up from about 2 years in 1980”.²²⁰ This theme continued with George H. W. Bush, who made drugs the subject of his first prime-time televised address in September 1989.²²¹ Bill Clinton then continued this trend by implementing the “three strikes and you’re out” Crime Bill in 1994. Consequently, this created more federal capital crimes, mandatory life sentences for some three-time offenders, and it authorized more than \$16 billion for state prison grants and expansion of state and local police forces.²²²

Drug Policy under the Obama Administration

In 2008, the Obama Administration took a step away from the history of criminalisation and instead began reformative measures to change the public perception of drugs abuse from being a crime, to being a health concern. Governmental efforts to control drug crime moved away

²¹⁸ “A Brief History of the Drug War.” *Drug Policy Alliance*, www.drugpolicy.org/issues/brief-history-drug-war.

²¹⁹ Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. (New Press 2016) 53

²²⁰ Jeremy Travis, Bruce Western, and Steve Redburn, ‘The Growth of Incarceration in the United States: Exploring Causes and Consequences’ (2014) The National Academies Press

²²¹ Jeremy Travis, Bruce Western, and Steve Redburn, ‘The Growth of Incarceration in the United States: Exploring Causes and Consequences’ (2014) The National Academies Press

²²² Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. (New Press 2016) 56

from marijuana and cocaine towards the crippling opioid and heroin epidemic that was sweeping across the nation. The president signed a bill in response to the epidemic that gave \$1 billion to fighting cases of heroin and opioid abuse in the realm of public health.²²³ Michael Botticelli, the leader of the White House Office of National Drug Control Policy, further stated “we can’t arrest and incarcerate addiction out of people”.²²⁴ In early 2016, President Barack Obama began pardoning and otherwise shortening the prison sentences for hundreds of federal inmates.²²⁵ While the noise of the 2016 election distracted from the Obama Administration’s response to the War on Drugs, it notably reshaped how drug abuse should be treated in the United States, turning a new page in US drug policy.

Current US Drug Policy

Obama began the process of decriminalisation in the United States; however, many of the harsh sentencing policies still remain for people struggling with drug abuse. Mandatory minimum sentencing, first introduced by Clinton is defined as a binding prison term for a particular length of time for people convicted of federal and state crimes. These sentencing laws first seemed like a quick-fix solution for crime but ultimately hindered courts by preventing judicial discretion in individual circumstances. Today, harsh mandatory minimum sentencing and the three-strike laws can lead to life in prison, or, due to the overly strict probation and parole rules, repeated incarceration. Research shows that these punishments are not effective.²²⁶

The three-strike rule, a relic of the Clinton Administration, can lead to a mandatory minimum sentence in excess of 25 years for non-violent drug offenders. In extreme cases, individuals can even be sentenced to life imprisonment without parole. This is the primary cause of mass incarceration, which has tremendous implications for the economic and social status of many in the US.²²⁷ Many commit crimes to support their drug habit or are arrested while using.

²²³ German Lopez, ‘How Obama Quietly Reshaped America’s War on Drugs.’ (*Vox Media*, 19 January. 2017) <www.vox.com/identities/2016/12/19/13903532/obama-war-on-drugs-legacy> accessed 29 November 2018

²²⁴ German Lopez, ‘How Obama Quietly Reshaped America’s War on Drugs.’ (*Vox Media*, 19 January. 2017) <www.vox.com/identities/2016/12/19/13903532/obama-war-on-drugs-legacy> accessed 29 November 2018

²²⁵ German Lopez, ‘How Obama Quietly Reshaped America’s War on Drugs.’ (*Vox Media*, 19 January. 2017) <www.vox.com/identities/2016/12/19/13903532/obama-war-on-drugs-legacy> accessed 29 November 2018

²²⁶ German Lopez, ‘Should America Legalize All Drugs? This Story Should Give Supporters Pause’ *VOX* (6 August 2018)

²²⁷ Bryan Stevenson, ‘Drug Policy, Criminal Justice and Mass Imprisonment’ (2011) The Global Commission on Drug Policies

Mandatory drug sentencing is also dramatically affecting the United States prison system, leading to exceptionally high rates of incarceration and unacceptable racial disparities within the criminal justice system.²²⁸ Overcrowding has become a key issue, with a 790 percent increase in prison population since 1980, almost half being related to drug related crimes.²²⁹ Low level dealers and users are filling the majority of this population, while “kingpins and distributors are still infiltrating the streets with drugs”.²³⁰ Rehabilitation and treatment for low-level users might be able to break the cycle, but this had failed to be a top priority for the current Administration.

Mandatory minimum sentencing impacts not only the prison system but it also takes a toll on drug offenders once they are released. While there are perceived social and community benefits from incarceration, these do not necessarily outweigh the potentially detrimental social consequences. Some negative effects include, broken families, loss of community income, and resentment toward legal and policing systems. Although it may seem counterintuitive, “research has shown that incarceration may actually increase crime.”²³¹ This can be from a number of reasons, including development of criminal networks while incarcerated, loss of employment, loss of stable housing, or even family disruption.²³² Of the more than 20,000 federal drug offenders who concluded periods of post-release community supervision in 2012, (the last year statistics are available), 29 percent either committed new crimes, or violated the conditions of their release.²³³

Despite a conservative incumbent government, nearly half of all US States have trended toward decriminalisation: “twenty-two states and the District of Columbia have decriminalized small amounts of marijuana. This generally means certain small, personal-consumption amounts are a civil or local infraction, not a state crime (or are a lowest misdemeanour with no possibility

²²⁸ Jim Parsons, ‘Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis.’ (2017) The Vera Institute of Justice

²²⁹ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 4

²³⁰ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 4

²³¹ Jim Parsons, ‘The Prison Paradox: More Incarceration Will Not Make Us Safer’, (2017) The Vera Institute of Justice

²³² Jim Parsons, ‘The Prison Paradox: More Incarceration Will Not Make Us Safer’, (2017) The Vera Institute of Justice

²³³ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 5

of jail time).”²³⁴ As previously mentioned, the Obama administration has planted the seeds to a new future of US drug policy. While it will take time to undo the past wrongs, a transition from criminal justice concern to a public health concern will strengthen the economic, social and emotional well-being of the country. By analysing evidence accumulated in the last five decades of the US response to drugs, as well looking to international examples, Ireland should choose policies that will make their country healthier and safer.

Costs and Effects of US Drug Policy

Mandatory sentencing for drug related crimes has not only had a detrimental impact on drug use and racial inequality, but it has also proven to be extremely costly. One study found that the increase in time served by drug offenders was the “single greatest contributor to growth in the federal prison population between 1998 and 2010, which surged taxpayer spending.”²³⁵ In a 2010 report published by the Cato Institute, Harvard economist Jeffrey Miron estimated that the cost of policing low-level drug possession offences exceeds \$4.28 billion annually, not including the massive additional costs of incarceration, supervision and court processing.²³⁶

State and federal spending on drug use reflects how the US has chosen to respond to the drug crisis, with punitive action. A 2009 report estimated that state and federal governments spent \$47 billion in 2005 on the justice-related consequences of substance use, compared to only \$8.7 billion spent on treatment, prevention and research combined.²³⁷ Evidence continues to demonstrate that an enforcement-led approach to drug use has not achieved its intended goals.

One common misconception is that increased drug enforcement policies limit the supply of drugs, leading to decreased usage. This can be very difficult to measure. One study evaluated one of the largest disruptions to the illegal drug supply in 1995 shut down 50% of suppliers’ materials used to produce methamphetamine nationally.²³⁸ Although the effects were dramatic,

²³⁴ ‘Marijuana Overview: Legalization’ (National Conference of State Legislatures, 13 November 2018) <<http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx>> accessed 30 November 2018.

²³⁵ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 6

²³⁶ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 7

²³⁷ Jim Parsons, ‘Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis.’ (2017) The Vera Institute of Justice

²³⁸ Jim Parsons, ‘Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis.’ (2017) The Vera Institute of Justice

it was short lived. The prices of meth quickly returned to “pre-intervention levels within four months”, and pre-intervention quality of the drugs returned within about 18 months, suggesting producers were able to find substitute materials quickly. Ultimately showing again, though heavy enforcement and policing can have some positive effects, they seem to be band-aid solution, quick and unsustainable.

Over the past few years there has been a continued increase in illicit drug use, which forces us to assess the current policies for tackling drug distribution and use. The current Opioid crisis across the States is a perfect example of this. This crisis points to the deadly increase in the use of drugs while demonstrating how mandatory minimum sentencing is not an effective deterrent, since there is an epidemic of use, abuse, and sharp increase of drug related overdoses.²³⁹ While drug related arrests have increased since the implementation of mandatory minimum sentencing, the availability and use of drugs in the United States has steadily remained unaffected.

International Reaction to the ‘War on Drugs’

In response to the failed attempts of the US government to control drug abuse, there have been social movements both within the US and across the globe calling for decriminalisation. Both the United Nations (UN) and World Health Organization (WHO) have stated their support and respect for movements to decriminalise drugs. In describing the benefits of decriminalisation, both entities recognize the urgently necessary cultural and societal shift in dealing with drugs, “not only does drug decriminalisation drastically reduce the number of people mired in the quicksand of the criminal justice system – it also, as the UN and WHO statement highlights, vastly improves public health. It decreases the stigma against people who use drugs and addresses the decriminalisation they historically face.”²⁴⁰ Perhaps no better message can properly bolster the argument than these international bodies calling for reform in stating, “[d]rug decriminalisation is a rational and fiscally sound policy rooted in health and human rights. Governments throughout the U.S. and around the world have an indisputable moral and

²³⁹ Leah Shirley, ‘Proposal to End Mandatory Minimum Sentencing for Drug Crimes and Decriminalize Possession of All Illicit Drugs’ [2017] Johns Hopkins Sheridan Libraries 3

²⁴⁰Suchitra Rajagopalan, ‘United Nations and World Health Organization Call for Drug Decriminalization’ (Drug Policy Alliance, 29 June 2017) <<http://www.drugpolicy.org/blog/united-nations-and-world-health-organization-call-drug-decriminalization>> accessed 30 November 2018.

scientific imperative to pursue it.”²⁴¹ A key example of this is the drug policy of The Netherlands (as discussed earlier), a nation that accepts that “hiding socially negative phenomena does not make them to disappear - on the contrary [it] makes them worse, because when concealed, they become far more difficult to influence and control.”²⁴²

Conclusion

The failures of U.S. drug policy have allowed generations of citizens to struggle in a vicious cycle of crime, drug abuse and imprisonment. As seen in “‘Not Criminals’, a report drawn up by the Ana Liffey Drug Project and the London School of Economics and Political Science, “there is “‘little evidence” that criminalising minor drug possession, acts as a deterrent to future drug use.”²⁴³ This section has examined the failures of US drug policy. With increasing costs, rising prison populations, a worsening racial divide and no meaningful decrease in drug use or drug activity, the ‘War on Drugs’ has been a failure. Hope may be placed in the movement of some states towards decriminalisation and legalisation of some drugs (namely marijuana), as representing a change in perspective of drug use and abuse. An examination of US drug policy provides the most effective argument against the idea that criminalisation and acting tough on drugs will deter the public from using, trading or producing illegal substances.

²⁴¹Suchitra Rajagopalan, ‘United Nations and World Health Organization Call for Drug Decriminalization’ (Drug Policy Alliance, 29 June 2017) <<http://www.drugpolicy.org/blog/united-nations-and-world-health-organization-call-drug-decriminalization>> accessed 30 November 2018.

²⁴²Peter Skelton, ‘Amsterdam Drug Laws’ (Amsterdam Info, 2018) <[https://www.amsterdam.info/drugs/.](https://www.amsterdam.info/drugs/)> accessed 30 November 2018.

²⁴³Conal Thomas, ‘Intent ‘should be key concern under drug decriminalization laws” (The Journal, 8 October 2018) <<https://www.thejournal.ie/new-study-sets-out-the-case-for-decriminalising-drugs-in-ireland-4273618-Oct2018/>> accessed 30 November 2018.

V: The Modern Drug Market

Lui Guiney, Aoife Cantrell

The Criminalisation of Newly Produced Drugs

The issue of Newly Produced Drugs (NPDs) first fell into the public eye with the rise of ‘headshops’ in the 2000s. Amongst the various drug paraphernalia sold in these stores, ‘designer drugs’ concocted in laboratories are sold that are designed to mimic the effects of more mainstream narcotics, many close cousins of MDMA²⁴⁴. Due to the fact that their chemical chains were slightly altered as compared to their mainstream counterparts, these drugs could not be considered as being officially banned. While many of these ‘legal-highs’ claimed to be safer substitute, their unregulated nature and lack of scientific oversight meant that this could not be guaranteed. These drugs made headlines after dozens of youths experienced adverse side effects or died²⁴⁵ and the Irish government has since sought to stitch up the legal loophole that allows for their creation and marketing.

The Misuse of Drugs Act 1977 and the Criminal Justice (Psychoactive Substances) Act 2010 are the principle pieces of legislation the Oireachtas have promulgated for regulating drugs in Ireland. Newly produced drugs (NPDs) are controlled in Ireland through two key mechanisms: S2(2) of the Misuse of Drugs Act 1977²⁴⁶ and the Criminal Justice (Psychoactive Substances) Act 2010. These will be discussed in turn.

Misuse of Drugs Act 1977

S 2 (2) of the Act vested power in the Government to declare any substance, product or preparation to come under the scope of the Act. This allows the Government to quickly declare a drug to be controlled and add it to the list of illegal substances under Section 2. This embodied a cat-and-mouse approach where the classification of a popular synthetic drug under the Act served only to result in the creation of an alternative synthetic drug for the older and illegal one. The issue regarding this form of *ex post* regulation is clear; it is inherently responsive and fails to prevent deaths before they occur. In an industry that is

²⁴⁴ Tome Wainwright, *Narconomics* (Ebury Press 2016) 168.

²⁴⁵ Adam Owens, ‘Irish teen (17) found dead in the street from “legal high”’ *Irish Independent* (Down, 14 April 2015) <<https://www.independent.ie/irish-news/irish-teen-17-found-dead-in-the-street-from-legal-high-31141809.html>> accessed 28 January 2019; Barry Roche, ‘Gardai believe new synthetic drug killed Cork teenager’ *The Irish Times* (Cork, January 18 2017).

²⁴⁶ S2(2) Misuse of Drugs Act 1977.

capable of responding to legislative change by merely creating a new unregulated drug, the Government's quick response to drugs merely created the incentive for NPD research and development teams to focus less on making the drug safe and more on making sure its chemical composition is legal.

In *Bederev v Ireland*²⁴⁷, the constitutionality of s 2 (2) was challenged on the basis that the Act outlined no principles or policies which should guide the Minister. Without such guidance from the legislature, it was argued that the Act blurred the fundamental distinction between Executive and the Legislature, allowing the Minister to perform a law-making function by declaring which substances would be controlled under the Act. The High Court's declaration of unconstitutionality was ultimately reversed in the Supreme Court, as the superior court sought to constrain the far reaching effects this would have had. While S2(2) survived its constitutional challenge, the increasing rate of NPDs is gradually rendering it ineffective.

Criminal Justice (Psychoactive Substances) Act 2010

In 2010, the government attempted to introduce a blanket ban on psychoactive substances. This ban came in the form of the Criminal Justice (Psychoactive Substances) Act.²⁴⁸ The Act criminalised the advertisement, supply and sale of a psychoactive substance and its scope of the statute was intentionally broad.²⁴⁹ The essential objective was to create a mechanism that would allow the law to be applied broadly against NPDs without having to provide an exhaustive list of substances. Theoretically, this approach may be somewhat sound, however its application has demonstrated it to be ineffective.

Law-making is often subject to the vagaries of the political process and therefore, often politicians, in an attempt to be perceived as proactive, create legislation which conceptually deals with issues of public concern "head on".²⁵⁰ In the case of the 2010 Act, at the time there was public concern over a proliferation of "head shops" selling NPDs. Barrett suggests that the

²⁴⁷ *Bederev v Ireland* [2015 IECA 38; [2016] IESC 34.

²⁴⁸ Criminal Justice (Psychoactive Substances) Act 2010, s 2 (2) gave exemption to caffeine, alcohol, tobacco and prescription medicines

²⁴⁹ David Barrett, 'How a Ban on Legal Highs Could Work' *Telegraph* (30th October 2014), <<http://www.telegraph.co.uk/news/uknews/crime/11197099/How-a-ban-on-legal-highs-could-work>> accessed 29 January 2019.

²⁵⁰ Burgess N, 'The Lost Symbol: A Semiotic Analysis of the Psychoactive Substances Act 2016' (2017) 7 *Aberdeen Student L Rev* 109

public's concern with headshops prompted the legislature to produce a piece of symbolic legislation, rather than a statute that would adequately address the needs of those suffering from psychoactive substance abuse.²⁵¹ Statutes which are categorised as symbolic have 'a layered structure of meaning: on the primary or literal layer of meaning, we find the conceptual content of the substantive provisions (rules of behaviour) and the provisions to secure.. compliance... whereas the secondary or symbolic layer contains immaterial values that are attached to this conceptual content'.²⁵² Van Klink typifies symbolic legislation as ambiguous and vague.²⁵³ The definition of 'psychoactive substances' provided by the 2010 Act is as follows;

"a substance, product, preparation, plant, fungus or natural organism which has, when consumed by a person, the capacity to; (a) produce stimulation or depression of the central nervous system, resulting in hallucinations or a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood, or (b) cause a state of dependence, including physical or psychological addiction."²⁵⁴

The use of the word "significant" is in itself rather ambiguous, the Act fails to provide any indication of what exactly satisfies the threshold of "significant". Moreover, the definition specifically designed to target newly developed synthetic drugs in its description of such drugs fails to use either of the words "new" or "synthetic".²⁵⁵ Consequently, the ambit of the legislation has not been accordingly reduced to deal with the primary focus of the Act- NPDs.²⁵⁶ The practical implication of this is that prosecutions made under the Criminal Justice (Psychoactive Substances) Act are difficult and as a result, few have succeeded.²⁵⁷ This further underpins the notion that while the legislation may be somewhat conceptually sound, it is not sound on a practical level.

Moreover, Losoya argues that the indiscriminate criminalisation of all psychoactive substances in NPD legislation has the potential to potentially negatively impact scientific research and

²⁵¹ David Barrett, 'How a Ban on Legal Highs Could Work' *Telegraph* (30th October 2014).

²⁵² B van Klink, 'Symbolic Legislation: An Essentially Political Concept' (Springer 2015) 22.

²⁵³ *ibid.*

²⁵⁴ S1(1) Criminal Justice (Psychoactive Substances) Act 2010.

²⁵⁵ Burgess N, 'The Lost Symbol: A Semiotic Analysis of the Psychoactive Substances Act 2016' (2017) 7 *Aberdeen Student L Rev* 112.

²⁵⁶ *ibid.*

²⁵⁷ 'Lack of Progress in Forming Government Means Delay in Closing 'Gap' in Drug Law' *The Journal* (April 9th 2016).

development, considering a significant proportion of such compounds potentially harbour properties of medical value.²⁵⁸ Usually, alternative synthetic drugs along with their changed molecular structure present varying effects – these effects can be subtle or dangerously drastic.²⁵⁹ However, in some cases, the alternative drug, developed to mimic another drug, has actually borne more preferable effects than its predecessor. Mephedrone (4-methylmethcathinone) was developed to provide a legal alternative to ecstasy (MDMA), which was in limited supply at the time.²⁶⁰ Mephedrone proved to provide the same effects as MDMA, however, the high was shorter and the comedown was softer.²⁶¹ Similarly, the original ‘legal-high’, benzylpiperazine (BZP), or BZP, first sold and produced in New Zealand was developed by Matt Bowden with the intention of creating a safe alternative to ecstasy after a family member died of an overdose²⁶². In 2008, the New Zealand government introduced a similar ban, and BZP was removed from the market, despite the fact that there had been no recorded death and it had been used by nearly one quarter of the New Zealand population²⁶³. A blanket ban on NPDs could eradicate the opportunity to research and highlight safer alternatives.

Equally, a blanket ban on psychoactive substances interferes with the NPDs for positive medical use. The 2010 Act provides a loophole enabling the Minister for Justice and Law Reform to, in consultation with the Minister for Health and Children, to approve exemptions to the application of the legislation.²⁶⁴ Most pharmaceutical products fall under the remit of ‘psychoactive substances’ and therefore, are categorically decriminalised. Pharmaceutical companies must apply for an exemption for whatever given compound they wish to research. This is a costly and time-consuming process. These burdens would be justified if it could be shown that proportionally the process of applying for an exemption was justified, but as will be seen, blanket bans have not shown to result in any decrease of drug use or deaths by overdose.

²⁵⁸ Losoya Z, 'Synthetic Drugs - Emergence, Legislation, and the Criminal and Legal Aftermath of Broad Regulation.' (2013) 66(2) SMU L Rev 423.

²⁵⁹ 'The Expanding Universe of Synthetic Drugs' *The Economist* (Amsterdam, 20th May 2017) <https://www.economist.com/briefing/2017/05/20/the-expanding-universe-of-synthetic-drugs>

²⁶⁰ *Ibid*

²⁶¹ Autonomous University of Barcelona, 'Combined immunomodulating properties of 3, 4-methylenedioxymethamphetamine (MDMA) and cannabis in humans' (Society for the Study of Addiction, 2007).

²⁶² Tom Wainwright, *Narconomics* (Ebury Press 2016) 172.

²⁶³ *ibid* 172-173.

²⁶⁴ S2(2) Criminal Justice (Psychoactive Substances) Act 2010.

Online Market for Drugs in Ireland

The ability to mask your identity and anonymise currency exchanges has revolutionised the modern drug trade, allowing dealers, manufacturers and customers to take their business online. It has further created a variety of headaches for national legislators, who do not have an international piece of drug legislation to cooperate with. Unfortunately, this area of the law in Ireland is lacking in empirical research due to the illegal nature and ethical implications of field work. However, the empirical research of other countries will be relevant as it can help to establish to the clearest picture of the cryptomarkets and the legal problems with controlling them. The ‘online revolution of drug trading’²⁶⁵ is the largest change in the legal landscape of drugs sale the world has seen in this century. The vast expansion has led to a legal lag in which the law struggles to catch up with the fast-paced ever changing online cryptomarkets.

Online markets for drugs, otherwise known as cryptomarkets, are online marketplaces that are part of the Dark Web, a heavily encrypted version of the internet, mainly devoted to the sale of illicit drugs. They combine tools to ensure anonymity of participants with the delivery of products by mail to enable the development of illicit drug trafficking.²⁶⁶ A cryptomarket employs from amongst a range of strategies to hide the identity of its participants and transactions, and the physical location of its servers. These include anonymisation services like Tor and I2P²⁶⁷ that hide a computer’s IP address when accessing the site; decentralised and relatively untraceable cryptocurrencies like Bitcoin and Litecoin for making payments; and encrypted communication between market participants via PGP²⁶⁸.

Silk Road

The site that started it all was Silk Road, created by Ross Ulbricht. This was a startup like no other, premised on the idealist libertarian mission statement of ‘Making the world a better

²⁶⁵ MC Van Hout & T Bingham, ‘Responsible vendors, intelligent consumers: Silk Road, the online revolution in drug trading’, (2014) 25(2) *International Journal Drug of Policy* 183–189.

²⁶⁶ J Brose ‘us et al, ‘Studying illicit drug trafficking on Darknet markets: Structure and organisation from a Canadian perspective’ (2016) 264 *Forensic Science International* 7.

²⁶⁷ J Aldridge, ‘Not an “eBay for Drugs”’: The Cryptomarket “Silk Road” As a Paradigm Shifting Criminal Innovation’, (May 13, 2014), available at SSRN <<https://ssrn.com/abstract=2436643> or <http://dx.doi.org/10.2139/ssrn.2436643>>.

²⁶⁸ *ibid.*

place'²⁶⁹ by allowing users to make their own decisions about what substances they wished to consume; while simultaneously protecting them from the threat of gangs and government control. This purported utopia of drug deals and more (contraband) came to an end when the FBI caught Ulbricht, spending two years attempting to reveal his identity. He was eventually convicted in 2015 and sentenced to life imprisonment without parole. On appeal to the Federal court a three-judge panel unanimously upheld the decision, however they also noted the policy on drugs is possibly in need of reform stating obiter;

“It is very possible that, at some future point, we will come to regard these policies as tragic mistakes and adopt less punitive and more effective methods of reducing the incidence and costs of drug use.”

The insight of this obiter comment is applicable to Ireland as it is the US. The policies ruin lives as much as, if not more so, than the prohibited substances themselves. Families which contain members who fall victim to drug addiction are pushed outside the law and this is a form of social ostracization which further erodes the family unit. As this is recognised in the Constitution as the fundamental unit of society policy makers must do more to ensure that the policies do not result in the unintended consequence of further harming those in need of help and support by inflicting harsh punishment for becoming involved in drugs.

The Current legal Position

The principal mode of regulation of the legality of the products purchased online comes from the 1977 and 2010 Acts. A variety of penalties are given, including tough repercussions for importing drugs. However, these traditional penalties have grown obsolete with regard to drug interactions that do not occur ‘face-to-face’ and for most dealers, the level of risk is significantly lower when dealing with the ‘*stealth-sophistication*’ of the cryptomarkets. When a buy meets a dealer on the street, or a drug smuggler attempts to import a batch of drugs into the country, they run the risk of being ‘caught red handed’. Online transactions have adapted to manage this risk, by conducting themselves through encrypted servers on platforms such as Tor browser. The currency used is likewise untraceable, being a Crypto currency like Bitcoin.

²⁶⁹ According to his LinkedIn profile, Ulbricht wanted “to use economic theory as a means to abolish the use of coercion and aggression among mankind.” See Andrew Norry, ‘The History of Silk Road: A Tale of Drugs, Extortion & Bitcoin’ *Blockonomi* (November 20 2018) <<https://blockonomi.com/history-of-silk-road/>> accessed on 30 November 18.

One of the benefits of face-to-face interaction in street trades is that it means quality can typically be assessed before purchase.²⁷⁰ The Online drugs trade has adapted to this by developing a ratings system that works in a similar way to review sites, such as Tripadvisor. The vendors attract clientele through reviews. The more positive the reviews and the number of people recommending a particular vendor the more likely they will send the real product, rather than burn one buyer and risk losing the reputation they have built. The comparison of ratings with street drug markets is the main point of interest for policy reform. The overall picture of drugs sales on the Dark Web sites is one of good quality and service, with issues of moral hazard less prevalent than one might initially surmise. Moral hazard problems with drugs trades on the street are well known. Moreover, poor product quality, and the likelihood of being ‘ripped off’ in purchasing drugs, seems to be less of a problem for drug consumers in street purchases.²⁷¹

Products; packaging/payment

The crypto dealer is extremely good at ‘stealth packaging’ which is how this issue of online drug proliferation has taken off. Packages received from the cryptomarkets are made of plastic, paper or adhesive tape.²⁷² The methods used are well thought out although expensive forensic analysis may lead to the detection of fingerprints or DNA traces.²⁷³ Interestingly, Van Hout and Bingham²⁷⁴ pointed out, through online interviews of vendors, many sellers are using latex gloves and masks to avoid leaving fingerprints or DNA traces into or onto packages. The packages of ordered products may lead to the detection of such traces for investigation purposes. This means that the area is highly sophisticated and unlikely to be easy to regulate. Recommendations for areas of reforms are, firstly; the Government should devise a strategy for regulating the cryptocurrency. Secondly; a committee of investigation into the Irish

²⁷⁰ *ibid* 5; Bhaskar, Linacre & Machin, ‘The economic function of online drugs markets’ [2017] *Journal of Economic Behaviour & Organisation*, <<https://www.sciencedirect.com/science/article/pii/S0167268117302007?via%3Dihub>> accessed 29 January 2019.

²⁷¹ *ibid*.

²⁷² *ibid*.

²⁷³ D Rhumorbarbe et al, ‘Buying drugs on a Darknet market: A better deal? Studying the online illicit drug market through the analysis of digital, physical and chemical data’ (2016) 267 *Forensic Science International* 173.

²⁷⁴ MC Van Hout & T Bingham, ‘Responsible vendors, intelligent consumers: Silk Road, the online revolution in drug trading’, (2014) 25(2) *International Journal Drug of Policy* 183–189.

cryptomarket for drugs should be set up. Thirdly; the penalties for importation should be improved to deter those who might be tempted to break the law in this manner.

Conclusion

The much needed in-depth research of this whole area of illegal activity is admittedly beyond the scope of this paper. Evidently, criminalisation, as an approach is not working. Criminalisation has instead proven only to push the realm of NPDs underground. While the Irish ban has succeeded in reducing the number of head shops, the businesses have seemed to merely have been pushed online. The proportion of young Irish people using legal highs has risen slightly since the ban, according to a survey by the European Commission²⁷⁵. A more practical and enlightened response seems to lie in the model used in New Zealand currently.²⁷⁶ This proposed model allows for NPD manufacturers to apply for permits and sell their drugs legally. Moreover, the model uses a categorisation system to classify drugs into varying bands depending on how dangerous their effects are.²⁷⁷ Reform is clearly needed and while this landscape of the law may be difficult to navigate, it is vital that a more practical and realistic approach is adopted in light of the fact that we do not live in a utopian society.

However, we can see that from the outset there is a real risk of drugs becoming more widely available to the ordinary consumer through the internet. The relative ease of access and anonymity creates a situation in which the average internet user can now come into contact with drugs with little to no risk at affordable prices. This new dawn of safe purchase and convenience will pose great challenges to the the legislature as the potentially unstoppable growth of these cryptomarkets threatens to engulf to street trade. If this trend did reach a tipping point, we could see in our lifetime a total wipeout of the traditional markets for drug sales and a dominance of the crypto market. With this in mind, we must find solutions with the focus on the long-term implications of this problem at the forefront of any policy or strategy.

²⁷⁵ As quoted, Karen McVeigh, 'Is Irish ban on legal highs driving markets underground?' *The Guardian* (30 June 2015) <<https://www.theguardian.com/society/2015/jun/30/risks-of-legal-highs-drive-bereaved-mother-to-campaign-for-uk-ban>> accessed 28 January 2019.

²⁷⁶ *ibid.*

²⁷⁷ *ibid.*

The conventional legislative approach, which has been employed to deal with traditional drugs in the past, has been rendered ineffective by the increasing rate of newly produced drugs (NPDs).²⁷⁸

²⁷⁸ Mandell J, 'Tripping over Legal Highs: Why the Controlled Substances Analogue Enforcement Act Is Ineffective against Designer Drugs' (2017) 3 University Illinois Law Review 1299.

VI: Drugs in Prisons in Ireland

Chloe Dalton, Caoilainn McDaid, Aoibh Cassidy

Over the last two decades, Ireland has seen a substantial increase in the size of its prison population, with the numbers in custody increasing by 68%.²⁷⁹ As of 2017, there were 3, 860 inmates in prison in the state. Most of those in prison are from deprived areas and vulnerable social groups.²⁸⁰ Unfortunately, drug users form a large portion of the overall prison population and while some prisoners do cease or reduce their use of drugs when incarcerated, others initiate or engage in more damaging behaviours upon entering the prison system. This poses many issues for the prisoners, who can be more at risk due to the poor quality of drugs available and the often unhygienic conditions in which they are used. With such a high proportion of the prison population having a drug addiction or drug misuse issue, prisons offer the opportunity to implement new drug policies and drug treatments in a controlled environment. However failures in drug policy may also be exacerbated by the lack of provision of addiction services and poor prison conditions.

This section will examine the following topics:

- the general situation of drug use in Irish prisons, with examination of statistics relevant to the area,
- the prevalence of blood borne viruses,
- the drug treatments currently available to offenders in Irish prisons,
- the provision of drug-free wings and detoxification wings in prisons, as well as the provision of addiction counselling,
- the availability of aftercare for addicted prisoners,
- the situation of prisoners post-release, with specific regard to the provision of accommodation,
- the impact addiction can have on the risk of recidivism.

Current Situation: Background

In order to fully comprehend the reality of prisons in Ireland, it is necessary to examine the characteristics of the prisoner population in Ireland. Unfortunately, it is difficult to find

²⁷⁹IPRT, 'Facts & Figures' (01 January 2019) <<https://www.iprt.ie/prison-facts-2>> accessed 29 January 2019.

²⁸⁰ *ibid.*

accurate, up-to-date information regarding the prison population in Ireland; the last thorough report on the backgrounds of prisoners is just over two decades old.²⁸¹ Internationally, a common feature of prison populations is that many inmates come from disadvantaged backgrounds plagued with social problems, and the evidence that we do have reveals that Ireland is no different.

The last study conducted into the social backgrounds of inmates found that over half of the prisoners in Mountjoy Prison came from six economically deprived areas in Dublin²⁸². Although there is a paucity of information regarding the socio-economic circumstances of prisoners in Ireland, more recent research has yielded comparable results even a decade later, showing that upon release from incarceration, there is a disproportionately higher number of prisoners reintegrating into the most deprived areas of the country as opposed to reintegration in the least deprived regions.²⁸³ When interviewed, many inmates in Mountjoy Prison, reported suffering trauma, intergenerational addiction, separation from family and deprivation.²⁸⁴ Furthermore, many prisoners have low levels of educational attainment; the Irish Prison Service conducted a survey among inmates in three different prisons between 2015 and 2017 which revealed that over a quarter of prisoners did not attend secondary school and 80% of inmates left school before completing a Leaving Certificate.²⁸⁵ A 2018 study also recorded that 17% of prisoners were homeless at the time of their incarceration.²⁸⁶ It is a common occurrence that those enduring hardship turn to substances to as a coping mechanism, and due to the relationship between the illegality of drugs and drug related crime, it follows that there is a disproportionate number of prisoners who have a history of addiction.²⁸⁷

²⁸¹ Paul O'Mahony, 'Mountjoy Prisoners: A Sociological and Criminological Profile' (1997) <<https://www.drugsandalcohol.ie/3464/1/616-mountjoy.pdf>>

²⁸² *ibid.*

²⁸³ Ian O'Donnell, Conor Teljeur et al, 'When prisoners go home: punishment and social deprivation and the geography of reintegration' (2007) 17(4) *Irish Criminal Law Journal* 3.

²⁸⁴ Mary Fennessy et al, 'Annual Report from Mountjoy Visiting Committee' (2016) <3 [http://www.justice.ie/en/JELR/Mountjoy_Prison_VC_Annual_Report_2016.pdf](http://www.justice.ie/en/JELR/Mountjoy_Prison_VC_Annual_Report_2016.pdf/Files/Mountjoy_Prison_VC_Annual_Report_2016.pdf)> accessed 28 January 2019.

²⁸⁵ Irish Penal Reform Trust, 'Progress in the Penal System: A Framework for Penal Reform' (2018) <<http://www.iprt.ie/files/PIPS2018.pdf>> accessed 28 January 2019.

²⁸⁶ Guatam Gulati, N Keating and et al 'The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses' (2018) *Irish Journal of Psychological Medicine* 1.

²⁸⁷ National Advisory Committee on Drugs and Alcohol, 'Main findings and recommendations arising from the study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prison population' (April 2014).

Current Situation: Drug Use in Irish Prisons

Having regard to the fact that inmates in Irish groups are deemed a high risk group when it comes to drug use²⁸⁸, it is necessary to get the full factual picture of drug use among prisoners. Among the prison population in Ireland, approximately 70% of inmates are characterised with having an addiction.²⁸⁹ In order to assess how resources need to be distributed to tackle the problem of drug abuse among inmates, Irish prisons have been placed into different categories based on low, medium, high and very high levels of drug use. Prisons with the lowest levels of drug use were Arbour Hill, Loughan House and Shelton Abbey. Prisons classified as having medium levels of drug use were Castlerea, Cork and the Midlands. Limerick (Male), Mountjoy, Portlaoise and Wheatfield are prisons with high levels of drug use, while Clover Hill, Dóchas and Limerick (Female) are prisons where there are very high levels of drug use.²⁹⁰

Among prisoners who reported drug use in the past year, 88% of cannabis users had used the drug while incarcerated, 84% of heroin addicts had the drug in prison and 53% of crack cocaine users were able to access the drug in prison.²⁹¹ While the rates of cannabis use were similar between males and females, use of heroin, methadone, crack cocaine, cocaine powder and benzodiazepines were greater among females rather than males.²⁹² Generally speaking, drug use was more prevalent with prisoners under the age of 35, however the use of cannabis and cocaine were more frequently used by younger prisoners in the 18-24 bracket, while heroin and crack cocaine were more commonly used by prisoners aged 25-34. A high fraction of lifetime opiate users had initiated drug use while in prison; 43% of heroin users and 38% of methadone users first became dependant while in prison.²⁹³

The Irish Prison Service recognises that drug abuse among prisoners is a complex, multifaceted problem and commits to both decreasing the supply of drugs into prisons while

²⁸⁸ *ibid.*

²⁸⁹ Sorcha Pollak, 'More than 70% of Prisoners have addiction issues', *Irish Times* (2nd February 2017) <<https://www.irishtimes.com/news/crime-and-law/more-than-70-of-prisoners-have-addiction-issues-1.2961144>>.

²⁹⁰ National Advisory Committee on Drugs and Alcohol, 'Drugs and Health in Irish Prisons 2011' (A Report for Prisoners, April 2014) <<https://www.drugsandalcohol.ie/21752/1/aNACDA-Drugs-and-Health-in-Irish-Prisons-.pdf>> accessed 29 January 2019.

²⁹¹ Irish Penal Reform Trust, 'Progress in the Penal System: A Framework for Penal Reform' (2018) <<http://www.iprt.ie/files/PIPS2018.pdf>> accessed 28 January 2019.

²⁹² *ibid.*

²⁹³ *ibid.*

reducing the demand of prisoners through various education and support programmes.²⁹⁴ The Irish Prison Service attempts to discern drug users at the earliest possible opportunity and offer medical support. The Irish Prison Service have reported an increase in the number of prisoners who come to prison already on a methadone maintenance programme who wish to continue in prison²⁹⁵. This should be viewed as a positive development, reflecting that there are lower levels of heroin use among prisoners compared to past decades.

Prevalence of Blood Borne Viruses

Associated with intravenous drug use is the prevalence of blood borne viruses (BBVs) such as Hepatitis B, Hepatitis C and HIV, which are disproportionately higher among prisoners than the general population. For instance, over half of intravenous drug users said that they had at some point shared drug paraphernalia, with 100% of female intravenous drug users sharing paraphernalia on at least one occasion.²⁹⁶ Over a quarter of inmates reported injecting drugs at one point, however, there was a considerably larger proportion of females who had a lifetime history of intravenous drug use, 44%, as opposed to 24% of males²⁹⁷. The findings of an investigation into the blood borne viruses among the Irish prison population show that the prevalence of BBVs among inmates was relatively low; 13% of prisoners had hepatitis C, with 2% of prisoners being HIV positive and 0.3% having hepatitis B²⁹⁸. The low prevalence of hepatitis B could be associated with the implementation of a new scheme by the Irish Prison Service which provided hepatitis B vaccinations to prisoners who have a sentence with a duration longer than eight months.²⁹⁹

Conclusion

While considerable improvements have occurred over recent decades with the approach to drug use in Irish prisons, there is still more progress to be made. Prisoners have demonstrated that when services are made available to them, they will use them. For example, 90% of prisoners who needed addiction counselling went to see a counsellor if one was available,

²⁹⁴ Irish Prison Service, 'Keeping Drugs Out of Prisons Drugs Policy & Strategy' (Dublin, 2006), <<https://www.drugsandalcohol.ie/11662/>> accessed 29 January 2019.

²⁹⁵ *ibid.*

²⁹⁶ Irish Penal Reform Trust, 'Progress in the Penal System: A Framework for Penal Reform' (2018) <<http://www.iprt.ie/files/PIPS2018.pdf>> accessed 28 January 2019.

²⁹⁷ *ibid.*

²⁹⁸ *ibid.*

²⁹⁹ Shane Allwright, Fiona Bradley and others, 'Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey' [2000] 321 *BMJ* 78.

80% of prisoners availed of detoxification programmes if they were able to and the participation of prisoners in programmes like Alcoholics Anonymous and Narcotics Anonymous was very high.³⁰⁰ However only four out of every ten prisoners who wished to be on a drug free wing were able to avail of one, and only 20% of prisoners who needed to detox from benzodiazepines were able to access one³⁰¹. This shows that more investment into resources for prisons to cope with drugs is not only necessary, but would have a large impact on prisoners who would utilise all supports available to them while imprisoned.

Approaches to Drug Treatments in Prison

The Irish Prison System offers ‘multidimensional drug rehabilitation programmes for prisoners’.³⁰² These programmes seek to change the offender’s perception of drugs through education, reduce the demand for drugs through treatment, and help the addicted offenders to become drug free through the rehabilitation services.³⁰³ The programmes that work in partnership with Community Based Organisations (CBOs)³⁰⁴ are estimated to cost the Irish Prison Services (IPS) 1.14 million euros per year.³⁰⁵ Throughout Ireland, six organisations are funded by the IPS to provide treatment programmes and services in Irish prisons. These organisations include The Harmony Project, Ballymun Youth Project, and Ana Liffey.³⁰⁶ It is a necessity that ‘comprehensive drug treatment options’ are available and ‘adequately resourced in all closed prisons in Ireland’.³⁰⁷ It is recommended that any new Irish approach preserve and/or improve the resources allocated to these programmes and organisations.

³⁰⁰ National Advisory Committee on Drugs and Alcohol, ‘Main findings and recommendations arising from the study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prison population’ (April 2014).

³⁰¹ *ibid.*

³⁰² Irish Prison Service, ‘Drug Treatment Services’ <<https://www.irishprisons.ie/prisoner-services/drug-treatment-services/>> accessed 20 October 2018.

³⁰³ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16 <http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³⁰⁴ *ibid* 19, these are funded by the IPS and Probation Services.

³⁰⁵ *ibid* 16.

³⁰⁶ These organisations are funded to by both the IPS and Probation Services to provide services in the community and in prison; the Harmony Project and Ballymun Youth Project provide modules in the Drug Treatment Programme in Mountjoy prison.

³⁰⁷ Department of Health, ‘New study on drug use in Irish prisons shows improvement in treatment provision and support services for prisoners’ (10 April 2014) <<https://health.gov.ie/blog/press-release/new-study-on-drug-use-in-irish-prisons-shows-improvement-in-treatment-provision-and-support-services-for-prisoners/>> accessed 19 October 2018.

Treatments Available to Offenders in Irish Prisons

Opioid substitution treatment, addiction counselling and detoxification are the main treatment programmes offered to prisoners in Irish prisons.³⁰⁸ Opioid substitution treatment involves prescribing ‘controlled amounts of longer acting but less euphoric opioids to reduce cravings and prevent withdrawal symptoms’.³⁰⁹ It aims to control rather than prevent drug use. Addiction counselling involves one to one counselling between the offender and a therapist and is often used in conjunction with opioid substitution treatment. There are two types of detoxification programmes offered to offenders in Irish prisons, which will be discussed below. Other treatments available include: group therapy, harm reduction, relapse prevention, gender groups, and meditation. Aftercare of the addicted offenders is also an important aspect of treatment. This involves access to addiction counselling and other services post-release for the entirety of the offenders life. Upon finishing treatment, ‘one-third will achieve total recovery, another one-third will manage their addiction safely, and around one-third will relapse’.³¹⁰ Relapse is often part of the cycle of recovery and in certain cases ‘multiple episodes of treatment may be necessary before a successful treatment outcome is received’.³¹¹ These figures, while successful, do suggest that it is important to support offenders in building ‘their own internal resilience and capacity to resist a return to addictive behaviours’, as when they leave prison drugs will be readily available in their environment.³¹²

In the Irish Prison System currently, there is a ‘drug treatment programme consisting of a core-multidisciplinary clinical addiction team’.³¹³ This is divided into three areas, and operates within a distinct and private unit of the prison. The division depends on the stage of the offenders treatment, and also contains a drug-free wing. The treatment programmes last around 8 weeks.³¹⁴ On arrival to the prison, all addicted prisoners will be assessed by a nurse,

³⁰⁸ National Advisory Committee on Drugs and Alcohol, ‘Main findings and recommendations arising from the study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prison population’ (April 2014) 19.

³⁰⁹ ‘The effectiveness of opioid substitution treatments for patients with opioid dependence: a systematic review and multiple treatment comparison protocol’ <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4171401/>> accessed 29 November 2018.

³¹⁰ National Advisory Committee on Drugs and Alcohol, ‘Main findings and recommendations arising from the study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prison population’ (April 2014).

³¹¹ *ibid* 30.

³¹² *ibid* 10.

³¹³ C O’Gráda, ‘Staff Perspectives on Drug Treatment Services in Prison’ (2010) 1, 4. <http://www.irishprisons.ie/images/pdf/cara_ograda.pdf> accessed 19 October 2018.

³¹⁴ For example The Drug Treatment Programme in Mountjoy is 8 weeks in length.

and before commencing a treatment programme, the offenders will be clinically assessed by a doctor.³¹⁵ The prisoners can discuss treatment options with medical staff, and addiction counsellors run preparation groups within prisons to ‘prepare offenders for the intensive group work they will face in a residential setting’.³¹⁶ Opioid substitution treatment³¹⁷ is the primary treatment provided in prison. It plays an ‘intrinsic role in supporting patients to recover from opioid dependence’.³¹⁸ The most commonly used substitute opioid is methadone. Methadone substitution treatment is available in 11 out of 14 prisons in Ireland. Opioid substitution treatment is also a part of the detoxification programme. Detoxification is becoming increasingly popular amongst prisoners.

Drug-Free Wings and Detoxification Wings in Prisons

Drug-free wings ‘are a form of residential correctional treatment programme with the objective of rehabilitating offenders with histories of illicit drug use’.³¹⁹ The prisoners residing in these wings are separated from the prison population and abstain from drug use.³²⁰ While these wings are effective,³²¹ it has been noted that more focus needs to be placed on increasing drug free areas in prison to ‘not only’ protect ‘against relapse occurring but also to protect non-dependent prisoners from exposure to drugs’.³²² A large gap exists between the availability of drug free-wings and the demand for them, which must be fixed in the future for progress to occur.³²³

³¹⁵ Irish Prison Service, *Health Care Standards* (2011) para 9.2.1.

<http://www.irishprisons.ie/images/pdf/hc_standards_2011.pdf> accessed 20 October 2018.

³¹⁶ Irish Prison Service, ‘Drug Treatment Services’ <<https://www.irishprisons.ie/prisoner-services/drug-treatment-services/>> accessed 20 October 2018.

³¹⁷ For example methadone. Methadone substitution treatment is available in 11 out of 14 prisons.

³¹⁸ ‘Clinical Guidelines for Opioid Substitution Treatment’ para 1.1

<<https://www.hse.ie/eng/services/publications/primary/clinical-guidelines-for-opioid-substitution-treatment.pdf>> accessed 29 November 2018.

³¹⁹ Drummond, A., Codd, M., Donnelly, N., McCausland, D., Mehegan, J., Daly, L. and Kelleher, C. ‘Study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prisoner population.’ (2014) Dublin: National Advisory Committee on Drugs and Alcohol para 2.5.3

³²⁰ *ibid.*

³²¹ Drug free units are effective in providing continuity of care on release, with 42% of offenders released from these units continuing the treatment.

³²² Department of Health, ‘New study on drug use in Irish prisons shows improvement in treatment provision and support services for prisoners’ (10 April 2014) <<https://health.gov.ie/blog/press-release/new-study-on-drug-use-in-irish-prisons-shows-improvement-in-treatment-provision-and-support-services-for-prisoners/>> accessed 19 October 2018.

³²³ *ibid.*, currently, 4 in 10 who needed access to a drug-free wing have access to one.

Detoxification is becoming more popular amongst prisoners as a form of treatment. Detoxification programmes are ‘currently centred on opiates’.³²⁴ There are two main types of detoxification programmes available within prison. The first is ‘detoxification off opiates using methadone’. This is an eight week programme for prisoners who are already ‘stable on 20mls or less of methadone’.³²⁵ As part of the detoxification, one to one counselling sessions and attendance at education programmes are a necessity.³²⁶ The second type of programme is a ‘slow detoxification programme’. This operates over six months, and similarly, those participating must attend one to one sessions with an addiction counsellor or psychologist.³²⁷ There are a limited number of ‘residential detox places available both in prison and in the community’.³²⁸ This led to the suggestion that more detoxification facilities should be available to prisoners in prison, pre-release, to help reduce the waiting lists for these programmes. It is a challenge when prisoners have completed the programme and must go back to the main prison. More support must be given to these prisoners.³²⁹

Addiction Counselling

Addiction counselling is also provided in prisons. For example, the organisation Merchants Quay Ireland (MQI) provides ‘one-to-one addiction counselling for prisoners, conducts assessments and makes referrals to CBOs’.³³⁰ There is a waiting list of up to three months in many prisons, for example Mountjoy. This is evidence that more funding and counsellors need to be provided to ensure that the offenders have access to this counselling and are benefiting from it while in prison. Ballymun Youth Action (BYA) also provides one to one

³²⁴A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 64
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³²⁵ *ibid.*

³²⁶ *ibid.*

³²⁷ *ibid.*

³²⁸ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 72
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³²⁹ For example peer led positive drug free environments within the prison, or transitions to community based rehabilitation programmes. See A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, para 11.9,
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³³⁰ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 47.
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

addiction counselling in prison. It is involved in pre-release preparation work for the prisoners, and continues the work that has been done while the prisoners were in the community. BYA runs the Drug Treatment Programme (DTP) in Mountjoy, which will now be discussed.

The Drug Treatment Programme

The DTP is run in Mountjoy Medical Unit.³³¹ The aim of the programme is ‘to assist participants in achieving drug free status’.³³² It is an eight-week programme, that operates five days a week. And if interested, the prisoner must be drug-free.³³³ The DTP takes prisoners from other Irish prisons into the programme, not just Mountjoy prisoners. Thus, there is ‘always a waiting list’.³³⁴ Protocols have been implemented to ‘streamline the referral and assessment processes’, for example prisoners nearing the end of their sentences are often given priority.³³⁵ There are eighteen places available on this programme, and there are five programmes run over the year, resulting in a total of ninety participants per year.

Aftercare for Addicted Prisoners

Aftercare is provided to the prisoners after their treatment, and the support programme lasts from six months to two years, depending on the organisation involved.³³⁶ In some circumstances, the support provided by the counsellors is indefinite. The prisoners are provided with access to addiction counselling for the duration of their life, and another organization provides prisoners with a ‘lifelong peer support programme’.³³⁷ Not all offenders who are provided with aftercare programmes ‘avail of it or complete it’.³³⁸ Studies have shown that it is important to integrate the model of aftercare into the treatment, and for

³³¹ Irish Prison Service, ‘Drug Treatment Services’ <<https://www.irishprisons.ie/prisoner-services/drug-treatment-services/>> accessed 20 October 2018.

³³² *ibid.*

³³³ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 66, <http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³³⁴ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 65. <http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³³⁵ *ibid.*

³³⁶ *ibid.*, 78.

³³⁷ *ibid.*, 79.

³³⁸ *ibid.*; an addicted offender must be linked with a community clinic before starting a drug treatment programme in prison, for example, opiate substitution, to ensure continuity of care upon release.

it to be mandatory.³³⁹ CBOs, such as MQI, discuss and form an aftercare plan with the offender and his/her counsellor, and this aftercare plan is forwarded onto their Probation Officer. Community prison link workers are also part of the aftercare programme. They meet with the offenders in prison to help them with their addiction, and to prepare them for their return to the community. When the offenders are released from prison, these workers meet them on a ‘one-to-one basis in the community’ in order to support their ‘re-integration through care planning’ and to continue the progress they made in prison regarding their addiction.³⁴⁰

Conclusion

While the treatment programmes in prisons are effective, it is evident that the demand and need for them is high, and the services available are low. The numbers of addiction counsellors and addiction psychiatrists are low considering the need and willingness of prisoners to avail of these. The lack of availability of spaces in these programmes, the long waiting lists and the lack of ‘appropriate facilities’ for prisoners is hindering their progress.³⁴¹

Drug Use Post-Release

Prisoners face many trials and tribulations upon release, many exacerbated by drug use. Issues post-release often have a negative impact on an ex-offender’s drug treatment. While there has been improvement in the area of release planning from prisons (for example the introduction of the Integrated Sentence Management system) the release of prisoners with an addiction, especially those who are chaotic drug users, is still of major concern, especially with regard to the fact that offenders with an addiction often have a complex set of needs. These can include poor literacy and numeracy skills, physical and mental health issues, and uncertainty as to accommodation and employment.³⁴²

³³⁹C O’Gráda, ‘Staff Perspectives on Drug Treatment Services in Prison’ (2010) 1, 15
<http://www.irishprisons.ie/images/pdf/cara_ograda.pdf> accessed 19 October 2018.

³⁴⁰ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 82
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³⁴¹ C O’Gráda, ‘Staff Perspectives on Drug Treatment Services in Prison’ (2010) 1, 7
<http://www.irishprisons.ie/images/pdf/cara_ograda.pdf> accessed 19 October 2018.

³⁴² A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 98
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

The transition from living in prison to having to reintegrate into society is a challenging one, and as such the Irish Penal Reform Trust has recommended that ‘increased emphasis in the Probation Service’s strategic plan should be placed on meaningful and successful reintegration of individuals into society’.³⁴³ Proper reintegration of ex-offenders into society, helped by the provision of services such as addiction treatment, support and counselling, is an important factor in a person’s ability to tackle their addiction. In terms of release from prison, the provision of accommodation and reducing the likelihood of recidivism are two areas of importance, especially relating to those suffering from an addiction.

Homelessness Post-Release

Accommodation is a critical issue faced by prisoners upon release, and one which is of particular importance for prisoners who are undergoing or who have undergone treatment for addiction. It is much more difficult to tackle addiction while living precariously, so it is of the utmost importance, not just for their general well-being and dignity but more specifically for the success of drug addiction treatment, that offenders be given adequate accommodation promptly upon release. Those released from institutions such as prisons face an increased risk of becoming homeless compared to the rest of the population.³⁴⁴ By entering the precarious lifestyle that homelessness entails upon release from prison, many ex-prisoners are subjected to the same or similar environment which may have led to their original imprisonment. The lack of opportunities faced by those who are homeless can be a factor in their reoffending. Moreover, ‘the absence of a fixed address can have serious repercussions for an offender in terms of access to medical cards, GP, social welfare, training and employment opportunities.’³⁴⁵

A particular issue in relation to accommodation post-release, especially with the current housing crisis, is the focus of policy on housing for families. There is a danger that accommodation for single men, which has suffered from lack of prioritisation in the past, will become an issue that is even more prominent.³⁴⁶

³⁴³ IPRT, ‘IPRT Submission to Inform the Role and Priorities of the Probation Service’s Strategic Plan 2018–2020’ (16 February 2018) 9, <<http://www.iprt.ie/contents/3255>> accessed 29 January 2018.

³⁴⁴ M Seymour and L Costello, ‘A Study of the Number, Profile and Progression Routes of Homeless Persons Before the Court and in Custody’ (2005) 2 Irish Probation Journal 52.

³⁴⁵ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16,76 <http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³⁴⁶ *ibid*, 23.

One policy which is of relevance to the accommodation upon release of prisoners who may suffer from addiction is the Housing First model, which provides a different approach to the housing of homeless people. This approach moves away from the traditional ‘staircase’ model of addressing homelessness, which involved those who are homeless going through several steps (for example, getting clean from drugs, completing various courses etc) before being allowed to transition to a house. The Housing First model instead involves, as a first step, the provision of a secure and permanent home. Support and recovery services are in turn provided for considerable periods of time. In Ireland, the Peter McVerry Trust has operated a Housing First project for people exiting custody. The project supplies accommodation units and comprehensive assistance and help to those who qualify for the programme and are leaving prison. Many of this cohort have ‘complex support needs including mental and physical health issues, drug and alcohol related issues, offending behaviour and challenging behaviour issues’.³⁴⁷

Offending and reoffending

There is a ‘strong link’ between crime and drug misuse, and this link is particularly prevalent in offenders aged under 45.³⁴⁸ Extensive research has been done on this topic,³⁴⁹ with the Clarke and Eustace Study³⁵⁰ reporting that ‘substance misuse is a known risk factor for offending behaviour and recidivism’. Moreover, the Irish Probation Service’s Drug and Alcohol Survey³⁵¹ found that for most offenders who misused alcohol and drugs, their misuse was related to their offending.

³⁴⁷ Peter McVerry Trust, ‘Annual Report 2015’ (2015) <https://www.pmvtrust.ie/news-media/publications/pmvt_annualreport_2015_webversion-lowest-res/> accessed 29 January 2019.

³⁴⁸ Probation Service, ‘Findings from the Drugs and Alcohol Survey 2011’ (May 2012) <<http://www.drugs.ie/resourcesfiles/research/2012/Drug+and+Alcohol+Misuse+among+Adult+Offenders+on+Probation+Supervision+in+Ireland.pdf>> accessed 29 January 2019.

³⁴⁹ T Bennett and K Holloway, ‘Drug Use and Offending: Summary results of the NEW-ADAM Programme’ (Home Office, 2004) <<http://www.dldocs.stir.ac.uk/documents/r219.pdf>> accessed 29 January 2019; T Budd and others, ‘Levels of self-report offending and drug use among offenders: Findings from a criminality survey’, (Home Office Online Report, May 2005) <<http://data.parliament.uk/DepositedPapers/Files/DEP2010-2377/DEP2010-2377.pdf>> accessed 29 January 2019.

³⁵⁰ A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 25 <http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³⁵¹ Peter McVerry Trust, ‘Annual Report 2015’ (2015) <https://www.pmvtrust.ie/news-media/publications/pmvt_annualreport_2015_webversion-lowest-res/> accessed 29 January 2019.

According to the Clarke and Eustace report, there is a ‘cohort of offenders with substance abuse issues’ who ‘continue to move in and out of the criminal system repeatedly’.³⁵² While this is proof of the problem of the link between recidivism and substance misuse, it also can be seen as an ‘opportunity to work with this cohort and seek to treat the addictions’.³⁵³ There is also the chance to enable offenders to deal with their substance misuse, which would in the long-run save the state money. As such, this issue does not have to be seen solely in a negative light.

Conclusion

Overall, an ex-offender’s experience post-release can be massively impacted by a struggle with addiction. This impact can be lessened by the effective provision of housing, addiction services and healthcare, with the aim of improving the health and well-being of these ex-offenders. This would also have the result of reducing recidivism rates.

Conclusion

When examining drug laws in Ireland, prisoners are a particularly important group to consider, since the levels of drug use and addiction are disproportionately higher among the incarcerated than those of the general population, as well as many committals being related to drug use. The link between social deprivation, drug use and criminality has unfortunately been a neglected area of research and even public discourse. Irish prisons have made substantial progress in recent times, and are doing well by international standards, however there are still more improvements to be made.

³⁵² A Clarke and A Eustace, ‘Drug & Alcohol Treatment Services for Adult Offenders in Prison and in the Community’, (Irish Prison Service, March 2016) 16, 23
<http://www.justice.ie/en/JELR/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf/Files/PS_IPS_Probation_Review_of_treatment_for_offenders.pdf>.

³⁵³ *ibid.*

VII: Current Harm Reduction Policies in Ireland

Blake Catriona, Catherine Teevan, Siofra Carlin, Kate Nolan

Ireland's current harm reduction policies are outlined in the National Drug Strategy 2017-2025 *Reducing Harm, Supporting Recovery*. The four main areas of harm reduction within this Strategy are as follows:

1. Supervised Injecting Facilities and Residential Treatment Services
2. The Drug Treatment Court
3. Opioid Substitution Treatment (Methadone) and Naloxone Training
4. Harm Reduction Policies Tailored for People with More Complex Needs

It is clear that the different strategies currently in use are wide-ranging and encompass the spectrum of approaches to drug use, from an approach utilising a punitive element (as seen through the use of the Drug Treatment Court) to an entirely destigmatised, healthcare-led approach (as seen through the introduction of Supervised Injecting Facilities). This section aims to provide an overview of each of the above policies of harm reduction, as well as the current progress of each policy.

Supervised Injecting Facilities and the Expansion of Residential Treatment Services

The current Irish drug and alcohol strategy- *Reducing Harm, Supporting Recovery*,³⁵⁴ aims to reduce harm related substance abuse and promote the rehabilitation and recovery of addicts, through an integrated public health led approach. The Strategy sets out a number of initiatives and recommendations that the government intends to put in place. Included is the introduction of a pilot supervised injecting facility in Dublin City Centre and an expansion of drug and alcohol addiction services which includes residential services.³⁵⁵

The illicit use of injected drugs has become arguably one of the greatest public health and social issues facing Ireland today. In a 2014 study, it was found that there were an estimated 18,988 opiate users in Ireland, with an estimated 13,458 of those users situated in County

³⁵⁴ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

³⁵⁵ *ibid* 33-53.

Dublin.³⁵⁶ Opiate drug users, particularly those who inject, face serious potential health risks of fatal overdoses or near fatal overdoses, along with the risk of contracting blood-borne diseases- which include HIV and hepatitis C, as result of unsafe injecting.³⁵⁷ These health risks are heightened by *street based injecting*,³⁵⁸ as injecting on the streets usually involves the sharing of drugs and sharing of equipment. Due to the cost or non-availability of injecting equipment, and the fear of criminalisation, a high number of street users will share needles,³⁵⁹ leading to a high percentage of drug users on the streets suffering from contracted blood-borne diseases.

Supervised Injecting Facilities

Supervised injecting facilities (SIFs) are an example of a public policy measure which aims to reduce the harm associated with injection drug use. SIFs have been in operation over the last three decades in Europe, Australia and Canada, and have become an integrated part of the drug treatment and harm reduction strategy across these regions. These facilities provide a place for people who inject drugs, to self-administer illicit drugs such as heroin, under the supervision of professionally trained staff in hygienic and safe conditions. The primary aim of SIFs are to reduce the acute risks of disease transmission through unsafe injecting, prevent drug related overdose deaths and also provide high risk drug users with access to appropriate addiction treatment and other health and social services.³⁶⁰ SIFs typically provide drug users with; “sterile injecting equipment; counselling services before, during and after drug consumption; emergency care in the event of overdose; and primary medical care and referral to social healthcare and addiction treatment services.”³⁶¹ The establishment of SIFs has

³⁵⁶ Gordon Hay, Ali Jaddoa and Jane Oyston Et al, ‘Estimating the Prevalence of Problematic Opiate Use in Ireland Using Indirect Statistical Methods’ (The National Advisory Committee on Drugs and Alcohol, 2016)
<https://www.drugsandalcohol.ie/27233/1/nacda_estimating_ireland_opiate_use%20final.pdf> accessed 28 October 2018.

³⁵⁷ Ian Malkin, ‘Establishing Supervised Injecting Facilities: A Responsible Way to Help Minimise Harm’ [2001] 25 Melbourne University Law Review 681.

³⁵⁸ Craig Fry, Sandra Fox and Greg Rumbold, ‘Establishing Safe Injecting Rooms in Australia: Attitudes of Injecting Drug Users’ (1999) 23 Australian and New Zealand Journal of Public Health 501.

³⁵⁹Open Society Institute Public Health Program, ‘At What Cost? HIV and Human Rights Consequences of the Global 6 “War on Drugs”’ (March 2009)
<https://www.opensocietyfoundations.org/sites/default/files/at-what-cost_20090302.pdf> accessed on 28 October 2018.

³⁶⁰ European Monitoring Centre for Drugs and Drug Addiction, ‘Drug consumption rooms: an overview of provision and 7 evidence’ (June 2018) <http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en> accessed 24 October 2018.

³⁶¹ *ibid.*

received some resistance, primarily due to the fears that they might encourage drug use, delay treatment entry, aggravate the problems of local drug markets and attract crime to surrounding communities.³⁶² However, research has shown that the implementation of SIFs is associated with a reduction in unsafe injecting practices which has led to a decrease in the number of fatal overdoses- one Canadian study finding a 35% decrease in the fatal overdose rate in the area after the opening of the SIF,³⁶³ and a reduced risk in the transmission of blood-borne diseases.³⁶⁴

In order to allow for the establishment of a SIF, it has been necessary to modify specific laws in order to decriminalise drug consumption in the SIFs and to allow for the regulation in these facilities. As a result, the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was passed, thus enabling the establishment, licensing, operation and regulation of supervised injecting facilities.³⁶⁵ This Act purports to, “...enhance the dignity, health and well-being of people who inject drugs in public places; to reduce the incidence of drug injection and drug related litter in public places and thereby to enhance the public amenity for the wider community”.³⁶⁶ However, the possession of controlled drugs will continue to be an offence outside a SIF. The Minister of State for Communities and the National Drugs Strategy, Catherine Byrne welcomed the passing of the Misuse of Drugs (Supervised Injecting Facilities) Act 2017, describing this progressive step as a “...health-led and person-centred approach to the drug problem”.³⁶⁷

³⁶² Elana Gordon, ‘What’s the Evidence That Supervised Drug Injection Sites Save Lives?’(National 9 Public Radio, September 2018) <<https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives?t=1540393204198>> accessed 24 October 2018.

³⁶³ BD Marshall, MJ Milloy, E Wood, JS Montaner & T Kerr, ‘Reduction in Overdose Mortality After the Opening of 10 North America’s First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study’ *The Lancet* (April 2011) <[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)62353-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62353-7/fulltext)> accessed 28 October 2018.

³⁶⁴ Jo-Anne Stolz, Evan Wood, Will Small, Kathy Li, Mark Tyndall, Julio Montaner & Thomas Kerr, ‘Changes in 11 Injecting Practices Associated With the Use of a Medically Supervised Safer Injection Facility’ [March 2011] 29 *Journal of Public Health*, 35-39.

³⁶⁵ Misuse of Drugs (Supervised Injecting Facilities) Act 2017.

³⁶⁶ Misuse of Drugs (Supervised Injecting Facilities) Act 2017 <<https://www.oireachtas.ie/en/bills/bill/2017/18/>> accessed 18 October 2019.

³⁶⁷ Department of Health, ‘Ireland’s First Supervised Injecting Facility a Step Closer As Legislation Passes All Stages in the Oireachtas’ (Press Release, May 2017) <<https://health.gov.ie/blog/press-release/irelands-first-supervised-injecting-facility-a-step-closer-as-legislation-passes-all-stages-in-the-oireachtas/>> accessed 29 January 2019.

The Health Service Executive announced that Merchants Quay Ireland (MQI), a voluntary organisation based in Dublin City Centre, which aids people with addiction and accommodation issue, has been chosen to operate Ireland's first medically supervised injecting facility.³⁶⁸ The service will initially only operate as a pilot project, and will be closely monitored and subject to evaluation by the HSE, it is hoped that the pilot will inform future decisions as to the establishment of further SIFs in Ireland.³⁶⁹

Residential Treatment Services

The Strategy emphasises the importance of supporting the recovery and rehabilitation of an individual, in a way that is catered to their own personal needs and in alignment with their own recovery goals.³⁷⁰ There has been notable increase in the numbers of new drug treatment cases, which increased from 2,278 to 3,742 between 2006 and 2015.³⁷¹ With the increasing caseload, the HSE has implemented a 4-tier person-centred model of rehabilitation based on the principle of a 'continuum of care',³⁷² to further improve the support services available to individuals suffering from addiction. Tier 4 of the model provides for specialised and dedicated inpatient or residential units, which includes inpatient detoxification, residential rehabilitation and facilities for assisted withdrawal and stabilisation.³⁷³ In 2007, a Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Abuse) provided a detailed analysis of the treatment services available at the time and made recommendations to improve the services. They calculated a need for 887 residential rehab beds, of which 14 to 37 of these beds should be set aside for a separate adolescent service.³⁷⁴

³⁶⁸ Peter Murtagh 'Addicts Will be Able to Inject Under Medical Supervision at Dublin Centre' The Irish Times (Dublin, 15 February 2018).

³⁶⁹ Department of Health, 'Ireland's First Supervised Injecting Facility a Step Closer As Legislation Passes All Stages in the Oireachtas' (Press Release, May 2017) <<https://health.gov.ie/blog/press-release/irelands-first-supervised-injecting-facility-a-step-closer-as-legislation-passes-all-stages-in-the-oireachtas/>> accessed 29 January 2019.

³⁷⁰ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

³⁷¹ Health Research Board, 'Drug treatment in Ireland 2009-2015' (Dublin, Health Research Board May 2017) <<http://www.drugsandalcohol.ie/27023>> accessed 29 January 2019.

³⁷² Richard Bryant Jefferies, 'Models of Care for Drug Service Provision' [2004] Oxford Radcliffe Publishing Ltd.

³⁷³ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

³⁷⁴ Dr Des Corrigan, Dr Aileen O'Gorman, 'Report of the HSE Working Group on Residential Treatment & 21 Rehabilitation (Substance Abuse)' (May 2007) <<http://www.drugs.ie/resourcesfiles/reports/3966-42381118.pdf>>

Since then, there has been a significant increase in the number of residential beds. The most recent figures available demonstrate that there is a current provision of 787 residential beds, comprising 23 inpatient unit detoxification beds, 117 community-based residential detoxification beds, 4 adolescent residential detoxification beds, 625 residential beds and 18 adolescent residential beds.³⁷⁵ However, despite the improvements in service provisions, there are still various hindrances which prevent individuals from accessing appropriate treatment; including geographical obstacles, high costs,³⁷⁶ a lack in clinical governance and problematic referral processes. Residential services which do not having the adequate level of clinical governance cannot effectively respond to individuals with more complex needs and some services which necessitate particular entry thresholds may exclude those with more unstable patterns of drug use.³⁷⁷ The strategic actions which hope to target these inefficiencies include; the expansion and improvement of the available services, the strengthening of the capacity of services to cope with complex needs, the standardisation of the referral process and lowering the entry criteria, whilst ensuring adequate levels of clinical governance.³⁷⁸

The Drug Treatment Court

The drug treatment court was piloted in the Dublin District Court in January 2001³⁷⁹ and provides an alternative to a criminal conviction for drug addicts. Based on similar schemes implemented in other jurisdictions, it was established in response to the high number of drug-addicted offenders appearing before the courts in the mid-1990s.³⁸⁰ After an evaluation of the pilot scheme in 2002 recommended an expansion of the programme,³⁸¹ a subsequent

³⁷⁵ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 35.

³⁷⁶ Depending on the nature of the service, the cost of a treatment episode in a Short Stay facility ranges between €5,000 to €8,000 in a Therapeutic Community. Adolescent residential detox. costs on average €16,000 per treatment episode. Medical Detox. in Cuan Dara, Cherry Orchard hospital costs on average €13,000 see <<https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/pqs/pq-s-2018/pq-31725-18-pq-31726-18-medical-community-based-detox-beds-final-24-7-18.pdf>>

³⁷⁷ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 37.

³⁷⁸ *ibid.*

³⁷⁹ Department of Justice, Equality and Law Reform, 'Review of the Drug Treatment Court' (May 2010) 5 <<http://www.justice.ie/en/JELR/Pages/drug-treatment-court-review>> accessed 29 January 2019.

³⁸⁰ Farrell Grant Sparks Consulting/Dr. Michael Farrell, 'Final Evaluation of the Pilot Drug Court' (Courts Service, October 2002) 2 <www.irpt.ie/files/drug_court_evaluation.pdf>.

³⁸¹ *ibid.*

review in 2005 recommended that the Drug Treatment Court should cease to be a pilot, and that a permanent judge should be assigned to the Court and that the Court should have a permanent geographical location.³⁸² A relatively new component to the State's strategy to tackle drug addiction in Ireland, it is largely unheard of outside of the court system and indeed outside of Dublin as it is only beginning expansion to the rest of Ireland.³⁸³

Criteria for entry to the Drug Treatment Court is strict. Applicants must be over seventeen years of age and must persuade the judge that the crime of which they have been accused is linked to their drug addiction.³⁸⁴ Either the addict themselves or their solicitor must request in court that the judge considers referring them to the Drug Treatment Court in lieu of the punishment under the relevant criminal legislation.³⁸⁵ Furthermore, applicants with an address in Dublin 1,2,3,6,7 and 8 are prioritised for referral by the courts, indicating the Dublin-focused nature of the programme.³⁸⁶ In essence, the applicant must persuade everyone involved in the programme (including An Garda Síochána, the courts and the Probation Service) that “referring [them] to the Drug Treatment Court Programme will not be a waste of time.”³⁸⁷

After an induction process that can take up to two months,³⁸⁸ the applicant commences the bronze phase of the programme. They have one year to complete this phase before progression to the silver phase, and one year to progress from silver to gold phase, with each phase requiring weekly drug tests and attendance at classes at an adult learning centre. By the

³⁸² Department of Justice, Equality and Law Reform, 'Review of the Drug Treatment Court' (May 2010) 5 <<http://www.justice.ie/en/JELR/Pages/drug-treatment-court-review>> accessed 29 January 2019.

³⁸³ Conor Gallagher, 'Drug Treatment Court: Life-saving option for drugs offenders', *The Irish Times*, (Dublin, 6 January 2017).

³⁸⁴ Courts Service, 'The Drug Treatment Court Programme a guide to the induction and bronze phases for participants' (February 2013)

<[http://www.courts.ie/Courts.ie/library3.nsf/\(WebFiles\)/9C4903CB6AD11F6B80257B1D0061EA91/\\$FILE/Induction%20and%20Bronze%20Phases%20-%20revised%20Feb%202013.pdf](http://www.courts.ie/Courts.ie/library3.nsf/(WebFiles)/9C4903CB6AD11F6B80257B1D0061EA91/$FILE/Induction%20and%20Bronze%20Phases%20-%20revised%20Feb%202013.pdf)> accessed 26 October 2018.

³⁸⁵ Farrell Grant Sparks Consulting/Dr. Michael Farrell, 'Final Evaluation of the Pilot Drug Court' (Courts Service, October 2002) 2 <www.irpt.ie/files/drug_court_evaluation.pdf>.

³⁸⁶ Courts Service, 'Drug Treatment Court Programme'

<<http://www.courts.ie/offices.nsf/lookuppagelink/5C3FCB8E070ADAA280256E7B003B1D9F>> accessed 26 October 2018.

³⁸⁷ Courts Service, 'The Drug Treatment Court Programme a guide to the induction and bronze phases for participants' (February 2013)

<[http://www.courts.ie/Courts.ie/library3.nsf/\(WebFiles\)/9C4903CB6AD11F6B80257B1D0061EA91/\\$FILE/Induction%20and%20Bronze%20Phases%20-%20revised%20Feb%202013.pdf](http://www.courts.ie/Courts.ie/library3.nsf/(WebFiles)/9C4903CB6AD11F6B80257B1D0061EA91/$FILE/Induction%20and%20Bronze%20Phases%20-%20revised%20Feb%202013.pdf)> accessed 26 October 2018.

³⁸⁸ *ibid*

end of the gold phase, the applicant must be completely drug-free. After successful completion of the gold phase by the applicant, the judge will strike out the charges against them, allowing them to stay focused on remaining drug-free and working on finding the skills to gain employment.³⁸⁹

The 2002 pilot evaluation made the observation that the DTC suggested that the programme would be successful in rehabilitating drug-addicted offenders if it could retain these offenders within the first few months of their participation in the programme.³⁹⁰ Unfortunately, retention of offenders remains a major concern for the programme today. The 2010 *Review of the Drug Treatment Court* notes that between the period of January 2001 and December 2009, only 14% of those inducted into the programme have successfully completed or “graduated” from the programme.³⁹¹ Between January 2001 and May 2018, just sixty-nine participants have completed the gold phase of the programme, and just five have completed the silver phase.³⁹² The 2010 report contains a number of reasons for the low success rate of the programme, including the disqualification of those under the age of seventeen from participation in the programme, the requirement that offences be non-violent and a lack of awareness of the existence of the DTC amongst judges and other legal professionals.³⁹³ In addition, the strict catchment area of inner-city Dublin is disqualifying many otherwise suitable applicants from participation in the programme.³⁹⁴

The report recommends that immediate action be taken to resolve these issues. As a key issue relating to the DTC is difficulty in accessing this service, the 2010 report recommends that the catchment area for the court is widened, as the boundaries established in the 2005 report had not been adjusted at the time of publication of the 2010 report.³⁹⁵ In 2011, the catchment

³⁸⁹ *ibid.*

³⁹⁰ Farrell Grant Sparks Consulting/Dr. Michael Farrell, ‘Final Evaluation of the Pilot Drug Court’ (Courts Service, October 2002) 2 <www.irpt.ie/files/drug_court_evaluation.pdf> 6.

³⁹¹ Department of Justice, Equality and Law Reform, ‘Review of the Drug Treatment Court’ (May 2010) 5 <<http://www.justice.ie/en/JELR/Pages/drug-treatment-court-review>> accessed 29 January 2019.

³⁹² Michelle Hennessy, ‘“I understand people can relapse, but you have to be honest”: Inside Dublin’s drug treatment court’ *The Journal* (11 August 2018) <<https://www.thejournal.ie/drug-treatment-4158196-Aug2018/>> accessed 25 October 2018.

³⁹³ Department of Justice, Equality and Law Reform, ‘Review of the Drug Treatment Court’ (May 2010) 5 <<http://www.justice.ie/en/JELR/Pages/drug-treatment-court-review>> accessed 29 January 2019, 14-16.

³⁹⁴ *ibid.* 18.

³⁹⁵ *ibid.*

area of the DTC was extended to cover all areas of Dublin north of the Liffey³⁹⁶ and in 2016 the DTC accepted its first case from outside of Dublin.³⁹⁷ This bid to make the DTC more accessible to drug users in geographical locations across Ireland links into the ongoing aim of the National Drugs Strategy 2017-2025 to provide equal access to treatment options for both urban and rural drug users.³⁹⁸

Drug treatment courts in other jurisdictions have begun to face criticism for remaining largely ineffective.³⁹⁹ Findings suggest that drug treatment courts are more appropriate for dealing with serious drug-related offences,⁴⁰⁰ and that drug use offences which cause no harm to others should be regarded as a matter outside the realm of criminal justice.⁴⁰¹ Due to the small-scale nature of the drug treatment courts in Ireland, it has been difficult to discern if the drug treatment court in this jurisdiction has been plagued with the concerns identified in drug treatment courts abroad. The low success rate of the Irish programme⁴⁰² would indicate that the drug treatment court has been largely ineffective, however it can be argued that a lack of resources (both monetary and otherwise)⁴⁰³ is the root cause of this ineffectiveness, and that the government should increase spending on the DTC (as recommended in the 2010 report on the programme) before any definitive findings can be made on the effectiveness or otherwise of the programme.

The Drug Treatment Court remains a largely-unpublicised strand of Ireland's National Drug Strategy, in part due to its strict criteria and also because of its more punitive approach to drug addiction than other, healthcare-led approaches. However, it has proven to be effective for a small profile of drug addicts and this success seems to indicate that, with further resources, the drug treatment court could further improve upon its success. The programme

³⁹⁶ 'Drug treatment court scheme extended', *The Irish Times*, (Dublin, 25 July 2011).

³⁹⁷ Conor Gallagher, 'Drug Treatment Court: Life-saving option for drugs offenders' *The Irish Times* (Dublin, January 6 2017).

³⁹⁸ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

³⁹⁹ Drug Policy Alliance USA, 'Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use' (2011) 9.

⁴⁰⁰ *ibid* 18.

⁴⁰¹ *ibid* 24.

⁴⁰² Farrell Grant Sparks Consulting/Dr. Michael Farrell, 'Final Evaluation of the Pilot Drug Court' (Courts Service, October 2002) 2 <www.irpt.ie/files/drug_court_evaluation.pdf>.

⁴⁰³ R Department of Justice, Equality and Law Reform, 'Review of the Drug Treatment Court' (May 2010) 5, 20 <<http://www.justice.ie/en/JELR/Pages/drug-treatment-court-review>> accessed 29 January 2019.

follows the approach as outlined under the National Drug Strategy of lessening the focus on criminalisation of drug use in favour of a renewed focus on healthcare and de-stigmatisation of drug addicts within the community and within society as a whole.

Opiates

Opiates, such as heroin and methadone, have pain killing properties and produce feelings of well-being. Opiates are derived from the opium poppy. Opium is the dried milk of the opium poppy which contains morphine and codeine, both effective pain-killers.⁴⁰⁴ In response to the growing heroin abuse problem in Ireland, opiates began to be distributed to moderate and monitor the health and safety of addicts and misusers.

In 2009, the Health Service Executive provided more accessibility towards the Opioid Substitution Treatment around the country.⁴⁰⁵ This was furthermore acknowledged in 2010 when the Opioid Treatment Protocol was introduced by Michael Farrell and Joseph Barry under the HSE.⁴⁰⁶ The aim of this project was to monitor the maintenance and distribution of methadone⁴⁰⁷ which commenced being distributed in 1997 under the Methadone Treatment Services Review Group which had been set up by the Department of Health and Children.⁴⁰⁸ Methadone's use is to assert heroin independence among addicts.⁴⁰⁹

The Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 came into operation in July 1998.⁴¹⁰ Prior to the Methadone Protocol, opiate dependents were forced to travel to Dublin in order to be prescribed their pharmaceuticals as methadone was only being distributed by a small number of general practitioners. This in turn led to the high risk and substantial evidence to conclude that large quantities of methadone were being sold on the black market. Therefore, the Methadone Protocol established multiple

⁴⁰⁴ Department of Tourism, Sport and Recreation, 'National Drugs Strategy 2001 – 2008' (2001) <https://health.gov.ie/wp-content/uploads/2014/03/nds_2001-08-1-report.pdf>

⁴⁰⁵ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

⁴⁰⁶ HRB National Drugs Library, 'The introduction of the opioid treatment protocol' (2010) <<https://www.drugsandalcohol.ie/14458/>> accessed 29 January 2018.

⁴⁰⁷ *ibid.*

⁴⁰⁸ Department of Health and Children, 'Review of the Methadone Protocol' <http://www.drugs.ie/resourcesfiles/research/2005/methadone_review.pdf?direct=1>

⁴⁰⁹ *ibid.*

⁴¹⁰ *ibid.*

recommendations and guidelines to ensure the success and progress of the system in 2005.⁴¹¹ The results of the Methadone Treatment Protocol of 2005 illustrated that twelve of the nineteen recommendations had been implemented.⁴¹² These recommendations ranged from the role of pharmacies and general practitioners to the correct formulations of methadone distribution.

Methadone evaluation was furthermore implemented by the National Drug Strategy 2001-2008. This review concluded that the most commonly used drugs in Ireland were cannabis and ecstasy however in terms of harm to an individual or a community, the most harm impacted was from heroin.⁴¹³ Under 6.1.5 of this Strategy, the results of methadone substitution were epitomised through the facts that approximately 40% of methadone maintenance users have returned to work between 1998 and 2000.⁴¹⁴

The National Drugs Strategy 2009-2016 was implemented to investigate the previous strategy and construct recommendations following from it.⁴¹⁵ This Strategy identified the benefits of methadone substitution as 2,900 individuals completed their treatment in the period 2000 to 2007.⁴¹⁶ The National Drugs Strategy 2017-2025 interpreted and criticised the monitoring of the distribution of methadone. It was suggested that brief periods of stabilisation followed by detoxification and repeated attempts is preferable to long term Methadone substitution which robs individuals of their health and life, just as much as heroin does.⁴¹⁷ This Strategy also highlights the importance of naloxone which is a drug prescribed to drug misusers to prevent overdose.⁴¹⁸

In Ireland in May 2015, the Health Service Executive (HSE) established a take-home naloxone project which was recommended by the World Health Organisation (WHO) that will assess the efficacy of take-home naloxone in preventing drug-induced deaths, with an initial target of 600

⁴¹¹ Department of Health and Children, 'Review of the Methadone Protocol' <http://www.drugs.ie/resourcesfiles/research/2005/methadone_review.pdf?direct=1> accessed 29 January 2019.

⁴¹² *ibid* 4.

⁴¹³ *ibid* 1.

⁴¹⁴ *ibid*.

⁴¹⁵ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019.

⁴¹⁶ *ibid*.

⁴¹⁷ Department of Health, 'Report on Public Consultation undertaken to inform the new National Drugs Strategy' (May 2017) <<https://health.gov.ie/wp-content/uploads/2017/07/Report-on-the-public-consultation-undertaken-to-inform-the-NDS.pdf>> accessed 29 January 2019.

⁴¹⁸ *ibid*.

participating opioid users. Participants are required to learn by video-training about overdose signs, risk factors, administration of naloxone, and basic life support. If knowledge of these can be shown, the participant is given a take-home naloxone kit.⁴¹⁹ To date, the legislation and regulations primarily focuses on methadone maintenance. However, throughout Europe, emphasis is placed on the evidence proving that buprenorphine and buprenorphine plus naloxone are staple treatment agents. It is the review's view that buprenorphine or buprenorphine plus naloxone would provide an important expansion in treatment options and would also be useful in promoting services with pathways of progression from stabilisation to detoxification.⁴²⁰

The Naloxone Demonstration Project placed significance on the training of the distribution and administration of naloxone. The design of the Naloxone training was led by the Chief Pharmacist (Denis O' Driscoll) and the National Liaison Pharmacy Worker (Tim Bingham) with initial and ongoing consultation with a wide range of stakeholders.⁴²¹ Training sessions were conducted to cover overdose risk factors, observable signs of overdose, what Naloxone is and how to administer it and what to do in an overdose situation. Full participation in the training was a prerequisite for frontline workers seeking to access the Naloxone and Overdose Frontline Workers Pack for use on location in their service. This pack includes a training manual and related resource materials for use by frontline workers with service users in conjunction with four videos available on www.drugs.ie/naloxone.⁴²² The manual covers overdose risks, what Naloxone can and cannot do, where to keep Naloxone, how to identify an opioid overdose, calling an ambulance, procedures for obtaining resupplies of Naloxone, what to do in the event of needle-stick injury and steps to take in responding to an overdose.⁴²³ The training sessions are in keep with ensuring the safety and well-being of drug misusers and their services that are available to them.

⁴¹⁹ Aoife Cannon, 'Take-home naloxone' 57 *Drugnet Ireland* 22
<<https://www.drugsandalcohol.ie/2549>> accessed 29 January 2019.

⁴²⁰ Health Service Executive, 'The Introduction of the Opioid Treatment Protocol'
<<https://www.hse.ie/eng/services/publications/socialinclusion/addiction/opioid%20treatment%20protocol.pdf>> accessed 29 January 2019.

⁴²¹ Health Service Executive, 'Evaluation of the HSE Naloxone Demonstration Project',
<<https://www.hse.ie/eng/services/publications/socialinclusion/addiction/naloxonedemoproject.pdf>>

⁴²² *ibid.*

⁴²³ *ibid.*

Ireland also has measures for harm reduction put in place in regards to needle exchange programmes. Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. There are now 34 exchanges in the country, operating three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations.⁴²⁴ All 31 services reported that staff received training on the assessment of clients' sexual risk practices and injecting practices, and on emergency responses such as overdose prevention techniques.⁴²⁵ Pharmacy Needle Exchange (PNex) has also been implemented and there are currently 107 pharmacies across the country using this.⁴²⁶ The Irish Pharmacy Union (IPU) recommended that pharmacies that participate in the Methadone Treatment Scheme and/or Needle Exchange Scheme receive training from the HSE on the administration of Naloxone and receive an ongoing supply of Naloxone from the HSE, as these pharmacies are more likely to encounter a person with an opioid overdose. Crosscare Homeless Services recommend that needle exchange packs should include Naloxone.

Harm Reduction as Adapted for People with more Complex Needs

The Department of Health recognises that there is a diversity amongst substance users and the provision of services must be adapted and targeted to properly accommodate this diversity.⁴²⁷

Unemployed Persons

It is recognised that employment can contribute immensely to progressing and maintaining recovery and help combat social exclusion.⁴²⁸ The Community Employment Programme, administered by the Department of Employment Affairs and Social Protection (DEASP), is designed to help people who are long-term unemployed (or otherwise disadvantaged) to get back to work. This programme allocates 1,000 places to people in recovery through a number of dedicated Drug Rehabilitation CE schemes.⁴²⁹

⁴²⁴ HRB National Drugs Library, 'Profile of needle exchange services in Ireland' (2008) <<https://www.drugsandalcohol.ie/12145/>> accessed 29 January 2019.

⁴²⁵ *ibid.*

⁴²⁶ Health Service Executive, 'Review of Needle Exchange Provision in Ireland', <<https://www.drugsandalcohol.ie/23916/1/Review%20of%20Needle%20Exchange%20Provision%20in%20Ireland%20.pdf>> accessed 29 January 2019.

⁴²⁷ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 44.

⁴²⁸ *ibid* 40.

⁴²⁹ *ibid.*

People in recovery may require additional supports to facilitate their return to the workplace. This is achieved through the Social Inclusion and Community Activation Programme (SICAP), which is managed at a local level by Local Community Development Committees (LCDCs) in each local authority area and is delivered by Programme Implementers (PIs).⁴³⁰ PIs work with marginalised communities and service providers using a community development approach to improve people's lives. For example, helping people to find work or to upskill, providing CV training or a personal development course, helping them onto a work placement programme such as CE or Tús, which assist in moving individuals closer to or into the labour market.⁴³¹

Women

It is recognised that women can experience barriers to engaging and sustaining involvement with treatment and rehabilitation services. Many women who suffer from addiction have also experienced domestic abuse and services should be equipped to deal with this appropriately.⁴³² Services such as Women's Aid, the Rape Crisis Centre and the National Counselling Service can provide support for women who are experiencing domestic violence.⁴³³

Lack of, or limited access to childcare can be a barrier for women attending treatment and after-care services.⁴³⁴ There are some programmes that provide wrap-around services for female drug-users in recovery and their children, such as SAOL in North Inner City Dublin, which has an in house creche.⁴³⁵ However, Coolmine Ashleigh House is currently the only residential treatment service, where mothers can keep their babies with them during treatment.⁴³⁶

⁴³⁰ *ibid.*

⁴³¹ Pobal, 'Social Inclusion and Community Activation Programme 2018 – 2022' <www.pobal.ie/programmes/social-inclusion-and-community-activation-programme-sicap-2018-2022/> accessed 28 October 2018.

⁴³² Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 44.

⁴³³ HSE, 'Domestic Violence and Abuse' <<https://www2.hse.ie/wellbeing/mental-health/domestic-violence-and-abuse.html>> accessed 28 October 2018.

⁴³⁴ Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 42.

⁴³⁵ Saol Project, 'SAOL BeAG - Our Children's Centre' <www.saolproject.ie/childrenscentre.php> accessed 28 October 2018.

⁴³⁶ Coolmine Community Services, 'Residential Services' <www.coolmine.ie/services-new/residentials/> accessed 28 October 2018.

There are currently three Drug Liaison Midwives.⁴³⁷ The Drug Liaison Midwives see pregnant women who are opioid dependent in special clinics. Their job is to case manage the women and provide them with information and support throughout their pregnancy and for then six weeks post-natal. They can arrange for inpatient detoxification or stabilisation if necessary. Each one is attached to one of the three maternity hospitals in Dublin; the National Maternity Hospital, the Rotunda and the Coombe Women & Infants University Hospital.⁴³⁸

A National Women & Infants Health Programme (NWIHP) was established in 2017 to lead the management, organisation and delivery of maternity, gynaecological and neonatal services.⁴³⁹ It was recommended in National Maternity Strategy that the NWIHP examine the need to provide Drug Liaison Midwives and specialist medical social workers in all maternity networks.⁴⁴⁰ A booklet “Substance Misuse in Pregnancy” has been developed to provide women with information on the possible effects of drug use during pregnancy.⁴⁴¹

Members of the Travelling Community

It is recognised that there is a high prevalence of problem drugs and alcohol use within the traveller community. Since 2007 the National Drug Treatment Reporting System has recorded the ethnicity of individuals seeking treatment. This should allow service providers to better understand the specific needs of Travellers with problem substance use and provide them with targeted, effective services.⁴⁴² Travellers represent approximately one half percent of the population of Ireland. However, 3.6% of people treated for problem drug use in 2015 were from the Travelling community.⁴⁴³ The Department of Health acknowledges that good

⁴³⁷Department of Health, ‘Reducing Harm, Supporting Recovery’, (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 42.

⁴³⁸ Department of Health, ‘Creating a Better Future Together: National Maternity Strategy 2016 – 2026’ (2016) 61 <<https://health.gov.ie/blog/publications/national-maternity-strategy-creating-a-better-future-together-2016-2026/>> accessed 29 January 2019.

⁴³⁹ ‘National Women & Infants Health Programme’ (HSE) <www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/> accessed 28 October 2018.

⁴⁴⁰ Department of Health, ‘Creating a Better Future Together: National Maternity Strategy 2016 – 2026’ (2016) 61 <<https://health.gov.ie/blog/publications/national-maternity-strategy-creating-a-better-future-together-2016-2026/>> accessed 29 January 2019.

⁴⁴¹ibid.

⁴⁴² Anne Marie Carew and others ‘Travellers accessing addiction services in Ireland (2007 to 2010): analysis of routine surveillance data’ (2013) 12(4) Journal of Ethnicity in Substance Abuse 339 <www.drugsandalcohol.ie/20892> accessed 28 October 2018.

⁴⁴³ Department of Health, ‘Reducing Harm, Supporting Recovery’, (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 42.

practice guidelines, produced on behalf of this community, provide useful and practical advice on supporting Travellers who need to use treatment services and should inform and guide service providers.⁴⁴⁴ An example of such guidelines is the ‘Pavee Pathways: Good Practice Guidelines for drug and alcohol services working with Travellers’.⁴⁴⁵

People with Co-Occurring Mental Health and Substance use Problem

The HSE’s Mental Health Division is working with the Clinical Strategy and Programmes Division to develop a National Clinical Programme for assessing and managing patients who have co-morbid mental illness and substance misuse problems, i.e. Dual Diagnosis.⁴⁴⁶

The aim of this Programme is to develop a standardised evidence-based approach to the identification, assessment and treatment of co-morbid mental illness and substance misuse. This includes increasing awareness of the frequent coexistence of mental illness and substance misuse; ensuring there is a clear clinical pathway for management of people with such a dual diagnosis, including when they present to Emergency Departments; ensuring a standardised service is provided throughout the country; and ensuring adolescents are also included within the scope of this Clinical Programme.⁴⁴⁷ It is intended that this programme will be integrated across the Primary Care Division. However, it is unclear when it will become mainstreamed in Mental Health Services. On its establishment, the estimated time frame was two years.

Homeless Persons

People who are homeless are at a far higher risk of problem drug use than people in secure housing. As of 2015, 9.2 percent of people seeking drug treatment were homeless.⁴⁴⁸

⁴⁴⁴ibid 47.

⁴⁴⁵ Siobhan Cafferty, ‘Pavee Pathways: Good Practice Guidelines for drug and alcohol services working with Travellers’ (Pavee Point Travellers Centre, 2011)
<<https://www.drugsandalcohol.ie/16232/>> accessed 29 January 2019.

⁴⁴⁶Department of Health, ‘Reducing Harm, Supporting Recovery’, (2017)
<<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 42; ‘Programme for those with Dual Diagnosis’ (HSE Social Inclusion)
<www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/dual-diagnosis/> accessed 28 October 2018.

⁴⁴⁷ Department of Health, ‘Reducing Harm, Supporting Recovery’, (2017)
<<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 47.

⁴⁴⁸ Health Research Board, *Drug Treatment in Ireland NDTRS 2009-2015* (2017) 7.

In *Rebuilding Ireland: Action Plan for Housing and Homelessness*, the Government committed to a tripling of the target for tenancies to be provided.⁴⁴⁹ The Budget 2019 reflects this commitment, by allocating an additional €30 million for homelessness services, €60 million extra in funding for additional emergency accommodation and €1.25 billion for new social housing.⁴⁵⁰

Conclusions and Recommendations

Looking at international studies it is clear that SIFs are a progressive and beneficial public policy measure taken to counteract the problem of the use of illicit drugs on the streets in reducing the harm associated with such drug use. The introduction of the first SIF in Ireland is a welcome and necessary step in aiding and accommodating individuals suffering from addiction. SIFs are a way to promote recovery whilst preserving an individual's dignity in the treatment process. Therefore, emphasis on the further establishment of SIFs would be a positive addition to the new drug policy.

In relation to residential treatment services, it is clear that some progress has been made to improve services, however, inefficiencies within the services still exist, for example the incapacity to cope with complex needs and the problematic referrals process. This further marginalises individuals with drug addiction problems from seeking help. As a result, it is recommended to that these inefficiencies be effectively targeted through the policy.

It is evidently recognised that some drug users have more complex needs than others and steps have been taken to improve access to treatment for various vulnerable groups such as women and members of the traveller community. More specialised policies such as these should be developed and implemented to ensure vulnerable drug users continue to obtain the services they need.

The Drug Treatment Court in Ireland has the potential to help a very narrow category of drug users who already have a support system available to them to keep them motivated and on

⁴⁴⁹Department of Health, 'Reducing Harm, Supporting Recovery', (2017) <<https://health.gov.ie/blog/publications/reducing-harm-supporting-recovery-2017-2025/>> accessed 27 January 2019, 45; Department of the Taoiseach, *Rebuilding Ireland: Action Plan for Housing and Homelessness* (2016).

⁴⁵⁰ The Department of Finance, *Expenditure Report: Part II - Expenditure Allocations 2019-21* (2018) <[http://budget.gov.ie/Budgets/2019/Documents/Part%20II%20-%20Expenditure%20Allocations%202019-21%20\(2\).pdf](http://budget.gov.ie/Budgets/2019/Documents/Part%20II%20-%20Expenditure%20Allocations%202019-21%20(2).pdf)> accessed 28 October 2018.

track throughout each phase of the programme. However, as mentioned above, each drug user brings with them individual circumstances and challenges and the DTC is currently ill-equipped to deal with this multitude of user profiles.

VIII: Movements to Reform

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The aim of this section is to discuss and analyse the movement to reform approaches to drug use. First, it will analyse the potential domestic legislative reforms on the horizon, with particular regard to the Controlled Drugs and Harm Reduction Bill 2017. It will show how the policy embedded in this Bill reflects the aims and aspirations of the reformist movement. Second, It will discuss the concept of alternatives to punishment more broadly, charting the increasing calls by international bodies such as the UN and the OAS for such alternatives to be introduced. Third, it will discuss the arguments for reform of public healthcare to adequately provide for cases of dual diagnosis, whereby the patient suffers from mental illness and substance abuse concurrently. It will conclude that in each area of discussion there is clear evidence of a desire for reform, but much of this has failed to be implemented in policy or practice. Such implementation is paramount for this movement to reform to have any actual impact.

Pending Legislative Reforms

With indications that attitudes in the country are becoming more liberalised towards possession of certain drugs for personal use,⁴⁵¹ some legislative proposals on the topic have either already been put forward (as in the case of the Controlled Drugs and Harm Reduction Bill 2017), or are expected in the near future (as with the pending governmental national drugs strategy working group report covering, inter alia, possible decriminalisation, expected in early 2019). For many years, the government as well as NGOs, such as the Ana Liffey Drug Project, have been developing various working groups and policy proposals to devise a ‘new approach’ for how to effectively tackle drug use in Ireland.⁴⁵² Since drug decriminalisation is such a charged legal and political debate, taking substantive steps towards decriminalisation of any kind has proved a daunting task. It can be tempting for successive governments to establish working group after working group, or request policy paper after policy paper, none of which eventuate in substantive legislative reforms, so as to pass the buck to the next administration.

⁴⁵¹ See Darragh Brophy, ‘Almost Half of Irish People Are In Favour of Legalising Cannabis for Recreational Use’ *thejournal.ie* (Dublin, 04 December 2016) <<https://www.thejournal.ie/cannabis-recreational-use-ireland-poll-3115926-Dec2016/>> accessed 20 October 2018.

⁴⁵² The Ana Liffey Project has been heavily involved in researching the potential decriminalisation of controlled drugs for personal use and has been heavily supportive of such decriminalisation; see their most recent report on the subject: ‘Decriminalise people who use drugs in Ireland – New Report’ (ALDP, 08 October 2018) <<http://www.aldp.ie/news/decriminalise-people-who-use-drugs-in-ireland-new-report/>> accessed 19 October 2018.

No legislation to decriminalise the possession of controlled drugs for personal use in Ireland had been put forward until the Controlled Drugs and Harm Reduction Bill 2017 (hereafter ‘the 2017 Bill’). After all, the language in s 3 of the Misuse of Drugs Act 1977 as it exists currently, criminalising the possession of controlled drugs, is uncompromising and reflects the inflexible stance taken in Ireland to date towards drug usage. The offence is for possession *simpliciter* and does not discriminate as to whether the possession was for personal use or not.⁴⁵³ It is an equal-opportunities offence in that all that must be proved is the accused did have the drugs in their possession.⁴⁵⁴

The 2017 Bill was spearheaded by Senators Lynn Ruane and Aodhán Ó’Ríordáin. This private member’s bill was put up for debate in the Seanad on 31 May 2017 but was opposed by the government based on concerns over the removal of the offence of possession from existing legislation as well as a desire to wait for impending National Drug Strategy reports.⁴⁵⁵ The Bill is nonetheless worth examining on account of its bold ideas for reform, in particular the decriminalisation of controlled drugs for personal use (up to a certain quantity) and the establishment of a drugs dissuasion service based on the Portuguese model, which may well form the blueprint for future legislation even though the Bill is not itself likely to progress into law.

Decriminalising the possession of controlled substances for personal use is the central thrust of the 2017 Bill. This is undertaken in section 3 therein, which proposes to amend the Misuse of Drugs Acts 1977-2017⁴⁵⁶ to the effect that ‘[a] person who has a controlled drug in his possession shall not be guilty of an offence [in cases where] the possession is for personal use only [and] the quantity possessed does not exceed the maximum amount for personal use and possession’.⁴⁵⁷ Notably, the delimitation of the permitted maximum quantities for possession for different drugs is assigned to the Minister for Health, per s 3(2) of the Bill. This in part

⁴⁵³ *State (Gleeson) v District Judge Connellan* [1988] 1 IR 559 at 561: ‘The question of *use only* arises in relation to the penalties to be imposed if and when the accused person is convicted of the offence.’

⁴⁵⁴ See Martin McDonnell, *Misuse of Drugs: Criminal Offences and Penalties* (Bloomsbury Professional 2010) at 206.

⁴⁵⁵ See the comments of the Minister of State at the Department of Health Catherine Byrne during the debate on the Controlled Drugs and Harm Reduction Bill 2017 in the Seanad: Seanad Deb 31 May 2017 <<https://www.kildarestreet.com/sendebates/?gid=2017-05-31a.442>> accessed 21 October 2018.

⁴⁵⁶ Construed together for convenience, per s 13(2), Misuse of Drugs (Supervised Injecting Facilities) Act 2017. See also *People (DPP) v Power* [2007] IESC 31.

⁴⁵⁷ Controlled Drugs and Harm Reduction Bill 2017, s 3(1).

reflects the reality that with so many permutations and new types of drugs being introduced on a frequent basis, it is extremely difficult to lay down in legislation the particular specifications for all drugs without such legislation constantly being in danger of obsolescence. However, it also accords the Minister a great deal of responsibility and discretion in this area, and we have seen, in the case of *Bederev*, how the absence of legislative guidance can cause significant administrative problems in the context of drug classifications.⁴⁵⁸

The second most significant proposal in the 2017 Bill is the establishment of a ‘Drugs Dissuasion Service’.⁴⁵⁹ This element of the Bill is modelled heavily on Portugal’s eighteen dissuasion commissions, as discussed in Part IV.I, which consist of a lawyer, psychiatrist, and social worker. The dissuasion service proposed in the 2017 Bill is consciously less adversarial than its Portuguese inspiration and instead sets out a system whereby a ‘case officer’ is assigned to carry out drug dissuasion assessments with persons referred to her, rather than a tripartite panel.

Under the 2017 Bill, the case officer can make one of four recommendations: that the referred person undergoes a drug awareness programme (eg for first-time or infrequent drug users); a drug rehabilitation programme (for persons suffering from drug addiction or entrenched usage); a community engagement programme (essentially the same as community service but with a greater emphasis on helping and encouraging the referred person to overcome their drug usage); lastly, the case officer has discretion to make no recommendation to any of the previous three programmes if the officer decides the drug usage in question is too inconsequential to warrant further action. Notably, the wording of this section was replicated in the public consultation questionnaire carried out by the Department of Health on the topic in the summer of 2018, indicating the Bill has had an impact within the government and its provisions have been taken into account.

The Controlled Drugs and Harm Reduction Bill has been stuck in the second stage of the legislative process since its adjournment in the summer of 2017. While the Bill is unlikely to see passage into law, it has broken the taboo on introducing legislation to decriminalise the

⁴⁵⁸ See *Bederev v Ireland* [2014] IEHC 490; [2015] IECA 38; [2016] IESC 34; the High Court’s declaration of unconstitutionality temporarily made all controlled substances under the 1977 Act legal, before this was remedied by the Supreme Court overturning the judgment.

⁴⁵⁹ 2017 Bill, ss 5; 9-20.

possession of drugs for personal use in Ireland. It remains to be seen how much of the Bill's substance, if any, will be incorporated into the government's upcoming working group report, due for release in the beginning of 2019. What is certain is that where decriminalisation of possession would once have been seen as absolutely inconceivable among lawmakers and the public alike, the needle has now shifted and the emphasis is firmly on treating drug users rather than imprisoning them.

Alternatives to Punishment

Contemporary movements have called for reform with regards to the legal consequences of drug related crimes, asking the Government to consider alternatives to straight-forward punishment that would better serve all parties involved; the offender, the State and the tax payer. The alternatives to punishment put forward usually take one of two forms; alternatives to imprisonment, or alternatives to punishment in every respect. This is a critical distinction to make when considering the future of reforming consequences for drug crimes in Ireland. Obligatory rehabilitation may offer a suitable alternative to imprisonment. However, it does not necessarily represent an alternative to punishment, which would require an outright decriminalisation of drug use.⁴⁶⁰ While 'alternatives to conviction or punishment' emphasises the aim of the policy response, 'alternatives to prison' emphasises the setting.⁴⁶¹ As affirmed by The OAS Drug Report,⁴⁶² a recent report which focused on the drug related problems of the two American continents, responses to drug use which are punitive in nature tend to discourage those who are most vulnerable to addiction and substance abuse from seeking the healthcare and the prevention programmes that they require.⁴⁶³ The current

⁴⁶⁰ EMCDDA, 'Prisons and the Criminal Justice System' (Policy and Practice Briefings) <http://www.emcdda.europa.eu/best-practice/briefings/prisons-and-the-criminal-justice-system_en> accessed 29 January 2019.

⁴⁶¹ *ibid.*

⁴⁶² Reos Partners, 'The OAS Drug Report; 16 Months of Debates and Consensus' (May 11 2015) <<https://reospartners.com/publications/the-oas-drug-report-16-months-of-debates-and-consensus/>> accessed 29 January 2019.

⁴⁶³ The Technical Secretariat Working Group on Alternatives to Incarceration, 'Technical Report on Alternatives to Incarceration for Drug-Related Offenses' (CICAD, 2015) <http://www.oas.org/en/media_center/press_release.asp?sCodigo=E-185/15> accessed 29 January 2019.

punitive regime applied to drug crimes in Ireland places sanctions that are arguably too severe on those at the lowest level of the drug trafficking chain, who only possess and consume small quantities. Therefore, it would seem a desirable outcome for all if drug-dependent offenders were to engage with treatment as a consequence of misuse of drugs, as opposed to serving time in prison. There is reasonable evidence for the effectiveness of this approach in reducing recidivism, hence reducing overcrowding in prisons and the financial burden on the taxpayer to support such institutions.⁴⁶⁴

In spite of this, there are few countries in Europe that have introduced this model for alternative to punishment. It is more common, and often more desired by a country, to simply introduce outright decriminalisation that would incite no punishment at all for drug use. However, the argument may be made that this may put those in serious need of rehabilitation treatment at risk of not receiving help if mandatory rehabilitation is not considered a part of the legal alternative to punishment for drug use.

It is important to note that incarceration often worsens the already complicated lives of those who abuse drugs, especially young offenders, rendering them more likely to return to drug use upon release from prison. There is also no evidence to support that a person who has been incarcerated for drug use would be any less likely to commit a new offence than another offender sentenced to an alternative community or rehabilitative sanction.⁴⁶⁵ In fact, evidence shows that there is no direct link between the nature of punishment and the rate of a crime.

The prison environment can in fact bring offenders closer to other criminals and crime groups, creating a damaging sense of criminal identity and making offenders more vulnerable to turning to drug use upon release from prison.⁴⁶⁶ Many of the offenders who currently end up in prison for drug related crimes suffer from mental health problems, come

⁴⁶⁴ *ibid.*

⁴⁶⁵ Mariam Razmadze, David Otiashvili, Nino Balanchivadze, Mzia Tabatadze, 'Alternatives to Incarceration for Drug-Related Offences; Policy Review Paper' [2015] <https://www.researchgate.net/publication/314170569_Drug_Situation_in_Georgia_Analytical_report_for_2015> accessed 29 January 2019.

⁴⁶⁶ *ibid.*

from deprived backgrounds or experience addiction. They need rehabilitation, training and after-care.⁴⁶⁷

The IDPC Drug Policy Guide⁴⁶⁸ suggests that drug use be considered as a health issue and that incarceration should only be used as a last resort, and only for high-level, violent drug offenders. The report affirms that ‘a paradigm shift is urgently needed, in order to address this situation’ and highlight the importance of recalling that most prison inmates are incarcerated for drug offences of a minor, non-violent nature.

The United Nations Office on Drugs and Crime⁴⁶⁹ asserts that, from a public health perspective, the recommended approach to drug crimes is not conviction nor punishment, but rather the provision of treatment and care for people with drug problems as before anything else, they are patients. They suggest ‘a pragmatic public health response to the drug problem.’ This incites that alternatives to incarceration of people with drug use disorders must therefore be reconsidered; ‘in line with the international drug control conventions, people affected by drug use disorders do not need to be punished.’⁴⁷⁰ Alternatives to imprisonment for drug related crimes which placed an emphasis on treating addiction rather than punishing drug users would appear the best route for the Irish government to take in reforming the criminal justice system as applied to drug offences.

Dual Diagnosis

Dual Diagnosis is defined by Dual Diagnosis Ireland as “the term used when a person suffers from both a substance addiction problem and another mental health issue.”⁴⁷¹ It is contended that Dual Diagnosis is not the focus of mental health and addiction treatment that it ought to

⁴⁶⁷ Alan Shatter, ‘Alternatives to Prison are in the Best Interests of Irish Society’ *The Irish Times* (Dublin, 2 May 2014).

⁴⁶⁸IDPC, ‘Alternatives to Incarceration’ <http://fileserv.idpc.net/library/IDPC-guide-3-EN/IDPC-drug-policy-guide_3-edition_Chapter-3.4.pdf> accessed 29 January 2019.

⁴⁶⁹ UNODC, ‘Alternatives to Imprisonment’ (Criminal Justice Handbook Series, 2007) <<https://www.unodc.org/unodc/en/hiv-aids/new/alternatives-imprisonment.html>>.

⁴⁷⁰ *ibid.*

⁴⁷¹Dual Diagnosis Ireland, <<https://www.dualdiagnosis.ie/>> accessed 29 October 2018.

be. Rather, a dualistic approach of treating a patient's addiction and their mental health illness separately is favoured. It is submitted that this dualistic approach fails to provide Dual Diagnosis patients with the integrated care that they need. Furthermore, while numerous calls for an integrated approach in Ireland have been made, they have all failed to be implemented as policy. The Irish approach will be contrasted with the stance taken in the United Kingdom, where policymakers have established a stronger framework, allowing for a more integrated approach to occur.

As MacGabhann, Moore and Moore note,⁴⁷² the dualism in treatment begins at the institutional level. Policy for mental health treatment was initially developed by the Department of Health and Children. In contrast, policy development for substance misuse and addiction was developed as part of the National Drugs Strategy by the Department of Tourism, Sport and Recreation. Dual Diagnosis was not mentioned in the policy of either department, nor was it provided following a report on Dual Diagnosis in Ireland by the National Advisory Committee on Drugs in 2004.⁴⁷³ The consequences of this division led to, inter alia, exclusion policies that functioned as Catch 22s for patients with Dual Diagnosis, with addiction treatment programmes excluding patients who also suffered from psychosis, and psychiatric treatment programmes excluding patients who suffered from addiction.⁴⁷⁴

Calls for Reform

Repeated calls have been made for reform of addiction services and mental health care towards a more integrated approach. The 2006 Vision for Change Report recognized Dual Diagnosis under the term comorbidity. It recommended for the establishment of specialist Dual Diagnosis community mental health teams.⁴⁷⁵ Likewise, the publication of the 2009

⁴⁷² Liam MacGabhann, Angela Moore and Carol Moore, 'Dual diagnosis: evolving policy and practice within the Irish healthcare system' 2010 3(3) *Advances in Dual Diagnosis* 17,18.

⁴⁷³ Liam MacGabhann, Alexandra Scheele, Triona Dunne, Pamela Gallagher, Pdraig MacNeela, Gerry Moore & Mark Philbin, 'Mental Health and Addiction Services and the Management of Dual Diagnosis' (2004, National Advisory Committee on Drugs) <<https://www.nacda.ie/index.php/publications/110-mental-health-and-addiction-services-and-the-management-of-dual-diagnosis-in-ireland.html>> last accessed January 07 2019.

⁴⁷⁴ Liam MacGabhann, Angela Moore and Carol Moore, 'Dual diagnosis: evolving policy and practice within the Irish healthcare system' 2010 3(3) *Advances in Dual Diagnosis* 17,19.

⁴⁷⁵ Government of Ireland, 'A Vision for Change: Report of the Expert Group on Mental Health Policy' (2006) <<https://health.gov.ie/future-health/mental-health-a-vision-for-change/a-vision-for-change/>> accessed January 7 2019.

Interim National Drugs Policy called for addicts to have clearer links to mental health services once they went through a detox period.⁴⁷⁶ Unfortunately, while these reports raised awareness around Dual Diagnosis, they were never implemented as policy.

More calls for reform came in 2009, when a report on addiction services was published by the office of the Comptroller and Auditor General (CAG). The Report found that poor data collection meant that all clients had received insufficient outcomes, not just clients with Dual Diagnosis. It recommended that the accuracy of information be improved, and that a national care planning framework be developed.⁴⁷⁷ Most recently, a proposal for a facility for co-occurring conditions in North Tipperary was brought before the Oireachtas, and while it was favourably received, “it has been effectively ignored ever since.”⁴⁷⁸

Dual Diagnosis in the United Kingdom

Unlike Irish treatment services chastised in the 2009 CAG Report for inaccurate information, reliable statistics regarding Dual Diagnosis are readily available from the UK. These serve as an important indicator of how many people suffer from co-occurring conditions. For example, up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems.⁴⁷⁹ Similarly among offenders in the UK, coexisting substance misuse and mental health issues are the norm rather than the exception.⁴⁸⁰ Parliament has also been more active in furthering Dual Diagnosis in Britain. Since 2007, the All Parliamentary Group on Complex Needs and Dual Diagnosis has “sought to ensure the issue is kept on the political agenda”.⁴⁸¹ Unlike in Ireland, the UK government adopted some of the more radical

⁴⁷⁶ Department of Community, Rural and Gaeltacht Affairs, ‘National Drugs Strategy (Interim) 2009–2016’ (Dublin, 2006) <www.pobail.ie/en/OfficeoftheMinisterforDrugs/file,10108,en.pdf> accessed October 29 2018.

⁴⁷⁷ Comptroller and Auditor General, ‘Special Report: Drug addiction treatment and rehabilitation’ (Dublin, 2009) <<http://audgen.gov.ie/viewdoc.asp?DocID=1142&CatID=5&StartDate=1+January+2009>> accessed October 29 2018.

⁴⁷⁸ Chris O’Donnell, ‘Plight of those with ‘dual diagnosis’ most evident in the homeless’ *The Irish Times* (Dublin, 27 July 2018).

⁴⁷⁹ Turning Point, ‘Dual Dilemma: The impact of living with mental health issues combined with substance and alcohol misuse’ (2016) 3, <https://www.turning-point.co.uk/_cache.../dual_dilemma-5090910000020596.pdf> last accessed 07 January 2019.

⁴⁸⁰ See Keith Bradley, ‘The Bradley report: Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system’ (2009) <<https://lx.iriss.org.uk/sites/default/files/resources/The%20Bradley%20report.pdf>> accessed 07 January 2019.

⁴⁸¹ Turning Point, ‘Dual Dilemma: The impact of living with mental health issues combined with substance and alcohol misuse’ (2016) 3, <https://www.turning-point.co.uk/_cache.../dual_dilemma-5090910000020596.pdf> last accessed 07 January 2019.

strategies put forward to tackle this issue, which emphasised the importance of mental health and allowed for the creation of more integrated approaches to care by local authorities. This implementation of proposals into policy has led to legislation furthering these objectives, with the 2012 Health and Social Care Act that integrated local authorities and the NHS even further. While “joint commissioning across addiction support and adult psychiatry, remains rare with many service users continuing to fall through the gaps in service provision”⁴⁸² the approach in the UK towards prioritizing Dual Diagnosis seems to be advancing at a much quicker pace than in Ireland. One can only hope that the Oireachtas begins to implement more strategy into policy, as failing to do so means the majority of people with co-occurring conditions will go without the integrated care they need.

Conclusion

Evidence of a desire for reform is clear within the various areas of focus discussed above. However, it is submitted that the movement to reform will be a movement without momentum unless concrete policy changes are enacted that reflect this public desire, and examples of procrastination to take this step are equally evident from the discussion above. Thus, the 2017 Bill has stagnated on its journey through the lengthy legislative process, and we can only hope that some of the ambitious proposals within it will be reflected in the forthcoming working group report. While successive governments have failed to act on this issue for fear of public opprobrium, it has been discussed how alternatives to punishment for drug use are being called for by international bodies worldwide. With that in mind, it is contended that the current government is more likely to gain public as well as international support from adopting a more holistic, progressive approach to drug use, rather than adhering to the jaded punitive orthodoxy that is increasingly challenging to defend. A good first step for this movement to reform would be for Irish mental health and addiction support services to coordinate their efforts by giving the concept of dual diagnosis the importance it deserves. As drug users make up the majority of people requiring assistance from both forms of support, failure to adopt dual diagnosis is failure to provide the most effective care to the majority of those seeking it. It is hoped that in this process of treating drug users with the dignity and support they deserve, the movement for harm reduction and an alternative

⁴⁸² Russell Webster, ‘Mental Health and Substance Misuse: A Dual Dilemma’ (11 April 2016) <<http://www.russellwebster.com/mental-health-substance-misuse-a-dual-dilemma>> accessed 07 January 2019.

approaches to punishment will gain increasing momentum, leaving a lasting impact on domestic policy going forward.

Conclusion and Recommendations

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As a result of the research conducted in this project the following recommendations can be made:

General Reformation in Irish Drug Policy

- The Irish strategy should be refocused towards demand-centric policies and away from efforts that only look at controlling supply. Supply-centric law enforcement activity has done little to measurably increase the price of drugs on the Irish market or make the provision of drugs less available. Rather, it has encouraged organised crime to become more creative in methods for supply and inadvertently been a contributor to gang violence in Ireland. A reorientation towards demand measures would involve reallocating resources towards drug rehabilitation, providing infrastructure in poverty-stricken areas and reinforcing educational projects to teach about the dangers of drug abuse.
- Any new Irish policy must address the rise of newly produced drugs (NPDs). Ireland should look at developing more responsive legislation and closing the loopholes contained in the Criminal Justice (Psychoactive Substances) Act 2010. The Act should be modified to enforce the original blanket ban on NPDs as originally intended, with exceptions given to prescription drugs and NPDs that are shown to be non-harmful to the public. Ireland should consider legalising drugs that offer safe alternatives to mainstream dangerous drugs, such as benzylpiperazine (BZP) and Mephedrone (4-methylmethcathinone), both of which act as safe substitutes to MDMA.
- Ireland should cooperate with other nations to create an international piece of legislation that would address the rise of crypto markets and the internationalisation of the illegal drug trade. Ireland should address head on the multi-jurisdictional issues that arise through the use of the Internet.

Reformation of Legislation

- This paper also recommends that the criminal offence of possession be removed from the Misuse of Drugs Act 1977. In a manner similar to the Czech Republic and Portugal, possession under a certain quantity should be decriminalised as being

merely possession for personal use. As in current Irish legislation, the line between possession and intention to distribute should be drawn by the amount of a controlled substance possessed. This should be characterised by the weight of the drug and an estimate of what a day's supply would be, rather than the street value of a drug which can be difficult to ascertain with a degree of certainty.

- Possession of a controlled substance should be restructured to require administrative penalties, in a matter similar to Portugal. The use of administrative punishments could provide an adequate deterrent effect without punishing an offender for their addiction. In particular, the use of a mandatory addiction programme could be particularly effective in Ireland.
- Legislators should also intervene to provide a satisfactory definition of possession under Irish law. Measures led by the courts have led to conflicting case law, particularly regarding the requisite knowledge required to prove possession. Guidelines should be given to the courts as to what level of knowledge is required, what level of control necessary for constructive possession and how to determine knowledge of controlled drugs in containers.
- Like the Irish Penal Reform Trust, this paper also recommends the removal of the mandatory minimum under S27 of the Misuse of Drugs Act 1977. Through much academic study, both in Ireland and abroad (mainly the U.S.), mandatory minimums have been proven to be an ineffective deterrent. Rather, set guidelines for sentencing should be given to judges, maintaining their ultimate discretion to decide on the length of the sentence, while also helping to ensure some form of consistency between cases.

Legalisation of Low-Risk Drugs

This paper also tentatively suggests the legalisation of low-risk drugs, such as marijuana.

There are several reasons for this:

- The harm caused by these drugs may be confined only to their inadvertent contribution to organised crime. As stated in the introduction to this paper, the prohibition of drugs has led to the expansion of organised crime, providing cartels with a key source of income. In particular, cannabis makes up the majority of criminal revenues. By legalising cannabis, Ireland would remove one of the key sources of income for organised crime at home and international cartels abroad.

- Ireland should look to regions such as Spain and The Netherlands who have legalised cannabis in structuring their policy. The use of CSCs in Spain could be a meaningful alternative, ensuring that marijuana use is contained within small networks of people.
- Moreover criminalisation of low-risk drugs also acts as an ineffective deterrent for use. Coupling this with the fact that these drugs are low-risk, criminalising them is a waste of public expenditure and causes more harm by subjecting these individuals to imprisonment or other sanctions than good. With controls as to when these drugs can be used, in a manner similar to alcohol, low-risks drugs can be regulated in a safe manner.

Reformations in the link between Mental Health, Poverty and Drugs

- Considering the results of the Illicit Drug Markets in Ireland 2014 Report, focus should be placed in providing facilities, investing in lower income areas and providing a structure for support in areas most affected by drug abuse.
- Efforts must also be made to assure that whatever resources are made available in urban areas are also made available in rural areas; so as to close the urban-rural divide in drug management. The Drug Treatment Court should be extended outside of Dublin and made available to a greater rural region. Increased investment and research into this Court would provide valuable knowledge as to whether this type of response is effective in decreasing drug use.
- The homeless must be recognised as an important target group for any new piece of drug policy, particularly with regard to the fact that over half of the homeless population reported having tried drugs, and the proportion addicted to more dangerous drugs, such as heroin, is higher than the rest of the population. Greater provision should be given for residential treatment services in order to make these facilities more available to homeless individuals recovering from substance abuse.
- For health and safety reasons, namely to decrease the prevalence of BBVs, there should be continued and greater investment in supervised injection facilities. Similarly opioid substitution and naloxone treatment should be made more available, particularly outside of Dublin.
- Drug policy should adopt a new health-oriented approach that emphasises the importance of dual diagnosis. Mental illness and drug addiction must be dealt with in conjunction and it should be recognised that one feeds off the other. Thus, in any

harm reduction facility, such as the supervised injection centres, drug counselling should be made available for those who seek help.

Prison Reformation

- Prisons are in desperate need of greater funding and investment. The research studies quoted throughout this project demonstrate that prisoners will avail of the facilities if made available to them, but most prisoners cannot access the rehabilitative help they desire. Efforts should be made to make drug-free wings and detoxification programmes more available in prisons. The close relation of substance abuse and addiction to reoffending justifies drug treatment as being a top priority in prison policy.
- Greater focus should be given to prisoners in need of aftercare following their release from prison. The government should fund projects that provide prisoners with temporary accommodation, employment or addiction services.

Final Conclusion

This project has discussed at length the current concerns that exist in drug policy both in Ireland and abroad. At the centre of this issue is the social stigmatism that surrounds drug addiction. For too long, drug addicts have been dismissed as being criminals, uneducated or outside the realm of assistance. It is time for Ireland to finally establish a new paradigm that treats drug abuse addicts, their families and their communities with the dignity and respect they deserve.