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An Comhchoiste um Dhlí agus Ceart, Cosaint agus Comhionannas

Tuarascáil ón gCoiste maidir le cur chuige Laghdaithe Dochair agus
Athshlánaitheach i leith méideanna beaga drugaí neamhdhleathacha a
shealbhú

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Houses of the Oireachtas

Joint Committee on Justice, Defence and Equality

Report of the Committee on a Harm Reducing and Rehabilitative approach
to possession of small amounts of illegal drugs

November 2015

31/JDAE/035

APPENDIX 3

Submissions Received on the Review of Ireland's approach to the possession of limited quantities of certain drugs

Doc. No.	Received From
2015/599	Brian Rainsford Marshall (Member of the Public)
2015/600	Shay Dillon (Member of the Public)
2015/602	Harry O'Brien (Member of the Public)
2015/603	Seamus O'Shea (Member of the Public)
2015/604	Mark Colfer (Member of the Public)
2015/605	Anthony Colclough (Member of the Public)
2015/606	Joanne Scanlon (Member of the Public)
2015/607	Conor Madden (Member of the Public)
2015/608	Ciaran Wallace (Member of the Public)
2015/609	Niall Dawson (Member of the Public)
2015/610	Noel Phelan (Member of the Public)
2015/611	Jonathan Victory (Member of the Public)
2015/612	Cormac O'Loughlin (Member of the Public)
2015/613	Anthony Forrest (Member of the Public)
2015/614	(Member of the Public)
2015/615	Anwar Hssn (Member of the Public)
2015/616	Andrew Begley (Member of the Public)
2015/617	Brendan Egan (Member of the Public)
2015/618	Davis Eoghan (Member of the Public)
2015/631	Robert Kane (Member of the Public)
2015/632	Clondalkin Drugs and Alcohol Task Force
2015/633	Citywide Drugs Crisis Campaign
2015/634	BeLonG To
2015/635	Stephen Dennis (Member of the Public)
2015/636	Eadaoin Doyle (Member of the Public)
2015/637	Claire Bissett (Member of the Public)
2015/638	Fr. Peter McVerry SJ (Member of the Public)
2015/639	Gráinne Kenny (Member of the Public)
2015/640	Stephen Tyrrell (Member of the Public)
2015/641	Michelle Byrne (Member of the Public)
2015/642	Ciaran Rogers (Member of the Public)
2015/643	Tabor Group
2015/644	Transform Drug Policy Foundation
2015/645	Denis Murray (Member of the Public)
2015/646	Daniel Richardson (Member of the Public)
2015/647	Gary Devitt (Member of the Public)
2015/648	Drew T O'Gorman (Member of the Public)
2015/649	Lysette Golden (Member of the Public)
2015/650	Clondalkin Drugs and Alcohol Taskforce Coordinators Network
2015/651	Colm Walsh (Member of the Public)
2015/652	John Oakley (Member of the Public)

2015/653	Stephen Harris (Member of the Public)
2015/654	Robert Rodrigues (Member of the Public)
2015/655	Chris Murray (Member of the Public)
2015/656	Salvation Army, St Bricins Military Hospital Emergency Accommodation
2015/657	Ella Goddin (Member of the Public)
2015/658	Patrick King (Member of the Public)
2015/659	Conor McQuillan (Member of the Public)
2015/662	Florian Scheibein (Member of the Public)
2015/663	CDA Trust Ltd
2015/664	Rebecca Griffin (Member of the Public)
2015/665	James Conway (Member of the Public)
2015/666	Kid de Winter (Member of the Public)
2015/667	Human Rights Watch
2015/668	Dublin North East Drugs Task Force
2015/669	David Mc Vicker (Member of the Public)
2015/670	Family Therapy Association of Ireland
2015/671	Maria Langan (Member of the Public)
2015/672	Rachael Keogh (Member of the Public)
2015/674	Annmarie Condra (Member of the Public)
2015/675	U-Casadh Ltd
2015/676	National Organisation for the Reform of Marijuana Laws Ltd
2015/677	Timothy Murphy (Member of the Public)
2015/678	DCU Students for Sensible Drug Policy Ireland
2015/679	Release
2015/681	Irish Congress for Civil Liberties
2015/682	Community Awareness of Drugs
2015/683	Ana Liffey Drug Project
2015/684	Union of Students in Ireland
2015/685	Karolina Simonaviciute (Member of the Public)
2015/686	Association of Criminal Justice Research and Development
2015/687	Nathan Douglas (Member of the Public)
2015/688	Irish Penal Reform Trust
2015/689	Fr Peter McVerry Trust
2015/691	Irish Association of Social Workers
2015/692	Merchants Quay Ireland
2015/705	Irish Hospital Consultants Association
2015/707	Union for Improved Services, Communication and Education
2015/708	Neil Mannion (Member of the Public)
2015/709	Finglas Cabra Drug and Alcohol Task Force

Submission to the Committee on Justice, Defence and Equality

By

Brian Rainsford Marshall

A cairde,

I have been involved in activities related to raising awareness of alternative drug policies for three years now, I am happy to see that this committee has been set up and that we are having this much needed conversation.

It takes a lot to make an honest person become a criminal. This is the last line of the report. I could not disagree with this statement more. All it takes to make an honest person a criminal is to legislate against something that is beyond their control. Drug users should not be treated as criminals, this approach only serves to push them to the fringes of society. It makes a medical issue a legal issue, something which should never be the case. A system similar to that used in Portugal, which the report studies, is a much better approach than our current system. I think the report outlines that pretty clearly.

A further example of how getting rid of the criminalisation of drug users has a massive benefit on a society I would like to make the committee aware of the recent legalisation of cannabis in Colorado in the United States of America.

Article 18, section 16 of the Colorado state constitution currently outlines the following (Paraphrased):

(1) PURPOSE AND FINDINGS.

(a) In the interest of the efficient use of law enforcement resources, enhancing revenue for public purposes, and individual freedom, the people of the state of Colorado find and declare that the use of marijuana should be legal for persons twenty-one years of age or older and taxed in a manner similar to alcohol.

(b) In the interest of the health and public safety of our citizenry, the people of the state of Colorado further find and declare that marijuana should be regulated in a manner similar to alcohol so that:

(I) Individuals will have to show proof of age before purchasing marijuana;

(II) Selling, distributing, or transferring marijuana to minors and other individuals under the age of twenty-one shall remain illegal;

(III) Driving under the influence of marijuana shall remain illegal;

The first stores to legally sell cannabis opened their doors on January 1st of 2014. The Drug Policy Alliance made a report a year later which found the following:

According to the state's department of revenue, the first ten months of legal marijuana sales have resulted in nearly \$40 million in tax revenue. The city of Denver saw a decrease in violent crime rates in the first 11 months of 2014, following a similar trend in 2013. Statewide traffic fatalities continue to decline, according to the Colorado Department of Transportation. Upwards of \$8 million has been allocated to fund youth education and drug prevention efforts. And the state is experiencing economic growth and the lowest unemployment rate in years.

This is just an example of what can happen when a sensible drug policy based of reason is undertaken by a society, instead of the current system that is based on fear and

criminalisation.

As a recommendation I would suggest that the commission be made aware of the report published by the Global Commission on Drug Policy entitled:

Taking Control: Pathways To Drug Policies That Work (2014)

The report finds that the only sensible way to combat the problem of drugs in society is to completely change our approach to policing their users.

Backers of the report include the likes of former Secretary General of The United Nations, Kofi Annan, former President of Brazil, Fernando Henrique Cardoso, former President of Colombia, Cesar Gaviria, and the former President of Portugal, Jorge Sampaio,

Page thirteen of the report states the following, on the topic of enforcement based drug policy:

Fueling crime and enriching criminals

Rather than reduce crime, enforcement-based drug policy actively fuels it. Spiralling illicit drug prices provide a profit motive for criminal groups to enter the trade, and drive some people who are dependent on drugs to commit crime in order to fund their use.

- Drug prohibition has fuelled a global illegal trade estimated by the UNODC to be in the hundreds of billions. According to 2005 data, production was valued at \$13 billion, the wholesale industry priced at \$94 billion and retail estimated to be worth \$332 billion. The wholesale valuation for the drugs market is higher than the global equivalent for cereals, wine, beer, coffee, and tobacco combined.*
- Illicit, unregulated drug markets are inherently violent. Paradoxically, successful interdiction efforts and arrests of drug cartel leaders and traffickers routinely create power vacuums. These in turn can spur renewed violence as the remaining players compete to gain market share.*
- The trafficking in illicit drugs can strengthen armed groups operating outside the rule of law. For example, the opium trade earns paramilitary groups operating along the Pakistan-Afghanistan border up to \$500 million a year.*

To summarise my points and recommendations for the committee

- Our only true option in the fight against drugs is to change our current drug policy to a similar approach to Portugal.
- To stop treating drug use as a criminal issue, and to start treating it as a public health issue

- For the committee to be made aware of the Global Commission on Drug Policy's report *"Taking Control: Pathways To Drug Policies That Work (2014)"*

I would like to make it aware that I would be more than happy to appear in a public session at any committee meeting.

Shay Dillon

To whom it may concern

I'm a 24 year old male I've been smoking marijuana 7 years now not only does it help with headaches I get but helps overcome anxiety sometimes

My first view on this whole drug crisis is the simple fact that over 50 percent of people in court are there for minor offences nothing more than possession

Secondly some people are being convicted of such crimes which in turn has an effect later in life either getting jobs or travelling abroad. If it was proposed that this law was to take place then there would be a drastic change not only to the court system but also to supply

Further more if it was taken into account that medical marijuana was sold in shops to card holders with medical problems prescribed by a certain g.p the this would not only reduce the age of people beginning to smoke it but also create a vast sum of tax by the government

Marijuana is at its highest ever price in Ireland if the government came in and undercut the price all around Ireland it would not only lead to the shut down of major crime units but to the jail problem in this country aswell

I hope someone has took the time to read this and in some way this changes views to this current crisis

Regards

S.D

Sent from my Samsung Galaxy smartphone.

Harry O'Brien

i) I am a retired Garda who spends 6-9 months of the year in Portugal with my wife, in the region of Algarve. I am writing this e-mail from Ireland as I am home for my daughter's 40th Birthday.

ii) One of my neighbours in Portugal has a son who is a Police officer there. During my conversations with him, which happen regularly at birthdays, BBQs, etc., he told me that very little of his time was wasted with petty drug crimes, contrary to my experience as a Garda.

iii) I recommend that Ireland follows Portugal drug possession model, as it would allow the Gardaí to run more efficiently and effectively, saving the State time and money. I believe it was also lead to increased productivity as I know from experience that filling out unnecessary drug-related paperwork is certainly one of the few cons of being a Garda.

I hope my experiences can help The Committee decide whether they should change their approach to possession of limited quantities of certain drugs.

Seamus O'Shea

Dear Sir/Madam

I have long thought our drug policy wasn't working and that we need to take a more realistic approach, a criminal approach certainly does not work. The approach that Portugal has taken is a good model with proven results over a long period of time and I think it would be a most sensible and effective system when compared to complete illegality, that is the worst option available. Great to see us moving forward policy wise as a nation. You have my support. Thank you for your time.

Yours sincerely

Seamus O'Shea

Mark Colfer

I have no area of expertise in the matters that are currently under consideration in regards to altering the way in which drugs are classified in this state. I have however seen first-hand how easy it has been for friends and family to fall into the cycle of repeat offences caused by addiction.

Upon reading the article that was published by The Irish Examiner I was delighted to hear that the people are being given a chance to have their opinions on the matter heard. Something that is missing in most of the decisions made regarding legislation of any kind. I personally agree with the proposed system. The introduction of a safe injection clinic is something that I have believed in for several years as it will not only provide a safe place for addicts during their most vulnerable period, but will help to reduce the vast number of individuals that are using intravenous drugs in public places. This reduction of public drug use will I believe help to protect members of the public from the dangers that are left behind by these individuals, such as used needles. If the clinics are run in a competent manner it may also reduce the transmittal of infectious diseases, such as HIV and AIDs, within the drug use community as needle sharing could be phased out. If the cases of these diseases are reduced large savings could be made in the health system.

Submission

Dear Committee on Justice, Defence and Equality,

I am writing regarding your review of Ireland's approach to the possession of limited quantities of certain drugs. I am a teacher working in Dublin City. Given the overwhelmingly positive conclusions of the report written by your delegation of Committee members to Lisbon, it seems reasonable to me that Ireland adopt a similar drug policy. I would be wholeheartedly behind such a move. It seems to me that our current policy is based on regressive and uninformed ideas, has ignored all major pertinent social studies and is badly in need of updating.

Yours Sincerely,

Anthony Colclough

Joanne Scanlon

In relation to the proposal for decriminalization of drugs for personal use, I think this is a great idea. We are currently leading the way in change in the world, our vote for equality meant that USA took that step also. We are proving ourselves as being true big players in the world and ahead of the curve and progressive and we need that now more than ever. Things within the EU and Euro are quite unstable at the moment and I imagine more is to follow so I think it is really important that right now we brand ourselves as a nation. We may have to go this alone like we have before and it will be tough to start from scratch with that old trad Ireland brand nowadays. We have immense talents in the world of music and media and we have the potential to really make waves as a small nation and I believe this would be a step in the right direction.

We will be showing the world and our own people that when we said Yes to equality we meant it. It means that the people are being heard. The millions of people like me who cringe at every view of Ireland as a drunken place full of old stone walls and horse and traps, it would show Ireland in a true light, as a progressive nation that is really its own place that does not need to be held up by others such as the UK or EU, show the real Ireland.

People who purchase drugs for personal use do deserve some help. They deserve a chance; I mean rationally speaking a person who buys cannabis for personal use will most likely follow an extremely different path in life to the person buying heroin so they do not deserve to have their life ruined by a conviction. Also, to actually help people to get off drugs and make positive moves in getting off drugs is such a great message to put out there. It is Ireland saying that everyone can make a mistake but this country will not turn its back on you. We will help you, nurture you. Ireland is defined as being a 'she' a matriarch and it would make sense that this country should not punish human error but instead lend a hand and help like any caring mother.

I think this is a great idea for this country, I think there is hard evidence that this has worked before and it's great to see we are going to approaching this logically and from a sensible point of view. The idea is brilliant, it makes sense I just hope that this is represented in a logical way in the media and by campaigners as if the extremist on either side – left or right wing – get involved, all logic will be lost and potential good and the genuine sensibility of this idea will crumble.

I think it's great, I think you need to have educated people speak on this issue; it doesn't need to turn into a soapbox for the 'stoners' or the extreme 'ant-drugs' crew. I think if the facts in terms of State *saving* money etc are heard people will be on board.

And maybe more logical ideas will start to prevail and we might sort this country out before everyone is clinically depressed as most are already. So perhaps once this issue is taken care of we can focus on the issues within the private work sector in terms of mental health and health and safety and then the general mental health issues which are most likely growing and not being treated and worsened by the state of the economy and false lies and lack of progress and not being listened to.

Do it right, sell it well, no dumb PR moves or 'loud' representatives, logic and intellect can prevail here!

Great idea, keep up the good work on this stuff.

Thank you for reading this, I'll try to be brief.

The decriminalisation of drug-addiction is very welcome. The conclusion that all drugs will eventually be legalised is not only logical but desirable. Allow me to outline why. For the purposes of this submission I will assume all drugs will be legalised. Legalisation does not equate to condoning, Egg cigarettes etc. It is also worth remembering, one person's negative experience does not preclude others having positive experiences, in fact most of the harm associated is caused by the continued illegality of certain drugs. While full legalisation may be some time off, I believe proper planning for this inevitable eventuality is vital.

Portugal's approach is obviously working, now to fully control the market:

Sell all (currently illegal) drugs in government run shops.

In 2005 the estimation of the value of the illicit drug trade was €650m per annum*, not an insignificant amount. The problem with licencing and taxing supply is that while some of it goes to government in the form of taxes, lots more goes into private savings. This new model puts the government at the top of the supply chain. It allows the government collect nearly all revenue, reduces harm caused by underage/improper use, allows the government to responsibly control who takes drugs and where. We can also control where drugs come from, create employment, reduce criminality caused by addiction and, crucially, remove drugs and money from the hands of criminals.

Any revenue raised (and saved from hospitals, prisons, guards etc) should be ring-fenced for health, schools, infrastructure, art etc.

It is a simple fact: People will take drugs. If this submission is carried through I believe we would all benefit. Ireland has led the way for many things, this could be another.

Thank you for taking the time to read this, I am able to answer questions you may have.

Thanks

Conor Madden

*<http://www.irishtimes.com/news/illegal-drugs-trade-worth-650m-annually-1.1287885>

Cannabis:

Is legalisation right for Ireland?

Ciaran Wallace

(B.Sc.) Business and Law

DT321

Supervisor:

Sean Byrne

2015

Declaration

I hereby confirm that the following material, which I now submit for assessment as the 4th Year Research Project to help me achieve an undergraduate degree of B.Sc. in Business and Law, is completely my own work and has not been submitted for assessment for any other academic purpose elsewhere.

Ciaran Wallace

Date

Acknowledgements

I would like to thank a handful of people for their help along the way to completing this Research Paper;

First, I would like to say thank you to my supervisor Mr. Sean Byrne for setting me on the right path and giving me fantastic guidance on how to approach my topic.

Secondly, I would like to thank my loving family; Vincent, Rose, Iain, Keith and Laura for their continued encouragement and motivation when I needed it most.

Lastly, I would like to thank Rachael for always being there for me, Owen for his honest and extremely helpful feedback and Shane for making the short coffee breaks enjoyable and the long hours in the library bearable.

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Abstract

Title: Cannabis: Is legalisation right for Ireland?

Author: Ciaran Wallace

Cannabis plays a huge role in modern day Irish society, in this research project I will be examining the literature to see if legalisation of cannabis would be the right move to help Ireland take a step into a better and brighter future. In the literature review I will be looking at both the positive and negatives associated with cannabis legalisation, I will then be forming a personal opinion on the subject based on what the literature resembles and applying that knowledge in to the context of what I feel would be right for Ireland.

Introduction

A quick Google search of the word “marijuana” returns 107,000,000 pages, the word “cannabis” returns 65,900,000 pages. Similarly, a search of PubMed looking for scientific journals published within the last twenty years containing the word "cannabis" revealed over 8,637 results. If you add the scientific term "cannabinoid" the results increases to a staggering 20,991 articles. For context, that’s an average of more than two scientific articles published about the subject, per day over the last 20 years.

These figures, not only illustrate the significant scientific interest in the topic and the huge financial investment in attempting to understand more about cannabis and all of its components, but they also highlight the drastic need for high quality summaries, like the research project you are about to read.

In this research project, I’ll be discussing the positives and negatives of legalising the substance and whether legalisation would be the right decision for Ireland.

A lot of my research is based on primary research from America because of its reliability and because both Ireland and the US have a similar political and cultural lifestyle.

Basic background information

Cannabis is the most commonly used drug in the world, with an estimated 162 million current users, representing 3.9% of the worldwide population¹.

Cannabis use is more common in young people and in countries such as the US, Europe, Australia and New Zealand, though there is evidence to suggest that use is increasing globally².

Cannabis is said to give different types of “highs” to people, depending on the type and strength of the plant used. Some of which being:

Positives: feeling relaxed, feeling happy, increased enjoyment of music and art, more appreciation of the surroundings, forgetting cares and worries, better imagination and visualization, increased creativity, as well as more enjoyment of sexual activity and increased feelings of excitement³.

On the other hand, a number of negative side effects can also be attributed to cannabis use, including:

Negatives: Being forgetful, over sleeping, not getting things done, concentration difficulties, neglecting work or duties, loss of balance or dizziness, problems with performing tasks, and nausea⁴.

¹ United Nations Office on Drugs and Crime, 2006. World Drug report 2006. New York: United Nations.

² Hall, W and L. Degenhardt, 2009 Adverse health effects on non-medical cannabis use. Lancet, 374: 1383-1391

³ Hammersley R, Leon V (2006). Patterns of cannabis use and positive and negative experiences of use amongst university students.

⁴ Ibid

Chapter One:

Literature Review

What is Cannabis?

The hemp plant is said to contain over 450 different substances. Current research indicates only two of these substances are responsible for its intoxicating effect. Researcher's best understand these substances to be THC (delta-9-tetrahydrocannabinol) and Cannabidiol (CBD). They activate the two receptors in the body CB1 and CB2. Whilst the CB1 receptor in the central nervous system influences perception, the CB2 receptor in the tissue plays a crucial role in inhibiting inflammation⁵.

Cannabis can be defined as a genus of flowering plants. It can be broken up into three different species:

Cannabis Sativa

Cannabis Indica

Cannabis Ruderalis

All three species can be inter-bred freely, but Cannabis Ruderalis is rarely cultivated for its THC or CBD levels, so for the sake of this research project I will mainly be focusing on Cannabis Sativa, Cannabis Indica and a hybrid of both the Sativa and Indica breeds.

Cannabis Sativa⁶

Cannabis Sativa is classified as an annual herbaceous plant and a member of the Cannabaceae family.

They are a tall, outdoor plants that can grow up to 25 metres in height and are usually grown in warm to temperate regions around the world, but were originally native to the caucusus region of Eastern Europe, India, and Iran.

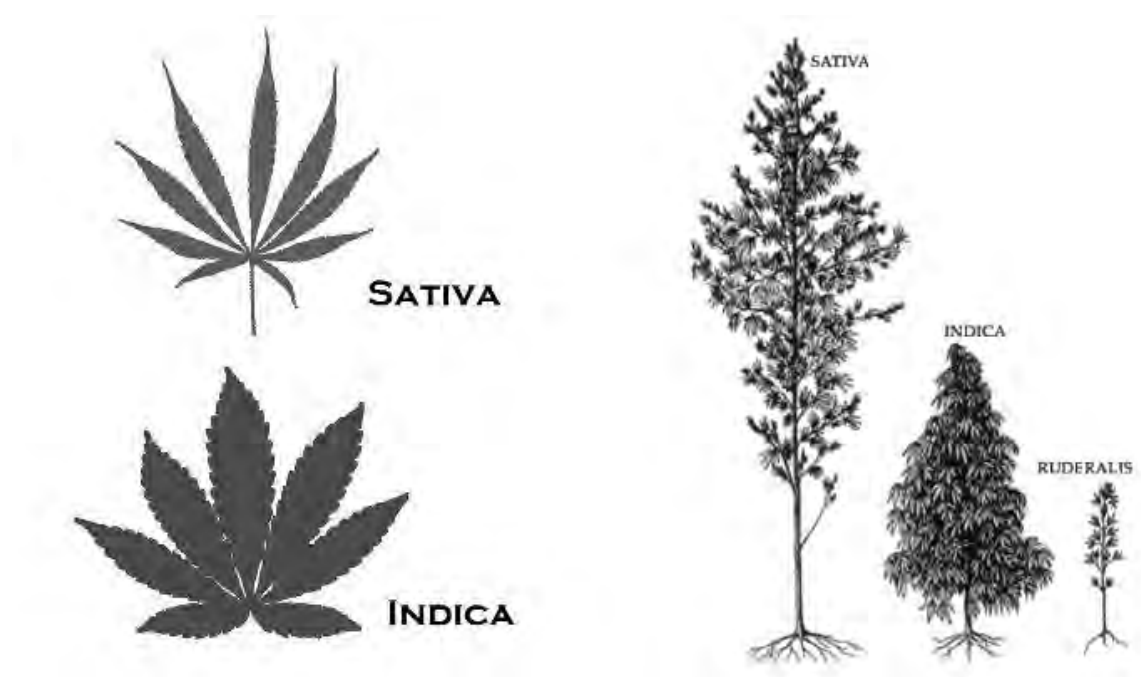
Although the plants may be different in appearance, it should be noted that Cannabis Sativa and Cannabis Indica are biologically the same plant. The name Indica refers to a geographical area in which the plant is grown.

⁵ Science Daily, 22 July 2008, ETH Zurich/Swiss Federal Institute of Technology. "Why Cannabis Stems Inflammation." <www.sciencedaily.com/releases/2008/07/080720222549.htm>.

⁶ Thomas Nordegren, 1 Jan 2002, The A-Z Encyclopedia of Alcohol and Drug Abuse, pg153, Universal-Publishers.

Cannabis Indica⁷

Cannabis Indica Is classified as a putative specie annual plant and a member of the Cannabaceae family. They are short but broad, indoor or outdoor plants. Its origin is said to come from Central Asia and the Middle East, the word Indica is Greek for India which helps to highlight its Asian background. The plants ability to be grown indoors means you can now find it in most places around the world.



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⁷ Ibid

⁸ <http://www.leafscience.com/2014/06/19/indica-vs-sativa-understanding-differences/>

Sexes of the Plant

Cannabis seeds are sexless. They grow into a female or male plant. Saying that genes can pass on from the mother plant that can influence how the seeds are likely to develop.

Feminized cannabis seeds are genetically modified to produce only female plants.

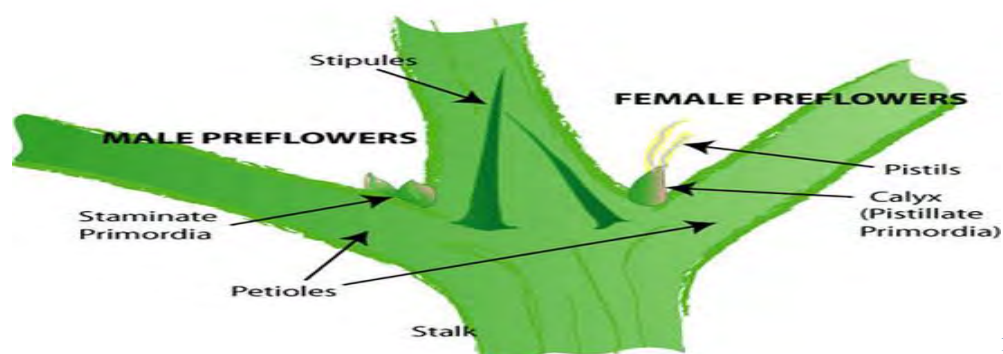
➤ Female Plants⁹

Female Plants have two very different roles to play, the first role involves producing the seeds needed to grow more plants this only starts to happen after the plant has been pollinated by either a male or hermaphrodite plant.

The second role for female plants is called Sinsemilla, it is where they grow large cannabinoid-rich buds while without seed, it is this version of the female plant that is widely used for recreational use of the plant because of the large buds it produces and the high levels of THC it can reach.

➤ Male Plants¹⁰

This type of plant produces very low levels of THC and practically no buds. Its main function is to pollinate the female plant, which will stop the female plant from producing THC and instead produce seeds which can be used for breeding, they are generally introduced into the grow area when a female plant reaches maturity and then removed and destroyed after pollination occurs.



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⁹ Leslie L. Iversen, The Science of Marijuana, pg 7, Oxford University Press, 6 Nov 2007

¹⁰ Jorge Cervantes, Indoor Marijuana Horticulture - Page 284, Van Patten Publishing, 2002

¹¹ <http://howtogrowmarijuana.com/how-to-grow-marijuana-outdoors/>

Functions of the Plant

Throughout recent history all parts of the plant have had a function in society. This can be broken down into three separate parts: the seed, the stem and the leaves:

➤ Seed

The seed of the plant has historically been used to create hempseed oil which can be used in cooking, paint, or lacquers. The seed itself has also been used to feed caged birds because of its high nutritional content.

➤ Stem

The stem was used to create hemp because of its high levels of durability and in turn was used to create industrial fibre.

➤ Leaves

The leaves of the Sativa plant are usually used for medical, religious, spirituality or recreational usage. The most common and fastest method of consumption would be smoking but it can also be swallowed and digested.

History of Cannabis

Let me introduce you to The Red Emperor - Shen Nung. He is known as the father of Chinese Medicine and ruled somewhere between 2838 B.C and 2698 B.C. (depending on what historical reference you use.) He is known as being the original author of The Great Herbal (also known as The Pen Ts'ao or The Materia Medica Sutra). This book is viewed as probably the world's oldest pharmacopoeia, and states multiple different herbal based remedies. Marijuana (eating the leaves or in a tea format) is listed as a cure for more than 100 different ailments including gout, rheumatism, malaria, absentmindedness and even balancing out your yin and yang.

The Shu King a book written by Confucius discussing Chinese ancient literature, dates back to around 2350 B.C., he discusses the soil in the province of Shantung "*whitish and rich...with silk, hemp, lead, pine trees and strange stones...*"¹²

In 1972 an ancient burial site that dates back to the Chou dynasty (1122-1249 B.C) in China was discovered¹³. At the site various fragments of cloth, weapons, pieces of Jade, and bronze containers were identified. After a close inspection it was discovered that the clothes were made from hemp, it is said to be the oldest preserved specimen of hemp in history¹⁴.

Although this is the oldest preserved specimen of hemp in history, the use of hemp to make clothes for religious purposes can be traced back to ancient Chinese culture, with it being directly referenced in the Book of Rites (2 B.C) "*it ordained that out of respect for the dead, mourners should not wear clothes made of animal skin but from hemp*"¹⁵

When archaeologists were examining artefacts dating back to the time of the Phrygians (a tribe of Aryans who invaded Turkey around 1000 B.C) they unearthed pieces of fabric containing hemp fibres in the debris of the ancient city of Gordion, which is located near present-day Ankara¹⁶.

¹² James Legge, 1865, Volume 3: The Shu King or the Book of Documents

¹³ Ernest L. Abel 1982, Marihuana: the first twelve thousand years, page 4

¹⁴ ibid

¹⁵ H. Li, "The Origin and Use of Cannabis in Eastern Asia: Their Linguistic Cultural Implications," in Cannabis and Culture, ed. V. Rubin (The Hague: Mouton, 1975), p.54.

¹⁶ L. Bellinger, "Textiles from Gordion", Bulletin of the Needle and Bobbin Club 46 (1962): 5-33.

An urn containing marijuana leaves and seeds - unearthed near Berlin, Germany, is believed to date from 500 B.C¹⁷.

Ancient Chinese manuscripts are said to be filled with passages urging the people to plant hemp so that they will have clothes on their back¹⁸.

Chinese monarchs set aside large portions of their land exclusively to make hemp bowstrings, the first agricultural war crop¹⁹.

In 5th century A.D., the author of *In A Handy Guide to Papermaking*, states "*hemp and mulberry... have long been used in worshipping the gods. The business of paper making therefore, is no ignoble calling.*"²⁰

The first time on record that cannabis was described as a possible medical remedy was in a Western medical text dating back to around 50-70 A.D. Pedanius Dioscorides a famous Roman physician, of Greek origin, created the *De Materia Medica*. It became to the West what the *Pen Ts'ao* was to the people of China. It was an encyclopaedia of plants referring to their native habitat and the names they were commonly referred by, it also noted the symptoms and conditions for which the plant might offer medical benefits for.

The book was hailed as one of the most important books ever written, so much so it was translated into nearly every one of the languages of the medieval world. No medical library was said to be complete unless it contained at least one copy of *De Materia Medica* and for the next fifteen centuries it remained an essential guide for all physicians.

The author Dioscorides, attempts to describe cannabis by saying that it "*was not only very useful for manufacturing strong ropes, but the juice of its seeds was also very beneficial in treating earaches and in diminishing sexual desires.*"²¹

¹⁷ Robert P. Walton, *Marijuana, America's New Drug Problem*, p. 17

¹⁸ M.D. Merlin, *Man and Marijuana* (Rutherford, N.J.: Fairleigh Dickenson University Press, 1968), p. 80.

¹⁹ W. Eberland, *The Local Cultures of South and East China* (Leiden: E.J. Brill, 1968), p. 102.)

²⁰ K. Chokoki, *A Handy Guide to Papermaking* (Berkeley: University of California Press, 1948), p. 2.)

²¹ E.L. Abel, *Marihuana: The First Twelve Thousand Years* 2013, pg 32

A famous Greek philosopher and physician in the Roman Empire by the name of Galen, who dates back to around 130-200 AD records that Romans who had money would eat a marijuana-seed dessert, which gave a warm and pleasurable sensation at their banquets. An overindulgence was said to be avoided because it may cause dehydration and impotence. Galen states that he thinks it contains other important properties like analgesia and anti-flatulence. *"If consumed in large amounts it affects the head by sending to it a warm and toxic vapour."*

In the 2nd Century A.D the famous Chinese surgeon Hua T'uo is said to have created one of the first ever anaesthetics, According to researchers that traced the surgeons own biography his anaesthetic was made from cannabis resin and wine²²

Side note: Just for the record modern medicine have now ruled out marijuana's properties being helpful for anaesthetic purposes²³.

One of the earliest known references to cannabis use within Egypt occurs around the 3rd century A.D. when Aurelian, a Roman emperor imposed a large tax on Egyptian cannabis²⁴.

There are different references to cannabis both as a remedy for backache and a delicacy within Greek literature dating all the way back to the fourth century B.C.²⁵

Although in general terms, the ancient Greeks were not aware of the intoxicating properties of the plant, but they still appreciated the amazing quality of its fibre.

As early as the 6th century B.C., Greek merchants had been carrying out a lucrative business transporting cannabis fibre to different ports along the Aegean²⁶.

A seventh-century Chinese physician, Called Meng Shen, said that if anyone wanted to see spirits, he should consume the seeds of cannabis for at least 100 days²⁷.

²² M.S. Julien, "Chirurgie Chinoise - Substance anesthetique employee en Chine, dans le commencement du III siecle de notre ere, pour paralyser momentanement la sensibilite," Comptes Rendus de l'Academie de Sciences, 28 (1894); 195-8

²³ STEVEN J. DICKERSON, Cannabis and its effect on anesthesia, , RN, BSN, Flint, Michigan, December 1980

²⁴ A.C. Johnson, "Roman Egypt", in Economic Survey of Ancient Rome, ed. T Frank (Patterson, N.J.: Pageant Books, 1959), 2: 3.

²⁵ T.F. Bruner, "Marijuana in Ancient Greece and Rome? The Literary Evidence", Bulletin of the History of Medicine, 47 (1973): 344-55.

²⁶ A.J. Warden, The Linen Trade (New York: A.M. Kelley, 1968), p. 43.

²⁷ H. Li, "Hallucinogenic Plants in Chinese Herbals", Journal of Psychedelic Drugs 10 (1978):17-26.

Cannabis has always had a preeminent place within the Tantric religion which evolved in Tibet around the 7th century A.D. out of an amalgam of Buddhism and local religion²⁸.

Cannabis was a very important part of the Tantric religious yoga sex acts that were done in honour of the goddess Kali. During the ritual, about 90 minutes prior to intercourse the members taking part would place a bowl of bhang before them and then utter the mantra: *"Om hrim, O ambrosia-formed goddess who has arisen from ambrosia, who showers ambrosia, bring me ambrosia again and again, bestow occult power and bring my chosen deity to my power."*²⁹

After repeating the mantra they would then drink the potion. Between the sex act and drinking the bhang, a delay was needed to allow the drug time to act so that it would heighten the senses and increase the feeling of oneness with the goddess³⁰.

In the tenth century A.D., physicians from China said cannabis might be useful in the treatment of *"waste diseases and injuries, clears blood and cools temperature, it relieves fluxes; it undoes rheumatism; it discharges pus"*³¹

A Chinese medical text (1578 A.D.) described the use of marijuana to treat vomiting, parasitic infections, and hemorrhage³².

In modern day China cannabis is still used as a folk remedy for dysentery, diarrhoea, and to stimulate a person's appetite.

Knowledge of cannabis spread across Asia through important trading routes like Silk Road, In India one of their lords Lord Shiva became known as Lord of Bhang.

Derived from cannabis, bhang is heavily incorporated into religious rites of Hindu. In the religion, holy men sometimes consume it to *"center their thoughts on the eternal."*³³

²⁸ M.R. Aldrich, "Tantric Cannabis Use in India" Journal of Psychedelic Drugs 9 (1977): 227-33

²⁹ A. Avalon, Tantra of the Great Liberation (New York: Dover, 1972), p. 73.

³⁰ Cf. Agehananda Bharati, The Tantric Tradition (London: Rider and Co., 1965) p. 251

³¹ Li, "Origin and Use", p. 56.

³² Aldrich MR. 1997. "History of therapeutic cannabis," in Cannabis in Medical Practice, Mathre ML, ed. Jefferson, NC: McFarland; Grinspoon L and Bakalar JB.

³³ Raymond Goldberg - 2009 - Drugs Across the Spectrum - Page 50

An early recipe for Bhang:

Cannabis: 220 grains, Almonds: 120 grains, Poppy seed: 120 grains, Pepper: 120 grains, Cucumber seed: 120 grains, Ginger: 40 grains, Cloves: 10 grains, Nutmeg: 10 grains, Caraway seed: 10 grains, Cinnamon: 10 grains, Cardamom: 10 grains, Rosebuds: 60 grains, Sugar: 4 ounces, Milk: 20 ounces - all boiled together.³⁴

Even if you examine Indian folksongs as far back as the 12th century A.D. warriors are said to consume the drink Ganja. Just as modern day soldiers sometimes drink alcohol before going to war, during Medieval India, warriors tended to drink small amounts of bhang or ganja to suppress feelings of panic.

A custom that earned bhang the cognomen of vijaya, "*victorious*" or "*unconquerable*"³⁵.

Professor Mircea Eliade, perhaps the world's foremost authority on the history of religions, has suggested that Zoroaster (A Persian prophet, from around seventh century B.C) may have been a user of bhang and may have relied on its intoxication to bridge the metaphysical gap between heaven and earth³⁶.

³⁴ M.V. Ball, "The Effects of Haschisch Not Due to Cannabis Indica", Therapeutic Gazette, 34 (1910): 777-80.

³⁵ I.C. Chopra and R.N. Chopra, "The Present Position of Hemp Drug Addiction in India", Indian Medical Research Memoirs 31 (1929): 2.

³⁶ M. Eliade, Shamanism (New York: Pantheon Books, 1964), pp. 399-400

Modern History of Cannabis

In the 1890's, the Indian Hemp Drugs Commission was summoned to investigate the use of cannabis use in India. After a major investigation they concluded that hemp was an “*integral part of the culture and religion*”³⁷.

The International Opium Convention was first signed in 1912 during the First International Opium Conference, it became the very first international drug control treaty.

On the international scene, the first notable mention of cannabis was at the Hague Conference in 1912, one of the closing protocols stated:

*“The Conference considers it desirable to study the question of Indian hemp from the statistical and scientific point of view, with the object of regulating its abuses, should the necessity thereof be felt, by internal legislation or by an international agreement.”*³⁸

The International Opium Convention came into force globally when it was incorporated into the Treaty of Versailles in 1919.

At the Advisory Committee on Traffic in Opium and Other Dangerous Drugs of the League of Nations, in 1923, this resolution was passed:

*“With reference to the proposal of the Government of the Union of South Africa that Indian hemp should be treated as one of the habit-forming drugs, the Advisory Committee recommends the Council that, in the first instance, the Governments should be invited to furnish to the League information as to the production and use of, and traffic in, this substance in their territories, together with their observations on the proposal of the Government of the Union of South Africa.”*³⁹

³⁷ J.M Campbell “on the religion of hemp” in Indian hemp drugs commission report (Simla, india: 1892-94), 3: 250-2

³⁸ Addendum and Final Protocol of The international Opium Conf., The Hague, 1912, quoted in W. WILLOUGHBY, supra note 50, at 492.

³⁹ ADVISORY Comm. ON TRAFFIC in OPIUM AND OTHER DANGEROUS DRUGs, REPORT To COUNCIL ON THE WORK OF THE SIXTH SESSION (1924), quoted in W. WILLOUGHBY, supra note 50, at 374.

In Geneva at a conference in 1925, an Egyptian by the name of Mr. El Guindy's presented a study on Hashish. In the study he stated:

“The illicit use of hashish is the principal cause of most of the cases of insanity occurring in Egypt. In support of this contention, it may be observed that there are three times as many cases of mental alienation among men as among women, and it is an established fact that men are much more addicted to hashish than women.”⁴⁰

There is no record of what scientific or medical evidence were used to support the inclusion of cannabis in the Convention. Nevertheless, it was the subject of Chapters IV and V of the 1925 Geneva Convention⁴¹.

In the League of Nations Treaty Series in 1928 they altered the 1925 Geneva Convention to impose restrictions on the export of Cannabis (Indian hemp), although total prohibition wasn't introduced.

In 1961 the convention was again superseded, but this time by the International Single Convention on Narcotic Drugs, which was introduced in an attempt to control global drug use and limit trading. The Convention stopped countries from treating drug addicts by prescribing alternative illegal substances, but instead only allowing medical and scientific uses of drugs. It's important to note, it did not introduce precise drug laws so instead countries had to pass their own legislation that followed the principles of the convention.

⁴⁰ Richard J. Bonnie & Charles H. Whitebread, II - THE FORBIDDEN FRUIT AND THE TREE OF KNOWLEDGE: AN INQUIRY INTO THE LEGAL HISTORY OF AMERICAN MARIJUANA PROHIBITION, Pg. 378

⁴¹ Geneva Convention of 1925, quoted in W.WILLOUGHBY, supra note 50, at 539.

Discovery of the Endocannabinoid System

Right up to the late 1980s, research on cannabis was a rather esoteric field involving only a small number of different scientists from around the world.

Although their efforts were circumscribed by the politicized agenda of the National Institute of Drug Abuse, which subsidized studies designed to prove the deleterious effects of cannabis while blocking inquiry into its potential benefits⁴².

Ironically, instead of discrediting cannabis, the National Institute of Drug Abuse inadvertently facilitated multiple major discoveries about how the human brain works.

These breakthroughs were seen as some of the most important developments in brain chemistry of the 20th century — it created a revolution in medical science and changed the basic understanding of our health and the healing process.

Raphael Mechoulam, the dean of the transnational cannabinoid research community described the breakthrough as *“By using a plant that has been around for thousands of years, we discovered a new physiological system of immense importance,”*

Cannabinoid receptors, which were initially identified by William Devane and Allyn Howlett, turned out to have the most neurotransmitter receptors of any type of receptor in the brain.

Cannabinoid receptors function as subtle sensing devices, tiny vibrating scanners perpetually primed to pick up biochemical cues that flow through fluids surrounding each cell⁴³.

⁴²Martin A.Lee, 2008, The Discovery of the Endocannabinoid System

⁴³ Martin A.Lee, Smoke Signals: A Social History of Marijuana – Medical, Recreational and Scientific Pg. 210

The Endocannabinoid system has two different types of receptors: CB1 and CB2⁴⁴.

- CB1 receptors are in the brain and help to mediate psychoactivity.
- CB2 receptors are in the brain but are also present in the Liver, spleen, heart, bones, kidneys lymph cells, blood vessels, gut, endocrine glands and reproductive organs – all of these receptors is why cannabis is believed to regulate the immune system.

The main reason cannabis is seen as such a versatile medicine is because of how widely dispersed these receptors are all over the brain and body.

Prior to the discovery of the endocannabinoid system, retrograde signalling was known to occur only during the embryonic development of the brain and nervous system⁴⁵.

Endocannabinoid deficits do exist and are heavily associated with a body's ability to adjust to chronic stress - whether the result of drug abuse, genetic factors, environmental toxins, a poor diet or even a lack of exercise. A prolonged exposure to stress can deplete a human's endocannabinoid tone, which will have an adverse impact on multiple physiological processes within the brain and body.

University of Washington neurologist Ethan Russo postulates that “clinical endocannabinoid deficiency” underlies migraines, fibromyalgia, irritable bowel disease, and a cluster of other degenerative conditions, which may respond favourably to cannabinoid therapies⁴⁶.

What Is The Endocannabinoid System?

The endocannabinoid system is an essential part of the biology of life and has historically adapted to environmental change whenever it's had to whether it's for tiny nematodes, sea squirts or any of the vertebrate species. After comparing the cannabinoid receptors in different species genetics, scientists believe the endocannabinoid system evolved in primitive animals more than 600 million years ago.

⁴⁴ <http://www.ukcia.org/research/CannabisTheScientificAndMedicalEvidence.php>

⁴⁵ Roger A. Nicoll and Bradley E. Alger, “The Brain's Own Marijuana,” Scientific American, December 2004.

⁴⁶ Ethan B. Russo, “Clinical Endocannabinoid Deficiency,” Neuroendocrinology Letters Nos. , Feb-Apr Vol. 25, 2004

In each tissue, the cannabinoid system completes various different tasks, but the overall goal always remains the same: **homeostasis**.

Homeostasis definition is *“the tendency of a system, especially the physiological system of higher animals, to maintain internal stability, owing to the coordinated response of its parts to any situation or stimulus that would tend to disturb its normal condition or function. Cannabinoids promote homeostasis at every level of biological life, from the sub-cellular, to the organism, and perhaps to the community and beyond⁴⁷”*.

Cannabinoids and Endocannabinoids are usually located at the intersection of various systems all around the body, they allow and improve coordination and communication between multiple different cells.

Cannabinoids can also influence a person's understanding and relationship with their external environment. Socially, the ingestion of cannabinoids clearly alters some aspects of human behaviour, often promoting humour, creativity and sharing.

The study of the endocannabinoid system and cannabinoids is an emerging science but one thing that's unquestioned is that it's essential for health and balance within the human body.

From embryonic implantation on the wall of our mother's uterus, to nursing and growth, to responding to injuries, endocannabinoids help us to survive in a quickly changing and increasingly hostile environment⁴⁸.

⁴⁷ <http://dictionary.reference.com/browse/homeostasis>

⁴⁸ Alistair Thomson - 20 January 2014 - Understanding the Endocannabinoid System

Positives effects of legalising Cannabis

Economic Benefits

Any reasonable Economist would agree that if a cost-benefit analysis on the subject in hand is to be done unmeasurable factors like the enjoyment gained by future users, or even current users who would now be able to get cannabis cheaper, more conveniently, safer and with less worry would have to be considered. But for this part of the research project, I will attempt to establish measurable economic factors that are deemed beneficial based on research conducted world-wide, but with emphasis on primary research from America.

Estimated savings from reduced spending on the criminal justice costs of cannabis law enforcement

According to Harvard economist Jeffrey Miron in his report “The Budgetary Implications Of Marijuana Prohibition”, legalization of Cannabis in America would reduce the need for prosecutorial, judicial, correctional, and police resource spending by approximately \$7.7 billion – \$13.7 billion per year, even though some revenue from court fines and asset forfeitures would be lost. Miron claims his estimates can be verified empirically and his calculations are adjusted for economic inflation and growth in enforcement spending over the past decade⁴⁹.

Projected revenues from additional taxes and streams of income

Tax Revenue

According to the Colorado’s state’s department of revenue, the first year of legal cannabis sales have resulted in nearly \$76 million in tax revenue⁵⁰.

The financial returns from cannabis have been so high, that the state legislatures are discussing giving a rebate back to its constituents.

⁴⁹ Jeffrey A. Miron, June 2005, The Budgetary Implications of Marijuana Prohibition, Visiting Professor of Economics, Department of Economics, Harvard University

⁵⁰ http://www.oregonlive.com/marijuana/index.ssf/2015/02/marijuana_news_colorado_collec.html

A study based in the UK came to the following conclusion:

A regulated market could reduce the government deficit by up to £1.25bn, whilst producing roughly £400m in "net benefit" for the country⁵¹.

In a study in June 1994 by Dale Gieringer, Ph.D. Coordinator, California NORML called *"Economics of Cannabis Legalization (1994) Detailed Analysis of the Benefits of Ending Cannabis Prohibition"* summarised the economic benefits in the following chart:

Table 2 Economic Benefits of Cannabis Legalization	
Excise Taxes	\$2.2 - \$6.4 Billion
Sales Taxes	\$0.2 - \$1.3 Billion
Enforcement Savings	\$6 - \$9 Billion
Hemp Industry	\$6 - \$10 Billion
Others: Spinoff industries, Reduced hard-drug and alcohol abuse	

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Create jobs/cut unemployment

If we look at the research collected from the Colorado job market, we can get a clearer image of how this sector would be influenced.

The Marijuana Industry Group (MIG) estimates that 10,000 workers in the state of Colorado are directly involved with cannabis, with 10% to 20% of them joining the industry since the legal change in stature from medical cannabis to full legislation.

The 10,000 workers equates for roughly 0.5% of the total workforce in Colorado

As of November 2014, Colorado's unemployment rate has dropped by 0.4% to 4.3% in October, the lowest level in more than 6½ years the success of the cannabis legalisation is seen as a major force.

Not only will new jobs be created, and unemployment will be cut because of the availability of these jobs that didn't exist before, new career paths open up to people with previous criminal records.

⁵¹ Mark Bryan, Emilia Del Bono, Stephen Pudney - Licensing and regulation of the cannabis market in England and Wales: Towards a cost-benefit analysis Institute for Social and Economic Research University of Essex

⁵² <http://norml.org/library/item/revenues-from-legalization>

Legalising cannabis creates whole new jobs spreading the scope of what type of people can be employed in the industry.

Collateral sector workers retained by marijuana businesses include: lawyers, accountants, construction workers, landlords, advertisers, consultants, security, insurance, transportation, and indoor growing-supply equipment providers.

Productivity gains from anticipated reductions in the rates of unemployment, employee turnover and absenteeism related to involvement with the criminal justice system

Criminal Records being overturned will open up new career paths for citizens that they previously didn't have access to, less people will be going to jail for cannabis usage reducing employee turnover and reduced court appearances for those who interact with cannabis will reduce work absenteeism.

Value of improvements in family stability and socioeconomic mobility within underprivileged communities, due to the reduction in incarcerations and disqualifying collateral consequences.

Citizens being released from prison, and cannabis consumers no longer being liable to possible criminal sanctions will improve family stability and reduce barriers associated with progressive socioeconomic mobility.

In 2014 Colorado was ranked by Business Insider as the #1 fastest-growing economy among U.S. states⁵³.

Save an industry

The agriculture industry has slowly been dying in recent decades because of improved technology and supermarkets taking advantage of economies of scale, the legalisation of Cannabis has the potential to slow down the decline in the short-term and diversify the industry.

Statistically, Cannabis is now the biggest cash-crop in the world, even in America – it's estimated to be worth more than the wheat (\$7.5 billion) and corn (\$23.3 billion) industry combined, best guesses estimated it at \$35+ billion.

⁵³ Andy Kiersz and Elena Holodny, "Here's How All 50 State Economies Are Doing, Ranked From Slowest To Fastest," Business Insider, August 4, 2014

In the state controlled system the Uruguayan government has implemented, farmers from all over the country are selected to grow cannabis for the state and are paid accordingly.

Reduce cost of national health expenditure

Cannabis is much cheaper than multiple leading pharmaceutical products and could potentially cure various different diseases and ailments (see Health Benefits chapter) before state intervention is needed or equally as important offer to supply a cheaper medicine to diseases that are currently being treated by expensive pharmaceutical products, statistically it also has less side-effects than the average pharmaceutical product which could further reduce the cost of National Health.

Legalisation of cannabis would also likely reduce the use of alcohol. This is particularly beneficial in Ireland, where the financial cost of alcohol is staggering.

Standard of living

In America which is that some 19 to 32 million people would no longer be treated as criminals and subject to arbitrary arrest, imprisonment, asset forfeiture and other punishment.

This benefit goes way beyond the criminal justice system's costs of enforcing cannabis laws. It is about the ability of those 19 to 32 million users, their families, and friends to live normal lives.

Open and regulated markets are safer than black markets, and our judicial system is clogged enough already with real criminals. Legalising cannabis rids the stigma that a criminal record for possession or use of cannabis may cause.

Reduce pressure on the prison system

Overcrowding in prisons is an issue for most countries, legalising cannabis would reduce the amount of people behind bars by a relatively large percentage, freeing up space and essential capital that is badly needed to maintain the prison system.

Tourism

In The Netherlands, Amsterdam has the legalisation of cannabis to thank for its highly successful tourism industry, although in recent years as franchise-chain coffee shops have start to spread, and serious criminal dealers have made the city there haven, local governments have started to try and change the image of the city.

In Colorado since the legalisation of Cannabis, tourism has been booming:

In 2014 Colorado ski resorts enjoyed a record-breaking season during the winter, with 12.6 million visitors⁵⁴.

While in Denver, 14 million tourists spent an all-time high of \$4 billion⁵⁵.

⁵⁴ Jason Blevins, "Colorado skier visits surge to 12.6M in 2013-14, set new season record," Denver Post, June 12, 2014.

⁵⁵ Jason Blevins, "Denver tourists spend record \$4.1 billion in 2013," Denver Post, June 18, 2014.

Health Benefits of Cannabis

There is currently no existing evidence that anyone has ever died of a cannabis overdose, but this doesn't rule out the possibility of experiencing adverse effects when it is consumed in large doses.

For comparison's sake, alcohol overdoses claim roughly 5,000 deaths per year, in America alone. This is one of the reasons that cannabis is seen as safer than other drugs, like alcohol⁵⁶.

1) General Health Effects

Anti-inflammatory

Cannabinoids from cannabis seem to help the gut regulate bacteria and intestinal function which is essential in fighting inflammatory bowel diseases like Crohn's disease and ulcerative colitis and other inflammatory related diseases like rheumatoid arthritis.

Cannabinoids have been tested in several experimental models of autoimmune disorders such as multiple sclerosis, rheumatoid arthritis, colitis and hepatitis and have been shown to protect the host from the pathogenesis through induction of multiple anti-inflammatory pathways.

- Cannabinoids may also be beneficial in certain types of cancers that are triggered by chronic inflammation. In such instances, cannabinoids can either directly inhibit tumour growth or suppress inflammation and tumour angiogenesis⁵⁷.

Neuro-protective

Chemical compounds found in the plant could help shrink the area of the brain affected by stroke.

Findings confirm that minocycline decreases brain damage caused by TBI and indicate for the first time, and that the activation of CB receptors is required for the neuroprotective actions of this compound⁵⁸.

⁵⁶) Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr. (1999) MARIJUANA AND MEDICINE: Assessing the Science Base, Editors Division of Neuroscience and Behavioral Health INSTITUTE OF MEDICINE NATIONAL ACADEMY PRESS Washington, D.C.

⁵⁷Prakash Nagarkatti - Future Med Chem. 2009 Oct; 1(7): 1333–1349. Cannabinoids as novel anti-inflammatory drugs

⁵⁸ Ana Belen Lopez-Rodriguez - CB1 and CB2 Cannabinoid Receptor Antagonists Prevent Minocycline-Induced Neuroprotection Following Traumatic Brain Injury in Mice, Cerebral Cortex, Oxford Journals, August 19, 2013

Antipsychotic effects

The University of Cologne in Germany, conducted a study on 39 people with schizophrenia who were hospitalized for a psychotic episode. Nineteen patients were treated with Amisulpride, an antipsychotic medication that is not approved in the U.S., but is similar to other approved drugs.

The remaining 20 patients were given CBD, a substance found in cannabis that is considered responsible for the mellowing or anxiety-reducing effects.

Daniel Piomelli, Ph.D., professor of pharmacology at the University of California-Irvine and a co-author of the study. “Not only was [CBD] as effective as standard antipsychotics, but it was also essentially free of the typical side effects seen with antipsychotic drugs.”

In the latest study, published in the journal *Neuropsychopharmacology*, Dutch and British researchers reviewed more than 66 past studies on CBD and psychosis, and concluded that the compound offers a number of advantages over current drugs.

“Given the high tolerability and superior cost-effectiveness, CBD may prove to be an attractive alternative to current antipsychotic treatment.”

Influence on Sleep

A study compared the sleep patterns of experienced marijuana users on tetrahydrocannabinol (THC) and a placebo. Feinberg reported reduced eye movement activity and less REM sleep in the THC condition. They also reported a REM rebound effect, which is more REM activity, on withdrawal from THC⁵⁹.

The acute effects of cannabis use on sleep appear to be a disruption to the sleep cycle reflecting a reduction in time spent in slow wave sleep and an increase in time spent in REM sleep. When the body is in slow wave sleep the body is in repair mode which may be one of the reasons why cannabis is known to encourage the human body to repair itself.

⁵⁹ Feinberg, I., Jones, R, Walker JM, Cavness, C, March, J. (1975). Effects of high dosage delta-9-tetrahydrocannabinol on sleep patterns in man. *Clin Pharmacol Ther.* 1975; 17(4):458-66.

According to a 2013 study published in Frontiers in Psychiatry:

"...Δ9-TetraHydroCannabinol (Δ9THC) stabilizes autonomic output during sleep, reduces spontaneous sleep-disordered breathing, and blocks serotonin-induced exacerbation of sleep apnea⁶⁰." Building off of this, the researchers went on to find that dronabinol, a man-made form of THC, did, in fact, improve sleeping conditions for 17 adults suffering from obstructive sleep apnea without reducing quality of sleep.

2) Disease Related Effects

Multiple- Sclerosis

One of the leading medicines in the fight against Multiple-Sclerosis is Sativex, it is a cannabinoid medicine for the treatment of spasticity. It comprises of THC from the Cannabis Sativa plant.

In a study published in the American Academy of Neurology about Cannabis and multiple sclerosis they concluded:

Cannabis-based medicine is effective in reducing pain and sleep disturbance in patients with multiple sclerosis related central neuropathic pain and is mostly well tolerated⁶¹.

Parkinson's Disease

Recent research from Israel shows that smoking marijuana significantly reduces pain and tremors and improves sleep for Parkinson's disease patients. Particularly impressive was the improved fine motor skills among patients⁶².

⁶⁰ Bharati Prasad, Miodrag G. Radulovacki - Proof of concept trial of dronabinol in obstructive sleep apnea—Frontiers in Psychiatry, January 2013

⁶¹David J. Rog, BMBS, Turo J. Nurmikko, PhD, Tim Friede, PhD and Carolyn A. Young, MD - Randomized, controlled trial of cannabis-based medicine in central pain in multiple sclerosis. , The Official Journal of the American Academy of Neurology, Neurology September 27, 2005 vol. 65 no. 6 812-819

⁶²Ed Susman - Smoking Pot Eases Tremors in Parkinson's Published: Jun 18, 2013
<http://www.medpagetoday.com/meetingcoverage/mds/39933>

Glaucoma

According to the National Eye Institute cannabis decreases the pressure inside the eye:

"Studies in the early 1970s showed that marijuana, when smoked, lowered intraocular pressure (IOP) in people with normal pressure and those with glaucoma."⁶³

Asthma

In January 2012, a study published in Journal of the American Medical Association, claimed that cannabis does not damage lung function and might even increase lung capacity.

It also may help reverse the carcinogenic effects of tobacco and improve lung health.

In a study of 5,115 young adults over the course of 20 years, researchers searched for risk factors of heart disease in relation to lung function. Tobacco smokers lost lung function over time, but pot users actually showed an increase in lung capacity⁶⁴.

Research has also indicated it can get rid of an asthma attack by instantly unrestricting the air ventricles.

AIDS

In the journal AIDS Research and Human Retroviruses by a team of researchers at Louisiana State University indicates that a daily regimen of THC may have a significant impact on the progression of HIV.

Researchers say that after delivering a daily dose of THC to monkeys for a period of 17-months, the diseased primates displayed a decrease in damaged immune tissue in the stomach -- a common spot for the infection to occur⁶⁵.

⁶³ <http://uk.businessinsider.com/health-benefits-of-medical-marijuana-2014-4?op=1?r=US#ixzz3SaDLrOz0>

⁶⁴ <https://technical420.com/cannabis-article/19-health-benefits-marijuana>

⁶⁵ <http://gwmac.com/medical-marijuana-hiv-racism/>

Appetite Stimulant

The drug Dronabinol is a man-made form of the active natural substance THC in cannabis. Dronabinol is prescribed by doctors to treat loss of appetite and weight loss in patients with HIV infection.

Nausea and Vomiting

Cannabis can help maintain control of chemotherapy-related nausea and vomiting. In a randomized, double-blind study of 469 adults with advanced cancer and weight loss, patients received 2.5 mg of oral THC twice daily, 800 mg of oral megestrol daily,. Appetite increased by 75% in the megestrol group and weight increased by 11%, compared with a 49% increase in appetite and a 3% increase in weight in the oral THC group after 8 to 11 weeks of treatment⁶⁶.

PTSD

In a recent study, researchers at the University of Haifa in Israel were able to prevent rats from developing post-traumatic stress disorder (PTSD) by treating them with the active compounds in cannabis.

Led by Dr. Irit Akirav from the Department of Psychology, the team used rats because of their similarity to humans in responding to trauma.

People with PTSD — a severe type of anxiety disorder — suffer from symptoms that can be set off by common triggers, also known as trauma reminders.

While PTSD is usually treated after symptoms appear, the team found that dosing rats with cannabinoids following a traumatic event could make them immune to future triggers. Dr. Akirav explained “In other words, cannabis made the effects of trauma reminders ‘disappear’. The treated rats showed no symptoms of PTSD. But rats that were left untreated did, including impairments in memory extinction, changes in pain sensation and increased panic behaviour.

⁶⁶ Jatoi A, Windschitl HE, Loprinzi CL, et al.: Dronabinol versus megestrol acetate versus combination therapy for cancer-associated anorexia: a North Central Cancer Treatment Group study. J Clin Oncol 20 (2): 567-73, 2002.

Pain Relief (particularly nerve, muscle and chronic pain)

Cannabis has been proven to have painkilling properties while lacking the negative physical and psychological effects of legal drugs such as Morphine, Vicodin, and Oxycontin, which are extremely hard on the body, and are also highly addictive.

Epilepsy

In one study using the rat pilocarpine model of epilepsy, they showed that the cannabis extract Δ^9 -tetrahydrocannabinol (10 mg/kg) as well as the cannabimimetic, 4,5-dihydro-2-methyl-4(4-morpholinylmethyl)-1-(1-naphthalenyl-carbonyl)-6H-pyrrolo[3,2,1-i,j]quinolin-6-one [R(+)]WIN55,212 (5 mg/kg), completely abolished spontaneous epileptic seizures⁶⁷.

Cancer

At the California Pacific Medical Centre in San Francisco, researchers reported in 2007, that CBD found in cannabis stops cancer from spreading by essentially '*turning off*' the ID-1 gene⁶⁸.

Anxiety

These results suggest that CBD reduces anxiety in SAD and that this is related to its effects on activity in limbic and paralimbic brain areas⁶⁹.

Alzheimer's

A study published in the journal of Molecular Pharmaceutics in 2006, found that THC, can slow the formation of amyloid plaques by blocking the enzyme in the brain that is associated with creating them.

A study based on that journal by the Scripps Research Institute, led by Kim Janda, found the amyloid plaque that were mentioned in the 2006 journal, are what can kill brain cells and potentially cause Alzheimer's.

⁶⁷Lobe Epilepsy Melisa J. Wallace, Robert E. Blair, Katherine W. Falenski, Billy R. Martin and Robert J. DeLorenzo - The Endogenous Cannabinoid System Regulates Seizure Frequency and Duration in a Model of Temporal JPET October 2003 vol. 307 no. 1 129-137

⁶⁸ McAllister SD1, Christian RT, Horowitz MP, Garcia A, Desprez PY. Mol Cancer Ther. 2007 Nov;6(11):2921-7.) - Cannabidiol as a novel inhibitor of Id-1 gene expression in aggressive breast cancer cells.

⁶⁹ J Psychopharmacol. 2011 Jan;25(1):121-30. doi: 10.1177/0269881110379283. Epub 2010 Sep 9. Neural basis of anxiolytic effects of cannabidiol (CBD) in generalized social anxiety disorder: a preliminary report. Crippa JA1, Derenusson GN, Ferrari TB

Lessens side effects from treating hepatitis C and increases treatment effectiveness.

A study in the European Journal of Gastroenterology in 2006 found that 86% of patients using cannabis successfully completed their hepatitis C treatment, while only 29% of non-smokers went on to complete their treatment, indicating that cannabis can help lessen the treatments side effects.

Cannabis can also improve the treatment's effectiveness: 54% of hepatitis C patients smoking cannabis got their viral levels to a low level and were able to keep them low, while in comparison to only 8% of non-smokers⁷⁰.

Regulate metabolism and control body's reactions to insulin

A study analysed data from more than 4,500 American adults — 579 of whom were current cannabis users. About 2,000 had used cannabis at some stage in their life, while the other 2,000 had never smoked cannabis.

They analysed their body's response to eating sugars: their blood sugar levels when they hadn't eaten in nine hours and their levels of the hormone insulin before and after eating sugar.

They discovered that in general, cannabis users tend to be skinnier, and that their bodies have a healthier response to insulin and sugar.

The study concluded:

We found that cannabis use was associated with lower levels of fasting insulin and HOMA-IR, and smaller waist circumference⁷¹.

⁷⁰ C, Sylvestre, Diana L.a b; Clements, Barry J.b; Malibu, Yvonneb - Cannabis use improves retention and virological outcomes in patients treated for hepatitis European Journal of Gastroenterology & Hepatology: October 2006 - Volume 18 - Issue 10 - pp 1057-1063

⁷¹ Elizabeth A. Penner - The American Journal of Medicine, July 2013 Volume 126, Issue 7, Pages 583–589 The Impact of Marijuana Use on Glucose, Insulin, and Insulin Resistance among US Adults

Negatives of Cannabis

UK Advisory Council on the Misuse of Drugs noted, in its 2005 cannabis review, that the evidence from the various studies *"suggests an association between cannabis use and the development of psychotic symptoms which is consistent between studies and remains after adjustment for confounding factors"*.

The council concluded that the *"evidence supports a causal association between the use of cannabis in adolescence and the later development of schizophrenia"*.

Economic Negatives

Productivity losses from work

The first thing to note is that nobody is advocating smoking cannabis or being high on the job, no more than anyone advocates drinking or being drunk on the job. People are expected to show up for work sober, and employers have always had the right to fire people who fail to meet that basic requirement. The issue, then, is whether smoking cannabis in one's free time impairs one's job performance. Long-term memory loss and "amotivational syndrome" have been alleged, but decades' worth of studies have debunked both of those claims.

The argument can also be claimed, that anyone who would like to smoke on the job, will already be doing so, and that the legality of the drug doesn't affect their decision.

A rise in health care costs including mental health

Health care costs associated with mental health will likely increase as abuse of the drug may lead to increase mental illnesses (see health negatives of cannabis section).

Reduction of learning capacity in students

Considerable evidence suggests that students who smoke marijuana have poorer educational outcomes than their non-smoking peers. For example, a review of 48 relevant studies found marijuana use to be associated with reduced educational attainment (i.e. reduced chances of graduating)⁷².

⁷² Macleod J, Oakes R, Copello A, et al. Psychological and social sequelae of cannabis and other illicit drug use by young people: a systematic review of longitudinal, general population studies. *Lancet*. 2004;363(9421):1579-1588.

A recent analysis using data from three large studies in Australia and New Zealand found that adolescents who used marijuana regularly were significantly less likely than their non-using peers to finish high school or obtain a degree⁷³.

Increases in drugged driving

Anti-cannabis legalisation movements claim drugged driving will increase, but according to The Journal of Law and Economics, cannabis legalisation is actually followed by a 7.2% decrease in traffic fatalities in non-alcohol related accidents.

Traffic fatalities fell 3% in the first year of legal marijuana sales in Colorado, from 481 fatalities in 2013 to 466 fatalities in 2014⁷⁴.

Roadside, we can test only for the presence of marijuana metabolites, not for inebriation. Metabolites can linger in the body for days after the drug's effects wear off — sometimes even for weeks. Because we all metabolize drugs differently (and at different times and under different conditions), all that a positive test tells us is that the driver has smoked pot at some point in the past few days or weeks.

Revenue losses from shifts in law enforcement policies

There is likely to be revenue lost in the process of shifting law enforcement policy to new policies, this initial cost will be caused by inefficiency and lack of standard practise guidelines because of how large a change would be expected to policies e.g new training costs, relocation of jobs, change of hierarchy within the organisational structure, certain units now being deemed obsolete etc.

Immediate and projected expenditures to address the known harms of cannabis use and to implement and enforce policy reforms

Large marketing costs should be expected to ensure the public understand any potential harms cannabis legalisation would bring into society. Children and schools would be the primary target of these campaigns as they would most likely be the segment of society with the biggest risk factor.

⁷³ Silins E, Horwood LJ, Patton GC, et al. Young adult sequelae of adolescent cannabis use: an integrative analysis. *Lancet Psychiatry*. 2014;1(4):286-293.

⁷⁴ "Fatal Crash Data," Colorado Department of Safety, <https://www.codot.gov/library/traffic/traffic-manualsguidelines/safety-crash-data/fatal-crash-data-city-county>.

Breaking International Treaties

The International Narcotics Control Board believes that any international treaty regarding cannabis should be interpreted to mean that states must prosecute drug possession offenses to the letter of the law.

They say the treaties clearly state that controlled substances should be restricted to medical and scientific uses.

Health Negatives of Cannabis

The main negatives of cannabis to a person's health are mostly seen as a psychiatric risk. The level of risk varies depending on the dose of the drug and inborn genetic vulnerability. It's also important to note most studies are based on heavy use of the substance.

Addiction

General opposition to cannabis with regards to addiction is generally comprised of:

- 1) That whatever potential medical value cannabis has to offer, is already fulfilled by other, equally effective drugs on the market.
- 2) Cannabis is highly addictive.

In terms of the 1st argument, the market is already full of drugs that do the same job as other products on the market, and they rarely have trouble receiving approval. If you look at Schedule 2 amphetamines and opiates, it proves that potential addiction is quite obviously not a basis for the different legal classification of certain drugs.

In terms of the 2nd argument, certain observational studies suggest that 1 in 9 people who smoke cannabis regularly may become dependent on it, but these studies have also been debunked by other observational studies which would indicate that cannabis being addictive or not isn't as straight forward as some studies would indicate.

A particular element for concern in terms of addiction could be based on the fact that the average THC concentration had risen from 4% to 7% in Europe. This increased level of potency might potentially accelerate the development of dependence⁷⁵.

Heart Problems

It is generally accepted in medical circles that cannabis use has no link to long-term cardiovascular problems for the average person.

Although one particular study claimed, in the hour after having smoking cannabis, the risk of a heart attack goes up five fold. This link is based on the fact that cannabis is known to increase the heart-rate of a user just after inhalation.

⁷⁵ Crippa JA, et al. "Cannabis and Anxiety: A Critical Review of the Evidence," Human Psychopharmacology (Oct. 2009): Vol. 24, No. 7, pp. 515–23.

Mental Health

Brain Development

A recent study, published in the Journal of Neuroscience in April 2014, found structural changes within brains of 18-25 year olds who smoked pot at minimum once a week, compared to people of the same age who have little or no history of cannabis use.

Using an MRI machine, researchers from North-western University detected minor alterations in the brain regions associated with emotion and reward processing. They found the heavier the cannabis use, the greater the abnormalities in both brain regions.

Other research has shown thinking, working memory, executive function (umbrella term for mental processes involved in organizing, decision-making, planning and meeting long-term goals) are all influenced in some way while under the influence of Cannabis.

A long-term study conducted in New Zealand followed 1,037 people born in Dunedin during 1972-73, from birth to early forties.

In a 2012 report, researchers from Duke University analysed the overall data from the Dunedin study and found that the earlier and more frequently a person smoked pot, the greater the loss of intelligence by age 38. Compared to their IQs measured at age 13, people who had started using cannabis as teens and maintained a daily pot habit into adulthood had, on average, a six-point drop in IQ.

A journal in PNAS found that individuals who began using cannabis heavily as adults did not show similar losses in IQ, but quitting pot did not seem to restore intellectual functioning in those who had been chronic pot users as teenagers.

Effects on Short-Term Memory

Studies have consistently demonstrated significant impairment of short-term memory for number sequences or verbal recall, although not for major events or factual elements of narratives. The effects of cannabis are usually subtle, and although statistically significant, the magnitude of any impairment tends to be dose-related and subject to tolerance of the drug's effects, on the personal characteristics of the user, and on the circumstances in which the drug is taken.

Cannabis may increase the likelihood of minor errors of time perception, verbal recall and similar factors, but not affect recall of important actions observed or experiences undertaken. In a regular user of cannabis, acute intoxication by the drug would have little effect on performance.

Cannabinoids appear to disrupt short-term memory by interfering with the filtering of information, such that a greater volume of information reaches consciousness, overwhelming the ability to store, or prioritise such information for storage in memory.

Psychosis

Several large observational studies suggest that using cannabis in the early teenage years may increase the risk of developing psychosis.

A study of more than 50,000 young Swedish soldiers found that those who had smoked cannabis at least once were more than twice as likely to develop schizophrenia as those who didn't smoke cannabis. The heaviest users (who said they had used the drug more than 50 times) were six times as likely to develop schizophrenia as the non-smokers⁷⁶.

Schizophrenia

There have been various different studies on the impact of cannabis use on schizophrenia and psychotic disorders. Findings from a 10-month prospective study that was printed in the *Psychol. Med.*, 37: 927-934 found that in those with a diagnosis of schizophrenia, cannabis use increased the severity of psychosis⁷⁷.

Another study found increased hallucinations and grandiosity in patients using cannabis⁷⁸. Half of all first episode psychosis patients have used cannabis⁷⁹ and the majority begin using cannabis before the emergence of their psychotic symptoms⁸⁰.

⁷⁶ <http://www.health.harvard.edu/mind-and-mood/medical-marijuana-and-the-mind>

⁷⁷ Degenhardt, L., C. Tennant, S. Gilmour, D. Schofield, L. Nash, W. Hall and D. McKay, 2007. The temporal dynamics of relationships between cannabis, psychosis and depression among young adults with psychotic disorders

⁷⁸ Katz, G., R. Durst, E. Shufman, R. Bar-Hamburger and L. Grunhaus, 2010. Cannabis abuse and severity of psychotic and affective disorders in Israeli psychiatric inpatients. *Comp. Psychiatry*, 51: 37-41.

⁷⁹ Barnett, J.H., U. Werners, S.M. Secher, K.E. Hill and R. Brazil et al., 2007. Substance use in a population-based clinic sample of people with first-episode psychosis. *Br. J. Psychiatry*, 190: 515-520.

⁸⁰ Sevy, S., D.G. Robinson, B. Napolitano, R.C. Patel and H. Gunduz-Bruce et al., 2010. Are cannabis use disorders associated with an earlier age at onset of psychosis: A study in first episode schizophrenia.

Cannabis use may also lead to a poorer long term prognosis, as stopping cannabis use is associated with better functioning and fewer negative symptoms⁸¹.

Anxiety

There are studies that have reported that about 20%-30% of recreational smokers may experience panic attacks and intense anxiety after smoking cannabis. The most vulnerable being those who had never used cannabis before⁸².

The amount of THC matters. At low doses and in balance with CBD, THC is usually sedating but at higher unbalanced doses cannabis can induce episodes of anxiety.

A study found that those who used cannabis frequently had the highest levels of anxiety⁸³.

One study sampled more than fourteen thousand participants from the general population and found that anxiety disorders were present in 18% of heavy cannabis users compared to 8.7% of non-users and more frequent risk further increased the risk⁸⁴.

A longitudinal study found that frequent cannabis use in adolescence was related to an elevated likelihood of anxiety disorders in young adulthood. This relationship was particularly strong for those who began using cannabis before the age of 15⁸⁵.

Another study found that weekly use in adolescence increased the risk of later anxiety by two fold and daily use increased the risk fivefold⁸⁶.

⁸¹ Gonzalez-Pinto, A., S. Alberich, S. Barbeito, M. Gutierrez and P. Vega et al., 2009. Cannabis and first-episode psychosis: different long-term outcomes depending on continued or discontinued use. *Schizophrenia Bull.*, 10.1093/schbul/sbp126

⁸² <http://www.health.harvard.edu/mind-and-mood/medical-marijuana-and-the-mind>

⁸³ Bonn-Miller, M.O., M.J. Zvolensky, A. Bernstein and T.R. Stickle, 2008. Marijuana coping motives interact with marijuana use frequency to predict anxious arousal, panic related catastrophic thinking and worry among current marijuana use among current marijuana users. *Depress Anxiety*, 25: 862-873.

⁸⁴ Cheung, J.T.W., R.E. Mann, A. Ialomiteanu, G. Stoduto, V. Chan, K. Ala-Leppilampi and J. Rehm, 2010. Anxiety and mood disorders and cannabis use. *Am. J. Drug Alcohol. Abuse*, 36: 118-122.

⁸⁵ Hayatbakhsh, M.R., J.M. Najman, K. Jamrozik, A.A. Mamun, R. Alati and W. Bor, 2007. Cannabis and anxiety and depression in young adults: A large prospective study. *J. Am. Acad. Child Adolesc. Psychiatry*, 46: 408-417.

⁸⁶ Patton, G.C., C. Coffey, J.B. Carlin, L. Degenhardt, M. Lynskey and W. Hall, 2002. Cannabis use and mental health in young people: Cohort study. *BMJ*, 325: 1195-1198.

Depression

A number of studies suggest that cannabis use may increase depressive symptoms and the risk of diagnosed depression. A study of more than fourteen thousand adults from the general population found that diagnosed depression was more common in heavy cannabis users compared to non-users⁸⁷.

Another study found that in those with no baseline affective disorders, cannabis use predicted major depression 3 years later⁸⁸. Another study reported that adolescents who use cannabis are more likely to have somatic complaints accompanying their depressive symptoms⁸⁹.

A study found that cannabis use in childhood, adolescence or young adulthood increased the risk of experiencing a major depressive disorder at age 27⁹⁰. A study found that 24% of cannabis users had experienced an episode of major depression by age 40, compared to just 15% of non-users⁹¹.

⁸⁷ Cheung, J.T.W., R.E. Mann, A. Ialomiteanu, G. Stoduto, V. Chan, K. Ala-Leppilampi and J. Rehm, 2010. Anxiety and mood disorders and cannabis use. *Am. J. Drug Alcohol. Abuse*, 36: 118-122.

⁸⁸ Van Laar, M., S. van Dorsselaer, K. Monshouwer and R. de Graaf, 2007. Does cannabis use predict the first incidence of mood and anxiety disorders in the adult population. *Addiction*, 102: 1251-1260.

⁸⁹ Rey, J.M., M.G. Sawyer, B. Raphael, G.C. Patton and M. Lynskey, 2002. Mental Health of teenagers who use cannabis: Results on an Australian study. *Br. J. Psychiatry*, 180: 216-221.

⁹⁰ Brook, D.W., J.S. Brook, C. Zhang, P. Cohen and M. Whiteman, 2002. Drug use and the risk of major depressive disorder, alcohol dependence and substance use disorders. *Arch. Genet. Psychiatry*, 59: 1039-1044.

⁹¹ Chen, C.Y., F.A. Wagner and J.C. Anthony, 2002. Marijuana use and the risk of major depressive episode epidemiological evidence from the United States National Comorbidity Survey. *Soc. Psychiatry Psychiatr. Epidemiol.*, 37: 199-206.

Why Was Cannabis Made Illegal?

The War on Alcohol (and in turn on Narcotics)

Cannabis was for all purposes legal in America. However, around the start of the 20th century, the theory of alcohol prohibition started to develop. The restrictive public policy with regards to cannabis was first initiated around the late twenties and early thirties, and has continued to the present day. It's important to note the war on cannabis is not an isolated phenomenon. At every level of the development of the nation's marijuana policy, the process and public perception has been heavily influenced by multiple other social issues that have stemmed from broader diverse cultural patterns. The idea of alcohol prohibition was based on acceptable reasoning that in general its consumption led to violence, crime and theft. The entire inception of an anti-cannabis policy was only implemented because of the damage alcohol was having on American society, because of this initial and bizarre link between the two, cannabis's fate in the courts have always been inseparably linked with the prohibition experiences.

In an essay for the New York Times in 1970, famous American writer Gore Vidal wrote, *"No one in Washington today recalls what happened during the years alcohol was forbidden to the people by a Congress that thought it had a divine mission to stamp out Demon Rum and so launched the greatest crime wave in the country's history, caused thousands of deaths from bad alcohol, and created a general (and persisting) contempt for the laws of the United States"*⁹².

If you look at the general structure of both the alcohol prohibition and narcotic prohibition movements, there are obvious similarities. Initially they were both directed against the evils of possible large scale use and then later down the line changed their agenda to be against all use. Even the rhetoric was practically the same: These euphorants guarantee pauperism, crime and insanity. Each movement began on state level and then picked up enough pace to secure significant congressional action. Finally and expectantly both movements ultimately got exactly what they were looking for within the judicial system.

⁹² Vidal. Gore, New York Times, September 26, 1970 Drugs: Case for Legalizing Marijuana

Even though major similarities existed between the movements, three obvious and key differences can be identified.

- 1) The prohibition movement was in the public eye and a key issue of public debate; the movement against narcotics was not.
- 2) Prohibition legislation was created by a highly organized nationwide lobby; narcotics legislation was mostly ad hoc.
- 3) Prohibition legislation was designed to stop known evils that were created by alcohol abuse; narcotics legislation was not based on any scientific or medical research and was largely anticipatory.

The Harrison Narcotic Act in 1914 was seen as being mostly anticipatory, the Government witnessed the damage alcohol was doing so they decided to lump all known narcotics into the same bundle (cocaine, heroin, cannabis, morphine, and opium) and make them illegal before they can cause any real damage.

The government tried to justify their actions of placing cannabis in The Harrison Narcotic Act by starting a propaganda campaign against cannabis itself.

The Chief Detective of the Los Angeles Police Department Joseph F. Taylor stated:

“In the past we have had officers of this department shot and killed by Marihuana addicts and have traced the act of murder directly to the influence of Marihuana, with no other motive. Numerous assaults have been made upon officers and citizens with intent to kill by Marihuana addicts which were directly traceable to the influence of Marihuana.”⁹³

These five drugs were included in the Narcotics Act was based on two different reasons:

- 1) Heroin, Cocaine and Morphine because of high levels of addiction among war veterans.
- 2) Racial stereo-typing:
 - Opium because of its link with Asian immigrants on the west coast of America.
 - Cannabis became known as “*Mexican opium*” that Mexican immigrants were using down South.

⁹³ Hayes & Bowery, Marihuana, 23 J. CRim. L. & CRIMINOLOGY (1932). pg1088

Addiction to Heroin, Cocaine and Morphine (and occasionally Opium) only became a problem because of their over prescription as pain medication. They were unlabelled because of lack of legislation, so people didn't know how much they could take or even know exactly what they were taking.

Cannabis use must be prohibited to keep addicts from switching to it as a substitute for the drugs which had become much more difficult to obtain after the enactment of the Harrison Act, and for alcohol after Prohibition⁹⁴.

Although cannabis was included in the Harrison Act there was no "national" public policy regarding it until the Uniform Narcotic Drug Act in 1932 and the passage of the Marihuana Tax Act in 1937.

⁹⁴ Simon Carlton, From Opium to Hasheesh, Scientific American, Nov. 1921, at 14-15

Different types of legislation for Cannabis:

A case study of Portugal, Uruguay, The Netherlands and Colorado

Portugal

In the 90's, Portugal realised its war on drugs was failing miserably, yet was still a massive financial burden on the Country. As a result, the government decided to change its drug laws in 2001 from being completely illegal to a new model of decriminalisation. This meant that all cases of personal drug possession for all hard and soft drugs, up to 10 days of personal supply, were now seen as a misdemeanour rather than a criminal offense. The reason it became a misdemeanour instead of completely legal was just to ensure the new legislation didn't break any international treaties. The country realised that the average cannabis user was never the source of any social problems, so keeping it illegal could not be justified. Hard drug users were a different issue, their drug habits did cause wider problems for society and acute problems for many of the users themselves as well as their loved ones. Under this model dealers could still be prosecuted.

Overnight there were drastic changes. Courts were now free from the needless daily ritual of criminalising perfectly decent citizens for petty drug offences⁹⁵. There was instantly less restraint on police resources, available manpower increased while costs decreased. Jail overcrowding became less of a problem. The police were now able to focus on career criminals rather than recreational drug users. Treatment centres found that hard drug users were more likely to ask for help now. This model was designed to view drug addiction as a disease rather than a criminal offense, the newly freed up funds were being used to aggressively targeted drug addicts with therapy rather than punishment. Drug users in Portugal are forced to attend classes aimed at getting them back on the straight and narrow.

⁹⁵ <http://www.dutch-passion.nl/en/news-and-development/portugals-drug-laws-a-new-european-model/>

Uruguay

Uruguay went down a different road than Portugal regarding drugs. They only changed their policy on cannabis, but instead of introducing decriminalisation they became the first country in the world to make cannabis completely legal, with a few restrictions to regulate the market (this is the road Portugal are planning to go down next, due to the obvious success the change in legislation has had on the nation).

By making cannabis legal it means that consumers would not face any penalty at all. However, more importantly, the main difference between decriminalising cannabis and making it completely legal is the influence it has on the supply side of the business—cultivation, transportation and retailing all become legal, helping to fight the battle against organised crime.

Uruguay's long term plan is to include a system of user registry, a tax, and quality control, all coordinated through the existing agency that monitors tobacco, alcohol, and pharmaceuticals⁹⁶. It's estimated that with current 70,000 cannabis users, the country will have to produce more than 5,000 pounds each month⁹⁷

They believe regulating the market is essential, because if the market was allowed to be a free-market its goal would be to maximise sales, which Uruguay don't want to do, they just want to take the power away from organised crime.

Possession for personal use is not penalized, although today's law does not specify quantity for "*personal amount*"⁹⁸.

The supply would be state regulated and foreigners would not be allowed to purchase cannabis, THC levels must be less than 15% and each consumer can buy up to 40 grams a month but only after they register with a database run by the Ministry of Health.

In August 2014 Uruguay legalized growing up to six plants at home, and in October 2014 the Government began registering growers' clubs, who will be allowed to grow a maximum of 99 cannabis plants annually⁹⁹.

⁹⁶ "Marijuana in the Americas: Legalize Me, Decriminalize Me, Prohibit Me". Revolución Pan Americana. 30 July 2012.

⁹⁷ Cave, Damien (30 July 2012). "Uruguay Considers Legalizing Marijuana to Stop Traffickers". The New York Times.

⁹⁸ "Cannabis South American laws". Erowid.org. March 1995.

⁹⁹ "Uruguay cannabis growers' clubs: Registration begins". BBC News. 31 October 2014.

The Netherlands

The Netherlands is known for its lenient view on drug consumption especially regarding its cannabis policy, but it's important to understand technically all drugs are still forbidden in the Netherlands.

In 1976 they introduced a new policy that effectively decriminalised the personal possession of up to 5 grams of cannabis, but only for adults. The policy also tolerated the existence of outlets for cannabis sales, called 'coffee shops'.

The coffee shops are allowed to operate under strict licensing conditions, which include age-access restrictions, a ban on sales of other drugs (including alcohol), and controls on the shops' external appearance, signage and marketing.

The approach has been broadly successful:

Although the use of cannabis in the Netherlands has risen since 1976, this has been in line with wider European trends.

Annually, the coffee shops generate an estimated 400 million euros in tax – money that would otherwise have accrued to criminal profiteers¹⁰⁰.

Drug policy in the Netherlands is based on the two principles that drug use is a health issue, not a criminal issue, and that there is a distinction between hard and soft drugs.

Rather than seeing an inexorable psychopharmacological link between cannabis and hard drugs, the Dutch hypothesized that the link was sociological, and they sought a way to "separate the markets" to keep soft drug users out of contact with hard drug addicts and dealers¹⁰¹.

There is a penalty up to a maximum of 4 years for importing or exporting large quantities of cannabis. The money saved on not having to prosecute personal cannabis use has allowed the Netherlands to invest more in prevention of drug addiction and available treatment.

¹⁰⁰ Grund, J-P. and Brecksema, J. (2013) Coffee Shops and Compromise: Separated Illicit Drug Markets in the Netherlands, Global Drug Policy Program, Open Society Foundations, p.52.

¹⁰¹ What Can We Learn from the Dutch Cannabis Coffeeshop Experience? Robert J. MacCoun WR-768-RC July 2010

The Netherlands spends significantly more per capita than all other countries in the EU on drug law enforcement. 75% of drug-related public spending is on law enforcement. Drug use remains at average Western European levels and slightly lower than in English speaking countries.

The Dutch policy is to keep anti-drug laws on the books while restricting enforcement of certain offenses in an attempt to reduce harm and not break any international drug treaties. They do this to avoid complications with the International Narcotics Board.

Colorado

As of January 1st 2014, Colorado has officially moved from a medical marijuana system to full legalization. Thanks to the passing of Colorado Amendment 64, Colorado's constitution now outlines a state-wide drug policy for cannabis. The measure passed on November 6, 2012, is now enacted as Article 18, section 16 of the state constitution, the law addresses "personal use and regulation of cannabis".

Adults aged 21 or older can grow up to six cannabis plants (with no more than half being mature flowering plants) privately in a locked space, legally possess all cannabis from the plants they grow (as long as it stays where it was grown) legally possess up to one ounce of cannabis while traveling, and give as a gift up to one ounce to other citizens 21 years of age or older. Consumption is permitted in a manner similar to alcohol. Consumption in public remains illegal. Visitors and tourists in Colorado can use and purchase cannabis, but cannot take it out of the state.

Anti-legalisation groups warned that Colorado would become a lawless wasteland but all data collected since its full legalisation point in the opposite direction.

According to the Drug Policy Alliance, the available data indicates that the state has collected around \$70 million in tax revenue, violent crime in Denver decreased for 11 straight months and Roughly 10,000 jobs have been created, helping economy growth.

Surprisingly, cannabis use among teenagers has actually dropped in Colorado and traffic data has proven that traffic fatalities have declined since legalisation was introduced.

The state has one of the lowest unemployment rates in the States – 6% – which is also the lowest rate it has been at since the recession started.

Literature Review Conclusion

After analysing all of the above literature, I believe the pros of legalising cannabis heavily outweighs the negatives. I will now apply what I have learned in my literature review and use that knowledge to explain why I think Ireland should legalise cannabis.

Chapter Two:

Contextualisation

History of Cannabis in Ireland

Cannabis was first introduced to Ireland by Dr. William O'Shaunessy. He was sent on a mission to Calcutta, India to discover new medicine, and it was there where he came across cannabis in 1839. At the time it was seen as an anti-compulsive remedy and hailed as a wonder drug, so he brought it back to Ireland to introduce it to the medical and scientific community.

In the late 1800's and 1900's, interest in cannabis started to increase in the UK but not in Ireland, interest had stagnated since O'Shaunessy's discovery of the drug.

Internationally, Ireland signed up to both the 1961 and 1971 UN drug conventions which were aimed at making a number of drugs, including cannabis use, illegal world-wide. At that point in time cannabis use was extremely rare in Ireland and first became illegal under the Misuse of Drugs Act of 1977 that was heavily influenced by the American and UK Drug Acts. It was made a Schedule 1 drug, right beside heroin.

In the 1980's Ireland became a back door to smuggling cannabis in to Britain because of its close proximity to the areas of demand like Manchester (which had a thriving drug and music scene) and low level security ports located on the east coast of Ireland.

In 1984 the Misuse of Drugs Act redefined the definition of cannabis under the Principal Act.

Even though cannabis was illegal during the 1980's, use of the substance began to rise. This rise can be attributed with the fact criminals in Ireland were now facilitating in the trafficking of cannabis to England, which increased supply, access and knowledge of cannabis within the borders of Ireland.

The Gardai attempt to stop the drugs trade had mostly focused on areas of import, for example, customs and national borders. Then grow-houses began to pop up around Ireland in the late 80's/early 90's to cut the cost of importing the product and maximise profit. These new grow-houses and the increase of drugs in general led to the creation of The Garda National Drugs Unit (GNDU) in 1995.

Cannabis use in Ireland has continued to steadily increase in the 90's, 00's and 10's and is currently Ireland's most popular drug because of its euphoric effect and multiple medical benefits.

Current Day Legislation - Ireland

The current legislation in Ireland for cannabis or cannabis resin depends on whether the court believes it was for personal use or supply for sale and distribution.

Possession:

According to the Misuse of Drugs Acts, anyone that is found in possession of cannabis or cannabis resin is seen as being guilty of an offence. If it's a first offence, a court can impose a class D fine based on a summary conviction from a District Court. The fine can be up to €1,270.

For a 2nd offence, a class D fine may be imposed again. On conviction on indictment, a fine of up to €2,540 can be imposed.

For a 3rd offence, a class C fine can be imposed along with a potential prison sentence of up to 12 months. On conviction on indictment, the court may decide on an appropriate fine and/or a prison sentence of up to 3 years.

Growing cannabis plants:

It is an offence to grow cannabis plants and on summary conviction for this offence, you could be liable for a class C fine and/or a prison sentence of up to 12 months.

Supply for sale and distribution:

Anyone found guilty of this offence is liable to a class C fine. On a summary conviction in a District Court, a fine and/or a prison term of up to 12 months can be given. Where the market value of the drugs is €13,000 or more, the person convicted is liable for a minimum sentence of 10 years. This does not apply, however, where the court is satisfied there are exceptional circumstances. Similar penalties apply to someone convicted of importing drugs with a value of €13,000 or more.

Cannabis in Ireland Today

In the Ireland and Northern Ireland Drug Prevalence Survey 2010/2011 it was concluded that *“1 in 4 Irish adults have used Cannabis¹⁰²”*.

Phillip Ryan of the Irish Independent wrote an article on 26/01/2015 stating that *“a third of people believe cannabis should be legalised¹⁰³”*

NORML (the American organisation, which drove the campaigns to legalise marijuana in Colorado and Washington states) launched in Ireland in 2013 to try help legalise cannabis.

The same year, Luke Ming Flanagan put forward the Cannabis Bill 2013, which, if it had passed, would have made Ireland the first country in Europe to vote to legalise Cannabis. The bill was voted out 111 – 8¹⁰⁴.

In 2014, Gareth McGovern one of Irelands leading addiction specialists says, after years of treating Irish addicts, that cannabis is *“not physically addictive”*.

UCD Professor of Economics - Ronald Davies. Speaking at the 2014 Think Big event suggested a conservative estimate, that cannabis legalisation could be worth around €560 million a year to the Irish Economy¹⁰⁵.

At the beginning of 2015, NUIG students voted whether their student union should *“actively supports the legalisation and regulation of the cultivation, sale and possession of cannabis for adults age 18 and over¹⁰⁶”* Of the 2,634 voters, 68% voted yes and 32% voted no. This result now gives the SU a mandate to support legalisation, making it the first SU in Europe to take such a stance.

Ciarán Maher, of the university’s Students for Sensible Drug Policy Society said *“our current legal system allows this very profitable industry to be controlled by criminal gangs, while needlessly criminalising normal people¹⁰⁷”*.

¹⁰² <http://www.independent.ie/irish-news/one-in-four-have-used-cannabis-with-education-a-factor-29389458.html>

¹⁰³ <http://www.independent.ie/irish-news/one-in-three-wants-cannabis-legalised-poll-says-30936624.html>

¹⁰⁴ <http://www.rte.ie/news/2013/1106/485090-cannabis-dail/>

¹⁰⁵ <https://irishcannabis.wordpress.com/2015/03/07/regulated-cannabis-revenue-potential/>

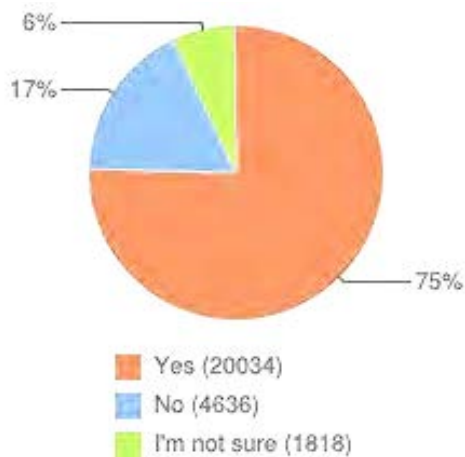
¹⁰⁶ <http://www.su.nuigalway.ie/component/k2/itemlist/tag/Cannabis%20legalisation>

¹⁰⁷ <http://www.galwayindependent.com/20150306/news/nui-galway-students-back-cannabis-legalisation-S51836.html>

National Polls on Cannabis Legalisation

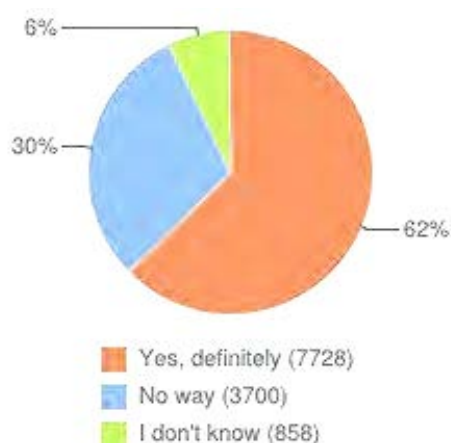
The first important factor to notice regarding this section is the fact that The Journal is the ONLY national media outlet asking the nations opinion on the subject of cannabis legalisation.

On the 15th of June 2013 in honour of the 7th annual Legalise Cannabis Ireland protest held in Dublin, The Journal ran a poll on “*Should we legalise cannabis in Ireland?*”



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In March 2015 The Journal asked the same question “*Should we legalise cannabis in Ireland?*” below are the results so far, but votes are still being collected and will be until August.



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¹⁰⁸ <http://www.thejournal.ie/poll-cannabis-952366-Jun2013/>

¹⁰⁹ <http://www.thejournal.ie/nuig-cannabis-1977726-Mar2015/>

In January 2014, The Journal ran a poll asking “*Who is more likely to support the Legalisation of Marijuana?*”

Who is more likely to support the Legalisation of Marijuana?

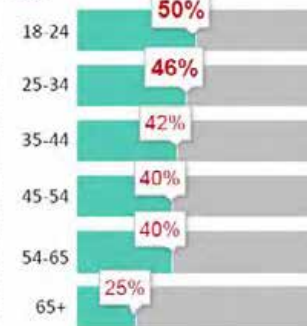
(Base: All Adults 18+ excluding Don't Knows - 953)



Gender



Age



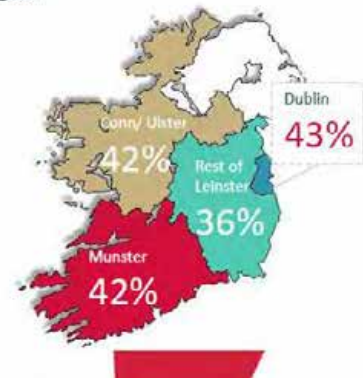
Social Class



Party Support



Region



110

The findings suggest that since the younger end of the population would like to make cannabis legal, the overall number of those wanting to legalise cannabis is likely to increase steadily over time.

¹¹⁰ <http://www.thejournal.ie/marijuana-legal-1256495-Jan2014/>

Arguments against Cannabis Legislation in Ireland

The Cannabis Bill 2013 created a debate about cannabis legalisation in the House of the Oireachtas and allowed members to explain why they are against legalisation.

Derek Keating TD FG Dublin Mid-West explained that cannabis is “*one of the most toxic substances*” that it “*damages the brain*” and then claimed “*8% of under 10’s in Ireland have used cannabis in the last 12 months*”.

Minister for Health James Reilly (FG) warned that there are “*Serious health risks associated with Cannabis*” while if you ask a doctor with years of medical and cannabis experience if this is true, they would give an answer along the same lines as Rd. Tod H. Mikuriya MD ,a well-respected doctor from Berkeley, did when he was asked about the health benefits of cannabis:

“In my practice over 200 different medical conditions responded favourably to cannabis, there is no medical product out there today that provides as much medical benefits as cannabis¹¹¹”

Or maybe an answer like Dr. Jeffrey Hergenrather MD gave when asked about the Cancer risks associated with cannabis:

“Cannabis has antiproliferative effects which prevents cancer cells from reproducing, the cannabinoids have antiangiogenic effects which prevents formation of new blood vessels needed by a tumor to grow, and there is also antimetastatic effects which prevents cancer from spreading to other organs. It even has an apoptotic effect which induces a cell to seek its own death.¹¹²”

Alex White TD Minister of State at the Department of Health and Minister in charge of the National Drugs Strategy said “*Cannabis increases seizures and epilepsy*” a fact dismissed by research stated in the health benefits section, in fact cannabis has been proven to greatly help stop seizures and help people cope with epilepsy.

¹¹¹ The Union (2007) film – personal interview

¹¹² <https://doctoravicenna.wordpress.com/tag/cannabis-oil/>

Mary Mitchell O'Connor TD (FG) stated: “*Cannabis increases the risk of lung cancer by 8% every year of use*” while Joe O'Reilly TD (FG) confirmed that “*Cannabis causes throat and lung cancer*”.

After 30+ years of NADA funded evidence, Dr. Donald Tashkin MD UCLA was asked does cannabis cause throat and lung cancer, he responded by saying:

“There is no evidence of increased risk of lung cancer related to cannabis smoking alone and the development of the growth of a cancerous tumour is actually suppressed by THC¹¹³”.

The Irish government is using the known negatives of tobacco to try and stop the legalisation of cannabis, two substances that have nothing in common with each other except for the fact it's possible to inhale both substances, as previously mentioned cannabis could indeed improve some of the health effects caused by smoking.

The government also tried to claim cannabis is a gateway drug. The Dutch system has proven that the gateway theory isn't true and that in fact it's actually because cannabis is illegal and consumers have to interact and get it off a drug dealer, which creates any possible gateway link between cannabis and harder drugs.

Even more than that, studies have shown it might be the perfect exit drug. People who want to get clean, should substitute their drug of choice with cannabis and it will heavily reduce the withdrawal effects and make the process much easier on the patient (user). There are currently 15,000 heroin addicts in Ireland that are still using heroin or substituting with state funded methadone – cannabis offers a legitimate, safe exit strategy from both.

The government argued that a regulated product would be too weak and too expensive to kill the black market for cannabis, this should not be a reason to keep it illegal but a valid reason to ensure a fair tax and pricing system is applied to the product.

The government did make a valid point when they said they'd be worried the legalisation of cannabis may increase tobacco use because of its association with the method of ingestion of cannabis, but with the right advertisements and warnings this link can be broken, there are multiple other forms of ingestion from e-cigarettes, vaporisers and even edibles.

¹¹³ <http://healthland.time.com/2012/01/10/study-smoking-marijuana-not-linked-with-lung-damage/>

Why Should Ireland Consider Legalising Cannabis?

David Nutt, a former advisor to the department of Health in England and well respected psychiatrist predicts that alcohol use would drop by 25% in Ireland if cannabis was legalised¹¹⁴.

Alcohol abuse costs Ireland 3.4 billion each year¹¹⁵, a 25% saving would be a staggering 850 million per year. According to the HSE 2,000 hospital beds per night are occupied for alcohol related reasons¹¹⁶, that's an extra much needed 500 hospital beds available every single night.

HSE stats indicate there are 88 deaths per month from alcohol in Ireland¹¹⁷, which is double all other drugs combined, if a 25% reduction in alcohol use is accurate, it would mean cannabis legalisation might even save 264 lives from dying of alcohol abuse alone.

There are currently 100,000 people in Ireland with a criminal record because of cannabis¹¹⁸, they would all be able to increase their economic activity. If they all increased their activity by even €1000 each, that's a €100m created instantly.

100,000 people in Ireland can't adopt kids, can't get a job as a doctor, nurse, police man or teacher all because they have a criminal record for cannabis possession. How can we claim we live in a free, open and democratic society if we're not even allowed to choose what we consume.

There are between 150,000-300,000 cannabis users in Ireland, if we take the extremely conservative number of 150,00 users, predict they are spending roughly €100 per month at 33% tax that's almost €60m a year in tax money alone for the government, that's without even considering potential new users, users increasing their consumption or tax generated by tourists buying cannabis.

¹¹⁴ <http://www.theguardian.com/science/2012/jun/19/david-nutt-alcohol-cannabis-cafes>

¹¹⁵

<http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/TRJ2013041700009?opendocument>

¹¹⁶ <http://alcoholireland.ie/facts/alcohol-and-costs/>

¹¹⁷ <http://www.imt.ie/mims/2015/01/alcohol-consumption-ireland.html>

¹¹⁸

<http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2013110600070?opendocument>

There are roughly 8,000 arrests a year in Ireland because of cannabis¹¹⁹. That's 8,000 less arrests the police and judicial system would have to deal with, yet alone the fact they will now be able to spend more time dealing with more dangerous crimes.

The government claims the medical benefits associated with cannabis are already supplied by other drugs, let's take Sativex as a perfect example:

Sativex that's used for MS is not currently sold in the Republic of Ireland but is available in Northern Ireland. It costs £125 for a 10ml vial that lasts 10 days¹²⁰, to compare 1 Oz of dried cannabis that would easily last 10 days use, can be grown for under €5 in the patient's own house and even at this hypocrisy, it's the pharmaceutical company that profits from these sales not the government which would reinvest the money into essential services. It's also important not to forget that the £125 doesn't include the transport costs a Republic of Ireland citizen has to pay to get to Northern Ireland or the legal risk they face for possessing the illegal drug "Sativex".

Ireland has the highest rate of MS in Europe. It has 30,000 new cases of cancer each year¹²¹ not to mention the thousands of patients who still have cancer. The country also has globally high levels of obesity and diabetes.

Cannabis actually has the ability to help all of these patients, not one, not some, all.

It has the potential to stop problems developing before they become a problem by regulating and balancing out different elements of the body e.g. sugar levels, gut bacteria etc. which in turn would make people healthier, increasing their standard of living, reducing their own financial health costs and even potentially reducing the cost of governmental medical care.

Ireland runs on a politically motivated economy, where social ethical morals are happily traded by politicians for a few guaranteed votes. The truth is there are a lot of votes in being seen tough on drugs, everybody has a brother, a sister, or even a child that they would hate to see become a drug addict, a fear that everyone has in the back of their minds, but voting out of fear is not a democratic free choice, its emotional blackmail. The war on drugs has taught us that continuing to keep certain drugs illegal has no effect on consumption.

¹¹⁹ <http://www.broadsheet.ie/tag/legalise-cannabis/>

¹²⁰ <http://www.theguardian.com/business/2010/jun/21/pharmaceuticals-industry-multiple-sclerosis>

¹²¹ <http://www.cancer.ie/about-us/media-centre/cancer-statistics#sthash.8veZd7xr.dpbs>

After analysing my case studies, I believe the cannabis legislation in the Netherlands led to one major problem, it created "border hot spots" for drugs to enter the Netherlands neighbouring countries which caused friction with international relations especially in the bordering countries of France and Germany, this would not be an issue in Ireland because it's an Island but the border with Northern Ireland may be cause for concern.

But What About Our Kids?

Illegal drug-dealers don't ask for ID, it's easier for kids to get cannabis than ever before. A legalised regulated system would make it harder for them to get their hands on it, and at an absolute minimum, it would take all the bad cannabis "skunk" off the streets and away from kids. Adult drug dealers recruit young children to sell drugs for them, the safest way to protect our children is to limit any contact with drug-dealers, not by giving drug dealers more and desirable products to sell that would entice children to interact with them. Drug dealers are currently getting very cheap labour from children being mules, less interaction with drug dealers would mean drug dealers would now have to pay more money to be able to hire adults to be there mule, therefore reducing their financial power even more. Kids are also much more likely to sell to other kids purely because of social interactions, like the interactions they make daily in schools.

Albert Einstein in 1921 said *"The prestige of government has undoubtedly been lowered considerably by the prohibition law. For nothing is more destructive of respect for the government and law of the land than passing laws that cannot be enforced"*

The respect the Irish people have for their own Government has never been lower, cannabis legalisation not only offers the government help in achieving monetary aims and creates fiscal benefits, it gives them the unique opportunity to win back the respect, of the youth of today.

Conclusion

After examining the literature, I believe prohibition is wrong for Ireland and that full legalisation is the correct route.

The literature indicates, the budgetary implications of legalisation exceed those of decriminalisation for three main reasons:

- 1) Legalisation eliminates arrests for trafficking in addition to eliminating arrests for possession.
- 2) Legalisation saves prosecutorial, judicial, and incarceration expenses; these savings are minimal in the case of decriminalisation.
- 3) Legalisation allows taxation of cannabis production and sale.

Founder and executive director of the Drug Policy Alliance, Ethan Nadelmann, once said: *“Clearly marijuana prohibition is unique among the criminal laws in America and most other open societies. No other law is both enforced so widely and harshly yet deemed unnecessary by such a substantial portion of the populace”.*

Even inside the Drug Enforcement Administration the view on Cannabis is widely divided their own administrative law judge, Francis Young, came to the conclusion in 1988 that *“marijuana may well be the safest psychoactive substance commonly used in human history”.*

Steve Rolles, the Senior Policy Analyst for the Transform Drug Policy Foundation believes *“Prohibition doesn’t improve public health, it actually endangers public health. It doesn’t protect children, it imperils children. It doesn’t reduce crime, it fuels crime. It’s very expensive and is delivering terrible outcomes”*

Transform, a group who are trying to get drugs under control, stated in their Practical Guide on how to regulate cannabis *“The experience of the past 50 years demonstrates that prohibitionist policies have not, and cannot, achieve their stated aims.”*

Diego Canepa, the president of the Uruguay's National Drug Board, said *“A regulated market that is visible has greater oversight than prohibition.”*

The war on cannabis seems to be slowly burning out, it needs to be replaced by a system of legalization, taxation, regulation, and education. Science should supersede politics.

The literature highlights the simple truth that people just want safe, natural and inexpensive treatments that stimulate our bodies' ability to self-heal and help our population improve its quality of life. Cannabis legalisation has the potential to offer this.

I whole heartily believe the literature I've reviewed proves that any negative or potential danger associated with cannabis is heavily out-weighed by the obvious social, economic and financial benefits that legalisation would bring to Ireland.

One area on this debate that's rather surprisingly constantly overlooked and I feel is actually very important, is the accuracy of long term social studies in regards to cannabis use.

The studies completed on long term cannabis use, is mostly based on cannabis purchased illegally from a drug dealer. This obvious flaw in the studies can have detrimental effects on the overall accuracy of the results. It can show cannabis in a much more negative light than it should be, because it's highly likely the standard of cannabis consumed would be extremely poor, not only would the THC to CBD ratio be severely unbalanced, but it's common practise for the product to be weighed down with fertilisers to make the product heavier, to make the product more profitable; and we all know drug dealers only care about the profit side of their business. It's the equivalent of claiming you're doing scientific studies on alcohol but using the famous "moonshine" product drank during alcohol prohibition as an alcohol substitute for the basis of your research.

It's obvious from reviewing the literature that cannabis is definitely not for everyone, but that doesn't mean it should be illegal to everyone. The no-win 'drug war' keeps driving up the price, users may commit crimes to cover the cost, making the public the overall loser.

THC can in high doses be linked with psychosis, but within the same plant it has CBD which is anti-psychotic. In a regulated system you can ensure the correct balance of chemicals, to limit any possible negatives associated with the plant.

If legalisation is implemented it's essential we keep the cannabis industry away from the tobacco industry, they should not be linked, they are not related, and the only link between them is that cannabis is sometimes consumed by mixing it with tobacco.

Tobacco has known carcinogens (chemicals that cause cancer), cannabis does not. A vaporiser or eating cannabis raw would be a much better health conscious option and would help push the association of cannabis and tobacco away from each other.

In my literature review I discovered It's illegal to patent plants, that's why pharmaceutical companies are currently funding anti-cannabis movements to buy themselves time to extract the different elements out of cannabis, to patent them and then to sell them as pharmaceutical drugs like there attempting to do with THC and Sativex. It is for this reason, I believe legalising cannabis as soon as possible is of major importance.

I'd advise, in a legalised system that the government is in control of supply and outsources it to businesses in the agriculture industry but limits how much each farm can produce – it's essential to stay far away from the big tobacco model.

I believe the literature evidence proves that THC limits must not exceed a maximum, and must be in line with CBD levels.

On evidence of the case study about Colorado, I'd recommend under selling cannabis for the first 6-12 months to cripple the criminal industry.

The literature would indicate, legalising cannabis may take business away from the pub industry, but as a whole this new legalised industry might be a tourist attraction for the nation. The people of Ireland (especially the youth) generally abuse the availability of alcohol, to such an extent it's difficult to socialise if you abstain from alcohol. The economic loss to the industry should be weighed against the economic and health benefits created by the cannabis industry.

A recent study by economists D. Mark Anderson and Daniel I. Rees found that semi-legalisation, in the form of medical cannabis, in 16 states led adults to consume more cannabis but to moderate their alcohol consumption, leading to a 9% decrease in traffic fatalities caused by drunk drivers¹²².

I've highlighted the success of Colorado's hands-off approach to cannabis legalisation and how it has proven to be successful, it's important to point out that Washington's more heavily-regulated market has led to some challenges. Due to rather aggressive tax rates on not just consumers, but on producers, processors, and retailers, many are finding it cheaper to stick to the black market. The licensing scheme for growers has also resulted in product shortages, driving prices even higher, and making product harder to find at retail locations.

¹²² http://www.huffingtonpost.com/ranjit-dighe/legalize-marijuana-economic-argument_b_4695023.html

If Ireland are going to be successful in legalising cannabis it's important they don't fall into the same trap that Washington has succumb to.

In summary, I believe Ireland is ready for the legalisation of cannabis and should look to do so in the near future. There are of course pros and cons of legalisation, which I've highlighted in the Literature Review, but when applied to the Contextualisation of Ireland, legalisation is clearly the best choice.

Over 100 years ago, in 1902, Thomas Edison said:

"There were never so many able, active minds at work on the problems of disease as now, and all their discoveries are tending toward the simple truth that you can't improve on nature."

This statement still holds true even today.

In my humble opinion, now is the right time to legalise cannabis in Ireland.

Appendix

While examining the literature and reviewing the case studies I've come across some key suggests that would help to ensure a safe rite of passage for the legalisation of cannabis in Ireland:

First, part of my advice would be to say, it's important to consider all elements of the legalisation – Possession, sale, transport, cultivation.

Very strict rules should be applied to the industry at the start because of Ireland's bandwagon effect. Available to over 21's to absolutely guarantee that the person's brain has fully developed. THC levels capped at a 10-15% maximum, no advertising what so ever, distribution centres should not be located anywhere near schools, it should be illegal to consume in a public place, taxes in line with alcohol and tobacco but for those with a medical card for cannabis should get it cheaper, membership only clubs should be allowed, limited tourism scheme regarding tourists purchasing cannabis in Ireland, distribution centres should have restricted opening – closing times and maximum amount you can buy. There should be a maximum amount you can carry around at any one time, I believe these restrictions should be put on in the short-term (3-5 years) to ensure that cannabis legalisation is well received by all aspects of the public. I would also advice Ireland to set up a research centre for cannabis, be a world leader in research and help provide jobs.

The list below are other suggestions that come to mind:

- Limiting outlet density
- Requiring plain paper packaging
- Ongoing drug-driving testing
- Licensed commercial growers
- A regulatory board to set prices
- Government as monopoly distributor and retailer

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Niall Dawson

Dear Comittee Members

First off I'd like to say this discussion is a great step forward for the States approach to the issue of illicit drug's, and if approved will considerably change the handling of dealing with drug's, and drug users.

What benefits will decriminalisation have?

A:

1. Decriminalisation is a step forward in the treatment and rehabilitation of drug users because rather than removing the problem, it's treating the problem. It was recently highlighted in the Irish Media the quantity of drug's in the Irish Prison Service. Addicts sent to prison are more inclined to use drugs because of the pressure put on them by criminal gangs operating within the prison.
2. Injection Centres - IV drug user carries a very high risk of terminal disease and illness such as Hepatitis and the HIV/AIDS virus. If addicts could inject in a medically supervised enviroment there would be less deaths among IV users; there would be less fresh cases of HIV/AIDS
3. Drug's will **ALWAYS** be in circulation regardless of their legal status. Let's take Saudi Arabia for example, a Country under Sharia Law who frequently uses Capital Punishment. Drug use is not a pipe dream in Saudi Arabia, there's users in their State who risk capital punishment for their actions; Ireland is nowhere like Saudi Arabia.

More needs to be done to highlight the effects, both short term and long term of drugs. If a person decides to do heroin for example, would it be best they take heroin without knowing what support options are there for them in terms of support or that they have this information before hand because drugs would be looked at in a different manner?

4. I have a saying that "All drugs are harmless, it's irresponsible users who make them dangerous." I've heard and seen quite a few fatalities in youth drug users. They refuse to go hospital because of the legal status of drugs in the Country.

These main points are all I feel needs to be raised.

I'd like to thank you for taking the time to read over this and I wish the Oireachtas Comittee the best of look into their review on the current drug policies in the State Of Eire.

Kindest Regards,
Maister Niall Dawson

Tuesday 7th July 2015

To whom it may concern,

I am making a submission to your committee for the following reasons:

- I work as a Drugs Education and Prevention Worker.
- I believe our present policy is failing.
- I see firsthand the devastation caused not only by drug misuse but also by the criminal behaviours associated with that misuse.
- I believe that the legal status of drugs has no relevance to the misuse of substances.
- In 1997 I was a participant on a 'Training the Trainers' course that was carried out in partnership with a group of psychologists from Portugal who were then looking at the connection between substance misuse and long-term unemployment. Over the course of that participation I learned a great deal from them about the need to change our approach to tackling substance misuse.

I would be willing to appear in public session at any committee meeting.

I would also like to take this opportunity to congratulate you on taking the first steps towards looking at a fundamental shift in our society's understanding of substance misuse.

I also sincerely hope that it will lead to a change in our laws, which in turn, will (I believe) lead to a reduction in the harm caused to our society through substance misuse.

Noel Phelan

Jonathan Victory Submission to Drugs Policy Consultation 2015

I commend the work Oireachtas members have done in visiting Portugal to investigate their regime of decriminalisation, focusing resources towards treatment and away from prohibition. I would urge the government to adopt Portugal's approach to drugs policy post haste.

When it comes to the specific substance of cannabis, I would advise the government that continuing to keep this particular substance illegal is an outdated attitude which ignores the double-standard in legalising far more dangerous substances like alcohol or tobacco. On a recent trip to the Netherlands, I found their model of allowing the legal sale of cannabis products to adults in specially-registered stores and coffee-houses that must be kept a certain distance from schools, to be a common-sense approach, one that has recently been followed in the US states of Colorado, Washington, Oregon and the District of Columbia. Legalising this substance would remove the criminal monopoly over it, provide the State with a source of tax revenue and be beneficial for various health issues. On a personal note, as someone on the autistic spectrum coping with acute anxiety problems, I was struck by the calming, relaxing effect that cannabis I sampled in the Netherlands had. The private, safe use of cannabis in moderation is something that could be of great benefit to me.

I believe decriminalisation of harder drugs along the lines of the Portuguese model and the regulated legalisation of softer drugs along the lines of the Dutch model would be a balanced, progressive approach for the government to take.

In relation to the review of Ireland's approach to the possession of limited quantities of certain drugs

The problems as they are known to me.

- Dependency and/or Addiction - Patterns of use that are harmful to the individual user.
- The funding of criminal elements of this black market to whatever purpose they see fit.
- Trafficking of contraband and worse.
- The victimisation of end users of "softer" drugs at the hands of the criminal justice system.

My points

- Firstly and most importantly this is a public health issue and not a criminal justice issue.

If an addict has a problem then most likely they want help, speaking with addicts first hand i know that the relapse temptation is huge however this is more likely due to improper and completely inadequate supports in getting back into a productive frame of mind...nothing to do with the treatment but who will shelter an ex junkie only a junkie funnily enough. Thus the pattern continues. And there is nothing the police do that helps at all in my opinion. If any person gets violent or steals something there are already laws to deal with them a person should not be deemed criminal for simply having a substance dependency and/or addiction.

- Current enforcement is hugely disproportionately targeted on the least harmful substances.

Currently 8 of 10 appearances in the courts system in the category of drugs offences, are for simple possession of cannabis , be it in herb or resin form. A further 1 of these 10 is for quantities of cannabis worthy of a sale or supply charge. leaving 1 of 10 for every other drug. removing the least harmful drugs (as rated independently by prof David Nutt in the UK) our police force currently bring charges for "harder" drugs in less than .5% of all court cases. However even our previous drugs strategy made clear note to avoid direct targeting of end users it is now clear that our police force cannot be trusted with the "discretion" they are so proud to brag about. I submit that there is no role for the criminal justice system in dealing with any problems related to substance abuse, except where an individual is otherwise being harmful to themselves or others.

- Current policy surrenders control to criminal gangs.

If there is a demand there will be a supply, this has been proven. Criminal gangs are the main providers of contraband in Ireland however the way they operate means they are well insulated from the law in many cases. I submit that even decriminalised unless people are

allowed to "grow their own" (With whatever licensing is deemed necessary) that there will be little or no impact on the criminal operations to grow distribute and supply in Ireland.

How my points relate to the top mentioned problems.

- Dependency and addiction: current treatments have a good approach to get someone clean , inadequate support after this is responsible for relapse, as such no measures would be complete without addressing this.
- Unless people are allowed to "grow their own" (With whatever licensing is deemed necessary) that there will be little or no impact on the criminal operations to grow distribute and supply in Ireland. I would advocate for a club model such as that of some spanish regions.
- Trafficking of contraband and worse: If the demand is met by self supply as per my previous suggestion there would be less to smuggle and as such is less profitable.
- The victimisation of end users of "softer" drugs at the hands of the criminal justice system.: This is to me the most shameful point of this submission, the fact that i have to resign myself to the fact that despite their rhetoric the gardai have shown themselves to directly target the soft targets at the low end of the danger scale and then spend huge resources so they can claim successes and have their budgets approved for next year. I have much first hand experience with the issues related to addiction and i can say honestly and under oath if necessary that i have never once seen the gardai be anything only a hindrance and an obstacle to treatment for those who most need it.

I hope this is considered in earnest as that is the context in which it was written.

--

Kind regards,
Cormac O'Loughlin

To whom it may concern:

I would firstly like to say that I welcome the appointment of Labour TD Aodhán Ó Ríordáin as minister of state for the national drugs strategy. I think it is proactive stance by the government on what is a critical issue that the state has been relentlessly fighting for decades in counting up the numbers of young and homeless deceased due to addiction due to drugs (not excluding alcohol).

I would like to say I am in favour of decriminalization of possession of drugs for a few reasons:

(1) You cannot stop an individual harming themselves - but **you can minimize harm** through education, initiatives and giving protection to users of substances.

(2) Individuals will **stop trying 'fake' or 'pseudo' alternatives like legal highs** (still available in the UK). This will reduce harm since emergency services have better information on current illegal drug overdoses and complications but would not have any pharmacological data on 'mystery substances'.

(3) It will **stop the criminalization of regular 'responsible' users** of substances who could otherwise end up with a criminal record if they are caught. Such responsible users of drugs are functioning members of society who work hard, pay taxes and know their limits. Drug Convictions can frustrate these individuals ability to get a good job which leaves the rest of the **tax payers supporting these individuals on social welfare** - INDEFINITELY.

(4) It will hopefully allow to **reintegrate people** with these drug related offences back into the work force and potentially give them initiatives to educate young people about the dangers of using certain drugs and above all else - **the dangers of mixing!**

(5) **Free up Garda Síochána** to work on more serious crimes and put dangerous individuals in jail as opposed to those who may have gotten themselves a conviction due to drug possession.

(6) **Alcohol and prescription medications are the leading causes of all 'drug' related fatalities** which are coupled more often than not with the 'mixture' of alcohol with other drugs - yet we persist with alcohol (the common denominator) and seek to ban or restrict substances which on their own are less harmful? Follow the science - not Richard Nixon.

<https://cognitivelibertyuk.files.wordpress.com/2012/08/graph-3-drug-harm-charts-graph-diagram-science-research-facts-data.gif>

I would like to conclude by appealing with 'reason' to the powers that be to take a logical and scientific view of the factors involved and be willing to move Ireland forward into a cleaner and safer society that respects individual's rights to enjoy all fruits of the earth responsibly. Far from the vision of drunks throwing up in front of tourists in Temple Bar.

Yours faithfully,

Anthony Forrest B.Sc.

Dear sir/madam

My name is _____ and I am a 36 year old student studying in Tallaght it .
I am writing to you as a citizen and am not a expert in any field although I have read up on medical cannabis and am a advocate of it

Cannabis is now being researched extensively in countries and a lot of the research shows that it is promising for such illnesses as cancer ms and crohn's along with other digestive disorders and diseases .

I feel that it is a wrong to deny patients this drug that is shown to help relive symptoms and improve the patients quality of life .

In my regard I have suffered digestive disorder in a ongoing un-diagnosed case where I was prescribed steriods (which have massive side effects) The last time it happened I self medicated with cannabis and felt a lot better and it relived my symptoms a lot better than what they were prescribing me and my disorder has not been back since (it is over a year now since my last symptoms) . This is my own antidotal story .

But I do include research which does back up this position .

<https://www.karger.com/Article/FullText/356512>

So Please for suffers of diseases that can be treated with this simple and effective treatment please make it legal for us to get so that we are not being made into criminals for wanting a better quality of life for ourselves .

Reagrds

2015/615

hi i recover from depression using marijuana and this natural plant is
amazing plz legalise in some amount
thank
anwar hssn

Sent from my iPad

For The Committee on Justice, Defence and Equality.

I will begin by briefly outlining why it is an absolute moral duty of the government to stop criminalising its citizens for personal drug use, and then detail the points that I think should be considered for more just, humane and pragmatic drug laws in Ireland.

Prohibition is very inconsistent with the substances it includes and clearly does more harm than good. In the face of recent evidence it is objectively wrong and nonsensical to continue with our current model of prohibition.

The following article from The Huffington Post makes reference to scientific studies and real life examples of how an organisms environment is the most substantial factor in determining whether or not the organism will become addicted to a substance:

http://www.huffingtonpost.com/johann-hari/the-real-cause-of-addicti_b_6506936.html

The following link leads to the website of Dr Carl Hart, PhD Neuroscience, who has made many contributions to understanding drug addiction and unveiling many of the myths prohibition propaganda has generated. He cites that; "80 to 90% of the people who use illegal drugs don't have a drug problem. Most are responsible members of our society, they are employed, they pay their taxes, they take care of their families..."

<http://www.drcarlhart.com/ted-talk-lets-quit-abusing-drug-users/>

With reference to these points, it is unjust for a government to condone the criminalisation of people who consume drugs without causing problems in their lives or others, and inhumane for the government to condone the criminalisation of people who are struggling with addiction when it is most likely due to an inadequate socioeconomic background for which the government is responsible for.

Although the evidence demonstrates that the Portuguese model is a much more pragmatic approach to dealing with drugs than our current approach, I believe an even better model is possible. Decriminalisation does free up a lot of police resources and allows more focus on harm reduction, but it does not solve the problem of adulterated substances being available to those who choose to take drugs. I believe that every person over the age of 21 should have access to laboratory grade, unadulterated, recreational drugs from a regulated government supply unit, which would document every purchase a person makes and be free to intervene when it is suspected that a

person is using drugs problematically. The success of the Portuguese model is not due to decriminalisation alone but to the counselling and education that is provided. I think that Ireland could improve on the Portuguese model by maintaining the same focus on education, intervention and counselling, while also allowing citizens the right to make their own personal decisions with regards to what they can put into their own bodies. Free information and education is key here.

Professor David Nutt of Imperial College London, who has done a lot of research on drugs and neuropsychopharmacology, has many forward thinking and practical thoughts on rational drug policies which I think are of great value in this discussion. Below is a link to his blog:

<https://profdavidnutt.wordpress.com/>

Many thanks for your time. I hope you consider the points I have made.

Kind regards,

Andrew Begley

Brendan Egan

Dear Minister/Committee

The current strategy for drugs especially regarding cannabis does not make any sense, I'm glad seeing the investigation of Portugal's successful drug policy but I ask you to go further and look at the Netherlands, Colorado and Washington and more states success in the legalization of cannabis, cannabis is an extremely un-harmful substance something on a par with heavily sugared doughnuts or maybe Red Bull although there are obvious harmful effects such as onset of schizophrenia (which can also be brought on with alcohol) and laziness, it is mainly a nice way to relax on an afternoon, much less harmful than the legal tobacco and alcohol,

Legalising cannabis would have multiple positive effects to name a few, increased government income from taxation, decreased addiction to hard drugs as it's my opinion and that of a lot of people and possibly yourself that the gateway effect of cannabis is not the cannabis but the fact of dealing with a drug dealer leading to a now easier opening to get hard drugs which would not have occurred if they were bought legally in a store, dealing with drug dealers themselves can lead to problems when people can't pay what they owe them, no one likes drug dealers and legalising this drug would cut the majority of their revenue leading to a decline in general of suppliers in Ireland. Another serious problem is criminalizing of good people who just enjoy cannabis and now have a criminal record and can't go to America or many other countries along with employment problems.

Drug addiction is a problem I agree but cannabis use is at an all time high making it illegal has not stopped the supply of cannabis and legalising states in the U.S have found a drop in cannabis usage indicating a lowered addiction rate.

All together I see decriminalization a solid and good step in the right direction but implore you to bring Ireland to be one of the smarter nations of the world and legalise cannabis while focusing more on the other harder drugs as it is clearly becoming the future,

I also hope you allow people to grow cannabis legally for their own consumption to stop the drug dealer gateway effect I talked about earlier while decriminalizing this, up to 6 plants similar to Spain's current status should be sufficient

Thank you for reading.

Davis Eoghan

1. Marijuana has never killed anyone, far more than what you could say for tobacco and alcohol.
2. People should do with their own bodies what they want to.
3. Govt. will gain tax revenue and will spend less on policing marijuana, resulting in more money

Response to Public Comment Request by The Oireachtas Joint
Committee on Justice, Defense and Equality

July 27, 2015

Dear Ladies and Gentlemen of the Committee:

My name is Robert Kane and I am writing this letter with the hope of effecting a change in the national drug policy of Ireland. As a citizen of both the United States of America and Ireland, it is an honor to address such an important issue.

My college years in the 1970s and 1980s were, like those of many young people, a time of experimentation with drugs and alcohol. It was only thanks to the discretion and compassion of a law enforcement officer, that I did not incur an arrest record for a small amount of cannabis.

As a parent, I feel that my ability to openly discuss drug-related issues with our children helps to keep our family close knit and well adjusted. It is unrealistic to expect that my kids abstain completely from the use of drugs and/or alcohol as they grow older. I believe (as does my wife) that a harm reduction approach is what works best in our home. The last several decades have shown that the global "[War on Drugs](#)" cannot be won, and that the casualties include countless broken families left to struggle when a family member goes to jail for a drug related offence. Under current U.S. laws, even a

small amount of cannabis can, in some states, result in lengthy prison terms and costs of \$10,000.00 or more in legal fees. This is unacceptable.

Ireland has the opportunity to serve as a leader in drug policy reform. It is the moral imperative of any legislative body to preserve the integrity of the family unit, as this is the foundation of a healthy modern society.

The world is growing weary of the mass incarceration of those convicted of victimless crimes and non violent drug offences. Our prison population (in [the U.S.](#)) has quadrupled since the 1980's; largely due to excessive mandatory minimum sentences.

I propose that Ireland adopt a policy similar to the Portuguese Decriminalization Model. Portugal should not be the only place where an E.U. citizen can go to live and not have to worry that they might be incarcerated for possession of a personal amount of any drug. I urge legislators in Ireland to adopt steering and oversight committees which could expand on the Portugal Model in several positive ways.

Bearing in mind the fact that [drug use will likely not rise](#) upon decriminalization, the Government of Ireland can and should take the progressive step of allowing addicts to legally procure prescriptions from doctors; and safe access centers be created with social workers, mental health and medical staff on hand for the usage of controlled substances. The goal would be to assist the addict through counseling, education, rehabilitation and ultimately re-introduction into society as part of a productive work force. This concept could potentially reduce petty thefts and other crimes addicts

commit to fund their habits; thereby enabling law enforcement to focus efforts on white collar and violent crime. If the government controlled the supply of hard drugs, these substances could then be closely regulated and dispensed via medical professionals. This approach would insure that quality and purity of various substances are held to pharmaceutical industry standards and are free of unwanted adulterants; while effectively displacing the criminal syndicates which now supply the demand. Cannabis should be legalized for personal use with regulations and taxation implemented. The revenue generated could be used for education similar to the U.S. [State of Colorado](#).

While many countries are undergoing a [paradigm shift](#) on this topic, the timing seems right for Ireland to transform its drug policy and become the standard to which other nations will aspire to replicate. The potential for medical and psychological clinical research is virtually unlimited once restrictions are eased. Studies presently underway in [Israel](#), the [Beckley Foundation](#) in the U.K. and elsewhere show exciting promise with such diseases as Alzheimer's, many cancers, digestive disorders and depression among others. Cannabis shows promise of alleviating [opioid dependence](#) and [certain cancers](#). Easing restrictions on medical and clinical research of previously banned substances could pave the way for universities and corporations to develop new treatments and improve the public's overall quality of life. This would involve U.N. restrictions to be relaxed, which may be plausible in the near future as evidence mounts in favor of decriminalization.

In summation, it is time for a change in our collective attitudes from that of a punitive culture of judgment, where those with illness and addictions are treated as criminals, to one of compassion and acceptance. When the mystique and allure is stripped from the drug, people may find that moderation is and always will be the key to a healthy and balanced life.

Sincerely,

Robert G. Kane



Clondalkin Drugs and Alcohol Task Force

Draft Submission to the Oireachtas Committee on Justice, Defence and Equality

August 2015

The CDATF board welcome the fact that the Oireachtas committee are seeking submissions in relation to the issue of the decriminalisation of drugs.

The board of the CDATF recognises that there is a need for a serious national debate in relation to the current approach to addiction at national policy level in the Irish context where it is primarily treated as a criminal justice issue rather than a public health issue.

Members of the CDATF board which includes representatives of stakeholders in the community, voluntary and statutory sectors have expressed concerns about criminalising people with addictions. They have consistently highlighted the fact that this approach does not act as a deterrent, rather it causes significant harm to individuals future prospect given that under Irish Law the person carries a conviction for their whole life and the requirement to disclose previous convictions never lapses. However members also recognise and have serious concerns about the intimidation and violence that is impacting on people's lives as a result of the illegal drugs trade.

While acknowledging that these are complex issues members of the CDATF agreed that a change in national drugs policy is required and would broadly support the decriminalisation of drugs. However they also would like highlight the fact that what may be effective in other jurisdictions may not necessarily be appropriate to the Irish context. In addition any change in national policy will be ineffective without a commitment from government to provide adequate resources to ensure that those most affected have access to appropriate services.

Taking into consideration these issues the CDATF recommend that any change in national policy must be based on a wider debate within a framework of Human Rights, Criminal Justice and Public Health which is informed by evidence from the Irish context and from other jurisdictions in terms of the impact of any changes may have and the outcomes for individuals, families and communities most affected.

The CDATF board are also recommending that Local Drugs and Alcohol Task Forces be given a lead role at local and national level in facilitating further debate, discussions and consultations



Submission to the Oireachtas Committee on Justice, Defence and Equality

August 2015

Clondalkin Drug Users Forum

Clondalkin Drug Users Forum welcomes the fact that the Oireachtas committee are seeking submissions in relation to the issue of the decriminalisation of drugs. As a group of drug users we have met to discuss this issue and are delighted to be given the opportunity to make a submission.

Overall the idea of decriminalisation of all drugs is a very welcome idea and a significant change in drug policy that we feel will acknowledge the fact that drugs and problem drug use needs to be viewed as a public health issue rather than a criminal justice issue. Given that in 2014 there were 15,933 people prosecuted under the Misuse of Drugs Act and 11,279 of those were for possession for person use (Central Statistics Office, 2015), this highlights the level of resources that are required to manage this in the criminal justice system when those resources could be used for treatment and rehabilitation services. Decriminalisation will hopefully also break down some of the stigma that is attached to us as drug users every day.

In order for decriminalisation to work in Ireland there needs to be access to all treatment and rehabilitation services across the continuum of care so that when an individual faces a committee to discuss possession of drugs that all avenues are immediately available to that individual to get appropriate support and therefore reduce the risk of re-offending.

CITYWIDE DRUGS CRISIS CAMPAIGN



**SUBMISSION TO THE COMMITTEE ON JUSTICE, DEFENCE AND
EQUALITY**

**ALTERING THE PRESENT APPROACH TO SANCTIONS FOR
POSSESSION OF DRUGS FOR PERSONAL USE**

31st JULY 2015

Introduction

Citywide Drugs Crisis Campaign is a national network of community organisations that are involved in addressing the drugs issue and it represents the community sector on the National Committees of the National Drugs Strategy(NDS). The consultation process carried out during the development of our Strategic Plan in 2012 highlighted the concern in our communities about the negative impact of criminalisation on drug users and their families and for the first time Citywide called in the 2012 plan for an open debate to take place about decriminalisation in Ireland. As a first step in opening up the debate, Citywide organised a conference in May 2013 called “Criminalising Addiction – is there another way?” Speakers outlined the current legal situation in Ireland and how it works, presented evidence about the impact of criminalisation on the lives of drug users and looked at the emerging trends in decriminalisation across a number of other countries. Following the conference Citywide launched a leaflet which was circulated widely to generate informed discussion on the issue of decriminalisation and we have continued to debate the issues through our community networks, through political briefings and in public and policy statements on the drugs issue.

Citywide very much welcomes the initiative of the Oireachtas Committee on Justice in travelling to Portugal to see at first-hand the experience of decriminalisation in that country and in calling for submissions on altering the present approach in Ireland to sanctions for possession of certain amounts of drugs for personal use. It is Citywide’s view that drug use should be decriminalised and should be addressed as a social and health issue rather than as a criminal justice issue. We do not believe any person should be deemed a criminal simply because he/she uses a drug.

This paper is set out under the following headings:

1. The distinction between decriminalisation and legalisation
2. Negative effects of criminalisation in Irish drugs policy
3. Background to the International experience of decriminalisation
4. The experience of decriminalisation in Portugal
5. What Ireland can learn from the experience of Portugal
6. Conclusions and Recommendations

1)Distinction between decriminalisation and legalisation

Based on our experience to date of debating and discussing the issue of decriminalisation, it is important at the start of the discussion to make a clear distinction between decriminalisation and legalisation, as the two are often confused and conflated. **Decriminalising** drugs means that the actual use of a drug would not be a criminal offence; a person found in possession of drugs for personal use would

not be given a criminal conviction, although administrative or civil sanctions can apply.

This is clearly distinct from the concept of '**legalising**' drugs, where using, buying, importing and selling drugs would become a market regulated by the state in the same way as alcohol and tobacco. With decriminalisation, the individual drug user and his/her use of a drug is no longer treated as a criminal offence but the drugs trade remains illegal and subject to criminal law and no drug that is currently illegal is made legal.

In our experience of debating the issue over the last few years, the vast bulk of objections to decriminalisation arise as a result of confusing it with legalisation and are not about decriminalisation per se.

2)Negative effects of criminalisation in Irish drugs policy

- Citywide works in partnership with drug user and service user groups and is keenly aware of the stigma and discrimination that is experienced by drug users because of their involvement in an activity that our society deems to be criminal. Families also share in this stigma and discrimination and fear of criminalisation of a loved one can be a serious barrier to looking for help. Stigma and discrimination against drug users is wrong and decriminalising their use of drugs is an important step in working to end it.
- In 2012 almost 72% of convictions for drug offences in Ireland were for possession of drugs for personal use. Most convictions for possession do not result directly in a prison sentence; however, there is a significant cost to the state through use of police, legal aid, DPP and court resources. There is no evidence that conviction for drug possession reduces drug use and these resources would be better invested in social and health services.
- This conviction stays with a person for their whole life and has a potential negative impact on them in many aspects of their lives, including employment, accessing training, future travel, getting a visa, and getting insurance. In addition, in recent times, an increasing number of employment positions and voluntary activities in Ireland require Garda vetting – many former drug users will not even consider applying for positions that require Garda vetting as they believe most potential employers will not give them a chance if they see a drugs conviction on a vetting form.
- Recent research carried out by Citywide has highlighted the barriers to rehabilitation, including criminalisation, which are experienced by people on Drug Rehabilitation Projects and how time, effort and resources are invested by the projects and their participants in working to overcome these barriers. This experience highlights how different branches of the state are currently at odds in their policy objectives in relation to drug use. On the one hand, the NDS promotes rehabilitation and re-integration of drug users as a key

objective but, on the other hand, the current policy of criminalising drug users acts as a barrier to meeting this objective.

- This conflict of objectives is also evident in relation to youth work services. The aim of these services, in particular in our most disadvantaged communities, is to divert young people away from the criminal justice system, yet under our current laws if a young person is found to be using drugs, they will be channelled in to that system. Criminalisation for drug use is particularly inappropriate and damaging for a young person whose key needs are for support and diversion.
- Increasing the involvement of service users through local, national and regional fora is also an objective of the NDS. Criminalisation is a serious barrier to supporting and promoting the development of a strong drug user voice to inform the development of services and policies and the absence of the drug user voice in our NDS is a serious gap.

3)Background to the International experience of decriminalisation

Citywide participates in a number of EU and global networks, including the EU Civil Society Forum on Drugs, the IDPC and the VNOGC. Our participation in these networks has enhanced our knowledge and understanding of the international situation in relation to decriminalisation and the extent to which policies of decriminalisation are being enacted in many countries across the world. It is not just a recent trend; some countries have had decriminalisation policies in place since the early 1970s and others never criminalised drug use and possession to begin with.

A country that decriminalises is no longer the odd one out but rather part of a growing evidence-based trend. There are between 25 and 30 countries now having some form of decriminalisation in place and in the past 15 years, a new wave of countries have moved in this direction. This recent trend towards decriminalisation has not been centred on one continent or in richer or poorer nations. Countries as disparate as Belgium, Chile, the Czech Republic, Estonia, Jamaica, Mexico, Portugal, Switzerland and Uruguay among others, have all adopted some form of decriminalisation policy in the last decade or so.

There has been no significant increases in overall levels of drug use evidenced as a result of this broad increase in decriminalisation. Our colleagues in Release, International Drugs Policy Consortium (IDPC) and Transform are making a submission which provides greater detail on the international experience.

4)The experience of decriminalisation in Portugal.

Portugal introduced decriminalisation in 2001, as a result of a growing consensus among law enforcement and health officials that the criminalisation and marginalisation of people who use drugs was making the Portuguese drug problem worse, and that under a new, more humane, legal framework it could be better managed. Portugal decriminalised the personal possession of all drugs; this means that it is no longer a criminal offence to possess drugs for personal use, but it is still treated as an administrative violation, with a civil or administrative sanction.

The specific penalty to be applied is decided by 'Commissions for the Dissuasion of Drug Addiction', which are regional panels made up of legal, health and social work professionals. The intervention in Portugal, as the name of the Commissions imply, is still based on directing people away from drug use and on the view that a professional assessment process is likely to be far more effective at doing this than a criminal justice intervention.

The most recent figures that are available on the drugs situation in Portugal since drug use was decriminalised show the following:

- Levels of drug use are below the European average
- Drug use has declined among those aged 15-24, the population most at risk of initiating drug use
- Rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – have decreased
- Between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased
- There are significant decreases in drug-related deaths, HIV, Hep C and B amongst drug users

5)What Ireland can learn from the experience of Portugal

There is a significant body of evidence now available on the Portuguese experience of decriminalisation which can help to inform our discussions here in Ireland. Citywide believes that there are some key elements of the Portuguese model that are of particular relevance to the Irish context.

- Concerns have been expressed that removing the criminal sanction in Ireland for drug possession for personal use will mean that there will be no intervention to prevent a person, in particular a young person, from going on to develop a more serious drug problem. But it is clear that, in Portugal, the fact that possession for personal use is no longer a criminal offence does not mean that there is no intervention. What has changed under decriminalisation is that it is now a public health intervention rather than a criminal justice intervention.

- The intervention which takes place requires the person to take part in an assessment process. This process enables a distinction to be made between first time drug use, repeat drug use and problematic drug use. This is important, as different types of service will be appropriate depending on the nature of the drug use. Citywide has consistently made the case that we don't have just one type of drug use or drug problem in Ireland, we have a range of types of problematic drug use that are different in nature. Therefore it is important that people are directed at the earliest stage towards the level of service that is most appropriate to their needs. This leads to the best outcomes for the drug user and is also the most effective use of resources.
- When decriminalisation was introduced in Portugal, it was recognised by government that it needed to be accompanied by a significant level of investment in services. The Dissuasion Committees are made up of a legal expert, a health professional and a social worker, supported by a team of psychologists, sociologists and social workers. The engagement of a range of professionals is intended to provide a comprehensive service for drug users and to provide the opportunity to address any underlying issues. We need to be realistic in recognising that this level and range of services is not available in Ireland and a significant increase in investment in services would be required to put anything like this level of service in place.
- The Portuguese experience has highlighted the importance of local availability of services as part of an effective response. Under the NDS Ireland has also favoured a model of having locally based services, but recent years have seen serious challenges to maintaining this model. There have been significant cuts in the budgets of existing community services and a lack of development of new services. There are also many parts of the country where there are effectively no local services and these gaps need to be urgently addressed.
- A key feature of the Portuguese model is the pro-active approach to providing employment opportunities for recovering drug users, with incentives to employers to take on and support people in their transition. This is in marked contrast to the Irish experience, where increased expectations are being placed on drug users to progress into employment without a pro-active approach to increasing the job opportunities that are available to them. Recovering drug users are at a disadvantage in a competitive employment market and it is not enough to leave their chances to the market; the Portuguese experience demonstrates the value of a more pro-active intervention by the state.
- In Portugal one of the key difficulties that emerged for reintegration of drug users into the community was lack of housing and this is very much mirrored by the current experience in Ireland. Lack of access to decent affordable housing is currently a major barrier to rehabilitation and reintegration. Again in

Portugal the need for a specific intervention was recognised and access to transitional housing is provided.

- The Portuguese model is crucially dependent on an interagency approach based on co-operation across state departments and agencies engaged in social, health, education, justice, employment and housing services. This will sound familiar to us in Ireland, where an interagency partnership approach is set out as underlying the implementation of our NDS. However, the major difficulties in implementing this interagency approach over recent years have been well documented by Citywide and others and it is essential that these difficulties are addressed if we are to have any chance of providing an effective context for decriminalisation.
- In Portugal there has been a strong national structure (formerly the Institute of Drugs and Drug Addiction, now General-Directorate for Intervention on Addictive Behaviours and Dependencies), responsible for overall co-ordination and implementation of the interagency approach and headed by a Director with overall responsibility for the national drugs strategy. The clarity of co-ordination, accountability and leadership that is required has not been evident in the Irish NDS for some time, despite the existence of structures, and this needs to be urgently addressed.
- It is important to note in looking both at Portugal and Ireland that decriminalisation does not operate in a vacuum from other broader social policies. Like Ireland, Portugal has experienced severe economic recession in recent years and there is a real risk that significant reductions in health and welfare budgets will undermine many of the drug-related health and social improvements that have come about since decriminalisation.

6)Conclusions and recommendations

Those who are responsible for drugs policy in Portugal do not overclaim for decriminalisation and do not present it as a solution to the drugs problem. However, it is viewed as a crucial element of an overall policy and Citywide concurs with this view and believes it is time to introduce decriminalisation in Ireland. The introduction of decriminalisation will provide a legal framework for our response to drug use to be implemented through a social and public health approach rather than through a criminal justice one, and all the evidence from Portugal and elsewhere in the world shows this to be the more effective approach.

Implementing a decriminalisation policy means that the capacity is required to direct people who use drugs away from the criminal justice system and into health and social services. This will only be effective if the relevant services are in place. The Portuguese experience shows us that it is essential to invest significantly not only in drugs services but in a broad range of health and social services and securing this level of investment represents a major challenge in the Irish context.

The importance of interagency working is also highlighted through the Portuguese experience, as indeed it has been in Ireland throughout successive NDSs. It is essential that in parallel with the introduction of decriminalisation, there is strong political leadership in reviving the interagency partnership approach which has not been supported in recent years and in putting in place the day to day leadership within the NDS structures to ensure that this approach is implemented in reality.

The introduction of decriminalisation in Portugal in 2001 was an acknowledgement that criminalisation and marginalisation often go hand-in hand and it coincided with a significant expansion of the Portuguese welfare state in an effort to counter marginalisation and poverty. While it was recognised in Ireland in the mid 1990s that massive state investment in disadvantaged communities was the real solution to the serious drugs problem, any political commitment to implement this has long since disappeared. Citywide believes that we should use the decision to introduce decriminalisation in Ireland as an opportunity to refocus and re-invest in our national drugs strategy and also to refocus on the underlying social and economic causes of the drugs problem.

We recommend that a time-limited Working Group is established to be chaired by the Minister with responsibility for the NDS, who works across both Health and Justice departments, to draw on all the relevant expertise both in Ireland and internationally to discuss and agree the key elements of introducing legislation for decriminalisation.

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Submission prepared by:

Anna Quigley, Citywide Drugs Crisis Campaign



Submission to:

Joint Committee on Justice, Defence and Equality

on its

Review of Irelands approach to the possession of limited quantities of certain drugs.

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Introduction

BeLonG To Youth Services is the national youth service for lesbian gay bisexual and transgender (LGBT) young people in Ireland. BeLonG to was established in 2003 and envisions a future in which LGBT young people are safe and supported in their families, schools and communities, and all young people are equally cared for, valued, and respected.

BeLonG To welcomes and appreciates the Joint Committee of Justice, Defence and Equality's invitation for written submissions from interested groups on altering the present approach to sanctions for possession of certain amounts of drugs for personal use.

BeLonG To Youth Services submission to the Joint Committee on Justice, Defence and Equality is to advocate 'in favour' for altering the present approach to sanctions for possession of certain amounts of drugs for personal use. BeLonG To believe it is in the best interests of LGBT young people and indeed all young people that legislative change is needed to address how we treat young people who are found to be in possession of illegal drugs for their own personal use.

BeLonG To Drug & Alcohol Service was set up in late 2007 in response to a national study, funded by The Dept of Community Rural & Gaeltacht Affairs on drug use among LGBT young adults in Ireland, titled *Drug use amongst Lesbian, Gay, Bisexual and Transgender young adults in Ireland* by Dr Kiran Sarma, C. Psycol 2006.

The service's main aim is to support Lesbian, Gay, Bisexual & Transgender (LGBT) young people in relation to drug and alcohol use. This is the only designated LGBT drugs service in Ireland. Currently BeLonG To has one staff member coordinating this service, the position of Drug Education and Outreach worker is funded through CDYSB and administered by the North Inner City Drug and Alcohol Task force.

BeLonG To Drugs and Alcohol service falls under the Prevention Pillar of the National Drug Strategy. The drug and alcohol service follows the model of harm reduction with an emphasis on support, awareness raising, education and empowerment.

The BeLonG To Drug service informs its work through the roles as chair of the North West Inner City Drugs working group, membership of the North Inner City Prevention and Education Committee, Gay Health Network and sits as a Project Promoter at North Inner City Drugs & Alcohol Task Force.

Advocacy and representation

- Project Promoter on North Inner City Drug & Alcohol Task Force
- Chairperson of North West Inner City Drugs Working Group
- Member of Prevention & Education Committee
- Member of the Gay Health Network

Why decriminalise possession of illegal drugs for personal use?

Studies have revealed that drug use is widespread among LGBT young people and is more prevalent than the general youth population. Findings from the report ¹ commissioned by BeLonG To include the following:

- 65% of respondents had used drugs
- 21% have systematically used drugs (i.e. have done so on more than 60 occasions)
- 60% had taken drugs over the 12 months preceding the survey
- 46% of drug takers had engaged in unprotected sexual intercourse while under influence
- 11% of drug users had been sexually assaulted while 'incapacitated due to drugs'
- 49% of drug takers have experienced 'black outs' resulting from drug taking
- LGBT young people are 2-5 times more likely to consume drugs than their heterosexual counterparts

LGBT young people remain among the most marginalised young people in Ireland. Many LGBT young people experience many forms of discrimination and social exclusion, mostly visibly in the form of homophobic/transphobic bullying in schools, communities and even their families. As a result, LGBT young people are most likely to suffer from poor mental health and experience high levels suicide ideation and self harm and adopt problems with alcohol and drugs use. A large study *Supporting LGBT Lives*², which was funded by the HSE, found that:

- 27% of LGBT people have self harmed
- 50% of LGBT people under 25 have seriously thought of ending their lives.
- 20% of LGBT people under 25 have attempted suicide

From the statistics above we can see a correlation between mental health and drug use. With such high levels of drug use and mental health issues among the LGBT population, surely the response to this needs to be dealt with and prioritised as a health issue rather than one of criminal justice. If LGBT young people are 2-5 times more likely to consume drugs, it stands to reason that they are 2-5 times more likely to be criminalised for being found using or in possession of illegal drugs.

Fear of criminal sanction & stigma

BeLonG To has no catchment area and works with a broad intersection of society. The young people who seek support through our services come from all different backgrounds, cultural and socio-economical. There is representation of LGBT young people from upper, middle and working class backgrounds as well as travellers and other ethnic minorities. When young people come to the service, as soon as they cross the door, they are treated on an equal footing but we know in society that this is not the case. In facilitating the only LGBT specific drugs support service in Ireland, we know from our experience it is mostly working class young people that are targeted and who

¹ Sarma, K. (2007) "*Drug Use Amongst Lesbian, Gay, Bisexual & Transgender Young Adults in Ireland*".

² Mayock, P.; Bryan, A.; Carr, N. & Kitching, K. (2009) "*Supporting LGBT Lives: A Study of the Mental Health and Well-Being of Lesbian, Gay, Bisexual and Transgender People*".

come into contact with the criminal justice system. They are more likely to be stopped and searched and to be found in possession of drugs for personal use and those most likely to be criminalised. As previously mentioned research has illustrated that young LGBT people already face enough prejudice, discrimination and stigmatisation. Adding further to this a criminal sanction for being found in possession or using drugs further marginalises these individuals and prevents them from seeking support to address the multitude of issues they face on a day to day basis and can ultimately ruin their lives. We believe that the current approach is counterproductive and is not the way we should be dealing with young people who have substance misuse and addiction issues.

Criminalisation of drug use often lends itself to the stigma that surrounds it. It puts barriers in place for young people to seek support with or even disclose their drug use. Drugs users are seen mostly by society as people who are moral failings and criminals. As a result of this they are in turn patronised and pathologised. The type of education young people receive is inconsistent and not always based on science. We believe that decriminalising drugs for personal use, will lift the barriers and stigma surrounding drugs and drug use. The resources used to criminalise possession and use of drugs can then be redirected into good honest evidence based education and treatment and smart campaigns, that will not only educate the public, but also de-stigmatise the people most affected by this issue and open it up to society having better understanding of drugs and addiction.

Current legislation

The current legislation has its shortcomings. The intention of the current legislation is to outlaw and prevent people from using drugs, but as the research above shows it has not achieved this. There are extremely high levels of drugs use among the LGBT youth population. A national study³ carried out among the student population due to be published in September has shown that aside to 98% having used alcohol; up to half have used illegal drugs. Drug use and the availability of drugs is widespread and crosses all sections of society, surely its realistic to think that for those using drugs, it has now become a public health issue and should be treated as such. It is now imperative that Irelands approach to possession of limited quantities of certain drugs is reviewed and that the Portuguese model is adopted into our legislation.

International evidence

In 2001 Portugal decriminalised all drugs, in reaction to having one of the highest rates of drug use in Europe with 1% of the population addicted to heroin. An Irish delegation's report⁴ on the visit to Portugal has shown that there has been significant societal impact in relation to decriminalisation of drugs for personal use. With the acknowledgment that it is still illegal to possess and sell drugs in Portugal, there has been a significant decrease in drug related crime, overdose, HIV/AIDS and particularly drug use especially among the youth population since they decriminalised possession for personal use. In

³ National Student Drug Survey 2014 Bingham, T O'Driscoll, C. and de Barra, G.

⁴ Joint Committee on Justice, Defence and Equality, Lisbon, June 2015, Report of visit by a Committee delegation to examine the impact of Portuguese approach to the possession of certain drugs.

Portugal citizens with drug problems are now offered help and incentivised to participate in civic society by gaining employment, holding down full-time jobs and other opportunities which under their previous law were prevented. The idea that we can live in a drug free world is out of touch with reality. The reality is that people use drugs whether legal or not; criminalising them for doing so is not a deterrent, it only further marginalises them. It is of no surprise that other countries are following suit, like Portugal, European countries such as Spain, Italy, Switzerland, Czech Republic, Netherlands now treat drug use as a public health issue instead of criminal justice. International bodies such as the World Health Organisation, The Cato Institute, The International Drug Policy Consortium and The Global Commission on Drug Policy all call for decriminalisation of drug use. The current drug crisis here in Ireland needs immediate attention and looking internationally we can see that there are other alternatives to the current policies not working here.

BeLonG To Youth Services is in favour of altering Irelands present approach to the possession of limited quantities of certain drugs. From our professional experience, we know that the current legislation actually prevents LGBT young people to seek help for their drug use for fear of criminal sanction. LGBT young people are also less inclined to disclose or discuss their drug use due to the stigma that surrounds criminality, drugs and addiction which places them more at risk of harm. We have come to know and believe that while the current legislation has been set up to outlaw and prevent drug use, it has in fact not achieved this in Ireland. International evidence has shown that the stated aims and objectives of prohibition of illegal drugs have not been successful. Ireland has a unique opportunity to learn from the approach taken in Portugal and move towards a future that treats drugs users in a more humane and dignified way by addressing drug use and addiction as primarily a health issue. We need to have an effective drugs strategy that compliments a new and effective drugs policy; otherwise we run the risk of continuing to fail. To quote the delegations report on the visit to Portugal, "It takes a lot to make an honest person to become a criminal".

BeLonG To Youth Services would be delighted to come to a meeting of the Joint Committee to discuss our recommendations in more detail. As previously mentioned, BeLonG To runs the only designated LGBT specific drug service in Ireland and has specific knowledge and expertise that we would like to have the opportunity to share on this matter.

SUBMISSION TO WHOM IT CONCERNS

This will be a brief document explaining why I a sovereign being of Ireland and the earth, and most of the people in Ireland more than 50% strongly know(not believe anymore) (CANNABIS) should be legalised in Ireland and upon every land on this earth so that all peoples have their god/creators given right to grow what they wish, without another being or corporation impinging upon their right to do so, especially corporate governments but that doesn't pertain to this discussion as we're talking solely of Ireland and its people.

God said, "Behold, I have given you every herb yielding seed, which is on the surface of all the earth, and every tree, which bears fruit yielding seed. It will be your food.

We the sovereign people of Ireland want and Demand cannabis be Fully Legalised Without licencing, so people can Freely grow it at home or outside on their land for food or medicine if they wish to do so that's their God given Right e.g (Organic hemp seed unheated not from manufacturers is a wholesome food) or medicinal purposes- cannabis main active compound (tetrahydrocannabinol) DOES in fact Cure Cancer and skin Cancers and will continue to Cure it.among other benefits of reducing debilitating life long pain and giving a person a better way of life with reduced pain with minimal no side effects.(unless you consider laughing and happiness a side effect) rather than taking prescription pharmaceuticals for the rest of their life. No human has EVER died from cannabis but how many people continually die from prescription drugs from trillion dollar pharmaceutical companies or alcohol and tobacco? i will provide a link video proving it cures cancer. nobody can take our human rights away and it will be given back to us by the will of the most high creator whom i call Ormazd who has power over all things and sees all corrupt deeds.

All the children and people in hospitals around Ireland with cancer, getting chemo and radiated without no other alternative nor choice or say in the matter eg parents of children, to take/ give and ingest cannabis THC oil that could save their life or their children's lives, it's quite logical to say a lot of lives could have been saved if cannabis were legal, the fault is with the law in this country regarding cannabis it's a farce and backwards, and needs to be Abolished immediately, in retrospect there should be no law regarding cannabis as there never was throughout history in fact farmers used to pay their taxes with hemp and the ropes on the Titanic were made from hemp.it has endless uses. not only would it help our economy majorly and stop wasting the time and resources of our police, the crime rate would drop drastically, and alcoholism would Decline fast also as most people would have the choice available to smoke cannabis as the SAFE and healthier alternative, alcohol can kill and does kill a lot of people every year. cannabis can not kill never has, It's a fact. And antisocial behaviour (because) of alcohol would drop also, as cannabis promotes feelings of peace and a feeling of wellbeing and not reckless, depressive, and depraved behaviour as alcohol does.

the conspiracy of why it's illegal obviously lies with the major money hungry corporations and oil industries and pharma industries as hemp bio fuel could be used to replace oil and gasoline, and the plant can be used to cure ailments without the need for prescription drugs or invasive ludicrous treatments such as chemo and radiation which only serves to make you further ill and then you die in the vast majority of cases.

CONCLUSION

my conclusion is that cannabis should ONLY be fully legalised without licencing it or the need to get a licence to grow or use it medically. im not speaking for any other drugs as i only agree with cannabis. i felt the need to write this short document as i wanted to vocie my say on this issue that needs to be corrected asap.

i urge all people who see and read this document to watch this video of how a father cured his son of cancer, see for yourselves link below.

<https://www.youtube.com/watch?v=TB8mHcuSFek>

Then once you have watched that video i also urge all who see this document to view these pictures below. Id like to thank all persons who have read this brief document and please take it into consideration, id be most willing to appear in public session at any Committee meeting to voice my say with others.

CONTACT INFORMATION

I do not see the need to create a cover letter, as i shall write all necessary information about myself here. Regards and good day.

Stephen Dennis





MELANOMA TREATED WITH CANNABIS OIL

IN LESS THAN 60 DAYS THIS MELANOMA WAS TREATED FROM A 7MM DEEP HOLE DOWN TO THE BONE TO NEARLY BACK TO NORMAL.

CANNABIS OIL, ONCE AGAIN, SUCCESSFULLY TREATS CANCER!!!

THE CANNABIS CONSULTANTS

Did You Know? THC Shrinks Tumors and the U.S. Government Has Known Since 1974 and Lied About It

In 1974 researchers learned that THC, the active chemical in marijuana, shrank or destroyed brain tumors in test mice. But the DEA quickly shut down the study and destroyed its results, which' were never replicated -- until Feb 2000.

The term medical marijuana took on dramatic new meaning in February, 2000 when researchers in Madrid announced they had destroyed incurable brain tumors in rats by injecting them with THC, the active ingredient in cannabis.

The Madrid study marks only the second time that THC has been administered to tumor-bearing animals; the first was a Virginia investigation 26 years ago. In both studies, the THC shrank or destroyed tumors in a majority of the test subjects.

Most Americans don't know anything about the Madrid discovery. Virtually no major U.S. newspapers carried the story, which ran only once on the AP and UPI news wires, on Feb. 29, 2000.

www.facebook.com/Citizens.Action.Network

ANNUAL DEATHS

Tobacco	435,000
Poor Diet/Exercise	365,000
Alcohol	85,000
Prescription Drugs	32,000
Motor Vehicle Crashes	26,347
Homicide	20,308
Aspirin	7,600
Peanuts	100
Marijuana	0



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LEGALIZE HEMP

It Can Save Our Planet

"I don't know if Hemp's gonna save the world, but I'll tell you this... it's the only thing that can" - Jack Herer



Hemp makes more than 50,000 Products including Food, Clothing, Shelter & Medicine

The U.S. Government refuses to Legalize Hemp claiming that, "it will confuse law enforcement officials and send a wrong message to children". Most people don't even know that Hemp is Not Marijuana and contains No THC. You can Smoke a Hemp Joint the size of a telephone pole and Not Get High. Hemp is however, our planet's most valuable natural resource that is Environmentally Safe and Biodegradable. It can be our sole source for Fiber, Fuel, Paper, Plastic, Fiberboard and more. Hemp Fuel can provide all of the world's Energy needs, eliminating the Global Dependency on our nearly depleted Fossil Fuels. We'd never have to cut down another Tree. Say goodbye to Recycling, Pollution, Acid Rain, Global Warming and Deforestation. Before the Civil War, Hemp was the Nation's second largest cash crop. Today, planting one Hemp plant can get you thrown in jail for 20 years.

Truth Beckons

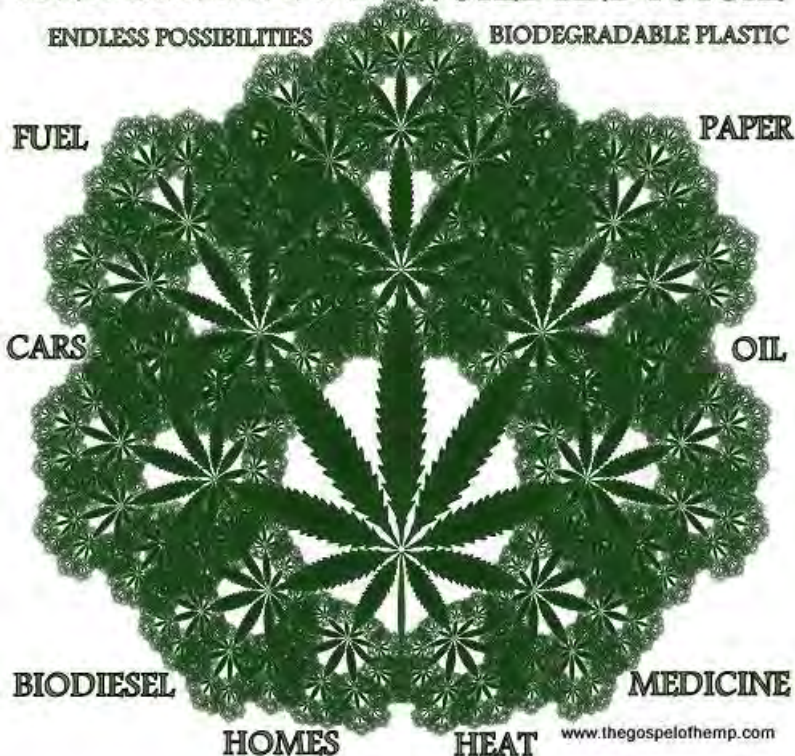
Cannabis

- Stops cancer growth
- Reduces neurological impairment
- Relaxes muscles, antispasmodic
- Prevents Migraines
- Treats Glaucoma
- Treats ADD, ADHD
- Reduces IBS, Crohn's Disease
- Cures Epilepsy
- Prevents Alzheimer's
- Treats PMS
- Anti-Psychotic
- Makes bio-degradable plastic
- Makes Paper
- Makes Fuel, solvents, lubricants
- Makes Industrial Textiles
- Makes Consumer Textiles
- Makes Building Materials
- Could end deforestation
- Could end dependence on oil, gas and coal
- Can be grown almost anywhere

PreventDisease.com

STILL WONDERING WHY IT'S ILLEGAL?

HEMP CAN SAVE OUR WORLD AND FUTURE



Eadaoin Doyle

To whom it concerns,

I am a 22 years old student of Nuig. My whole life I grew up thinking that drugs were evil things that only people that chose to waste their lives became involved in. This idea was completely wrong. Drugs are common, most people have taken something at least once and it is not the be all and end all of the vast majority of those who choose to partake.

I have dear friends that live high functioning lives that have dangerous and prolonged addiction problems behind closed doors. You would never know this, they do not look like your typical drug abuser and yet they need help just as much as your misfortunate, average street junkie. The problem is that there is no safe place to go and the facilities currently in place are worse than the addiction itself and not worth a visit.

It is not right that that anyone is locked up for the possession of drugs if they are not a mass supplier. People who suffer from addiction problems need places to go where they can get help not the false rehabilitation that prison has to offer.

We are all humans, with real hopes, dreams, families and aspirations; instead of locking up our most unfortunate citizens who struggle with drug addiction, we have to help them get back on track and overcome their troubles. I hope that drugs are decriminalised so we can destroy the ridiculous mindset behind their usage and help people who are suffering without aid. Also the decriminalisation of marijuana has to happen. It is ridiculous that someone can be sent to jail for possession of an utterly harmless substance. What a backward way of dealing with things! I wouldn't mind but I don't think I know all that many people who don't use marijuana regularly, and it doesn't affect their lives in any way. I myself am a regular smoker and honestly, I live a 100% happy life with no repercussions bar it costing way too much money.

I urge you to think outside the box we have been reared in in Ireland and see decriminalisation for the wondrous idea that it really is. The war on drugs is over, it has failed and it is time a came at it with a different approach. Ireland should lead by example once more and show our intelligence, compassion and foward thinking to the rest of the world.

Yours hopefully,

Eadaoin.

03/08/2015

I believe my strong agreement to follow Portugal's decriminalisation of drug use would fall in line with the majority of the Irish public's opinion. Having grown up on the north side of Dublin in the 90's, my drug education began with seeing first hand the effects of the heroin epidemic on the previous generation within my community. As I grew up through the Celtic tiger years I watched as cocaine flooded my area and then seen the rise of legal highs after the economy crash. And having researched thoroughly the crystal meth epidemic in the U.S., I am fearful of the day Ireland has to deal with this issue.

The drug problem in this country is out of control and for anybody who has walked along the streets of our country's towns and cities only to randomly pass an addict alone or with others injecting openly in public or have to dodge dirty used needles lying around our streets will most likely agree that the current approach has been a failure and has indirectly exposed all sections of society to the dangers of drug abuse. The fact the addicts so blatantly inject in public also paints the picture that the Guards have accepted among themselves policing cannot control the issue.

I fully agree with this, policing cannot solve this issue. However, the current approach of turning a blind eye has turned our city centre into a drug playground. My first suggestion to the committee would be to designate a certain area for addicts as soon as possible and let them know they can drink, smoke, inject or whatever they like within this certain area with no hassle whatsoever from the Guards. Make it publicly known that addicts are able to congregate and go on with their usual business within this certain area, however if they use or sell drugs outside they will fully be prosecuted under the law. So rather than having the current situation where we have addicts congregating randomly all over the city, they will be contained to one specific area and the rest of the general public can avoid this one contained area, rather than having to pass multiple sites in the centre which is the current living situation for travelling on foot through Dublin. While other more long term solutions, like injection centres, are obviously more suitable sustainable ideas, I believe this idea could be enforced quickly and effectively and can help sustain the issue until more suitable alternatives have been researched and decided on.

I would suggest to the committee that they look into the origins of the self contained city of Christiania in Copenhagen, Denmark. (<http://www.visitcopenhagen.com/copenhagen/culture/alternative-christiania>)

The idea behind this place had similar origins- keep the drug use in one specific area so the rest of the city can be drug free and I believe it could be a suitable alternative to the current situation in Ireland.

I also fully support the opening of injection centres as soon as possible. These centres have been successful in other countries that have already accepted that trying to take the moral stance that people just shouldn't take drugs and trying instead for harm reduction for the individuals taking the drugs. There have been a necessity created for these centres because of the harm involved in the use of heroin. At present in Dublin you just need to take a walk around the back of the Custom house and down the board walk along the quays to see the extent of the drug problem in Dublin and how our police force already turn a blind eye to an issue they seem to have silently accepted that they cannot police.

Another point this raises is that if the wise decision to open these centres goes ahead, why should we still restrict other less harmful drugs like cannabis from the public and threaten them with criminalisation for the preference to smoke a plant rather than, say, have a pint. Why do we sell alcohol in corner shops, supermarkets, garages, off licence and where ever else while cannabis

remains illegal when it has been proved to be a less dangerous drug.

<http://www.iflscience.com/health-and-medicine/new-study-suggests-risks-marijuana-use-have-been-overestimated>

<http://www.nbcnews.com/storyline/legal-pot/no-high-risk-marijuana-may-be-less-harmful-alcohol-tobacco-n312876>

<http://www.washingtonpost.com/news/wonkblog/wp/2015/02/23/marijuana-may-be-even-safer-than-previously-thought-researchers-say/>

<http://www.telegraph.co.uk/news/health/news/11433448/Cannabis-is-many-times-less-dangerous-than-alcohol-claims-study.html>

<http://europe.newsweek.com/cannabis-more-100-times-safer-alcohol-study-finds-309035>

Possibly because the failure of alcohol prohibition in the US in the 1920's demonstrated how much more dangerous a potentially fatal substance like alcohol is when left unregulated and in the hands of criminals.

<http://www.cato.org/publications/policy-analysis/alcohol-prohibition-was-failure>

Why not allow the section of the public to legally grow for personal use so they can remove themselves from dealing with these criminals and stop living under the threat of criminalisation for something that is a personal choice and does not harm anybody else.

We now need our government to accept we cannot police this issue and we must look at alternative solutions. Addicts tend to fall into one of the most vulnerable sections of society, many with abusive backgrounds, issues with mental health and homelessness; and how our current laws dictate to resolve this issue is to treat these people as criminals for falling into the 'trap' of drugs.

And generally when we use the phrase 'trap', we tend to say it under the impression the trap is drug use itself, when in fact the 'trap' is actually how our legal system deals with the use of certain drugs. For example, say a person is addicted to heroin, now because that drug is illegal just for that person to be in possession of the drug in question our law says they deserve to be convicted. And as there are less options available than if they are trying to combat an addiction to a legal drug like alcohol or cigarettes, where there are a lot more government funded services or advice available from their doctors, they are more likely to continue abusing the drug, funding an unregulated market where violent criminals make a tax free profit and cut their drugs with whatever they can, focusing solely on making a profit. A person's life, whether through a drug related shooting or murder or an addict overdosing, is no concern to them. And when an addict engages in criminal activity to fund their habit, these vultures are the ones who make the profit and benefit the most.

And every time an addict shoplifts or robs a person to support their habit their drug abuse negatively spills out into another section of society and every shop on our streets and the people who walk them are vulnerable to this. Each time a Guard has to attend to arrest an addict shoplifting or take the statement of a robbery victim that Guards resources and time is robbed from other sections of the community. And if the law is successful in enacting the repercussions for the addicts crime, they spend time in a prison at the tax payers expense and when they are released they will have a conviction attached to their name, further discouraging them from ever being a productive member of society, leaving them vulnerable to falling back into that 'trap'.

We need to accept addiction as not a crime issue but a health issue, and a serious one in Irish society. To arrest an addict, waste the money and resources through the courts and prisons to engage this person and then throw them back in society with a criminal conviction that deters any place from employing them; who could genuinely say this could have any sort of result but to push that person back into the cycle of abuse? Why cant we use our resources to help that person,

provide them with the necessary education and rehabilitation so they can get a proper chance to make a life for themselves?

And so long as there is a demand for substances and the huge profit involved there will always be dangerous people willing to do whatever it takes to have control over that market. As gangland crime, shootings and murders have soared over that last two decades, with the top 'heads' more likely to have their run ended by a rival gunning for the main spot than being arrested and convicted by the laws of the state, when can we be mature and logical enough to accept the war on drugs as a failure.

And I suggest that we look at each drug individually, assess the harm associated with each substance and regulate it accordingly. Then educate everybody in the state from an early age, so should they find themselves at a later stage in life in a situation where the option to do drugs is available to them, they can make a rational, educated decision as to whether or not to do the drugs in question. If a person is allowed to have the personal choice as an adult as to whether to purchase a packet of cigarettes or a pint in the pub then why not regulate substances that are no more, or even less harmful and give them that same choice, rather than threaten them with prosecution?

So long as there is demand and the enormous profit to be made in the supply; drug use and abuse will continue to exist in our society and to try to deal with this issue through policing will continue to fail. Any little success in stopping supply has only resulted in an increase in price for the drugs and prompted the synthetic drug market, a lot of which is more harmful to the user than a drug originating from or being a plant

<http://www.alleganyhealthdept.com/addictions/Synthetic%20Drugs%20-%20ACHD%20web.pdf>

But as they are easily made, they are more readily available and cheaper. So for example say the Guards have a good week and intercept a massive amount of cannabis before it reaches the streets. Now that will be hailed across the media as a massive success and in their standard press release they will claim they have helped communities by stopping the supply. But what they seem to always fail to acknowledge is that within those communities the demand still exists and an individual in that community who wants to smoke cannabis is not going to suddenly cease wanting to just because the Guards had temporarily succeeded in stopping the supply. So they will try every contact they have to get some cannabis, they might be able to contact a dealer, knowing the supply is low, who has some left who decides to increase the price, or they might find a dealer who has 'cut' his product with some unknown, possibly dangerous, substance in order to profit off the lack of supply. Although the easiest option the person would most likely have would be to buy some synthetic cannabis, because even though they have no idea what chemicals the product is made of or what harm it causes to smoke, it is readily available and cheaper than traditional cannabis. And the dealers selling this will surely see their custom increase due to lack of traditional cannabis available because of the seizures.

Overall I believe the current approach has been a complete failure and the sooner we start alternative methods the better. I would like to again give my full support to decriminalisation of all drugs and would like to suggest to the committee to look into full legalisation for certain substances. Decriminalisation leaves grey areas and the supply in the hands of criminals. Why not take an approach like Colorado and legalise cannabis, regulate it, tax it and pour the profits back into our economy

<http://money.cnn.com/2015/02/12/news/economy/colorado-marijuana-tax-revenue/>

Or the Dutch approach of providing government issued heroin to long term addicts who failed traditional rehab methods,

<https://www.rnw.org/archive/free-heroin-brings-everyone-bit-peace>

<https://news.vice.com/article/only-in-the-netherlands-do-addicts-complain-about-free-government-heroin>

Dramatically reducing drug-related petty crime and profits of heroin street dealers.

To summarise:

I strongly support following Portugal's approach and decriminalising drug use

I urge the committee to urgently deal with the open injection problem in city centres with small confined areas where drug use is allowed to allow the rest of the city to be drug free.

I urge the committee to support opening injection centres as soon as possible

I believe that we must accept prohibition as failure and move the money spent in the courts and attempting to police this issue to education and rehabilitation facilities in order to reduce further harm to the communities of Ireland.

I suggest the committee look to thoroughly research each substance available and regulate each accordingly

I also suggest cannabis users be allowed to grow for their own personal consumption in order to remove themselves from having to interact with street drug dealers, limiting the chance of being offered more harmful drugs and also so they can be fully knowledgeable about the the production of the substance they will use for personal consumption. And of course no longer risk a conviction for consuming a plant.

Sincerely,

Claire Bissett

Jesuit Centre for Faith and Justice

26, Upper Sherrard St., Dublin 1.

Tel: 01 – 855 5002 Fax: 01 – 855 4586 mobile: 087 – 257 9616

email: pmcverry@jesuit.ie

To: Oireachtas Joint Committee on Justice Defence and Equality

4th August 2015.

Please find enclosed a submission on the decriminalization of drug possession for personal use.

I have been working with homeless people since 1979. Currently most of my work is in a drop-in centre run by the Peter McVerry Trust, an organisation which also provides a range of accommodation services for homeless people, a residential drug detox centre on the Dublin/Meath border, a non-residential drug stabilisation programme in two centres (one in Dublin City Centre and the other in Swords), and several drug-free aftercare recovery houses. A high proportion of the people I encounter in my work over the past thirty-six years have, or have had, a drug problem so I have extensive experience of drug users, how they think, the difficulties they face and the efforts they make to come off drugs. This submission is a personal one based on my own experience.

I would be very happy to appear in public session at a Committee meeting, if required.

Yours sincerely,

Fr. Peter McVerry SJ

Submission on Drug Possession
To Oireachtas Committee on Justice, Defence and Equality

I have been working for the past thirty-five years with homeless people, many of whom have, or have had, a drug problem. I am convinced of the desirability of decriminalising the possession of all drugs for personal use for several reasons.

Criminalising drug use isn't working

The key reason for advocating a change in policy regarding the possession of drugs is that the current approach is simply not working. For decades, we have tried to reduce the availability and use of drugs, primarily through the use of the criminal justice system. Thousands of people have been prosecuted for the possession of drugs for personal use (in 2014 alone, 10,842 individuals appeared before the District Courts for drug offences¹) and yet more and more drugs are now available in every town and even village in Ireland. As other countries have discovered, after years of fighting the drug menace with criminal justice policies, at considerable expense, the war on drugs has long been lost. In effect, this country now has a free market in drugs. 'Illegal' drugs are sometimes referred to as 'controlled drugs', but the reality is quite patently the very opposite! In some areas, including the area in which I live, you can have your drug of choice delivered to you quicker than a pizza.

Furthermore, our criminal justice policies, involving the detection and punishment even of recreational drug users, may actually increase the likelihood of such a person becoming more deeply involved in drugs, as such policies criminalise the individual, may lead to loss of employment or livelihood, may make it more difficult to find employment and housing, may reduce the options for travel, may result in expulsion from school and may destroy their self-esteem, all of which can push a person into social exclusion and into further anti-social or criminal behaviour. Indeed, if criminal justice policies were 100% effective, (meaning that every crime was detected and every perpetrator convicted), then one person out of every four² living in Ireland would now be a convicted criminal! The first to object would be parents who would see their teenage child, who experimented on one or two occasions with cannabis, carry a criminal conviction with them for the rest of their lives, with all the negative consequences which that brings with it. If we want to reach out and help young people who take drugs, then declaring a war on them is not the best way to do it.

There is a fear that decriminalising drug use would remove the deterrent effect of detection and prosecution. The supposed deterrent effect of detection and prosecution has never been based on empirical evidence. The (admittedly limited) research that I am aware of, which has explored why young people do not take drugs, suggests that concern about the legal consequences is not the main consideration. This resonates with my own experience which is that the threat of prosecution and/or imprisonment is, at most, a marginal factor in decisions regarding drug use. The vast majority of recreational drug users are never – and can never be – detected by the Gardai, while the threat of detection and prosecution for addicted drug users is irrelevant; to believe otherwise is to underestimate the influence of

¹ Courts Service, *Annual report 2014*, Dublin. The Courts Service p55

² The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) report 2014

peers, in the case of people who are beginning to experiment with drugs, and to discount the power of addiction in the case of those who have a serious drug problem. Many drug users continue their drug use while in prison and the vast majority, within hours of release, are seeking out their old drug supplier and resuming where they had left off. If few are deterred by their detection and imprisonment, fewer still are rehabilitated while in prison. A custodial drug treatment centre, in lieu of imprisonment, as allowed for in the Misuse of Drugs Act 1977, still does not exist.

It is widely accepted that most drug users who are addicted to hard drugs come from areas of deprivation, are likely to have dropped out of school early, have no skills or qualifications and have a history of unemployment. While it is beyond the remit of this submission, it is necessary to point out again that addressing the drug problem involves addressing poverty, inequality and social exclusion in Irish society. Relying predominantly on the criminal justice system to address the drug problem can never succeed.

I am aware that the Oireachtas Committee members have visited Portugal, where decriminalisation measures were introduced in 2001. While drugs are still 'illegal', possessing small, defined, amounts is treated as a misdemeanour, like a parking ticket. While this policy continues to have its critics, it is clear that, at worst, there has been no increase in drug use in Portugal and in many respects, there has been significant success, namely in a decrease in HIV infections and drug related deaths and in a reduction in drug use amongst 15 to 24 year olds, the age-group most at risk.

Value for Money

Value for money is a primary consideration today when evaluating policies; by this criterion, the enormous cost of arresting and prosecuting people for possession of drugs for personal use over the past thirty to forty years has been a total waste of money, as not only has it failed to achieve its objective, namely reducing the availability and use of drugs, but the evidence is clearly to the contrary. One might argue that the drug problem in Ireland would now be even worse if we had not treated possession a criminal offence, but this is obviously incapable of being proved. Policies should be evidence based, not based on hope or wishful thinking.

The cost of Garda time, court proceedings and imprisonment involved in prosecuting, and penalising, people for the possession of drugs for personal use is probably impossible to quantify, but it runs to hundreds of millions of euro. In 2014 alone, 11,877 such offences were prosecuted in the District Courts (the fact that they were prosecuted in the District Courts suggests that they involved small amounts of drugs which did not warrant being sent to the Circuit Court). In that year, 382 people (including 4 juveniles) were sentenced to prison by the District Courts for such offences; 2,309 (including 8 juveniles) were fined (which involves substantial Garda time spent in collection), 1,611 (including 46 juveniles) were placed on probation and 306 were sentenced to community service.

I have personally been in court with a young man who was charged with possession of cannabis to the value of €2. As it was not his first such offence, he was granted free legal aid. The case was adjourned a number of times, with the prosecuting Garda in court each time, sometimes for most of the morning, and on one occasion, having to return in the afternoon to wait for the case to be called. The Judge told the young man that he was considering a three-month sentence but would ask for a pre-sentence report from the Probation Service, prior to sentencing. The young man met the Probation Officer on two occasions (at the expense of

the State), and, having got a positive report, was spared a prison sentence. He is still using cannabis!

Community projects, receiving state funding of ten or twenty thousand euro a year, will be rigorously evaluated to see if they are providing value for money – and establish whether they should continue to receive state funding. But a system which costs hundreds of millions of euro a year is never evaluated and would fail dismally any evaluation which sought to ‘test’ this expense in terms of effective outcomes.

Investing in treatment

Decriminalising the possession of drugs for one’s own personal use would, on its own, save huge amounts of money. However, to be effective, the savings would need to be invested in enhanced treatment services and in information and education about drug use. The essential argument is that our current reliance on criminal justice policies to reduce both supply and demand have failed and should be replaced by policies which minimise the harm which drug misuse causes to both the individual and society. This entails taking the responsibility, and funding, for drug enforcement away from An Garda Síochána and the court system and transferring it to the Department of Health. It means “medicalising” drugs, not criminalising their users. It means focusing policy, not on the elimination of drugs, (which is recognised as an unrealistic objective) but on harm reduction (which is seen as realistic and attainable). It involves seeing drug consumption as a public health problem, not a criminal issue; it involves treating addiction as a health issue, which requires support and treatment, and not as a badness which requires punishment. It sees drug mis-users as vulnerable people in need of help, not criminal outcasts. It means a state response to drug use that emphasises the role of health professionals and counsellors, not lawyers, and thereby frees the Gardai from having to invest heavily in tackling drug consumption, allowing them to focus their resources on drug dealing. In other words, primary responsibility for interacting with drug users would then be given, not to the Gardai, but to health professionals, whose task it is to ensure that those who want help get help.

In my experience, every drug user, at some point or points in his or her life, becomes fed up with their drug dependency and wants to enter treatment. There is a small window of opportunity, perhaps several weeks or, at most, several months, in which the person using drugs is open to, and even eager to, engage in treatment. But if that treatment is not available, they are likely to become demoralised, feel that they will never get the help they need and their desire for treatment may fade.

Treatment options for drug mis-users in Ireland are very inadequate. Outside Dublin, treatment may be patchy or even unavailable. Even in Dublin, long waiting lists for treatment are common, the length of waiting time often depending on where within the city or county you live. There is a heavy emphasis on methadone provision as the primary form of treatment, and relatively little expenditure on residential detox and treatment centres.

Changing attitudes

A public debate that questions policies which are, at this time, largely unquestioned and unquestionable, needs to take place in a calm and non-emotive atmosphere. Many fear that change of policy regarding the possession of drugs for personal use would give the message to our young people that we do not consider their drug misuse to be an issue of concern. Drug misuse *is* of concern, just as alcohol misuse is. But it is a health and social issue. After

all, we do not criminalise alcohol misuse, per se (although other countries, other cultures do); in this country, we criminalise some of the *consequences* of alcohol abuse, such as violence against another, being disorderly or driving above the alcohol limit. Just as we treat alcohol misuse as a health and social issue, so we need to treat drug misuse. By providing adequate and easily accessible community-based and residential treatment programmes, and investing in health professionals who could work with drug mis-users in the community, we give the far more effective message that drug misuse is bad for your health, for your family, for your community - and that help to address the problems which it is causing is readily available.

Again, many people, particularly parents, have, understandably, a fear of drugs and any attempt to decriminalise illegal drug use might be seen by them as increasing the likelihood of their children using drugs. I get many calls from parents who are in a panic wondering what to do because they have discovered that their son or daughter has taken drugs; I have never had a call from parents to ask what they should do having discovered that their son or daughter has taken alcohol! They do not have the same fears about alcohol, although alcohol does far more damage to individuals, families and communities than all illegal drugs combined. Educating parents, and the wider public, regarding the issue of drugs is essential if a decriminalisation policy is to be considered.

Conclusion

What is advocated here is a U-turn in our approach to drug misuse. It is based on the observation that current policy, which depends on criminalising drug use, has patently failed, by any criteria. New policies, such as decriminalising drug use, which are evaluated by evidence-based outcomes, and which aim at reducing the harm which drugs cause to individuals, families, communities and society now need to be tried.

DRUG DECRIMINALISATION IN IRELAND.....A CASE AGAINST (Justice Committee) July 2015

INTRODUCTION

May I begin by commending you for your considered approach to this very contentious problem and welcome the concerns of all of you to bring a positive response to Ireland's drug problem. However, progress will not happen overnight. It will take several small steps but change will come if those steps are careful and considered. This opinion comes from over 35 years experience in this field.

In 2013 the Dail voted 111 to 4 against drug legalisation as proposed in a Private Members Bill by the then deputy Ming Flanagan and his fellow Irish directors of US NORML a pro drug entity. Among these founding directors were two HSE doctors administering the methadone programme. Surely a conflict of interest? (See question on methadone maintenance below)

Now time has moved on and the debate has switched to decriminalisation. However, one would need to seriously consider the consequences of breaking the Irish agreement with the United Nations on Drug Control Policy. The UN Conventions on Narcotic Drugs Psychotropic Substances and Doping Agents has been signed and ratified by almost 200 nations. This month a group of lawyers in Dublin from the Law Society have presented an alternative drug policy to circumvent this agreement to the Oireachtas for consideration. This was done at the request of the Anna Liffy Project and Merchants Quay who are engaged in Harm Reduction. There are other international groups working on altering the Conventions so that all drugs will be legalised. This is not new. Each March the UNODC meet in Vienna to debate drug policy with Civil Society Groups and other experts. EURAD (European Action on Drug Policy) has Consultative Status with ECOSOC. The Irish Government is represented usually by a Drugs Minister with Advisors. This is the Forum where Irish decriminalisation should be debated with UN Experts and the new legal advice presented for discussion. This is a valuable source of advice and debate. While there may be elections before March nevertheless this is an important issue and no steps should be taken before then. It must not be used as a vote getter. I would be happy to direct the Irish group to established international experts there.

WHAT DOES DECRIMINALISATION MEAN?

Decriminalisation will bring the drug problem out of the scope of penal (criminal) law. Law enforcement will no longer be provided for the export. Import, manufacture, distribution, sale, publicity, possession and use of drugs that are up till now controlled within the scope of international conventions. The consequences are that society will have no law or lever to use to direct drug addicts towards help and treatment. Neither does society have means to suppress trafficking.

LEGALISING would require that the government facilitate a more or less free distribution of drugs as in the case of tobacco and alcohol. Questions would arise such as would they be taxed similar to tobacco? If so a black market would immediately undercut the legal price. Who would sell them etc etc.

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ARE DECRIMINALISATION AND LEGALISATION THE SAME THING?

Yes they are. It is complete capitulation. Users who are the root and motive force of the drug market will be more or less free to use and possess drugs, and traffickers will feel it worth the risks to extend the traffic to MORE people. Success is guaranteed due to the ADDICTIVE CHARACTER of drugs. Changing laws will not change the chemical content of banned drugs which have been advised as unfit for human consumption. Nor will it defend against DRUG DEBT a major factor in more drug users being forced into dealing to pay off debt. This is a serious factor among young cannabis smokers . It would be an irresponsible act on behalf of the many young people affected by the negative fallout.

OTHER EU STATES EXAMPLE

Netherlands drugs are NOT decriminalised there. They engage in separation of the market. It is termed 'de facto decriminalisation' there. . (Police are instructed to turn a blind eye) If terms are breached then the dealer is faced with a tough jail term.. This was done because of political pressure on the government due to drug issues not been solved... similar to Ireland. While they got rid of the criminal aspect drug use is still on the rise there. Criminal elements supply coffee shops. Now they are closing many coffee shops and banning drug tourism due to public objections and those of neighbouring countries due to the drug tourism it creates there. This would also be a problem for us with Northern Ireland and the UK. While "Look at the Dutch example" has become the mantra of the drug legalisers/decriminalisers. Holland's half baked experiment in de facto decriminalisation has led them to be known as the drug capital of Europe. The Netherlands is recorded also as the murder capital of Europe. This was where our own most dangerous drug criminals fled. There are however, positive happenings in the Netherlands coming from civil society. The de Hoop Drug Rehabilitation Centre is a christian mental health holistic treatment facility with excellent results. It is innovative and worth exploring. See below for details.

The **UK** down-classified cannabis from Class B to class C in 2004. In 2009 the Blair Government was forced to reclassify the drug back to Class B due to a 1% increase in use among young teens. 1% increase among the British population would amount for many thousand children. Has this been taken into account by government advisors? Would any Irish politician or government be able to justify this result in Ireland?

The 10-year followup research on the Lambeth 'depenalisation' cannabis experiment showed a rise in crime and in hospital admissions from drugs. This is despite a simultaneous police crime crackdown in the area. (www.dbrecoveryresources.com, click News tab and enter "Lambeth" into search box.)

The Portuguese have allowed new cannabis clubs to operate in an attempt to calm public concerns while continuing to feed users addiction and remove drug use from public sight. Their reports of success have been rejected by the UNODC. Portugal introduced it's first-ever harm reduction programme at the same time it decriminalised drugs. This 3.

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widespread programme is more likely to have accounted for any of the positive statistics (deaths) than going soft on pot. This was supported by a crackdown on crime. Indeed, would the HR figures have been better without the latter it could be asked. EMCDDA reports show that since Portugal's decriminalisation of drugs lifetime prevalence rates for drug use rose for all drugs for all ages and categories between 2001-2007. This despite the discredited (by ONDCP) report from Dr Goulao's Institute in 2007. CATO has not published figures since then to ONDCP. (Office of National Director for Drug Control Policy) These facts are in stark contrast to those presented to the Irish delegation recently. But then there were vested interests involved on the Portuguese side from the CATO's Dr Goulao who was the author of the decriminalisation strategy and the government who have supported it. The Portuguese example has been promoted by people promoting full drug legalisation our own Fr McVerry among them. Does this not ring alarm bells within a government that has rejected drug liberalisation in a Dail vote in 2013? Surely Portugal is not an example that Ireland should follow.

Sweden has among the lowest levels of drug use in the developed world. It is considered un Swedish to use drugs. (CONSUMPTION is illegal) Swedish policy uses the criminal justice system to prohibit both the SALE and USE of drugs, including cannabis. It offers non violent drug users help through social and medical services. Instead of long prison sentences, non violent drug users are directed to treatment and required to become and to stay drug free while remaining in the community. This approach resembles the 2,700 drug courts in the US that offer treatment for a small percentage of convicted persons. In the US long prison sentences are almost invariably limited to drug sellers or those possessing drugs in quantities that exceed amounts for personal use. In the US as in Sweden, simple drug possession, especially cannabis possession, does not lead to imprisonment. It did not require a change in the law. Job/skills training is an important component. A person will not attain a criminal record if they cooperate fully with the State. As in Portugal, Sweden has invested heavily in education, prevention, family support and treatment. If they do not comply then they will be charged accordingly and swiftly. It has not required a change in the Swedish law that would breach the UN Conventions signed by Sweden and Ireland. Croatia and France also. Has a delegation considered going there to study their success? Why only study Portugal?

CONSEQUENCES

New drug driving tester kits are shortly to be introduced here in Ireland . How does Minister O'Donohoe with responsibility for road safety feel about softer drug laws?

Breaking the UN Conventions on Narcotic Drugs Psychotropic Substances and Doping Agents is a serious step for any government to take leaving Ireland outside the community of Nations concerned with defeating the drug menace. It would also breach the UN Convention on the Rights of the Child (art.33) as more young people would be inducted into the drug sub culture as in the UK and Portugal.

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CONSIDERATIONS

Invest more finance in prevention and early intervention with early treatment where necessary instead of holding people on methadone when a treatment facility should be introduced. More finance to treatment facilities so they can employ a psychiatric nurse to monitor detox. Thus saving the State money and ensuring the addict a recovery programme in place of a lifetime on methadone. Hereby, reducing the latest figures of three drug deaths a week in the community.

Inner City traders are understandably upset at public dealing and using in Dublin and asking that something be done to clean up the city. Surely that is a job for policing? Instead, are we to follow the Portuguese example or will we become more proactive in reducing drug use while increasing Gardai and outreach workers on the street

The new strain of 'weed' in use here is causing an alarming rise in mental health issues not to mention rising addiction. (www.cannabisskunksense.co.uk) Our own Dr Bobby Smyth (Child and Adolescent Psychiatrist) head of the Addiction Studies Course in Trinity (among other treatment specialist) is on record for warning against legalisation of this drug. Decriminalisation would clearly be an issue. Dr Smyth has great concerns around cannabis use among young people. Decriminalisation will give the wrong message to children. Similar to alcohol and tobacco young people will think they are safe.

The United Nations have advised that research shows the main dealing of drugs takes place in or around the school vicinity. If cannabis or other drugs were to be decriminalised it would be easier for dealers carrying small quantities of the drug to operate there without penalty. Thus ensnaring more potential users..... and dealers due to drug debt. Changing the laws on drugs will not alter their chemical makeup or addictiveness. Even more young people will be seduced into the drug sub culture. This is the gravest danger in downgrading drugs. We are bound to protect our most valuable asset. Young people. (UN Convention of Childrens Rights art33)

Drug use does not begin and end in the inner city . Can the Oireachtas afford to change the law around drug dealing to satisfy a small section of Ireland? Surely homelessness is a grave factor often highlighted by Alice Leahy Director and founder of Trust who has been working in this area for longer than anybody. How would decriminalising drugs ease homelessness? Has this been discussed with Trust? Perhaps another perspective to that of Fr McVerry would be helpful.

Have we questioned why drug addicts on the east coast are not being referred on to treatment facilities but kept in the straightjacket of another addictive opiate. Some being told it would be unethical to take them off methadone, they would only revert. Figures of 3,300 addicts still on methadone after ten years is indefensible. The result of this is a steep

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spike in HIV among injecting addicts. Mirrored with high instances of Hep C this adds to the cost of addiction. Who is responsible? How can decriminalisation help this? Addicts can and do recover. To deny this is denying them their basic human right and an enormous cost to the State. Introduce new measures on methadone maintenance and have them independently peer reviewed. This saving could be invested in paying for a psychiatric nurse to monitor detox in treatment centres. This too would cut waiting lists. Have we given consideration to rural communities and their experience? Have we asked rural parents and guardians how they would feel if in light of a lack of garda presence there, drugs were to be decriminalised resulting in a free for all. Garda Stations have been closed throughout Ireland leaving rural communities at the behest of drug dealers.

Decriminalisation will prove an asset to dealers in these areas that are now without local policing knowledge. Dealers can carry small amounts of drugs to comply with the new legislation.

Drug use has stabilised in Europe (EDMCDDA). Ireland still has unacceptable levels of drug use due to lack of education for prevention and treatment facilities needing a detox programme. General health cutbacks have affected this and changing the law accordingly is not an acceptable answer. Drug education appears to have fallen off in recent years...to be replaced by harm reduction. Harm reduction is not prevention nor is it treatment if there is no clear guide on recovery in a peer reviewed treatment centre. Young people need to have a very clear message against involvement and use of illegal drugs (UN Conventions on the Rights of Children art33) Our new Drugs Minister a former teacher would be well placed to advise on needs in the classroom around drug prevention. This should not ignore children coming to school hungry and poverty of course. Also social workers aware of and dealing with addiction and other problems within the home. But blue collar and private areas should be included equally. Closing the Head Shops and outlawing so called legal highs has caused a steep drop in their use. Also emergency hospital visits have dropped accordingly. This has taught us that our present laws are working. We should also learn from our alcohol and tobacco use. These legal drugs kill more people because more people use them. Not because they are more dangerous.

Decriminalisation and legalisation go hand in glove. Invest in more drug courts for non violent drug crimes to avoid a criminal record. Invest in diversion programmes through the Gardai these have always been effective. More Gardai on the street perhaps using the volunteer members of the Force to engage with people.

The media among others claim that people are being unfairly convicted and getting criminal records that impede progress in later life. However, democracies need laws to protect us from each other and should be respected. This is not true of everyone. In my former role as counsellor I often accompanied young men to the Courts. None of them ever got a criminal record. They did stop drug use and dealing. Those people were mostly students. They did tell me however, that if they had been told in school what I had taught them they would never have been in this position. This clearly exposes a lack of drug education for young people and their parents. We are failing our young people by

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neglecting their basic right to a decent drug education while in school to equip them for later in life. To remove legal sanctions is a fire brigade action. It should also be minded that not only people from deprived areas use drugs. White collar people in the workforce also use drugs. This brings it's own problems with absenteeism etc. University students...supposedly our brightest and most privileged..... educated at the expense of the taxpayer... use drugs. Not all of course. Students for Sensible Drug Policy (Galway NUI)defend drug use in calling for drug legalisation in line with their international pro drug counterparts. Speakers from NORML and other international pro drug liberals visit our universities in a successful bid to bring students on board. This is a dangerous situation.Why should socially advantaged people be treated any differently to impoverished people by the law? Drugs destroy society. The benefit of drug courts is that people will be judged equally and treated accordingly for non violent offences.

POSITIVE OPTIONS

The Tiglin Drug Treatment Community in Devils Glen, Co. Wicklow which has been visited by Minister O'Riordan is a good example of drug free treatment coupled with skills training. I was present recently at their ITEC presentation ceremony. It was an impressive and joyful experience for those residents. Investment in this programme could bring added benefits.

The director of the Cluain Mhuire Centre in Athy has publicly expressed a wish to have funding to detox residents within her Centre. Why not include more centres in this facility as in Coolemine which has been successful.

There are excellent facilities for young people and their families in our own Aishling Centre in Kilkenny. We know from experience that intervention at a young age is the key to reducing drug use in general. Has anyone from the Oireachtas been to visit the Aishling Adolescent Centre in Kilkenny? If not why not consider this and invest in expanding the programme. I brought a City Hall delegation including the Lord Mayor of Belfast there some years ago and they were so impressed with what they saw expressed a desire to replicate it in Belfast. This would broaden the discussion on criminal records for young people. We have a lot to offer here in Ireland that proper funding would assist.

A fresh and clear education programme in schools with a 'no drug message'. Harm reduction messages are self defeatist. This will provide an opportunity to explain what a drug conviction would mean in their lives. A community Gardai or JLO would be well placed to do this particular input on the law. In an encouraging way.

Diversion programmes not only involving Gardai but communities also. Not using drugs should not be dull there needs to be a substitute that is positive and fun. Job training and a home is clearly essential. Especially for more impoverished communities. Again the volunteer arm of the Gardai could be usefully employed here to work within the community. Not only in city areas but rural areas also. (Where unemployment and family

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emigration is woeful.) In my experience drug dealers go anywhere there is a school and young people.

THIS IS TOO IMPORTANT TO BE RUSHED IN BEFORE A GENERAL ELECTION AS A VOTE GETTER WHICH IT WOULD APPEAR TO BE.

A visit to EURAD affiliates RNS Stockholm. RNS are a Swedish national association for a drug free society founded in 1969 by Swedish psychiatrist Nils Bejerot in response to a sudden epidemic of drug use there. See www.rns.se also info@rns.s They are long established and knowledgeable.

Study visit to drug rehabilitation group de Hoop in the Netherlands. See www.dehoop.

also EURAD's vice President Dutch Psychiatrist Dr MartienKooyman(martienkooyman@planet.nl)

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To believe that because drug decriminalisation has been deemed to have worked in another country means it will work in Ireland is wrong. Each country has a wide range of complex factors that make them unique. Even if decriminalisation eventually works in Portugal and it has not presently(UNODC)it does not mean it will work in Ireland. Irish people are more prone to addiction than many other countries in the world and this needs to be accounted for.

Can Ireland honestly afford to spend the millions of euros spent by the Portuguese government in drug decriminalisation. Where would we find the money with current restrictions imposed by Europe?

Perhaps a little bit of counselling humour on "how to eat an elephant"..... In very small bites!

Good luck with this particular elephant.

End.....

Grainne Kenny

Hon.President and co Founder EURAD (www.eurad.net)

Dublin Lord Mayor's Award 1996 and Women of Europe Award 1989

Dublin

(Eurad has no religious or political affiliation)

End.

Drug Policy

Name: Stephen

Occupation: Student

Age: 20

What's wrong with the current policy in your opinion?

Current policy is way too strict and harsh, the fact someone can get a longer sentence for possession of a recreational substance than someone else committing a serious crime is a joke.

Do you think the current policy has the people's interest at heart?

No, I think it's quite the opposite and only has the interest of An Garda Siochana at heart. The current policy is geared towards their "war on drugs". The fact of the matter is that handing out prison sentences and convictions left right and centre for personal use of recreational drugs, leaving people with permanent marks on their records in regards to employment etc is hardly in the interest of the people.

What benefits could we see should we change it?

Decriminalisation won't create a free for all across the country. We'll free up our prisons and valuable time of the AGS to be redirected towards dealing with actual crimes as opposed to hassling youths. Drug abuse can be a major problem in lower income areas, ones where job opportunities and development are harder to come by. Leaving them with convictions on their records is hardly going to help in the push for them to get jobs and get them off of social welfare payments.

What changes (if any) could you suggest that would make it better?

Decriminalisation would be the number one change I would push for. More time and resources for AGS to be put towards more pressing issues.

Drug Policy

Name: Michelle Byrne

Occupation: (eg Student) Education Officer Students' Union

Age: 23

What's wrong with the current policy in your opinion?

Current policy is hindering people's futures. Caught with a small personal amount of drugs leads to a conviction and people being unable to get jobs, visas etc.

Do you think the current policy has the people's interest at heart?

Current policy does not benefit people. They are treated like criminals instead of being referred to help. We currently have one of the highest death rates from drugs in Europe!

What benefits could we see should we change it?

Less people in prison, causing the taxpayer €65,000 per person per annum. More addicts receiving help. Less stigma and segregation to those who need it most. Less drug convictions.

What changes (if any) could you suggest that would make it better?

Decriminalise carrying small personal amounts of drugs. Send people to health institutions over criminal institutions.

The war on drugs has failed, globally, in embarrassing fashion.

This is a sentiment I first heard just last year from a documentary facetiously titled “How to make money selling drugs”. I had never really thought about the method in which 95% of the world’s governments deal with illicit drugs, and how perhaps the zero tolerance approach taken by most countries is not the most effective.

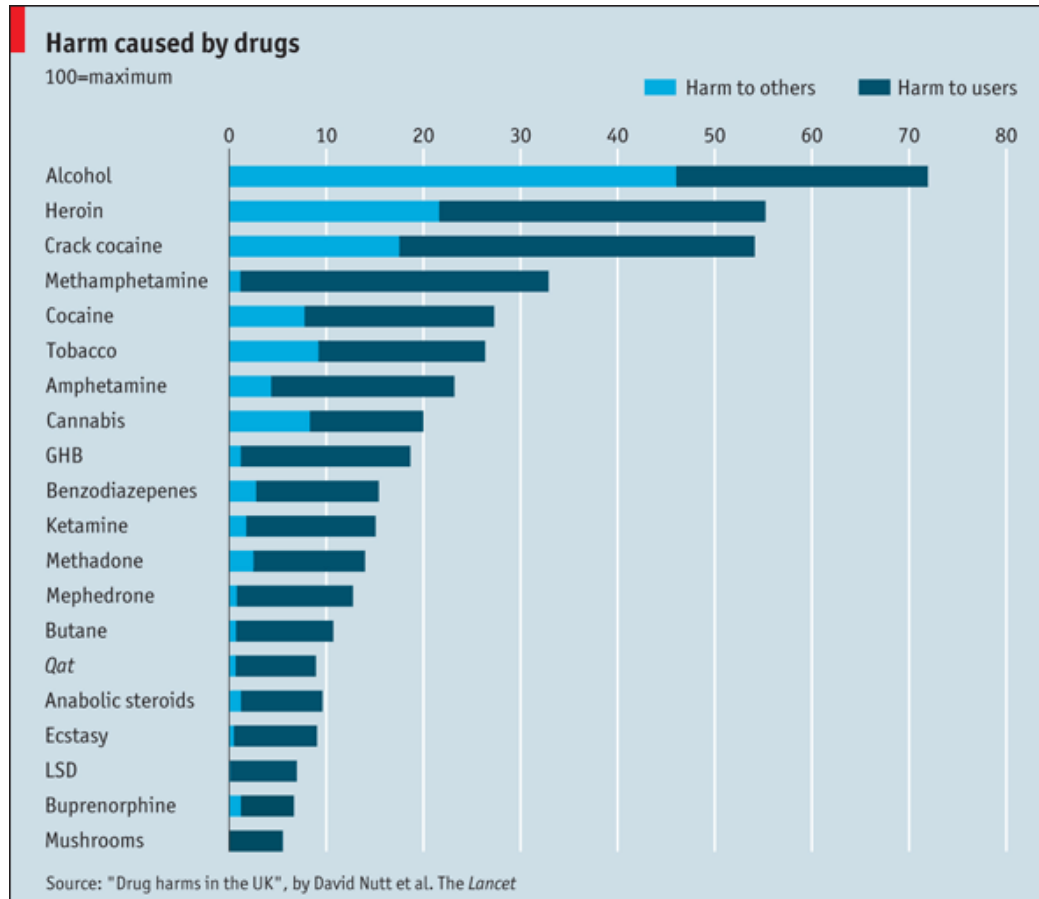
My name is Ciaran Rogers, I am a 20 year old physics student in DCU. I possess no expertise in the scientific or social aspects of drugs, drug use or drug distribution. I am not an expert. I am speaking as a normal civilian, on behalf of a large demographic of youths who know better than to believe that smoking weed will kill you, or taking magic mushrooms will put you in hospital for weeks. These are erroneous allegations that have been forcefully cemented and ingrained into our society’s subconscious. From day one, we are told that drugs are bad, that any and all drugs will inherently damage your life. This was a notion I grew up with and it seemed pretty logical to me, folks injecting heroin tend to be a little bit more worse for wear than those who have abstained. I believe this particular example to still be true. Heroin is one of the most terrible and dangerous drugs out there, and there isn’t much debate on that subject. What I feel is being misrepresented and contorted here is the status of what the government would regard as ‘less lethal’ drugs, or, the actual word, non lethal drugs. The likes of cannabis, MDMA, LSD, and mushrooms. These drugs, amongst others have been demonised and crucified because of uneducated and biased research which took place in a different continent forty years ago. Since then real scientific research has taken place and has not only quenched many of the myths surrounding these ‘dangerous drugs’ but have in fact shown that there can be beneficial aspects to consuming them in appropriate doses. I’m not trying to make the argument that taking drugs is a healthy thing to do on a regular basis, but if as a nation we can consume on average 15+ litres of pure alcohol per-person, per-annum¹, and look at it as a normal leisure activity, then why is it illegal to consume a different type of drug, which does far less damage than alcohol does in its pure form?

This brings me to the crux of the argument being made on drug reform, which is that alcohol kills tens of thousands of Irish people every year, the number of people dying from smoking cannabis or taking LSD is arguably zero, unless we begin counting the deaths due to substances added by drug dealers (which by definition is a death due to the added substance and not the marketed drug itself).

¹ <http://alcoholireland.ie/facts/how-much-do-we-drink/>

For a more concise view of the comparative detrimental effect of drugs on the person, and on others, see below David Nutt, Neuropsychopharmacologist and former advisor to the British Department of Health's chart:

Figure 1.²



This isn't hearsay or propaganda, it is genuine, objective research, and it is accepted within the scientific community as accurate. It is difficult to see how there is even a feasible argument for the opposing side to make when evidence such as this is so readily available. When one of the most powerful countries in the world is in the middle of a domino effect of legalising cannabis, disputing that it can be fatal comes across as rather fatuous.

Finally, my motion on what to change regarding drug policy, and the answer has been implemented already, very successfully on another drug in dozens of countries for the past ten years. The smoking ban.

To try and alleviate the number of people smoking and appease non-smokers, we introduced strict regulations on cigarettes. We began with banning advertising, indoor smoking bans, steep taxes and duties and now, we're bringing in plain packaging to deter and dishearten future potential smokers, and embolden current smokers to quit, and it has worked miraculously well. Smoking has dropped

² http://www.economist.com/blogs/dailychart/2010/11/drugs_cause_most_harm

almost 10% in the first ten years³. The campaign is still very young, and the trend indicates that smoking rates will continue to drop and drop.

A quick history trip to America in the 1920s. Alcohol is banned nation-wide, and very soon, the production, transportation and distribution of alcohol is controlled by gangsters. Everyone still wants to get drunk just like they do today, so they buy unsafe, untested liquids in glass jars and guzzle it down for over a decade, until eventually, after all the deaths from rival gangs and poisoned consumers, the ban is lifted, and the world didn't hear much from Al Capone after that. (Never skip your taxes)

Does this world of unregulated drugs, gangsters and death seem vaguely familiar? I might be reaching here, but to me it sounds a little bit like the situation we currently find ourselves in, where the government's prohibition on drugs is providing a lucrative income for thousands of criminals in our country and millions around the world, and is causing the deaths of thousands due to the deregulation of these substances. I scarcely need to mention how well decriminalisation has worked in Portugal over the past 15 years. Deaths are down, addiction is down, the figures are out there, I don't think I need to try to convince anyone how effective it has been for one of our neighbours. A member of the Support don't Punish movement made the valid point outside the GPO at a rally for drug reform, that our current policy wishes to exist in an ideal world where eventually no one will do these 'terrible' drugs, but we need drug policy for a realistic world, for our world. People will always want to get high, or have unprotected sex, or skydive. We do things that inherently can put us in danger, it is up to us a society to not kill ourselves doing these innately human things.

My proposition is that all drugs are made legal to buy over the age of 18, and become strictly regulated, have no advertising allowed, and the use and misuse of all of these drugs should be taught to everyone, ridding the world of ancient stigmas grounded in superstition and misconception. People know that methamphetamine will kill them, we know that smoking weed all day won't lead to productive life, we know that taking pills every week for years will leave us pretty skaggy. Trust needs to be put into the people to smoke a spliff if they want to, just as we can have a pint if we want to and the world won't fall into disrepair. What goes into our own bodies should be the choice of the individual, not the government.

Thank you.

³ <http://www.irishtimes.com/life-and-style/the-health-effects-smoking-rate-falls-from-29-to-22-in-10-years-1.1733892>



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07 August 2015

**Submission to Committee of Justice, Defence and Equality
Ireland's Approach to Possession of Limited Quantities of Drugs**

Background

Tabor Lodge Addiction and Housing Services Limited is an addiction treatment agency in Cork, established since 1989. We deliver a 28 day primary residential treatment programme to over 200 people each year in Tabor Lodge and 3 month residential extended treatment intervention in units at Fellowship House and Renewal to more than 40 people each year in each centre. Independent living accommodation for a further 3 month period is also available.

Through its Primary and Extended Residential Treatment facilities, Aftercare programmes, Family programmes, Relapse Prevention programmes and Day-care programmes for women, Tabor Group has developed the capacity to offer comprehensive treatment interventions to people addicted to alcohol, drugs, gambling and food.

Many of our clients who attend use illicit substances. In 2015 105 of the 210 patients admitted to primary treatment reported that they used an illicit substance as their first, second or third drug of choice.

We have experienced many of the younger population who have been arrested for possession of illicit drugs being referred to Tabor Lodge by Court or Solicitors. We have a Service Level Agreement in place with the Probation Services which supports us in delivering treatment to clients, sometimes as an alternative to custodial sentencing.

Treatment Philosophy of Tabor Group

Tabor Lodge has always considered addiction as a chronic health condition. Our treatment philosophy is centred on the Minnesota Model of treatment which sees addiction as a primary, chronic, progressive and potentially fatal health condition.



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Tabor Lodge services are designed to intervene and offer counselling, education, information and ongoing support so that a rehabilitation process can take effect in the person's life, leading to a full recovery from addiction and successful management of this chronic health condition.

We therefore advocate for the decriminalisation of people who are in the criminal justice system because of their inability to manage their chronic health condition.

Tabor Group Contribution to this Discussion

Decriminalisation of addicted people for use of illicit substances is supported by Tabor Group.

Such a measure entails a paradigm shift in how we view the addicted person; from seeing them as a criminal offender to seeing them as a person in need of healthcare interventions.

This has implications for treatment services.

If the Portuguese model is to be taken as an example worth implementing in the Irish setting, then there will be many people no longer seen as offenders but seen as needing treatment intervention.

This factor must be taken into account before the decriminalisation process begins.

The success of the process will depend on many factors. Primary among these is that the initiative is underpinned by a national treatment infrastructure, fit for purpose, properly resourced and with the capacity to offer effective care and support for the individual over a sustained period of time.

Careful consideration should be given to the resource implications of diverting a number of citizens into health care services.

Evidence and support for decriminalisation of possession and use of drugs

United Nations / International

Ban Ki Moon *UN General Secretary*

*"We must consider alternatives to criminalization and incarceration of people who use drugs"*¹

The World Health Organisation

*"Countries should work toward developing policies and laws that decriminalize injection and other use of drugs and, thereby, reduce incarceration"*²

UNAIDS

*"Punitive laws and policies, whether via prohibiting the provision of sterile injecting equipment and opioid substitution therapy, criminalising drug use, possession of injecting paraphernalia, or denying HIV treatment to people who use drugs, violate people's right to health and harm the community. Such punitive policies not only fail to reduce HIV transmission but create unintended harms – for instance, by driving people who inject drugs away from prevention and care and resulting in prison overcrowding. Responses to HIV should transcend ideology and be based on scientific evidence and sound human rights principles; they should support, not punish, those affected."*³

UN Development Program (UNDP)

*"laws criminalizing drug use/possession of small amounts of drugs for personal use impede the access of people who use drugs to basic services such as housing, education, health care, employment, social protection and treatment."*⁴

"While it is difficult to make generalized conclusions across a wide range of such decriminalization policy models, longitudinal and comparative analyses suggest that there is no clear link between more punitive enforcement and lower levels of drug use, and that moves towards decriminalization are not associated with increased use. In Portugal, for example, since 2001, when the law

¹ Ban Ki Moon: Message on the International Day against Drug Abuse and Illicit Trafficking - 26 June 2015 <http://www.unodc.org/drugs/en/sg/secretary-general-message-2015.html>

² World Health Organisation 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations' July 2014 <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>

³ Introductory comments from Michel Sidibé Executive Director, UNAIDS 'The Global State of Harm Reduction' Harm Reduction International, 2012 http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf

⁴ 'Addressing the Development dimensions of Drug Policy' UNDP, 2015 <http://www.undp.org/content/dam/undp/library/HIV-AIDS/Discussion-Paper--Addressing-the-Development-Dimensions-of-Drug-Policy.pdf> p. 31

decriminalizing the possession and use of illicit drugs in small enough amounts to suggest personal use came into effect, there has been a small rise in drug use, which is comparable to neighbouring countries, and a rapid decline in HIV incidence linked to injection, as well as decreases in school-age drug use and injecting drug use by school-age children and a fall in lifetime heroin use in 16–18-year-olds.”⁵

“Ways to promote development-sensitive policies and programmes on drug policy and control:

- Address abuses that interfere with access to comprehensive harm reduction services, including laws criminalizing drug use and possession of small amounts of drugs for personal use and drug paraphernalia*
- Take advantage of flexibilities available in the drug conventions on penalization of possession and use of controlled substances, including decriminalization of drug use and possession of small amounts of drugs for personal use”⁶*

UNAIDS/UNDP Global Commission on HIV and the Law

*“Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. **Countries must Decriminalise the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society.**”⁷*

Kofi Annan *former UN General Secretary*

“Obviously, we all want to protect our families from the potential harms of drugs. But if they do develop a drug problem – that is a chronic relapsing illness as the WHO has defined it - they should be viewed as patients in need of treatment and not as criminals. In what other areas of public health do we criminalise patients in need of help? Surely it cannot be the job of the criminal justice system to prescribe remedies to deal with public health concerns. This is the job of public health professionals.

And the UNODC Executive Director Yury Fedotov has said, “the conventions are not about waging a “war on drugs” but about protecting the “health and welfare of mankind”. We should focus on that objective. The current drug policies are not achieving that goal. So the question is: what policies would enable governments and health authorities to counter and reduce the social and health harms that drug use can cause? If I may, I would like to make three suggestions.

First, decriminalize drug use. Punitive measures do not work and put lots of people in prison where their drug use may actually get worse.”⁸

⁵ ibid p.31

⁶ ibid p.34

⁷ <http://www.hivlawcommission.org/>

⁸ Speech to World health Assembly May 2015 <http://www.tdpf.org.uk/blog/kofi-annan-makes-call-legally-regulate-drugs-world-health-assembly>

Anand Grover UN Special Rapporteur on the Right to Health

"While drugs may have a pernicious effect on individual lives and society, this excessively punitive regime has not achieved its stated public health goals, and has resulted in countless human rights violations."

"People who use drugs may be deterred from accessing services owing to the threat of criminal punishment, or may be denied access to health care altogether. Criminalization and excessive law enforcement practices also undermine health-promotion initiatives, perpetuate stigma and increase health risks to which entire populations — not only those who use drugs — may be exposed."

"Member states should: Decriminalize or de-penalize possession and use of drugs [and] Repeal or substantially reform laws and policies inhibiting the delivery of essential health services to drug users, and review law enforcement initiatives around drug control to ensure compliance with human rights obligations"⁹

The Organization of American States

"Decriminalization of drug use needs to be considered as a core element in any public health strategy"¹⁰

The Global Commission on Drugs

"Criminalizing people for the possession and use of drugs is wasteful and counterproductive. It increases health harms and stigmatizes vulnerable populations, and contributes to an exploding prison population. Ending criminalization is a prerequisite of any genuinely health-centered drug policy"

"Stop criminalizing people for drug use and possession – and stop imposing 'compulsory treatment' on people whose only offense is drug use or possession. Criminalization of drug use and possession has little to no impact on levels of drug use in an open society. Such policies do, however, encourage high risk behaviours such as unsafe injecting, deter people in need of drug treatment from seeking it, divert law enforcement resources from focusing on serious criminality, reduce personal and government funds that might otherwise be available for positive investment in people's lives, and burden millions with the long-lasting negative consequences of a criminal conviction. Using the criminal justice system to force people arrested for drug possession into 'treatment' often does more harm than good. Far better is ensuring the availability of diverse supportive services in communities. This recommendation, it should be noted, requires no reform of international drug control treaties."¹¹

⁹ Anand Grover, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'

¹⁰ The Drug problem in the Americas 2013

http://www.oas.org/documents/eng/press/Introduction_and_Analytical_Report.pdf p.103

¹¹ Global Commission on Drugs 2015 'taking control; Pathways to drug Policies that work'

http://static1.squarespace.com/static/53ecb452e4b02047c0779e59/t/540da6ebe4b068678cd46df9/1410180843424/global_commission_EN.pdf

EU European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

*“the model implemented in Portugal, where the whole administration addressing drug users is under the healthcare sphere, with several rehabilitative measures available, has been described [by the EMCDDA] as **a consistent and coherent policy**. This approach has been functioning since 2001. There has been no major increase in drug problems that can be attributed to the new system (Hughes and Stevens, 2010), and there is no political will to return to the previous system. In 2013, the former Executive Director of UNODC, Antonio Maria Costa, said when interviewed about the Portuguese system, ‘I applaud the fact that finally we recognise that drug addicts are not criminals ... I see drug policy, on the use side, as a health problem, period’ (Costa, 2013). In addition, as described earlier, a number of other countries appear to be moving towards the gradual implementation of similar systems, recognising that first contact with the non-problem user is an opportunity for (indicated) prevention in order to address future levels of problem drug use.”*

American Public Health Association (APHA)

*“Policy 7121 first expressed APHA’s belief that **people who use drugs should not be criminalized**: ‘because substance abuse is viewed primarily as a public health problem, this Association recommends that no punitive measures be taken against the users of alcohol, marijuana, or other substances when no other illegal act has been committed.’”¹²*

UK Government’s Advisory Council on the Misuse of Drugs (ACMD)

*“The ACMD also believe that there is an opportunity to be more creative in dealing with those who have committed an offence by possession of drugs. **For people found to be in possession of drugs (any) for personal use (and involved in no other criminal offences), they should not be processed through the criminal justice system** but instead be diverted into drug education / awareness courses (as can happen now with speeding motor car offenders) with concomitant assessment for treatment needs (if the person consents), or possibly other, more creative civil punishments (e.g. loss of driving licence or passport). If, however, there were other trigger offences (e.g. theft, burglary etc) then the usual test and treatment procedures would occur. Such approaches may be more effective in reducing repeat offending and reducing costs to the criminal justice system. There should be “drugs awareness” courses to which those found in possession can be referred as a diversion – this would be the equivalent of the apparently successful “speed awareness” courses to which drivers can be referred as a diversion. These could also be available to those being conditionally cautioned where there is evidence of drug use.”¹³*

¹² <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse>

¹³ <https://www.gov.uk/government/publications/sentencing-guidelines-council-acmd-response-2011>

Richard Horton *Editor: The Lancet*

*"...the evidence tells us that until we see drug use as an issue for society, and not one for our criminal justice system, we will be condemned to worsening, not improving, the lives of those who come into contact with drugs. Why is criminalisation not the answer? There is just no reliable evidence that tougher criminal sanctions deter drug use or offending. On the contrary, criminalisation worsens the health and wellbeing of drug users, increases risk behaviours, drives the spread of HIV, encourages other crime and discourages people who use drugs from seeking treatment."*¹⁴

*"Most countries have used the criminal justice system, not the health system, to address the problems of people who use drugs. But these legal approaches have failed. Criminalisation has reduced access to health care for people at risk of drug use. Legal approaches do nothing to tackle the root causes or risk environments of drug use (it might actually make them worse). Put simply, locking people up does not work. As the Series of papers we publish today shows, governments should reject law enforcement and embrace health solutions—specifically, policies of harm reduction"*¹⁵

Fiona Godlee *Editor – The British Medical Journal*

*"In a beautifully argued essay Stephen Rolles calls on us to envisage an alternative to the hopelessly failed war on drugs. He says, and I agree, that we must regulate drug use, not criminalise it."*¹⁶

Sir Ian Gilmore – (then) president of the **Royal College of Physicians** (since retired)

*"I personally back the chairman of the UK Bar Council, Nicholas Green QC, when he calls for drug laws to be reconsidered with a view to decriminalising illicit drugs use. This could drastically reduce crime and improve health,"*¹⁷

¹⁴ Richard Horton 'Drug use is an issue for society, not the criminal justice system' Sydney morning herald, Spet 10 2012 <http://www.smh.com.au/federal-politics/political-opinion/drug-use-is-an-issue-for-society-not-the-criminal-justice-system-20120909-25m4h.html#ixzz3g8qSijpg>

¹⁵ Richard Horton, Pam Das 'Rescuing people with HIV who use drugs' The Lancet [Volume 376, No. 9737](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961025-2/abstract), p207–208, 24 July 2010 <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961025-2/abstract>

¹⁶ Fiona Godlee 'Ideology in the Ascendant' BMJ, 17 July 2010 Vol 341 <http://www.bmj.com/bmj/section-pdf/186618/0>

¹⁷ <http://www.bbc.co.uk/news/health-10990921>

International Federation of Red Cross and Red Crescent Societies

“We often ignore the evidence that to be successful in our drug policies, health services must provide a comprehensive package known as harm reduction programmes that combine the measures we have previously mentioned. Instead, the best people who use drugs can hope for is to be driven underground to live with the addiction in the dark back streets and abandoned buildings of our towns and cities. Or even worse, they are criminalized and jailed with little or no regard for their healthcare rights or the impact of this policy on the health of their communities”.

“To conclude, the IFRC, on behalf of the most vulnerable people affected by drug use, strongly calls upon key stakeholders and donors to exert all possible efforts to gather knowledge on the scale of the drug use epidemic at country level and decide on the proper response accordingly. Criminalization, discrimination and stigmatization are not such responses. Laws and prosecutions do not stop people from taking drugs.”¹⁸

Human Rights Watch

“..it became increasingly difficult—as we documented the atrocities, called for justice, and pressed the US to enforce human rights conditions on its assistance (the US provided Colombia more than US\$5 billion in mostly military aid in 2000-2010)—to ignore that many of the abuses we advocated to end would inevitably continue in some form unless US and global drug policy itself changed.

My later work on US policy towards such countries as Afghanistan and Mexico, and on the US criminal justice system, only strengthened my view—which others at Human Rights Watch shared—that drug criminalization was inherently inconsistent with human rights.

*After much discussion, **the organization in 2013 adopted a policy calling on governments to decriminalize all personal use and possession of drugs.** ”¹⁹*

The Vienna Declaration of the International AIDS Society (20000+ signatories)

*“**Decriminalise drug users**, scale up evidence-based drug dependence treatment options and abolish ineffective compulsory drug treatment centres that violate the Universal Declaration of Human Rights”²⁰*

¹⁸ Statement to the Commission on Narcotic Drugs, 55th Session <http://www.ifrc.org/en/news-and-media/opinions-and-positions/speeches/2012/to-the-commission-on-narcotic-drugs-55th-session/>

¹⁹ The Human Rights Case for Drug Reform How Drug Criminalization Destroys Lives, Feeds Abuses, and Subverts the Rule of Law

²⁰ <http://www.viennadeclaration.com>

Submission to Joint Committee on Justice, Defence & Equality

RE: Review of Ireland's approach to the possession of limited quantities of certain types of drugs and arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use.

From: Denis Murray

Dear committee members

I wish to confirm **that I am not opposed to the decriminalisation of possession of certain amounts of drugs for personal use.** However that being said I hold the belief that societies ought to have high expectations for the health and welfare of all people. **In the landscape of decriminalisation there is a greater need for Health Promotion Approach** in keeping with Ottawa Charter (WHO 1986) **which emphasises that a focus on activist and protective/preventative and health promotion measures** in addition to harm reduction programmes would allow for the possibility to break the cycle of addiction that has affected so many families. I carried out research in 2013 into “*Professionals’ Understanding of Risk Factors for Substance Misuse by Young People and Approaches to Intervention*” Please see below link to research and Abstract.

Link to

Research: <http://www.drugsandalcohol.ie/20350/1/AThesis%202013%20Final%20Copy%20%2024052013.pdf>

Research Abstract

Issues and trends in relation to substance misuse normally develop in the transitional phase of adolescence, as young people begin looking towards their peers for direction and are less subject to parental authority. Risk factors are predictors of the likelihood that an individual or group will be involved in activity leading to adverse consequences. Research indicates that some young people are beginning to initiate alcohol and drug use earlier than many adults suspect. In relation to substance misuse it is observed that risk and protection factors exist in equal measure within different context including within the individual, family, peer group, school and community settings. The enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse. If young people experiences substance use as enjoyable and without any negative

consequences then it is likely they will not perceive risks relating to such use. Parental disapproval of substance misuse is a strong predictor of delayed initiation, whereas family instability and parental or sibling substance misuse, are identified as significant risk factors placing young people at greater danger of developing lifetime trajectories involving substance misuse. Assessment is central to the identification of needs and forms the basis for the establishment of integrated care plans framed within the context of multi-disciplinary and inter-agency collaboration. Governments and other organisations are required to play an active role in supporting the well-being of individuals, families and communities. As such, the practice of including children within adult categories when referring to “normal” alcohol consumption levels needs to be re-evaluated. Parents’ and other adults require information about the risks and harmful effects of early onset substance misuse in order to make informed choices and to be empowered in taking a stance in relation to teenage substance misuse

In preparation for this submission I sought comments and reflections from parents of young people whose lives are affected by substance misuse. Please see below responses received.

Parent 1

“As a parent of a 16 year old who smokes weed are totally against the decriminalisation of these such drugs. Are familys life has been turned upside down and all because of these stupid drugs it’s like living in hell when are son is smoking this drug he gets very violent and has wrecked are house on numerous occasions are ten year old son is very fearful of his brother and this is not right. We have had to pay off drug dealers to save are 16 year old from getting a hiding or worse still shot”

Parent 2

“Life is a daily struggle when you have a young son addicted to this horrible drug. I deal with mood swings, a very aggressive child, a child who when he does not have his weed will verbally abuse me, physically abuse me, smash up my home, steal my property to buy his bag of weed, life is a night mare, I would not wish it on anyone. Before my son started smoking weed he was a champion boxer for 4 years, a good student who attended school every day, a very respectable human bean who I was so proud to call mine. Now I don’t know who my son is, this drug has ruined my family, taking away my son. Please Minister think carefully about your plans because us families who live with an addict know all too well the dangers of this substance, the heart break it brings” (Sad face)



Parent 3

“As a parent of a child who has smoked cannabis, it has been very disruptive to our family life. It affected everyone in the family not just the child that smoked it. It is very hard as a parent knowing and seeing the affects it has on your child. I found the worst part was that my child was very paranoid and extremely aggressive. The reason I say child is because it is children who are affected by this at a very young age”

Parent 4

“The impact of young people smoking weed is Huge for the Family. My child is paranoid gets into trouble via minor acts and attracts a cohort of friends who smoke weed and who would be unsavoury characters. Weed has taken my good natured and valued child away and has been replaced by a child who struggles to attend school, received JLOs and adds to the public purse to provide services to all i.e. Garda, Educational Providers, Counselling Services. Weed needs to be stopped from wrecking our children, families, communities and Nation”

In the course of my work it is my experience that the main concern for parent and indeed other professionals is that society will only focus on Harm Reduction in the interest of protecting business and the wider population and that a piecemeal approach to addiction treatment will continue. It is important that any shift in the Criminal Justice System is mediated by a shift in resources towards other supports and interventions, such as;

Family Support in order to encourage the involvement of partner's, parent's, caregiver's and significant other people in the lives of people who are experiencing problems in relation to addiction, especially young people. Professionals need to be aware of the benefits in supporting families towards strengthening informal social supports and building coping capacity especially where there is a family history of substance misuse. The provision of family support services in all formats from information giving, direct practical support, parenting support groups or family therapy can contribute to the empowerment of parents and caregivers. It is appreciated that young people are offered some protection when parents communicate openly, are emotionally supportive and monitor their children's activity. In circumstances where a young person is affected by parent/s substance misuse family support could be viewed as the most appropriate first step towards assessing and addressing the impact of such activity. In the context of the tiered model of family support and with supervision from child protection services such an intervention may eliminate the need for a young person requiring out of home care.

Inter-agency working and the establishment of protocols between services makes for good practice in the interest of children and families. In this regard there are specific recommendations within Report of the Working Group on Treatment of under 18 year olds (Department of Health and Children, 2005); National Drug Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009) and Steering Group Report on a National Substance Misuse Strategy (Department of Health, 2012). It is important that these recommendations are progressed and that professionals know how to respond to child protection issues. A multi-agency response is required where children's

lives are affected by personal and/or parental substance abuse. It is essential that all professionals and agencies especially GPs have a good understanding of the tiered model of intervention so that appropriate and timely referrals are made where a particular need is identified.

Delaying Onset and early intervention efforts to support young people in delaying induction or avoiding substance use in the first instance are likely to have an impact on lifetime trajectories in terms of substance use. The enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse. In this regard young people need to be supported in building resilience and the management of delayed gratification within all contexts. Given the prominence of peer influence as a predictor of adolescent substance misuse it is important to support young people in developing interests/activities that may lead to positive peer group associations. Additionally, parents/carers need to be informed and involved where there are concerns for young people in relation to substance misuse.

Elevating Concerns where there are concerns for adults and young people engaging in substance abuse. In relation to children in particular it is important that adults can identify processes and strategies to elevate concerns for such activity among young people themselves and with their parents, guardians and other adults, especially in circumstances where parents or significant other people are facilitating substance misuse and where there are signs that a young person's use of substances extends beyond curiosity and experimentation. Failure to act may be viewed as collusive and enabling. Organisations and services that are ideally positioned to assess a young person's circumstances and to elevate concerns include; Courts, JLO service, probation officers, hospitals, schools, training centres, social workers, GPs, practice nurses, adult addiction services, youth services and family support services

A research study by Truts and Pratschke (2010) comparing Irish school attendees and early school leavers shows higher levels of substance misuse among young people who are out of school or who are in alternative education. These findings are corroborated by Arteaga, *et al.* (2010) who makes links between early school drop-out, parent expectations for children's success, family conflict, instability of accommodation and a young person's dislike of school. It is proposed that remaining in mainstream education provides a level of protection against substance misuse and that positive relationship with teachers; favourable school experience and good communication between parents and school contribute to school retention (Truts & Pratschke, 2010). Moreover, McCrystal, *et al.* (2006) present research showing that young people in mainstream education have increased levels of home based activity, spend less time hanging out on streets and are least likely to engage in random activity. It is proposed that education and awareness programmes ought to focus on morality as well as on health issues as it is understood that moral discernments are learned and as such can be swayed, suggesting that interventions start at a younger age as 'moral development accelerates in primary school stage (5-12 years) and is almost complete by 15 years' (Amonini & Donovan, 2006. p. 284). In the process of encouraging young people's moral development it is important that they experience justice and fairness within society. Ultimately, the enhancement of decision making by young people could delay or inhibit their engagement in harmful activity including substance misuse.

A study comparing Multidimensional Family Therapy (MDFT) with CBT and enhanced service as usual (ESAU) revealed that MDFT produced better outcomes for young people

who presented with increased levels of substance use combined with psychiatric co-morbidity (Henderson, *et al*, 2010). These findings are corroborated by randomised controlled trials carried out in the Netherlands comparing MDFT and CBT (Hendriks, *et al*, 2011). MDFT is a family based therapy approach used with adolescents who are engaging in substance misuse and other behaviours. The approach involves intervening within the major domains of a young person's life, including family, peers, school, leisure and work (Liddle, *et al*, 2005). Within both studies it is identified that young people with more severe problems seem to benefit from family based treatments due to the fact that the approach encompasses a wider range of risk factors and involves parents and other family members in addition to significant other people.

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To whom it may concern

I am writhing on behalf of the Irish people to have there say on drugs been decriminalised which I feel is a brilliant opportunity which will help thousands of people and make the government millions. I have been looking closely at other country's that have already taken this step for example Portugal and Belgium and I have seen first hand experience of what these country look like brilliant u can walk down the Main Street and not see one addict begging on the street unlike O'Connell street and Abbey street which are like a scene from a war film that there is that menu addict its disgraceful . I recently spent the summer in California where cannabis is legalised for medical use which Ireland should have done years ago as countless test show that Cannabis has no bad effect on the brain and can make our country millions in revenue even take out of recession recently in Colorado USA have actually give tax money back to its citizen because it has mad so much money over the legislation of Cannabis the reason I am so for this decision is because recently I was diagnosed with chrons disease And was taken 15 tables a day to keep me without pain on a normal day after mouths of trying these tablets I decided to stop taken all tablets and start with the smoking cannabis and spreading of cannabis oil on my body and to no surprise I haven't had a pain in my body related to chrons in the last 6 mouths which has lead me to return to work and a healthy like. I feel that if the Irish government take this step forward in demcrimlise all drugs to help people instead of charging them with petty small amounts and causing them trouble in later life with such things as visa and if they ever wanted to adopt a kid. Imagine been told u can't have a family because when u wore a teenager you wore caught with a lgram of any drugs which is hardly anything and charged and convicted and have a recorded for like the Irish system is going back ward and it's time for a CHANGE !!!!!.

I also feel that the deadline day for this is to early as people did not get enough notice for this it was not in any newspapers or news stations and it almost looks like it's trying to be hidden it should be in sometime in September to make the decision when all students are back in class and can be educated on this.

Thanks you
Daniel Richardson

Sent from my iPhone

Dear Sir/Madam,

I write to you as a citizen of Ireland, as someone who has seen the current drug laws fail time and time again and as someone who can see the validity of the need to change our current drug laws.

Drug use is something that every person on this planet partakes in. Whether it's going to Boots to buy Rennie or going down to a shady alley to purchase heroin. People make up their own minds as to what level of drugs they wish to take, its human nature. The fact that there is a prohibition on certain substances highlights the inadequacy of these laws and the severe lack of choice drug users are forced into.

The current laws, as they stand, only suffice to line the pockets of the more dangerous criminals. Money which can be used for larger crimes and possibly even murders. There is no direct evidence proving that prohibition works, if anything it causes the crime syndicates to flourish and drug users to put themselves into dangerous situations trying to obtain these substances. Legalisation returns lost revenue to the legitimate taxed economy and removes some of the high-level corruption.

The coalition that was sent to Portugal to view how legalisation has worked has come back with airtight proof that legalisation needs to happen. They have seen first-hand how legalisation has decreased crime and HIV occurrences across the country. Portugal had a much worse drug issue than Ireland has so taking foresight from our European neighbours would be to our advantage.

The penalty does not befit the crime. Taking marijuana for a prime example, a user caught with any amount immediately gets a fine and a criminal record. All the user was going to do was smoke some marijuana, laugh at some movies and eat some good food. At no point is this affecting anybody's life and the user is enjoying themselves. However the money for this marijuana will trickle up to possibly fund a crime cartel, all because of the fact that there is prohibition in place.

To recap, I believe we need to model our drug reform on what Portugal has done, they have a proven record of reducing drug addiction. To continue with these laws you are only harming the drug addicts who are by nature, just trying to feel normal. Tax from the legalisation of drugs can also be used to improve the current health services for addicts.

I hope this message can make a difference as we are living in a forward thinking country!

Regards,
Gary Devitt

I am going too keep my e-mail short and sweet .

Ireland's drug policies have never worked .

The Guards' interaction on the illegal drug trade has zero effect with its current policies.

Legalizing Cannabis would free up the Guards to combat actual crimes such as Murder ..rape ..child molesters , the list goes on for Violent offenders yet these Violent crimes are actually punished less than Drug users . There has to be something wrong as I was under the opinion in a free society like Ireland the Punishment should equal the crime and obviously with our dated drug policies that is not the case . Colorado legalizing cannabis has had all positive effects as well as money in the Government coffers , do you not think as Ireland is on a road too economic destruction (the 99%) , all our national assets being sold off ..private roads ...health care stripped bare ...water Tax .. people dying in Irish hospitals on a daily basis ... Legalizing cannabis may actually help Ireland on the road too economic recovery as proven in every state or Country that has done it .

Our Drug Policies have never worked and if anything with the Policies we have now things are actually getting worse . Time to change and maybe for once become a leader in Europe with Forward thinking changes .

I am Dyslexic so please excuse the bad grammar.

Kind Regards and fingers crossed

Drew T O'Gorman

Drug Policy

Name:

Lysette Golden

Occupation: (e.g Student)

Student Representative

Age:

22

What's wrong with the current policy in your opinion?

In my opinion, the current drugs policy is out of date, unfair and inaccurate. Drug use is misinterpreted by the government. As a student rep for roughly 22,000 students, I can say that drug use is very much a common thing, even more so among first years than ever. I was a first year myself in 2011, and the difference from then and now is huge, and must be noticed. There is no sufficient, non-filtered drug information and education available to students, unless implemented by such student's rep like myself. Understandably it is a sticky subject, but the problem is it has to not matter, Gay marriage was a 'sticky' subject up until recent events, and it's about adapting and not being afraid to talk about things like drugs. Drugs are used, the government cannot stop anyone taking drugs via a law. It is illegal to serve a drunk person, yet walk into any nightclub on a Friday night and see how that is being managed – See intoxicating Liquor Act 2003.

Do you think the current policy has the people's interest at heart?

I think the current policy has no understanding of people's interest, it wastes time and money on both parts, and personal use of drugs is a choice made by that person, and affects essentially no one else. The interest is enforcing laws that really have shown to cause more problems than fix.

In 2013 the USA war on drugs budget consisted of 25.2 billion dollars. –

See <https://www.whitehouse.gov/ondcp/the-national-drug-control-budget-fy-2013-funding-highlights>

And what is there really to show for it?

What benefits could we see should we change it?

Evidence has showed the decrease of overdosing in countries such as Portugal. There would be a greater understanding and acceptance of those who take part in recreational drugs occasionally, who indulge in an occasional joint, without fearing that if they are caught, they may ruin their record, for something that is for personal usage and consented. The money saved from the courts fees and processing system could go to something highly important such as **homelessness or student accommodation.**

Addiction is a mental illness, not a drug related illness. **Please**

note: <https://www.youtube.com/watch?v=C9HMifCoSko>

What changes (if any) could you suggest that would make it better?

- Stop prosecuting those who chose to take recreational drugs, the drug user must want to stop themselves, like alcoholism, educate them and save money and time for everyone's sake.
- Implement an education mandate to secondary schools and universities about safe drug use.
- Provide funding for Student Unions and Schools to facilitate this.
- Talk openly about drug use, drugs will never go away.

Other relevant documentaries to take on board:

What's in my baggie? - <https://www.youtube.com/watch?v=dYzmZ1IU4zY>

Marijuana in America - Colorado Pot Rush - CNBC Documentary -

<https://www.youtube.com/watch?v=3m--ymG5FPI>

Local Drug and Alcohol Task Force Coordinators Network

Submission to the Oireachtas Committee on Justice, Defence and Equality on the Decriminalisation of Drugs

August 2015

Members of the Local Drug and Alcohol task Force Coordinators Network welcome the fact that the Oireachtas committee are seeking submissions in relation to the issue of the decriminalisation of drugs.

Members recognise that there is a need for a serious national debate in relation to the current approach to drug use at national policy level in the Irish context where it is primarily treated as a criminal justice issue rather than a public health issue.

However one of the main concerns expressed by individuals and organisations across all sectors including the Coordinators Network is the criminalising of people with addictions. They have consistently highlighted the fact that this approach does not act as a deterrent, rather it causes significant harm to individuals' future prospect given that under Irish Law the person carries a conviction for their whole life and the requirement to disclose previous convictions never lapses. However members also recognise and have serious concerns about the intimidation and violence that is impacting on people's lives as a result of the illegal drugs trade.

While acknowledging that these are complex issues members of the Coordinators Network agree that a change in national drugs policy is required and they would broadly support the decriminalisation of drugs. However they also would like to highlight the fact that what may be effective in other jurisdictions may not necessarily be appropriate to the Irish context. In addition any change in national policy will be ineffective without a commitment from government to provide adequate resources to ensure that those most affected have access to appropriate services.

Members of the Network recommend as a first step that the Spent Convictions Bill (2012) be extended to include drug related offences, including simple possession and sale and supply offences under €13,000 after a reasonable period (say 5 years) without new convictions.

However taking into consideration these issues the members of the CDATF Network recommend that any change in national policy must be based on a wider debate within a framework of Human Rights, Criminal Justice and Public Health which is informed by

evidence from the Irish context and from other jurisdictions in terms of the impact of any changes may have and the outcomes for individuals, families and communities most affected. They are also recommending that Local Drugs and Alcohol Task Forces be given a lead role at local and national level in facilitating further debate, discussions and consultations

Sandra Mullen

On behalf of the LDATF Coordinators Network

C/o Clondalkin Local Drugs and Alcohol Task force,

Unit 1 Weatherwell Business Park,

Clondalkin, Dublin 22

Email coordinator@cdatf.ie

Tel 086 0401375

Dear Committee

I am pleased to have the opportunity to submit my personal considerations on the review of Ireland's approach to the possession of limited quantities of certain drugs. For a number of years I have been perplexed as to the basis of these laws and the purported aims these laws were intended for. To say the war on drugs has been a failure is an understatement, it has deepened the divide between members of society since they were brought in. It has built up a long term level of distrust for the Garda Síochána amongst the lowest levels of society where the need for them is most important. The lowest level of the criminal syndicates, the users, are targeted and harassed while the higher levels profit from the suffering of others. The stigmatisation of drug users also has a disenfranchising effect which further deepens the divide between communities and health and policing officials. I hope that this Committee can push ahead and instead of decriminalising the possession of drugs, you actually set in motion the road map for the legalisation and sensible approach for drug use in Ireland. Ireland has already shown leadership in the smoking ban, same-sex marriage and other important initiatives. This is the opportunity for Ireland to show the world that the war on drugs has been a failed experiment and care and inclusion of all members of society is paramount to the state. The same-sex marriage debate showed how inclusive and caring Ireland as a society and country can be. We now need to show that we care about another group of people, those who use drugs and do not want to be penalised for having a preference for different habits and also for those who have self-control problems with drugs and do not want to be stigmatised for their personal troubles.

I believe that this issue is as important as the same-sex marriage issue and I believe most members of Irish society now believe in others freedom of choice in regards to their personal lives.

Let us allow that to be protected and let us take away the flow of money from criminals who try and undermine the state and the safety of communities.

Kind Regards

Colm Walsh

MY PROPOSAL

To allow possession for personal use, the substances described as psychedelics, particularly :

- 1) Magic Mushrooms, containing, Psilocybin/psilocin/muscimol
- 2) Cactii containing mescaline/peyote
- 3) Plants containing Dimethyltryptamine (DMT)
- 4) Possibly Cannabis should be made legal, for possession of no more than say one plant.

REASONS FOR CHANGING THE LAW FOR POSSESSION OF THESE SUBSTANCES

1) FINANCIAL BENEFITS

The amount of time freed for the various agencies of the state no longer required to pursue non-criminal but responsible citizens. This would include :

- i. Savings of Garda time collecting evidence and attendance at court.
- ii. Saving of time by employees of the courts service.
- iii. Savings to the prison service by avoiding unnecessary incarceration of citizens in jail

2) ECONOMICALLY WEAKEN CRIMINAL GROUPS

I would like to distinguish between drugs used on a very small scale by individual citizens, versus drugs supplied for sale by criminal groups.

My suggestion is that these plants or entheogens, should be made legal for possession in small quantities meant for personal use, but continued to be illegal for supply. This would help thwart criminal endeavours. If individuals could grow these plants, it would reduce the demand for these plants from criminal groups, thus weakening them economically.

3) HEALTH BENEFITS

- i. There has been some research from the John Hopkins Institute, into the use of psilocybin mushrooms to treat alcoholism and tobacco addiction.

http://www.hopkinsmedicine.org/news/media/releases/single_dose_of_hallucinogen_may_create_lasting_personality_change

- ii. Some promising research into the use of psilocybin to reduce cluster headaches & migraines
<https://www.wikimedia.com/wiki/magic-mushrooms-almost-illegal-in-the-netherlands/>
- iii. There was also an anecdotal report by Dr Paul Stamets of a man who had age related partial deafness, who had his hearing improved by psilocybin. More studies need to be carried out

4) SCIENTIFIC & RESEARCH BENEFITS

If these substances were reclassified, research institutes could carry out further research into the potential benefits of these substances. This could attract international funding to third level institutions.

5) SPIRITUAL BENEFITS TO THE INDIVIDUAL

The word “Entheogen”, comes from “Entheo” (God within), “Gen” (generating) ie these plants generate God within.

The profound positive mental & spiritual experiences that can happen to individuals who use these substances in the correct manner, with correct dose etc

See entry in Wikipedia on the experiences of people who have used magic mushrooms,

https://en.wikipedia.org/wiki/Psilocybin_mushroom

which quotes the John Hopkins study

“One-third of the participants reported the experience was the single most spiritually significant moment of their lives, and more than two-thirds reported it was among the top five most spiritually significant experiences. Two months after the study, 79% of the participants reported increased well-being or satisfaction”

Hopkins study

<http://www.newswise.com/articles/view/577702>

(John Hopkins continued ..) Two Practical Questions

Commenting on the findings, Jerome Jaffe, M.D., of the University of Maryland School of Medicine, who served as the first White House “Drug Czar” and has also been a consultant to the World Health Organization on drug issues, remarked, “The Hopkins psilocybin studies clearly demonstrate that this route to the mystical is not to be walked alone. But they have also demonstrated significant and lasting benefits. That raises two questions: Could psilocybin-occasioned experiences prove therapeutically useful, for example in dealing with the psychological distress experienced by some terminal patients? And should properly-informed citizens, not in distress, be allowed to receive psilocybin for its possible spiritual benefits, as we now allow them to pursue other possibly risky activities such as cosmetic surgery and mountain-climbing?”

6) FREEDOM OF EXPRESSION

The unnecessary incarceration of gentle non-violent individuals for merely possessing psychedelics. This can have severe negative effects on such people including loss of employment, financial penalties. There is also the economic cost to the state in incarcerating such people.

Freedom of expression in a 21st Century developed country.
Our minds are our own.

7) FREEDOM OF RELIGION

There are several groups worldwide who use these substances as an essential part of their religious rituals. It is in effect their Eucharist. Some of these groups are Christian and use these psychedelics as a means of experiencing the divine.

There could be difficult or embarrassing test cases for the state if such groups opened branches of their churches in Ireland. As examples of these religions see :

- i) The religion of Santo Daime who use DMT
https://en.wikipedia.org/wiki/Santo_Daime
- ii) The Native American Church and their use of Peyote in religious ceremonies
https://en.wikipedia.org/wiki/Native_American_Church

A COMPARISON BETWEEN EXISTING LEGAL DRUGS OF ALCOHOL & TOBACCO VS PHYCHEDELICS

When considering the legal designation of a plant/drug, a comparison should be made with the two most frequently used “legal” drugs of **alcohol** and **tobacco**. Such a comparison should include for example, the impact of alcohol versus mushrooms, in terms of :

- i. Violence & crime associated with use of each drug.
(Note the chart attached below, from the Lancet, showing almost to 0% of crimes being related to psilocybe mushrooms, while over 70% of violent crimes are related to alcohol).
- ii. Cost to the exchequer in terms of courts service & Garda time of crimes caused by alcohol abuse
- iii. Cost to exchequer in terms of burden on the health service, including long term alcoholism, and tobacco related lung cancer, and diabetes
Neither alcoholism nor lung cancer nor diabetes is associated with consuming mushrooms containing psilocybin, LSD or peyote.
- iv. The health implications to the individual or not
See also the HSE guide to ethnobotanicals by Sinead O’Mahony Carey.
The descriptions of the psychedelics mentioned above, shows them as less harmful, than alcohol & tobacco in nearly every category.
<http://www.drugsandalcohol.ie/13725/>
- v. Absenteeism from work as a result of consuming each substance.
- vi. Comparison of financial cost to the individual in obtaining each drug. Note that mushrooms have been proven to be non habit forming, unlike alcohol & tobacco which can often be a lifelong habit.
- vii. Positive/Negative spiritual experience. I am not aware of any positive spiritual or mental experiences as a result of consuming tobacco or alcohol, while there are very significant positive mental & spiritual experiences from consuming mushrooms (see lancet study previously quoted).

THE APPROACH TAKEN BY OTHER COUNTRIES

A **Dutch** government study in 2011 found that the use of magic mushrooms, rarely, if ever leads to psychological or physical dependence and that adverse effects are relatively minor. It also found that criminality related to the growing of these mushrooms was non-existent.

https://www.erowid.org/plants/mushrooms/mushrooms_health1.pdf

The **Czech** government decriminalised the growing of magic mushrooms and peyote cacti, as well as the growing of cannabis, in 2009. They had originally banned these plants after a kneejerk media campaign, but reversed this decision after calmly reassessing the situation.

THE USER COMMUNITY

Ayahuasca /DMT

The main substance used during the Ayahuasca ceremonies in the Amazon jungle, is Dimethyltryptamine DMT. (It is usually combined with Harmaline, which prolongs the duration of the DMT)

<http://templeofthewayoflight.org/shamanism-ayahuasca/medical-research-on-ayahuasca/>

see list of references at bottom of the above link, including the one below :

https://wiki.dmt-nexus.me/w/images/2/26/pharmacokinetics_of_hoasca_in_healthy_humans.pdf

I have a friend who took part in three Ayahuasca retreats over the past several years in “The Temple of the way of Light” in Peru. He described them as some of the most positive experiences of his life. As a result of his experience he now works fulltime in the charity sector

There is quite an unusual situation, in that the human brain contains natural DMT, so technically, everyone is guilty of possession of DMT !

https://en.wikipedia.org/wiki/N,N-Dimethyltryptamine#Endogenous_DMT

Terrence Mckenna

As a flavour of how the psychedelic community view these substances, it can be quite enlightening to listen to the Irish American philosopher/anthropologist/pharmacologist/scientist, Terrence McKenna. He was an advocate of consuming psychedelics infrequently but in high doses (to quote him take “a lot, a little”)

He talks about psilocybin mushrooms, and also DMT.

In the 1960's thousands of people experimented with LSD. In 1968 Berkeley was the nexus of this experimentation, and it spawned a vast amount of poets, scientists, philosophers, writers and musicians who were all positively influenced by such experimentation.

Example of his talk on shamanism & plant knowledge :

<http://www.matrixmasters.net/salon/2011/03/podcast-258-the-angel-in-the-monkey/>

see his talk 103 “mcpsilosa”, regarding psilocibin

<https://archive.org/details/Psychede2/iaRawArchivesOfTerrenceMckennaTalks>

STATISTICS, DAMMNED STATISTICS

It may be argued that mescaline or psilocybin could cause psychotic episodes to individuals, but this is no more true than large quantities of alcohol being consumed by an unstable or bipolar individual, causing similar disturbances.

When assessing the negative impacts of these psychedelic plants/substances and looking at the statistics of reported negative cases, the statistics must be adjusted to allow for the fact that there is likely a disproportionate use of these substances among underage & young adults, since these substances may in fact be easier to acquire compared to alcohol.

As a rule young people will have a higher incidence of overdosing on substances whether it be alcohol or drugs. Therefore the negative reports will be skewed against psychoactive substances.

The bell curve of alcohol use will be more evenly spread over the general age profile of the population, while the bell curve of psychoactive substances will be shifted to the left, towards the younger aged.

WHO..... GETS TO DECIDE WHICH PLANTS SHOULD BE PROSCRIBED ?

The spokespersons of the medical establishment are very well versed in presenting their opinions and specialist knowledge. However, medics will likely have a very narrow focus which is influenced by the fact that the vast majority of the people they meet who have used psychoactive substances, will almost certainly be those in need of medical help.

It is obvious that people who have very positive experiences of psychoactive substances, will not be going to visit their medic to tell them of the positive experience. As a consequence of this, the views of medics regarding psychedelics will be biased against such use.

In fact people who do have such positive experiences will keep a low profile due to the fact that many professions would marginalise employees who experimented with psychoactive substance even during their own downtime, even though these psychedelics are non-habit forming.

Who should have the final say in what substances individuals consume ? Should it be :

- i) the Medical profession,
- ii) the Gardaí,
- iii) the Media
- iv) The Politician
- v) the citizen who does not consume such substances
- vi) the citizen who does or who would like to consume

In my opinion groups (i), (ii), (iii), (iv) are there to serve the citizens of the land, while (v) are not talking from a position of direct experience of such substances.

Maybe widespread availability would result in casual use with consequent problems, , but at least if individual possession was allowed, it would only be people who are dedicated, and have the motivation, that would obtain these plants, but they could experiment in peace in this free country of ours. They would also only make up a very small group compared to consumers of alcohol

I would like to think in the future, we will look back at the banning of psychedelics, in the same way we now look back at the banning of James Joyce's books in the 1950's. Both were/are seen as exposing the mind/body/society, to dangerous experiences, whereas in fact, I think both widen the mind to new possibilities and wonder. One might say psychedelics are pointless, that the experience is merely imagined in your mind. That is not much different than reading Ulysses.

LIST OF REFEREFERNCES

https://www.erowid.org/psychoactives/statistics/statistics_info1.shtml

debunking gateway

https://www.erowid.org/psychoactives/statistics/statistics_info2.shtml

LSD survey

https://www.erowid.org/chemicals/lsd/lsd_survey1.shtml

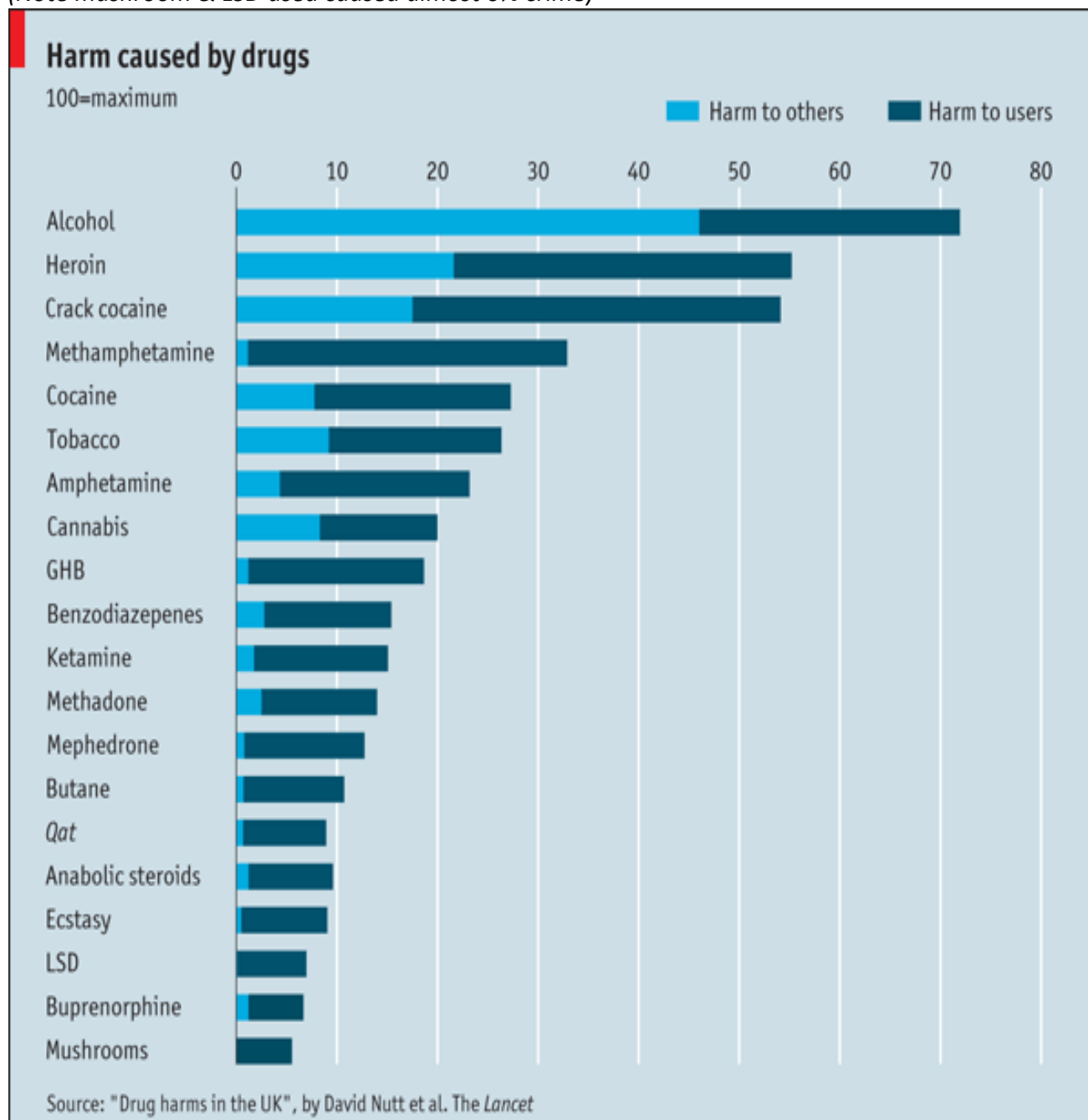
Harm caused by drugs

http://www.economist.com/blogs/dailychart/2010/11/drugs_cause_most_harm

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961462-6/abstract>

Chart from the Lancet, showing comparison of crimes caused by various drugs

(Note mushroom & LSD used caused almost 0% crime)



Wednesday 6th August 2015

Dear Committee,

My name is Stephen Harris, I am 23 years of age, currently awaiting my 1st year of college, and I am writing to you today, to voice my opinions on the current laws regarding the possession of cannabis. I thank you for the opportunity to do so. Hoping my points come across strong, clear, and brief. It is without a doubt, that the current laws regarding cannabis, cause numerous social and economic problems. The main one being, "The Black Market".

Cannabis funds a massive portion of gangland crime in Ireland (and any country for that matter).

In 2014 An Gardaí Síochána seized over 24,500,000 euro worth of cannabis herb and 12,300,000 euro of cannabis resin. This leads anyone to work out, how much is getting through the hands of the law, and profiting underground criminal organisations.

I personally smoke Cannabis, and hope that it would not lessen the value of my argument. But recent studies show how it is no more, or even less harmful than alcohol. Countries like Canada, United States of America, Holland, Argentina, Germany (Medicinal), Italy (Medicinal) Spain, Uruguay and Portugal, to which the Oireachtas Committee recently visited regarding drug policy, all show positive influence based on decriminalization/legalisation. With decriminalising the plant, it opens up the doors to rehabilitation for people genuinely in need, as opposed to a prison sentence.

"But Cannabis is the number one drug young people are in rehabilitation for, it must be destroying our children" people say... WRONG. When a young person is caught with an amount of cannabis once, maybe numerous times, the option is given, or undertaken, to enter a 12 week program to either avoid prison, or potentially lighten an upcoming sentence. If this was how we treated minors when they are stopped by Gardaí with open cans of alcohol, centres would be flooded with "young alcoholics", prohibition does nothing brush problems under the carpet.

Aside from the Black Market. I have 2 main points in support of Cannabis Legalisation in Ireland. They are Revenue and Medicinal Purposes. And I will briefly outline the benefits of each, starting with Revenue.

In the United States of America, where they have recently legalised the recreational use of Cannabis in some states. there has been an extremely

positive boost in the economy , simply due to taxation. Colorado for example, in 2014 collected \$44 million dollars in tax revenue .The numbers, reported by the Colorado Department of Revenue, show that January's school-designated Cannabis excise tax is more than 10 times the amount in January 2014(than the previous year), when the state first collected the tax on wholesale marijuana transactions. From December to January, the school tax sum jumped up about 21 percent, from about \$1.97 million to nearly \$2.35 million. In January 2014, the state collected \$195,318 in taxes allotted for school construction capital. This is all collected from an average 2.9% sales tax, which i believe the Irish government could fairly raise to 12% here.

The Medicinal Cannabis tax revenue for 2014 in :

California was between \$59 to \$109 million dollars with a sales tax of 8.4%

Washington was \$2.5 million dollars with an 8.9% tax rate.

Arizona made \$2 million dollars with a 5.6% tax rate.

Which quickly brings me onto my final point (keeping things brief). Medicinal Value.

No person with access to the internet can possibly be ignorant to the Medicinal Values of Tetra-Hydracannabinol (THC) and Cannabidiol (CBD) . For years , due to prohibition, the study of Cannabis and its values , has been limited, in fact frankly impossible.

The following is a quote from Tom Curran, the partner of MS sufferer Marie Fleming, "Rather than buying it on the street, I bought seeds on the internet and I grew it for Marie, and the results were incredible," Curran said. "You could see within two minutes of her taking it, her limbs stopped shaking. You could see the anxiousness in her was gone because the pain was dissipating."

This in an excerpt from an interview Tom had with the Irish Times on the 5th of April 2015. The article goes on to outline the complications that come along with the criminalisation of Cannabis, and its related , proven , effective medicine "Sativex". Sativex, an oral spray that contains extracts from the leaf and flower of the cannabis plant, is credited with easing MS symptoms and was cleared for use last year. But the drug, which would cost patients up to €500 a month, still cannot be bought or sold in Ireland because the Department of Health and the drug's Irish distributor have not yet agreed on a price. The National Centre for Pharmacoeconomics has estimated that the cost to the State would be between €4,500 and €5,000 for every MS patient.

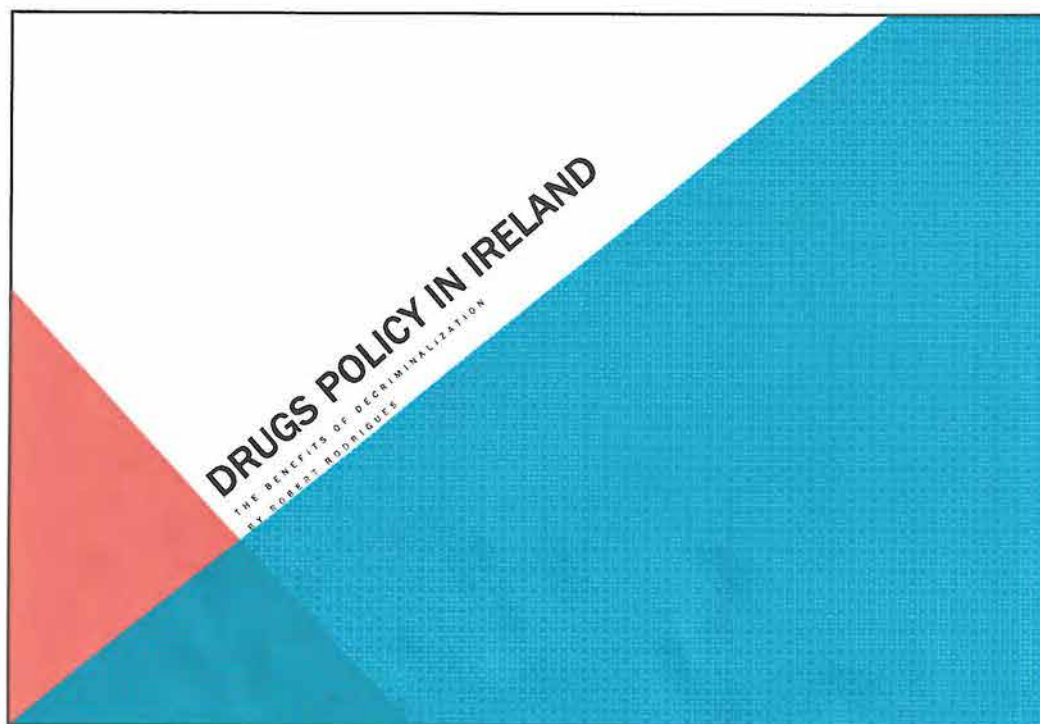
This cost could easily be slashed by a phenomenal amount, if the deficit cost of medicinal derivatives , was filled by the taxation of recreational Cannabis use, in tandem with strict laws regarding age, purchase limit, public consumption, driven under the influence. The exact laws that come into place with alcohol.

There are multiple ways in which i feel the government could benefit from updating the current laws surrounding Cannabis. The proof is in the countries around us. I ask of the committee to please, take on board what my fellow anti-prohibition citizens have to say. Look at the evidence. We did so ,only recently with gay marriage. Lets move forward with the world. We can't go on imprisoning people for what is , at the end of the day , a plant. A 100% natural , medicinal plant.

I would like to thank you again for this opportunity , and hope that it can play a role in the advancement of this country.

Yours Thankfully

Stephen Harris



DECRIMINALISATION

What is it ?

- If someone is caught with x amount of drugs for personal use they won't be given a criminal conviction.
- Instead they're given a warning, fine or sanctioned to go and receive help.

What its not?

- It is not Legalisation
- The sale or importing of drugs will still be illegal.
- Individuals caught breaching these laws along with theft, assault, intimidation in relation to drugs will still be prosecuted under the criminal justice system.

DECRIMINALISATION CONT..

Does Decriminalization increase drug use?

- No evidence supports this notion.
- Some countries, just like Portugal (Decriminalised 2001), have had a reduction in the use of drugs.

Would Ireland be the first to decriminalise?

- No! Many countries have decriminalised drugs.
- In the last 10 years more than 25 countries have decriminalised drugs.
- To name a few Australia, Portugal and Belgium.

CURRENT POLICY

Our Current System?

- Our current system is to process 'personal use' cases in the justice system.
- As a result individuals are given a conviction which lasts a lifetime.
- This can impede someone from being able to get a
 1. Visa
 2. Job
 3. Insurance
 4. Training
- It limits an individual's possible chances in life which results in them becoming dependant on the state
- The individual will be more likely to turn to crime as a way of sustaining their lives due to the impending conviction.

THE BENEFITS OF DECRIMINALISATION

Reduce criminal justice costs dramatically.

- In 2012 72% of drug convictions were for personal use (Central Statistics Office, Ireland)
- The taxpayer pays roughly €65,000 to imprison one person for a year (Irish Penal Reform Trust)

Help instead of Imprisonment.

- Individuals would be treated on the health care system instead of the penal system.
- Proper education on drug use and safety will be made available.
- The stigma of "criminal" will be removed and as a result more people will come forward for help.
- Portugal has seen a huge increase in drug dependant people availing of treatment. (Hughes CE, Stevens, British Journal of Criminology 2010.50.1014.)
- Also Portugal has seen significant reductions in TB and HIV. (Hughes CE, Stevens, British Journal of Criminology 2010.50.1014.)

PORTUGAL AND ITS PAST

Its Dark Past

- Prior to decriminalization Portugal had one of the worst rates of heroin use in Europe
- Along with this their drug related death rates were amongst the worst also.

Brighter Future

- Drug related deaths have decreased significantly.
- Reduction in young people becoming dependant on opiates
- Decrease in HIV and other viruses associated with drug use.
- Reduction in drug related crimes.

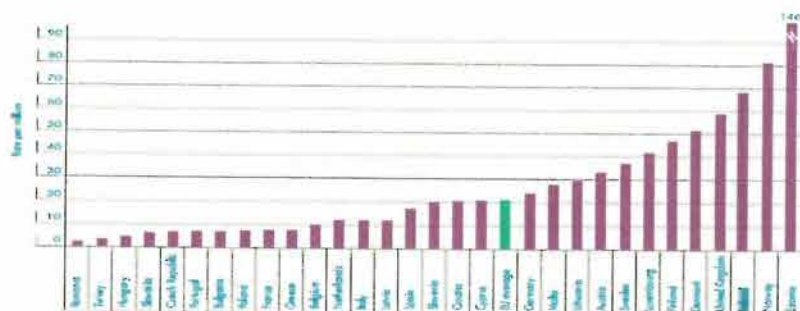
OUR IRELAND

The Broken System

- We currently have one of the highest drug related death rates in the EU.
- The prevalence of drug use in Ireland ranks within the highest across various drugs.
- While, in 2006, ranking above all other countries with heroin use. (EMCDDA, "The State of Drug Problem in Europe")
- Our citizens who are addicted to drugs are stigmatised and segregated instead of helped.
- Our streets (Dublin, Limerick, Cork etc..) are full of people high on drugs day and night.

PROOF

This figure displays the drug related deaths across various countries. It's a clear indication that our current policy isn't working while the Portuguese model is.



POSSIBLE NEW POLICY



ATTORNEY GLENN GREENWALD

"Judging by every metric, drug decriminalization in Portugal has been a resounding success. It has enabled the Portuguese government to manage and control the drug problem far better than virtually every other Western country."

CONCLUSION

Our system clearly isn't working. We have, as a Nation, the power to change it. We have a duty to our people to change it. Our current policy is designed to stigmatise and segregate rather than help those who need it most. We ostracise our citizens and place them within the Justice System.

A Justice System which seems to have forgot its duty. Need I remind you the fundamental duty of criminal law is to keep order in society and protect the citizens from harm inflicted by others. The use of any substance whether it be an apple, cannabis or heroin does not break the fundamental reason criminal law is in place.

So why are we been convicted as such. ITS TIME FOR CHANGE!

REPORT

The government has requested that members of the public put forward a submission regarding current and hopeful drug policies .

I've attached a template here

<https://dl.dropboxusercontent.com/u/36261763/Drug%20Policy.docx>

Just simply fill this template out make any changes you'd like and email it to drugsreview@oireachtas.ie by 3PM August 7th.

MORE READING

<http://enlightenme.com/criminal-laws/>

<http://core.ac.uk/download/pdf/91904.pdf>

http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2013/2013_citywide_decriminalisation_leaflet.pdf

<http://www.emcdda.europa.eu/publications/annual-report/2011>

THANK YOU FOR YOUR TIME

Dear Mr Aodhán Ó Ríordáin

This is my written submission for the Drugs Strategy.

I would like to see cannabis legalised for all adults to grow for personal use, with the idea of using an ID pass could be possible to protect minors. My reason would be that most cannabis users I know and have met throughout the years have been hard working people who are not lazy and of those who have had great results for their own medical issues. I really cannot understand why cannabis has been kept illegal for so long in this country when cannabis related deaths are actually 0. except for that synthetic chemical cannabis called (spice) has been known to cause serious problems for some users who cannot buy the real organic cannabis and get into danger under our laws. We must not forget that Alcohol is really the number 1 gateway drug... (ask most people) ! 47,000 people are admitted to hospital each year for 'mental and behavioural problems relating to alcohol.. If someone can go out and choose their own choice of wine/ beer / cider / cocktails or whatever it is only fair a cannabis user can also have the freedom and equality of choice. To safely sample or grow their own strains. We must Legalise, tax and regulate cannabis as it could earn the Irish economy up to 50 million in tax revenue pa and further reduce all harms associated with cannabis most of which are caused by prohibition rather than cannabis itself. How is this sum right ? Colorado has the same population as Ireland and I imagine there would be way many more cannabis users here in Ireland. Colorado Department of Revenue data, showed \$36.4 million of recreational marijuana was sold in 2014. I am in favour of decriminalising cannabis as It is after all, it's a victimless crime In that the only victim is me, the adult who occasionally likes to dabble in the odd novelty !

Yours Faithfully

Chris Murray

Submission to the Joint Committee of Justice, Defence and Equality

Re: Possession of Drugs

6th August 2015

1. Introduction

The Salvation Army is a worldwide Christian church and registered charity. Our work in the Republic of Ireland is part of the wider international Salvation Army that currently works in 126 countries offering unconditional friendship, providing practical help to people of all ages and advocating on behalf of those most in need in society.

In Ireland, the Salvation Army currently operates two churches, and four centres in the Dublin area.

On December 23rd 2015, the Salvation Army with the support of the Óglaigh na hEireann and the Dublin Simon Community opened a 25 bed one night only (ONO) service at St. Bricins Military Barracks.

Subsequently, a Peer Advisory Group was established at St. Bricins to provide feedback and make suggestions with regard to harm reduction practices used within the centre and to encourage greater ownership of client outcomes.

The author offers this submission on behalf of these clients in order that the views and the opinions of a much under-represented cohort may reach the committee. It also provides an opportunity for our service users to better understand the workings of the Oireachtas and gain insight into how decisions affecting themselves are made.

The views expressed herein do not necessary reflect the official position of the Salvation Army UK and Republic of Ireland or their partners.

2. Context

In order to contextualise some of the conversations currently being had, it is worth noting that although the earliest attempts to influence drug behaviour were an attempt to control the supply side of the equation, as early as 1961 there was already a move toward protecting the health of drug users themselves.

Article 38 of the 1961 United Nations Single Convention on Narcotic Drugs requested that special attention be paid to the care and rehabilitation of drug addicts. And while article 36 (1) requested that drug possession and distribution be considered an offence with suitable punishment up to and including imprisonment, article 36.1(b) inserted in 1972 to the 1961 convention stated that where such offences have been committed, 'Parties may provide... either as an alternative to conviction or punishment or in addition... that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration...'.

The idea of alternatives to criminal convictions then, are not new.

This submission advocates the decriminalisation of offences where the amount of controlled drugs carried comes under a threshold suggested for personal use.

A move from criminal punishment toward civil sanctions and education will remove a significant barrier to moving on from drug misuse. It is in the group's view that stigmatisation is a significant barrier to progressing outcomes for men and women currently experiencing homelessness and who are habitual drug users. The additional stigma of a criminal record for possession - which often is attributable to their homelessness - is an unnecessary impediment to future growth potential.

To this end, we wish to see a 'societal debt forgiveness' for individuals currently accessing homeless services who are facing charges of possession under the threshold limits adopted by the Portuguese model.

3. Stigma

Stigmatisation is an experience that anyone familiar with homelessness is all too familiar with. It is also an experience that many who have had even the briefest of contact with the criminal justice system have had to endure.

It is characterised by a reluctance on the part of an individual or an organisation to engage with an individual who fails to comply with certain social norms. The stigma may be economic in nature (resulting in lower wages) or social (difficulty in finding a spouse or employment) (Rasmusen, 1996 p50).

The economic effects of stigmatisation are difficult to accurately define given the inherent complexity however, we can state freely that a criminal record presents a major barrier to employment.

Net of other contributory factors such as broken families, poor education and geography, there is evidence that contact with the criminal justice system - however brief - negatively impacts on future opportunities for employment or future earnings potential (Freeman 1987, Western 2002). A situation that is compounded by the fact that both of these outcomes in turn predict a greater likelihood of recidivism (Shover 1996, Uggen 2000).

In 2012, over 70% of all recorded drug offences were for Possession of drugs for personal use.

We are advocating that among the alternatives to punishment being considered by the committee, that due consideration is given to the educational aspect of recovery and its value as a harm reduction principle.

More precisely, we advocate for something akin to the National Speed Awareness Scheme that operates in the UK for those found guilty of speeding as an alternative to criminal

charges. The course would be facilitated by a primary health care clinic where maintenance and alternative treatment options would also be available and would be offered as an alternative to financial penalties or custodial sentences. The session would aim to provide a fuller understanding of the consequences of drug use and change participant's attitudes to such risky behaviour.

Persons caught within the threshold quantities of certain drugs would be compelled to attend an information session that would cover safe injecting practices and drug awareness. Responsibility for this would fall on the Department of Health in order to reduce stigma.

One of the findings of the committee delegations visit to Portugal was the need for greater education, although their focus was on teenagers and school interventions. Our concern here is that this excludes many injecting drug users (IDU's) currently engaging in particularly risky behaviour around injecting for whom, greater education might prevent far greater harm.

One of the findings of our Peer Advisory Group is that there is a startling lack of information and education between IDU's in Dublin city. It is the group's opinion that this general lack of knowledge is replicated throughout the country and is a direct result of the stigmatisation that people addicted to illicit drugs encounter.

Removing criminal penalties and replacing them with civil sanctions and education would go some way to addressing this problem.

4. Recommendations

- A concerted effort to establish cross party support must begin now in order that a debate, which by its nature, is often polarised does not become used as a political football. It is essential that consensus be established among relevant stakeholders.
- While there exists a number of alternatives to punishment available across Europe, the evaluation of programmes is harder to quantify due to inadequate record keeping and data collection. The Irish response should bear this in mind in order to quantify effectiveness down the line and ensure value for money.
- For those caught within the threshold limits of personal possession and who are accessing homeless services, a caution and referral to a National Harm Reduction and Drug Awareness Scheme.
- An amnesty for all those currently homeless and accessing homeless services and registered on the Pass System for the past three months on all drugs possession charges or personal possession under the threshold limits set by the Department.
- A conscious decision be taken to frame the debate in a manner that promotes health over criminality, (as a response to a public health crisis rather than Nixon's 'War on Drugs')
- A realisation that a workable drugs policy must incorporate an introspective social diagnosis rather than relying on externalised individual diagnoses.

References:

United Nations (1961), Single convention on narcotic drugs (https://www.unodc.org/pdf/convention_1961_en.pdf).

United Nations (1971), Convention on psychotropic substances (https://www.unodc.org/pdf/convention_1971_en.pdf).

Freeman, Richard B. 1987. "The Relation of Criminal Activity to Black Youth Employment." *Review of Black Political Economy* 16 (1–2): 99–107.

Rasmusen, Eric. 1996. Stigma and Self-Fulfilling Expectations of Criminality. *Journal of Law and Economics* 29:519–43.

Shover, Neil. 1996. *Great Pretenders: Pursuits and Careers of Persistent Thieves*. Boulder, Colo.: Westview.

Uggen, Christopher. 2000. "Work as a Turning Point in the Life Course of Criminals: A Duration Model of Age, Employment, and Recidivism." *American Sociological Review* 65 (4): 529–46.

Western, Bruce. 2002. "The Impact of Incarceration on Wage Mobility and Inequality." *American Sociological Review* 67 (4): 526–46.

To Whom It May Concern,

Colorado's implementation of marijuana sales regulation is a case study in successful drug policy reform:

- * Teenage marijuana use continuing to decline.
- * Drug related crime decreased.
- * Traffic death unchanged.
- * \$76 million state revenues from tax and industry fees.
- * Justice system cost saving approximately \$60 million.
- * Increase available police personnel resources.
- * Reduction in societal and economic costs incarceration.
- * 10,000 new jobs.

Initially skeptical, labeling the move "reckless", Governor Hickenlooper, now a supporter, said: "To date, evidence shows that our regulatory system is beginning to work." Moreover, Governor Hickenlooper acknowledged his grave concerns proved unfounded: "It seems like the people that were smoking before are mainly the people that are smoking now. What that means is that we're not going to have more drugged driving, or driving while high. We're not going to have some of those problems."

Significantly, a governmental marijuana industry task-force was established. Link to the comprehensive annual report: https://www.colorado.gov/pacific/sites/default/files/2014%20MED%20Annual%20Report_1.pdf).

The entirety of legislation establishing regulatory control of recreational marijuana sales follows:

Article XVIII, Section 16: Personal Use and Regulation of Marijuana, Colorado Constitution

(1) PURPOSE AND FINDINGS.

(a) In the interest of the efficient use of law enforcement resources, enhancing revenue for public purposes, and individual freedom, the people of the state of Colorado find and declare that the use of marijuana should be legal for persons twenty-one years of age or older and taxed in a manner similar to alcohol.

(b) In the interest of the health and public safety of our citizenry, the people of the state of Colorado further find and declare that marijuana should be regulated in a manner similar to alcohol so that:

(I) Individuals will have to show proof of age before purchasing marijuana;

(II) Selling, distributing, or transferring marijuana to minors and other individuals under the age of twenty-one shall remain illegal;

(III) Driving under the influence of marijuana shall remain illegal;

(IV) Legitimate, taxpaying business people, and not criminal actors, will conduct sales of marijuana; and

(V) Marijuana sold in this state will be labeled and subject to additional regulations to ensure that consumers are informed and protected.

(c) In the interest of enacting rational policies for the treatment of all variations of the cannabis plant, the people of Colorado further find and declare that industrial hemp should be regulated separately from strains of cannabis with higher delta-9 tetrahydrocannabinol (THC) concentrations.

(d) The people of the state of Colorado further find and declare that it is necessary to ensure consistency and fairness in the application of this section throughout the state and that, therefore, the matters addressed by this section are, except as specified herein, matters of statewide concern.

(2) DEFINITIONS. As used in this section, unless the context otherwise requires, (a) "Colorado Medical Marijuana Code" means article 43.3 of title 12, Colorado Revised Statutes.

(b) "Consumer" means a person twenty-one years of age or older who purchases marijuana or marijuana products for personal use by persons twenty-one years of age or older, but not for resale to others.

(c) "Department" means the department of revenue or its successor agency.

(d) "Industrial hemp" means the plant of the genus cannabis and any part of such plant, whether growing or not, with a delta-9 tetrahydrocannabinol concentration that does not exceed three-tenths percent on a dry weight basis.

(e) "Locality" means a county, municipality, or city and county.

(f) "Marijuana" or "marihuana" means all parts of the plant of the genus cannabis whether growing or not, the seeds thereof, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or its resin, including marihuana concentrate. "Marijuana" or "marihuana" does not include industrial hemp, nor does it include fiber produced from the stalks, oil, or cake made from the seeds of the plant, sterilized seed of the plant which is incapable of germination, or the weight of any other ingredient combined with marijuana to prepare topical or oral administrations, food, drink, or other product.

(g) "Marijuana accessories" means any equipment, products, or materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, composting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, vaporizing, or containing marijuana, or for ingesting, inhaling, or otherwise introducing marijuana into the human body.

(h) "Marijuana cultivation facility" means an entity licensed to cultivate, prepare, and package marijuana and sell marijuana to retail marijuana stores, to marijuana product manufacturing facilities, and to other marijuana cultivation facilities, but not to consumers.

(i) "Marijuana establishment" means a marijuana cultivation facility, a marijuana testing facility, a marijuana product manufacturing facility, or a retail marijuana store.

(j) "Marijuana product manufacturing facility" means an entity licensed to purchase marijuana; manufacture, prepare, and package marijuana products; and sell marijuana and marijuana products to other marijuana product manufacturing facilities and to retail marijuana stores, but not to consumers.

(k) "Marijuana products" means concentrated marijuana products and marijuana products that are comprised of marijuana and other ingredients and

are intended for use or consumption, such as, but not limited to, edible products, ointments, and tinctures.

(l) "Marijuana testing facility" means an entity licensed to analyze and certify the safety and potency of marijuana.

(m) "Medical marijuana center" means an entity licensed by a state agency to sell marijuana and marijuana products pursuant to section 14 of this article and the Colorado Medical Marijuana Code.

(n) "Retail marijuana store" means an entity licensed to purchase marijuana from marijuana cultivation facilities and marijuana and marijuana products from marijuana product manufacturing facilities and to sell marijuana and marijuana products to consumers.

(o) "Unreasonably impracticable" means that the measures necessary to comply with the regulations require such a high investment of risk, money, time, or any other resource or asset that the operation of a marijuana establishment is not worthy of being carried out in practice by a reasonably prudent businessperson.

(3) PERSONAL USE OF MARIJUANA. Notwithstanding any other provision of law, the following acts are not unlawful and shall not be an offense under Colorado law or the law of any locality within Colorado or be a basis for seizure or forfeiture of assets under Colorado law for persons twenty-one years of age or older:

(a) Possessing, using, displaying, purchasing, or transporting marijuana accessories or one ounce or less of marijuana.

(b) Possessing, growing, processing, or transporting no more than six marijuana plants, with three or fewer being mature, flowering plants, and possession of the marijuana produced by the plants on the premises where the plants were grown, provided that the growing takes place in an enclosed, locked space, is not conducted openly or publicly, and is not made available for sale.

(c) Transfer of one ounce or less of marijuana without remuneration to a person who is twenty one years of age or older.

(d) Consumption of marijuana provided that nothing in this section shall permit consumption that is conducted openly and publicly or in a manner that endangers others.

(e) Assisting another person who is twenty-one years of age or older in any of the acts described in paragraphs (a) through (d) of this subsection.

(4) **LAWFUL OPERATION OF MARIJUANA-RELATED FACILITIES.** Notwithstanding any other provision of law, the following acts are not unlawful and shall not be an offense under Colorado law or be a basis for seizure or forfeiture of assets under Colorado law for persons twenty-one years of age or older:

(a) Manufacture, possession, or purchase of marijuana accessories or the sale of marijuana accessories to a person who is twenty-one years of age or older.

(b) Possessing, displaying, or transporting marijuana or marijuana products; purchase of marijuana from a marijuana cultivation facility; purchase of marijuana or marijuana products from a marijuana product manufacturing facility; or sale of marijuana or marijuana products to consumers, if the person conducting the activities described in this paragraph has obtained a current, valid license to operate a retail marijuana store or is acting in his or her capacity as an owner, employee or agent of a licensed retail marijuana store.

(c) Cultivating, harvesting, processing, packaging, transporting, displaying, or possessing marijuana; delivery or transfer of marijuana to a marijuana testing facility; selling marijuana to a marijuana cultivation facility, a marijuana product manufacturing facility, or a retail marijuana store; or the purchase of marijuana from a marijuana cultivation facility, if the person conducting the activities described in this paragraph has obtained a current, valid license to operate a marijuana cultivation facility or is acting in his or her capacity as an owner, employee, or agent of a licensed marijuana cultivation facility.

(d) Packaging, processing, transporting, manufacturing, displaying, or possessing marijuana or marijuana products; delivery or transfer of marijuana or marijuana products to a marijuana testing facility; selling marijuana or marijuana products to a retail marijuana store or a marijuana product manufacturing facility; the purchase of marijuana from a marijuana cultivation facility; or the purchase of marijuana or marijuana products from a marijuana product manufacturing facility, if the person conducting the activities described in this paragraph has obtained a current, valid license to operate a marijuana product manufacturing

facility or is acting in his or her capacity as an owner, employee, or agent of a licensed marijuana product manufacturing facility.

(e) Possessing, cultivating, processing, repackaging, storing, transporting, displaying, transferring or delivering marijuana or marijuana products if the person has obtained a current, valid license to operate a marijuana testing facility or is acting in his or her capacity as an owner, employee, or agent of a licensed marijuana testing facility.

(f) Leasing or otherwise allowing the use of property owned, occupied or controlled by any person, corporation or other entity for any of the activities conducted lawfully in accordance with paragraphs (a) through (e) of this subsection.

(5) REGULATION OF MARIJUANA.

(a) Not later than July 1, 2013, the department shall adopt regulations necessary for implementation of this section. Such regulations shall not prohibit the operation of marijuana establishments, either expressly or through regulations that make their operation unreasonably impracticable. Such regulations shall include:

(I) Procedures for the issuance, renewal, suspension, and revocation of a license to operate a marijuana establishment, with such procedures subject to all requirements of article 4 of title 24 of the Colorado Administrative Procedure Act or any successor provision;

(II) A schedule of application, licensing and renewal fees, provided, application fees shall not exceed five thousand dollars, with this upper limit adjusted annually for inflation, unless the department determines a greater fee is necessary to carry out its responsibilities under this section, and provided further, an entity that is licensed under the Colorado Medical Marijuana Code to cultivate or sell marijuana or to manufacture marijuana products at the time this section takes effect and that chooses to apply for a separate marijuana establishment license shall not be required to pay an application fee greater than five hundred dollars to apply for a license to operate a marijuana establishment in accordance with the provisions of this section;

(III) Qualifications for licensure that are directly and demonstrably related to the operation of a marijuana establishment;

(IV) Security requirements for marijuana establishments;

(V) Requirements to prevent the sale or diversion of marijuana and marijuana products to persons under the age of twenty-one;

(VI) Labeling requirements for marijuana and marijuana products sold or distributed by a marijuana establishment;

(VII) Health and safety regulations and standards for the manufacture of marijuana products and the cultivation of marijuana;

(VIII) Restrictions on the advertising and display of marijuana and marijuana products; and (IX) Civil penalties for the failure to comply with regulations made pursuant to this section.

(b) In order to ensure the most secure, reliable, and accountable system for the production and distribution of marijuana and marijuana products in accordance with this subsection, in any competitive application process the department shall have as a primary consideration whether an applicant:

(I) Has prior experience producing or distributing marijuana or marijuana products pursuant to section 14 of this article and the Colorado Medical Marijuana Code in the locality in which the applicant seeks to operate a marijuana establishment; and

(II) Has, during the experience described in subparagraph (I), complied consistently with section 14 of this article, the provisions of the Colorado Medical Marijuana Code and conforming regulations.

(c) In order to ensure that individual privacy is protected, notwithstanding paragraph (a), the department shall not require a consumer to provide a retail marijuana store with personal information other than government-issued identification to determine the consumer's age, and a retail marijuana store shall not be required to acquire and record personal information about consumers other than information typically acquired in a financial transaction conducted at a retail liquor store.

(d) The general assembly shall enact an excise tax to be levied upon marijuana sold or otherwise transferred by a marijuana cultivation facility to a marijuana product manufacturing facility or to a retail marijuana store at a rate not to exceed fifteen percent prior to January 1, 2017 and at a rate to be determined by the general assembly thereafter, and shall direct the department to establish procedures for the collection of all taxes levied. Provided, the first forty million dollars in revenue raised annually from any such excise tax shall be credited to the Public School Capital Construction Assistance Fund created by article 43.7 of title 22, C.R.S., or any successor fund dedicated to a similar purpose. Provided further, no such excise tax shall be levied upon marijuana

intended for sale at medical marijuana centers pursuant to section 14 of this article and the Colorado Medical Marijuana Code.

(e) Not later than October 1, 2013, each locality shall enact an ordinance or regulation specifying the entity within the locality that is responsible for processing applications submitted for a license to operate a marijuana establishment within the boundaries of the locality and for the issuance of such licenses should the issuance by the locality become necessary because of a failure by the department to adopt regulations pursuant to paragraph (a) or because of a failure by the department to process and issue licenses as required by paragraph (g).

(f) A locality may enact ordinances or regulations, not in conflict with this section or with regulations or legislation enacted pursuant to this section, governing the time, place, manner and number of marijuana establishment operations; establishing procedures for the issuance, suspension, and revocation of a license issued by the locality in accordance with paragraph (h) or (i), such procedures to be subject to all requirements of article 4 of title 24 of the Colorado Administrative Procedure Act or any successor provision; establishing a schedule of annual operating, licensing, and application fees for marijuana establishments, provided, the application fee shall only be due if an application is submitted to a locality in accordance with paragraph (i) and a licensing fee shall only be due if a license is issued by a locality in accordance with paragraph (h) or (i); and establishing civil penalties for violation of an ordinance or regulation governing the time, place, and manner of a marijuana establishment that may operate in such locality. A locality may prohibit the operation of marijuana cultivation facilities, marijuana product manufacturing facilities, marijuana testing facilities, or retail marijuana stores through the enactment of an ordinance or through an initiated or referred measure; provided, any initiated or referred measure to prohibit the operation of marijuana cultivation facilities, marijuana product manufacturing facilities, marijuana testing facilities, or retail marijuana stores must appear on a general election ballot during an even numbered year.

(g) Each application for an annual license to operate a marijuana establishment shall be submitted to the department. The department shall:

(I) Begin accepting and processing applications on October 1, 2013;

(II) Immediately forward a copy of each application and half of the license application fee to the locality in which the applicant desires to operate the marijuana establishment

(III) Issue an annual license to the applicant between forty-five and ninety days after receipt of an application unless the department finds the applicant is not in compliance with regulations enacted pursuant to paragraph (a) or the department is notified by the relevant locality that the applicant is not in compliance with ordinances and regulations made pursuant to paragraph (f) and in effect at the time of application, provided, where a locality has enacted a numerical limit on the number of marijuana establishments and a greater number of applicants seek licenses, the department shall solicit and consider input from the locality as to the locality's preference or preferences for licensure; and

(IV) Upon denial of an application, notify the applicant in writing of the specific reason for its denial.

(h) If the department does not issue a license to an applicant within ninety days of receipt of the application filed in accordance with paragraph (g) and does not notify the applicant of the specific reason for its denial, in writing and within such time period, or if the department has adopted regulations pursuant to paragraph (a) and has accepted applications pursuant to paragraph (g) but has not issued any licenses by January 1, 2014, the applicant may resubmit its application directly to the locality, pursuant to paragraph (e), and the locality may issue an annual license to the applicant. A locality issuing a license to an applicant shall do so within ninety days of receipt of the resubmitted application unless the locality finds and notifies the applicant that the applicant is not in compliance with ordinances and regulations made pursuant to paragraph (f) in effect at the time the application is resubmitted and the locality shall notify the department if an annual license has been issued to the applicant. If an application is submitted to a locality under this paragraph, the department shall forward to the locality the application fee paid by the applicant to the department upon request by the locality. A license issued by a locality in accordance with this paragraph shall have the same force and effect as a license issued by the department in accordance with paragraph (g) and the holder of such license shall not be subject to regulation or enforcement by the department during the term of that license. A subsequent or renewed license may be issued under this paragraph on an annual basis only upon resubmission to the locality of a new application submitted to the department pursuant to paragraph (g). Nothing in this paragraph shall limit such relief as may be available to an aggrieved party under [section 24-4-104, C.R.S.](#), of the Colorado Administrative Procedure Act or any successor provision.

(i) If the department does not adopt regulations required by paragraph (a), an applicant may submit an application directly to a locality after October 1, 2013 and the locality may issue an annual license to the applicant. A locality issuing a license to an applicant shall do so within ninety days of receipt of the application unless it finds and notifies the applicant that the applicant is not in compliance with ordinances and regulations made pursuant to paragraph (f) in effect at the time of application and shall notify the department if an annual license has been issued to the applicant. A license issued by a locality in accordance with this paragraph shall have the same force and effect as a license issued by the department in accordance with paragraph (g) and the holder of such license shall not be subject to regulation or enforcement by the department during the term of that license. A subsequent or renewed license may be issued under this paragraph on an annual basis if the department has not adopted regulations required by paragraph (a) at least ninety days prior to the date upon which such subsequent or renewed license would be effective or if the department has adopted regulations pursuant to paragraph (a) but has not, at least ninety days after the adoption of such regulations, issued licenses pursuant to paragraph (g).

(j) Not later than July 1, 2014, the general assembly shall enact legislation governing the cultivation, processing and sale of industrial hemp.

(6) EMPLOYERS, DRIVING, MINORS AND CONTROL OF PROPERTY.(a) Nothing in this section is intended to require an employer to permit or accommodate the use, consumption, possession, transfer, display, transportation, sale or growing of marijuana in the workplace or to affect the ability of employers to have policies restricting the use of marijuana by employees.

(b) Nothing in this section is intended to allow driving under the influence of marijuana or driving while impaired by marijuana or to supersede statutory laws related to driving under the influence of marijuana or driving while impaired by marijuana, nor shall this section prevent the state from enacting and imposing penalties for driving under the influence of or while impaired by marijuana.

(c) Nothing in this section is intended to permit the transfer of marijuana, with or without remuneration, to a person under the age of twenty-one or to allow a person under the age of twenty-one to purchase, possess, use, transport, grow, or consume marijuana.

(d) Nothing in this section shall prohibit a person, employer, school, hospital, detention facility, corporation or any other entity who occupies, owns or

controls a property from prohibiting or otherwise regulating the possession, consumption, use, display, transfer, distribution, sale, transportation, or growing of marijuana on or in that property.

(7) MEDICAL MARIJUANA PROVISIONS UNAFFECTED. Nothing in this section shall be construed: (a) To limit any privileges or rights of a medical marijuana patient, primary caregiver, or licensed

entity as provided in section 14 of this article and the Colorado Medical Marijuana Code;

(b) To permit a medical marijuana center to distribute marijuana to a person who is not a medical marijuana patient;

(c) To permit a medical marijuana center to purchase marijuana or marijuana products in a manner or from a source not authorized under the Colorado Medical Marijuana Code;

(d) To permit any medical marijuana center licensed pursuant to section 14 of this article and the Colorado Medical Marijuana Code to operate on the same premises as a retail marijuana store; or

(e) To discharge the department, the Colorado Board of Health, or the Colorado Department of Public Health and Environment from their statutory and constitutional duties to regulate medical marijuana pursuant to section 14 of this article and the Colorado Medical Marijuana Code.

(8) SELF-EXECUTING, SEVERABILITY, CONFLICTING PROVISIONS. All provisions of this section are self-executing except as specified herein, are severable, and, except where otherwise indicated in the text, shall supersede conflicting state statutory, local charter, ordinance, or resolution, and other state and local provisions.

(9) EFFECTIVE DATE. Unless otherwise provided by this section, all provisions of this section shall become effective upon official declaration of the vote hereon by proclamation of the governor, pursuant to section 1(4) of article V.

For your reference, a link to the legislation

above: https://www.colorado.gov/pacific/sites/default/files/2014%20MED%20Annual%20Report_1.pdf

And again, a link to the annual task-force report: https://www.colorado.gov/pacific/sites/default/files/2014%20MED%20Annual%20Report_1.pdf).

With the recent, globally significant success of marriage equality in Ireland (pop 4.595 million), I believe we, like Colorado (pop 5.356 million) are paving the way in progressive people-driven public policy reform.

Thank you for your consideration, and for your willingness to engage the citizenry.

Kindly,

Ella Goddin

I am a student of genetics in Trinity College Dublin with an interest in the health effects of drugs and the efficacy of differing drug policies.

It is generally taken at face value that the criminalisation of drugs reduces consumption and the associated health problems. This is sole justification for our current drug program that is costly, results in the imprisonment of citizens, and estranges drug users from the medical assistance they require. The information I wish to offer is evidence suggesting that drug criminalisation does not significantly reduce consumption and thus the cost of criminalisation comes with no benefits.

One striking example is the Netherlands whose rate of cannabis consumption in 2009 was 5.4%, below the 6.8% European average. This is despite the decriminalization of the drug. Study linked below.

r.reuters.com/vef87f

Another example is the UK. When the criminal status of cannabis was reduced to class C there was not an increase in the usage of the drug, but a marked decline. Article linked below.

www.theguardian.com/society/2007/oct/26/drugsandalcohol.homeaffairs

Finally a recent study from Portugal assessed the price of drugs post decriminalization and saw no significant decrease, as was predicted by critics of the policy. Article linked below.

papers.ssrn.com/sol3/papers.cfm?abstract_id=2568044

While there are insufficient data to prove that criminalisation has no reductive effect on consumption, the very fact that it is unclear is a serious indictment of our current policy. I would urge the committee to support the adoption of the measures taken in Portugal, which have not resulted in significantly increased consumption and have conclusively reduced the health problems associated with drug use. If policymakers and the public are made aware of the fact that treating drugs as a criminal and not a medical problem is not only problematic but impotent, I believe we can expect the much needed reform process to begin.

Conor McQuillan

Submission to Oireactas Joint Committee on Justice, Defence and Equality on Drug Possession

It is a welcome development that the Joint Committee have opened this issue to public consultation and a sign perhaps of a recognition that the War on Drugs has, to varying degrees between differing countries, had similar unintended and unwelcome consequences to the brief prohibition of alcohol in the USA.

In Ireland there is a problem now where laws around substance abuse do not match the policy aspirations of many professionals working in this domain. This is because many see a cycle of intergenerational drug abuse cycling families through poverty, drug abuse, courts, prison, unemployment even where rehabilitation is partially achieved and further poverty, and of course relaps by substance addicts. Current policies aren't working or reducing illegal drug supply, but there are no simple solutions. Harm reduction should become the focus of decision-making, not an inherited and arguably inconsistent moral stance on currently-illegal drugs.

Addiction to many legal substances can be harmful to the person, their family and community. But with legal substances like alcohol we recognise that an addict's possession of alcohol should not condemn them to prison. We offer treatment and a second (or more) chance. Prison is for many a psychologically and physically harmful experience. Sending someone to prison should be a last resort for harming others. Possession of small amounts of currently-illegal drugs does not necessarily harm others. Neither does consuming two pints of beer. Criminal behaviour like drink-driving or violence is punishable separately to consuming two pints. Why can't the same be true for currently-illegal drugs?

If we recognise (as many gardai, judges and lawyers do) that prison is not deterring illegal drug use or reducing demand, or harm, then decriminalisation as a policy to free police and legal resources to focus solely on trafficking and dealing, and as a policy freeing substance addicts to seek and receive help in a less fearful and less stigmatized environment, is a policy worthy of your consideration and, hopefully, support.

Submission from:

Florian Scheibein

This submission was hastily written –particularly the second on supervised drug consumption- and I would be more than happy to answer any questions in person.

(i)

- As part of the mandatory work placement requirement for my BSc. (Hons.) in Herbal Science from the Cork Institute of Technology I interned the Wo/Men's Alliance for Medical Marijuana –regarded as the “gold standard of the medical marijuana movement by Californian Federal Judge Jeremy Fogel- where I conducted a small clinical study of the variance (effects regarding high, nausea, appetite, pain, motor control, sleep etc.; side effects) in clinical utility of *Cannabis spp.* oil extracts prepared from four strains. I conducted this study under the tutelage of Valerie Leveroni Corral (co-author of Proposition 215 and SB420 which legislate for medical cannabis in California) and under the supervision of Dr. Hugh McGlynn (Head of School of Science and Informatics, Cork Institute of Technology). During this time I prepared a dossier on the merits and demerits of cannabis as a medicine which I sent to all TDs. I also helped prepare a seven article feature on medical cannabis for the Irish Examiner and since that day have been inundated with requests for more information from members of the public concerning the use of cannabis for a diverse range of conditions ranging from MS to cancer.
- My thesis for my MSc. in Science Communication from Dublin City University concerned itself with the framing and communication of the informed opinion of direct service provider stakeholders in Irish drug policy formation. As part of this research I conducted interviews with a Superintendent, a Detective Superintendent, a Chief Superintendent, a social worker, a treatment specialist and a harm reduction specialist.
- Whilst interning and subsequently working freelance as a medical reporter, in the clinical news section, of Irish Medical News, I researched and wrote feature length articles on medical cannabis and medically supervised injection sites/supervised injectable heroin treatment; I also wrote articles on MDMA (ecstasy) and advances in the clinical applications of cannabis but these were unpublished.
- As part of the Multidisciplinary Association for Psychedelic Studies Graduate Association I researched the potential harms and benefits of MDMA for people with autism spectrum disorders. Some of the anecdotal reports I gathered helped serve as justification for a now in progress FDA approved trial investigating this relationship.
- I obtained a Diploma in Drugs: Supply, Demand and Public Policies from the University of Lisbon having completed the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) summer school. As part of this diploma we visited the Portuguese Dissuasion committee and critically analysed the implications of the Portuguese decision to implement decriminalisation with staff members, members of the EMCDDA and EMCDDA President Dr. Joao Gualo.
- As part of my MSc. in Drug and Alcohol Policy from Trinity College Dublin I conducted a critical analysis of the role of the National Advisory Committee on Drugs and Alcohol (NACDA) in fulfilling the ‘research’ pillar of 21st Century Irish National Drug Strategies.

(II)

The decriminalisation of the medical use of cannabis

Approximately one in four Irish people have tried cannabis in their lifetime; approximately 8% have taken cannabis in the last month. There is a valid argument to be said that the criminalisation of a behaviour that has been effectively 'normalised' is untenable; especially in the current economic climate (see: recent decisions by English police forces to de facto decriminalise cannabis). Prohibition results in an unregulated black market that favours high potency (with associated increased risk of psychotic reactions) and unregulated quality (including contamination with bacteria due to incorrect processing and adulteration with synthetic cannabinoids like 'spice', lead or even fibre glass). It also leads to a mingling of markets i.e. cannabis dealers may deal other drugs which may lead to cannabis users being introduced to other more harmful drugs.

The argument that the use of cannabis for medical purposes should be decriminalised stands on even shakier premises: if someone is sick and derives benefit or could derive benefit from cannabis then this is a decision between medical professionals and patients.

Cannabis has medical value and that is [a well-established fact](#). The reason that this fact is even disputed is almost entirely product of the prohibition of cannabis –[which continues to stifle research](#)– but also due to the complexity of studying plant based natural products i.e. cannabis has around 100 cannabinoids and several hundred other compounds that vary according to strain, form, processing, storage and route of administration which make studying its medical utility problematic. It is worth mentioning at this juncture that many of these constituents are non-psychoactive i.e. they do not get people high but yet remain illegal; a non-psychoactive herbal form was recently developed in Israel.

I have reviewed the literature on herbal cannabis from traditional uses in various cultures to [recent studies](#); reviewed the [US government patent on cannabis](#); reviewed the literature on Marinol; reviewed the literature on Sativex and other GWPharmaceutical preparations; interviewed a recipient of the US government's [Compassionate Investigational New Drug Program](#); interviewed leading scientists; and most importantly interviewed dozens of patients who have obtained benefit from cannabis. The evidence is unequivocal: cannabis, many of its constituents and pharmaceutical preparations prepared from can have medical applications.

Every NACD general population survey suggests that that approximately 70% of the Irish public support the availability of cannabis for medical purposes. Concurrently, cannabis is being legalised for both medical and recreational purposes through-out the world-the decriminalisation of the medical use of cannabis is not particularly politically risky.

The argument that the medical use of cannabis should be prohibited because it is a gateway drug is, frankly, ridiculous: (a) the original theory considers alcohol and tobacco gateway drugs and these are legal; (b) most people who try cannabis do not go on to try other 'illegal' drugs; (c) many people try heroin before they try cannabis; (d) the reason the Dutch introduced their 'de facto' legalisation was to separate 'soft' drugs like cannabis from 'hard' drugs like heroin- a policy which has been largely successful.

The argument that cannabis should be prohibited because it can cause schizophrenia is a weak argument: (a) although there is a link between schizophrenia and cannabis use this implies correlation not causation, according to the British Advisory Committee on Drugs (ACMD) during the period where cannabis use –including high potency (high THC) cannabis- increased schizophrenia rates remained unchanged; (b) it is clear that in response to its value as a criminal commodity- similar to the predominance of hooch during alcohol prohibition- THC levels have increased at the expense of CBD (a constituent that counteracts the psychosis generating effects of THC and which shows promise as a treatment for schizophrenia). CBD shows great promise as a potential medicine and CBD rich and THC low cannabis strains –which could be bred in a decriminalised market- are far less likely to cause psychosis than current criminally produced strains.

The argument that medical cannabis should not be decriminalised because it may cause cancer is also weak: (a) alcohol and tobacco are both linked to several types of cancer and remain legal; (b) most evidence suggests that cannabis does not cause cancer; use may be associated with a decreased risk of cancer; and several constituents are being investigated as a potential treatments for cancer.

The argument that a medicine should not be smoked is another prevailing argument. However, this method of administration allows for easy titration of dose; people can smoke enough to gain relief without getting high. Evidence suggests that smoking only cannabis may actually reduce the risk of lung cancer in comparison to people who don't smoke at all and people who smoke cannabis with tobacco are less likely to get cancer than those who smoke only tobacco. However, it has been associated with bronchitis. There is evidence to suggest that there is a weak link with throat cancer but this likely to occur due to the common cultural practise of sharing joints due to potential spreading of the HPV virus; this risk is similar to the risk experienced by those that participate in oral sex (which is a non illegal activity).

Basically, cannabis has harms –that have often been overstated- but these harms could be reduced in a more regulated environment, especially for medical patients.

(ii) supervised drug consumption

There is clear evidence that drug consumption rooms do not increase crime, injecting or drug use. There is significant evidence to suggest that they serve as contact points between vulnerable populations and treatment providers, that they can reduce risk behaviours and street injecting. Legislation should be enacted to allow treatment providers –like Ana Liffey Drug project- to utilise this evidence-based drug policy.

Submission to the Joint Oireachtas Joint Committee on Justice, Defense and Equality regarding Drug Possession by CDA Trust Ltd

The team at CDA Trust Ltd wholeheartedly welcome the recent debate on drug possession and believe the new emphasis on treatment rather than punishment is a very positive step. We believe that punishment of drug use by the Irish criminal justice system has in effect become just another drug related harm and we believe it is time for a change. It is particularly encouraging that the government are now looking to the Portuguese model as a viable alternative. The key to the success of the Portuguese model is not just the effective decriminalisation of personal drug use, but correct investment in treatment and support services and the diversion of those found in possession of drugs into these services (Hughes and Stevens, 2010). Without this investment, decriminalising personal use of drugs in the Irish context will only ever be a half measure. It is imperative that the vast amount of resources freed up by decriminalisation is invested directly back into building capacity in treatment and support services.

We also call for the prioritisation of essential harm reduction services as a foundation for effective rehabilitation. Despite three successive drug strategies stating that needle exchange services and methadone/ opiate substitution treatment and residential detoxification services are a priority (NDS 2009), implementation of these targets outside of Dublin has been extremely poor.

In terms of changes to the criminal justice response to drugs, CDA Trust Ltd makes the following key recommendations:

- Where adults are caught in possession of small amounts of illegal drugs and no other crime has been committed, Gardai should not make an arrest. The suspected illegal drugs cannot legally be returned to the individual and therefore must be confiscated for disposal. All members of the Gardai should know the contact details of the local drug treatment centre, have leaflets/cards for same on hand and be able to discuss and make a referral to a treatment/advice centre if the individual is in agreement.
- Where minors are caught in possession of small amounts of illegal drugs and no other crime has been committed, Gardai should not make an arrest. They should instead take the young person home and inform their legal guardian. All members of the Gardai should know the contact details of the local drug treatment/advice centre, have leaflets/cards for same on hand and be able to discuss and pass on these details to the legal guardian.
- Where individuals are caught in possession of larger amounts of drugs, (i.e. more than could be reasonably deemed to be for personal use) they may be arrested

under the misuse of drugs act or psychoactive substances act and charged accordingly.

- Punishments under law for possession with the intent to supply should be on a sliding scale reflecting the quantity of drugs an individual is caught with. The heaviest sanctions should be weighted towards those at the top of the manufacturing and supply industry.
- Where an individual is arrested and taken to a Gardai station and drug use is suspected an instant drug screen should be used by the arresting officer. It should however be noted that drug screens are of limited use considering the range of new psychoactive substances. Where drugs are detected the option of a referral to a drug treatment centre should be explored. Depending on the seriousness of the charges the individual may be released and charges dismissed (e.g. in the case of minor public order offences). Where Gardai are concerned for the wellbeing of an individual in custody due to the effects of drugs (e.g. potential for overdose) a suitably trained doctor should be available on call. Methadone, benzodiazepine and other appropriate medication should be made available to the individual in custody once an issue is established.
- The Gardai should not seize drugs paraphernalia of any kind unless absolutely necessary for safety reasons. Syringes used or otherwise should not be seized. The Gardai should have the correct personal protective equipment and appropriate sharps bins for safe disposal. They should also receive appropriate training including naloxone training and be issued with kits as likely first responders. Where Gardai accept used injecting equipment, they should have available the standard 'one hit kits' available through the pharmacy based needle exchange.
- The Gardai should not make arrests when summoned to a suspected overdose. This should be a national policy and an awareness campaign should be run through treatment centres to highlight this.
- Where individuals appear in court for minor offences where drug addiction may be an antecedent factor, they should be given the option of entering a drug treatment/ rehabilitation programme and a suspended sentence and /or probation order.
- Considering the failure of the Drug Treatment Courts (Fischer 2003, Nolan 2001, Review of the Drug treatment Court 2010), the court should have no further role in the treatment/ rehabilitation programme. A clear distinction should be maintained between treatment and support services and the criminal justice system.

Urine/saliva screens should be inadmissible in court. Continued drug use and addiction should not result in criminal justice sanctions of any kind. Where a court has issued a suspended sentence/ probation order in lieu of an individual accessing a treatment/ rehabilitation programme, the court will be only entitled to a report on the individual's attendance. All individuals receiving a suspended sentence or probation order as an alternative to imprisonment should be given a clear timeframe for such sanctions to be in effect with no opportunity for such conditions to be extended by the courts on the basis of continued drug use.

- Neither drug use nor addiction should not be considered to be a mitigating factor in violent crime or other offences where significant harm or distress is caused to an individual.
- The Gardai should have a national policy of respecting treatment services and allow space for those who wish to access drug treatment. They should not monitor activity around treatment centres to gather intelligence. There should be a renewed emphasis on cooperation between organisations working under different pillars of the new National Drug and Alcohol Strategy. Membership of the joint Policing Committees should include representatives of drug and alcohol treatment and support services and the Gardai should contribute to the regional and local DATFs.
- All patients receiving treatment for addiction issues should have a standard letter issued by their GP to prevent seizure of their medication by Gardai.

It should be noted that the majority of these changes can be implemented immediately with a change in policing policy [as has been the case in the Netherlands for over thirty years (Garretson 2010)] and no legislative change is necessary.

The Continued Sale of New Psychoactive Substances in the Republic of Ireland

The Psychoactive Substances Act (2010) is progressive in that it makes no provision for the punishment of personal use or possession of new psychoactive substances. However the continued open sale of new psychoactive substances in the Republic of Ireland, particularly in Counties Monaghan and Cavan, has revealed that the act is not fit for purpose despite the fact that other EU member states are now considering implementing legislation based on the Irish model. Recent media scrutiny and a scientific investigation (Van Hout and Hearne 2015) into widespread synthetic cannabinoid use in county Monaghan has revealed significant difficulties in successfully prosecuting those involved in the manufacture and sale of new psychoactives.

There appears to be a great deal of confusion over the legality of new psychoactives within the criminal justice system, ostensibly because the laboratory used by the National Drug Unit are unable to define these new substances as psychoactive despite the fact that they are self-evidently so. As a result only a handful of arrests have been made since the closure of the headshops in 2010 and even fewer prosecutions. If there is no reliable means by which the psychoactive properties of a new substance can be identified, there is no actual legal impediment stopping the headshops from re-opening or the continued sale of NPSs by individuals.

If the Psychoactive Substances Act was amended to allow for the appointment of an expert advisory group who could look at all the available evidence (laboratory analysis of a new substance, accident and emergency admissions, user accounts etc.) they could then make an informed determination as to whether a seized product is psychoactive and therefore covered under the act. It should be left to the judiciary to determine whether the available evidence is sufficient to warrant conviction under the Psychoactive Substances Act.

We at CDA Trust Ltd appreciate the opportunity to make a submission regarding this issue and hope you will give it due consideration. We especially appreciate being recently invited to the Oireachtas Joint Health and Children Committee on the 9th of July of this year to make a presentation on the issue of New Psychoactive Substances in County Monaghan. Should you wish to discuss any of the above points further or require clarification we are again only too happy for you to contact us.

Kind regards,

Tim Murphy

Project Coordinator

CDA Trust Ltd

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Rebecca Griffin

Regulated Access for Adults.

Pain.

Pain hurts; I take my own pain very personally,

And at times, it brings me down.

But the study and treatment of Addiction is my speciality. I provide voluntary healthcare for addicts in my community.

We will give me 20 years of independent study, not only in Body Sciences and Somatic Research, but also in Buddhism, Philosophy, Spiritualism, Conflict Resolution and more..

Please tell me, what is

Medicine?

And what is the most potent and effective form of non-addictive, natural pain relief?

The answer is Medical Marijuana.

And Regulated Access for Adults has proven to be a great place to start with, in a process of Decriminalisation of the “Holy Herb”.

I have tried many different types of painkillers and anti-inflammatories for severe body pains, mostly without success.

I ask you, which does more damage; the pharmaceuticals, or the plant?

There is practically no danger of overdosing on marijuana.

Likely effects of consuming too much, maybe laughing or falling asleep.

It just doesn't kill, unlike alcohol for example, the gateway drug.

Medical Marijuana is now a known cure for,

Epilepsy, Cancer, PTSD, Depression, Stress, Insomnia, Pain,

The list goes on..

I'm asking you to please start with more compassion and understanding,

And then,

See the facts!

Name; James Conway

Note: I am submitting my view, as per your request for public opinion but I am not available to appear in public session at committee meetings at this time.

Introduction

My name is James Conway; I am a student in Mitchelstown CBS, Co. Cork going into 5th year. I noted that your Committee was looking for information/ public opinions, so I thought I would be an active citizen and bring my recommendations to the table. I feel I have something to offer to my community and the wider community of Ireland. Initially I was going to write a letter to Minister O' Riordain to congratulate him on his active approach towards community participation and in not brushing the emotive subject under the carpet! Then I saw that the people of Ireland were being asked to contribute to make the issue safer. Arguably, the fact that I am young, you may not appreciate what I have to say but I am knowledgeable on the subject and it is the majority of people just a few years older than me that are really affected by these laws. Therefore I feel my voice is of peer value.

Initially I will present some facts on issues related to drugs. This will be followed by my opinions on various headings including Prohibition, Decriminalisation and Legalisation. Finally I will wrap up conclusions on the topic and offer recommendations to assist the decision making processes.

Factual information re drugs (stats, facts, polls)

- Ireland has the third-highest rate of drug misuse deaths in Europe, according to a new study in the EU drugs report (www.???, 2015)

This correlates with the National students' drug survey (2015)* which states that:

- 49% of students had taken some form of cannabis
- 32% of students consumed ecstasy tablets
- 20% had taken cocaine
- 13% had taken legal highs/research chemicals
- 11% had taken LSD
- 11% had taken ketamine
- 48% had used illegal drugs before the age of 18; and
- 4% of alcohol users were admitted to A&E. this is 4 times higher than for other drugs

*Taken from the Irish Examiner, 29.06.2015 by Cormac O Keefe.

Online polls

Irish examiner: Yes 94% (6177 votes) no 6% (406 votes)

A new Red C poll found that almost four in 10 (38%) voters want to see the legalisation of cannabis in Ireland. When the 5% of people who responded "don't know" were removed, there was 40% support among the electorate for making the drug legal. The survey carried out by Paddy Power found greater backing for legalising cannabis [38%] among younger groups, with support falling with age.

In Britain at the moment an e-Petition to legalise cannabis has reached nearly over 200,000 signatures

Prohibition

The 'war on drugs' has failed. Not only have drugs dropped in price considerably but they are available to underage children and are widespread throughout every city, town and village in Ireland. Prohibition does not treat the real issue of drug misuse. People will always look for ways to alter their state of consciousness; it is up to society whether make sure users get a pure substance rather than a mystery tablet which could contain anything and everything including rat poison among other deadly additions.

The illegality barrier does not deter people from usage. The real deterrent to something is good quality education on how to do things safely, thus leading to attitudinal change.

Long gone are the dreams of a fantasy world where people say that children have the right to grow up in a society free from drugs when that same people smoke their cigarettes with a glass of wine and a cup of coffee! While all these substances are legal they have their own risks too. It is reasonable to argue that these elements of society are also oblivious to people rights once they are old enough to make decisions for themselves.

David Cameron looks at their current drugs scenario and says that it is working as the usage rate has dropped slightly but the death rate is very high. I would like to think that we would look at the matter in a more respectful way to the parents of an overdosed victim in Britain. I would rather that everyone took MDMA and only 5 people dying due to a predisposed condition, than some of the population taking it and 15 people dying due to another deadly substance mixed with it.

Decriminalisation

Decriminalisation is a good step as it keeps addicts or responsible drug users out of jail and makes sure they get proper education on the substance or the treatment plan if they are addicted. Decriminalisation of drugs would save the taxpayer paying for jail time of a heroin addict. It also frees up Gardai time so they can focus their resources on crimes like murder, robbery and rape. We don't put a person in jail for having cancer so why drug addicts are being penalised for the medical condition of addiction.

On balance, there are two downsides about decriminalisation and these are;

1. That the substances people buy could still be cut with various other drugs, either just as a filler, or as a way to make money off a serious addiction. For example in relation to a filler, an ecstasy user buying their tablets with not only MDMA (which is the chemical name for ecstasy) which, along with psilocibin is statistically shown to be only as dangerous as playing soccer or riding a bike is cut with PMA/PMMA (This filler is a serious drug which has many negative effects and has a very high overdose rate). Or, the tablet could be cut with methamphetamine, a highly addictive substance in order to get the user addicted to it, thus making more money off the user. The user would think they are being addicted to the ecstasy but in actual fact they are addicted to the meth in the ecstasy tablet.
2. The other negative thing about decriminalisation is that the money is still going to criminal gangs who use this currency to fund other crimes. Some of this money is also going out of our economy back to the suppliers of these drugs across the water in any direction.

Therefore, in order to prevent more drug related problem, it is reasonable to argue that even if full legalisation is not on the agenda yet, decriminalisation definitely should be.

Legalisation; At the moment I don't believe in full legalisation of all substances but by legalising just a few safer alternative products, usage rates and deaths should fall as users switch from the very hard drugs (which would be decriminalised) to the less harmful drugs. This can be seen from the fall in cocaine related deaths when mephedrone use rose.

Legalisation, which includes regulation of drugs, is the only way to ensure that products contain only what they are supposed to contain. A prime example of this is the alcohol industry who cannot mix other substances with the alcohol they produce apart from caffeine. By legalising we can regulate and tax the industry.

Regulation

By regulating the drugs industry it means we can control every aspect from advertising to sale to which persons it is sold to.

Tax

By taxing each substance and distributing costly licences to sell, the government will make extra revenue each year which can be put into other areas as well as into treatment centres and further studies on the topic.

Drug dealers hate the idea of legalisation. We have seen examples of this from the attack on headshops around the country by the back street dealers simply because these shops were stealing their customers. Now, I did not agree with headshops for a start as many of the substances sold were even worse than what's on offer from the local drug dealer. For instance synthetic cannabis sold in the head shops which left people hospitalised due to toxic components in the chemical makeup of the product. This compares to the sale of cannabis from the local back street dealer which is relatively unadulterated by comparison.

Many people say that alcohol and tobacco are legal and look at the damage they cause but then again these two drugs are even more dangerous and addictive than some drugs that are illegal at the moment. Nicotine is said to be nearly as addictive as heroin.

Drugs I think could be legalised some that already are

Drug	Addictive	Overdose	Why legalise?
Alcohol	Quite addictive	yes	already legal
Tobacco	very	no	already legal
MDMA	low	yes	quality control is needed to safeguard people health
Nitrous oxide	low	Only when people don't get sufficient oxygen	By making this legal then we can make it a legal requirement to have it oxygen 50% which means if they forget to inhale air they will still get required oxygen.

Methadone(for heroin addicts)	yes	yes	Already legal for heroin addicts as a safer alternative
Magic mushrooms	no	literally impossible	Safer alternative to LSD, non addictive
Mescaline cacti	no	Literally impossible	Safer alternative to LSD, non addictive
Salvia	no	no	Safer alternative to LSD, non addictive
Cannabis	Low addiction rate	Literally impossible	Safer alcohol alternative, use is widespread, medicinal benefits, criminal gangs would lose out on the income from its sale
Caffeine	Quite	yes	Already legal
mephedrone	Low	yes	Use would curb use in cocaine which has similar effects but mephedrone is safer and less addictive

Drugs I think should stay illegal (decriminalised for personal possession of over 18)

The list of drugs below should, in my opinion stay illegal (decriminalised for personal possession) because they are too harmful to the health of the individual in comparison to the softer/safer alternative drugs in the table above.

- Methamphetamine
- Crack cocaine
- Cocaine
- Heroin
- Solvents
- Skunk(high potency cannabis through regulation THC testing)
- PCP
- LSD (legalisation can be avoided with the plant based safer alternatives salvia mescaline and magic mushrooms)
- Ketamine (apart from veterinary use)
- Krokodil
- Oxycodone
- GHB
- scopolamine
- rohypnol
- All other psychoactive substances would be illegal(decriminalised) apart from medicinal used drugs (Ritalin and aderall) but the demand for other drugs would fall as people opt for the safer alternatives provided legally

Medicinal value of all drugs

Some drugs are already medicinally used worldwide for example, the American authorities now recognising marijuana as medicinal product in the treatment of a range of different ailments such as diabetes, cancer, chrons disease and Multiple sclerosis. Another example of the medicinal value of a drug is MDMA which has the potential to treat victims of post traumatic stress syndrome.

With the legalisation of some drugs their medicinal value can be studied, which will lead to people having a better quality life should they get an illness which can be treated by the newly legalised drugs, especially the use of psychedelics to treat addictions and other mental illnesses.

Education

We cannot educate people with propaganda in the hope that they will not try these drugs. The only way to make sure they stay safe when they take them is through factual information which could be presented with the product purchased. For instance, stay very well hydrated while on MDMA. There are many different websites already offering information on staying safe while on substances such as 'Dancesafe' and 'Rollsafe'

Drug testing kits should also be made widely available to make sure the product purchased is of a good quality. However, if legalisation occurs, then the need for testing would diminish as it would be officially done at manufacturing stage.

Research

Research can be done into each drug even to possibly remove the addictive properties that some drugs contain. Research can also be done into addiction treatments to help people who become addicted not only to hard drugs like heroin, meth and cocaine but to alcohol and tobacco too

The heroin epidemic

Heroin is a very addictive drug. Therefore I propose that safe injection centres be set up in cities. This would be way better than just leaving the heroin user 'shoot up' at home or on the street. New needles can be provided for the users and safe injecting techniques taught to the addict. This whole proposal will bring down various blood borne infection rates and the rate of overdoses leading to deaths would drop dramatically as there would be an educated person/mentor there to guide them when injecting.

Conclusion and recommendation

- If full legalisation for some drugs is not on the cards then decriminalisation for personal possession of over 18s is the next best step.
- All drugs should be decriminalised and the selling possession and cultivation of cannabis should be decriminalised or legalised if the government want to make money on it instead of dodgy drug dealers.
- Safe injection houses should be set up to reduce overdose deaths and make the use of heroin safer.

Recommended sites

- www.Dancesafe.org
- www.rollsafe.org

Dear committee,

My name is Kid, I'm a woman, half Dutch, half Spanish, I'm 50 years old.
I worked hard all my life and played lots of sports too, mainly squash, as a semi professional.
Right now, I live a quieter life in Spain where I have a veggie garden as I like my things organic.
I like to relax on a regular basis with some 'mary jane' or some 'chocolate', it is my meditation.
So yeah, I'm absolutely in favour of legalizing marihuana, I regard marihuana as a *good* thing.

Now, it would be so great if I could grow some marihuana next to my tomatoes and cucumbers without being in fear of getting into trouble with the law.

It would be so great to not be stigmatized for getting high every now and then, you know, for doing 'illegal drugs'.

My mum tells me, over a glass of wine (!), that I really shouldn't be smoking 'that stuff', coz you know, it's 'illegal' so it 'has to be bad for me', duh.

I lived in Amsterdam pretty much all my life.

After the then revolutionary step of decriminalizing soft drugs some 35 years ago, coffeeshops began emerging, typical Dutch entrepreneurship ;)

A bit of a struggle in the beginning as the rules around selling the stuff were non-existing or at the least not clear at all.

Supply routes (illegal!) needed to be established, who-knows-what licenses were needed, some form of taxation needed to be invented (or not?), etc.

Overall, certainly for the customers, coffeeshops were great; real marihuana lovers ran them, they knew what they were selling, you could get good quality stuff, the price was never a surprise and moreover, they could tell you what it was and where it came from.

But decriminalization means no clear rules and regulations exist, the public is not well informed, there's still the stigma, etc.

Worse still; not decriminalizing - let alone regulate - the *cultivation of marihuana* in Holland at the same time was always asking for trouble.

Where do the coffeeshops buy their products...?!?

So the cultivation of marihuana in the Netherlands is a highly, highly criminal business right now.

One of the problems is that the police go after the small guy with marihuana plants in their attic, as they are easy targets.

The big boys, the ones with the big plantations and the kalashnikovs, well, they are a bit more difficult to handle....

So the market is more and more ruled by criminals who really do not care how many chemicals they have to use to grow their stuff as quickly as possible.

You get dizzy and quite unwell on some of that stuff :(

These 'growers' add things like lead and hairspray to the buds, they don't do quality control.

And they threaten coffeeshop owners who refuse to buy their shit, all part of the so-called 'backdoor problem'.

Then there's all the uncertainty, coffeeshop owners need to apply for a new license every year, which means every year could be your last, and I could go on and on.

After many years in this illogical and unworkable situation, these days, many coffeeshop owners are borderline criminals too, or at least they are highly commercial.

If you love grass, if you have a heart for it, you don't wanna own or run a coffeeshop coz you're forced to deal with criminals.

So the last 10 years or so in Amsterdam, I mainly got my grass through friends again as the coffeeshops sell such bad quality, and at very high prices too.

Unfortunately, since about 15 years or so, Holland has been going completely backwards on the issue of soft drugs.

The objective is to shut as many coffeeshops as they can, they think of new restrictions all the time.

One of the latest ridiculous 'laws' is to shut all the growshops - ignoring the fact that you need the same equipment to grow everything else :-|

But government does whatever they want with the rules and regulations around coffeeshops coz, well, officially, it's illegal and many existing rules have to be bent in order to be able to allow coffeeshops in the first place.

So things just get messier and messier and the Netherlands has all sorts of problems in this area.

To summarize....

Legalize marihuana, have clear, enforceable rules and regulations around it and inform the public about it's effects and use.

And make sure everybody can grow they're own!

Next to that, *treat* people with addiction problems, *do not* put them in jail, these people need *help*.

Nobody has ever died from marihuana, ain't that something for an 'illegal drug'?

Really, it's *high time* to recognize the many medicinal values and the pleasure this plant gives to mankind.

Now let's make it official :)

Good luck with the drugs review.

Kind regards,

Kid de Winter

Love many, trust few; always paddle your own canoe.



Human Rights Watch Submission to the Joint Committee on Justice, Defence and Equality, Houses of the Oireachtas, Ireland on Drug Policy Reform

August 7, 2015

Human Rights Watch welcomes the opportunity to submit our comments as part of the Committee's review of Ireland's approach to the possession of limited quantities of certain drugs.

Human Rights Watch is a non-profit nongovernmental organization that works to defend the rights of people worldwide. We scrupulously investigate abuses, expose the facts widely, and pressure those with power to respect rights and secure justice. As an independent, international organization we work as part of a vibrant movement to uphold human dignity and advance the cause of human rights for all.

Introduction

For over two decades, this organization has documented the impact on human rights of drug policies that heavily emphasize criminalization of drug use, possession, production and distribution, at both global and national levels. Our research has consistently found serious human rights abuses that are often inextricably linked to such policies. And despite the vast sums of money invested to combat drugs through criminalization and enforcement, the global drug trade is thriving and drugs are widely available for recreational use in countries around the world. We have also documented how, due to excessive regulation stemming from policies focused on criminalization, in many countries patients with serious illnesses are unable to get access to essential medications that contain licitly produced controlled substances. These outcomes raise enormous questions about the effectiveness of drug policies in achieving objectives of curtailing recreational drug use and supply while ensuring respect for human rights.

Based on our extensive research and analysis of drug policy and human rights, Human Rights Watch [opposes the criminalization of the personal use of drugs and the possession of drugs for personal use](#). Based on a human rights analysis we submit that not only is criminalization of personal use and possession inconsistent with the right to privacy, it is also an inherently disproportionate response to private behavior that does not harm others. While Human Rights Watch recognizes that governments have a legitimate interest in preventing societal harms related to personal drug use, we believe that to deter, prevent, and remedy the harmful use of drugs, governments can rely on non-penal regulatory and public health approaches that do not violate human rights.

More broadly, our research has shown that criminal regulation of the drug trade is closely connected to human rights abuses in multiple countries around the world. We believe that by decreasing reliance on criminal regulation of the drug trade, and, where appropriate, adopting new legal and regulatory frameworks and adjusting enforcement practices governments can reduce the human rights costs of current drug policies.

Indeed, we would draw the Committee's attention to the June 2011 [report](#) of the Global Commission on Drug Policy, a group made up of former presidents of Colombia, Mexico and Brazil, former UN Secretary General Kofi Annan, former UN High Commissioner for Human Rights Louise Arbour, and public intellectuals, activists and officials such as Paul Volcker and Asma Jahangir, that reached conclusions similar to our own, noting that:

The global war on drugs has failed, with devastating consequences for individuals and societies around the world.... [F]undamental reforms in national and global drug control policies are urgently needed. Vast expenditures on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs have clearly failed to effectively curtail supply or consumption. Apparent victories in eliminating one source or trafficking organization are negated almost instantly by the emergence of other sources and traffickers. Repressive efforts directed at consumers impede public health measures to reduce HIV/AIDS, overdose fatalities and other harmful consequences of drug use. Government expenditures on futile supply reduction strategies and incarceration displace more cost-effective and evidence-based investments in demand and harm reduction.

The Global Commission report urges states to end the criminalization of personal drug use, urging them to experiment “with models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens.”

We understand that the Committee is conducting this review, having studied the model of decriminalization used in Portugal. Human Rights Watch has not itself conducted extensive in-country research of the model implemented in Portugal, but we understand from available analysis of the impact to date in Portugal, that in conjunction with comprehensive harm-reduction strategies, decriminalization has had positive results; rather than substantially increasing, drug consumption reportedly dropped in some categories—as did recidivism and HIV infection—and fewer people suffered the severe consequences of being caught up in the criminal justice system.

As many countries around the world gear up to debate global drug policy for the 2016 UN General Assembly Special Session on Drugs, Ireland now has an excellent opportunity to set an example for others by adopting a more rational, humane, and rights-respecting approach to drug use and possession, through decriminalization.

Below we outline some of the key human rights arguments for decriminalization of personal drug use and possession, and for reforming drug policy more broadly.

1. The Human Rights Implications of Criminalizing Personal Drug Use and Possession

Criminalizing personal drug use per se clashes with a person's right to privacy and basic concepts of autonomy underpinning all rights, and in practice interferes with and undermines the right to health.

The decision to use drugs, as the decision to consume alcohol and nicotine, is a matter of personal choice and an exercise of an aspect of the right to privacy under international law, a cornerstone of respect for personal autonomy. Limitations on autonomy and the right to privacy are justified only if they meet the criteria of legitimate purpose, proportionality, necessity, and non-discrimination. The criteria of proportionality and necessity require governments to consider what means are available to achieve the same purpose that would be least restrictive or pose minimal interference with respect for and exercise of human rights. Human Rights Watch believes that arguments for criminalization of personal drug use or possession of drugs for personal rarely, if ever, meet these criteria.

Different purposes have been advanced to justify the criminalization of drug use. One of those purposes is that of morality; drug use is seen by many as morally dubious or reprehensible, regardless of whether someone is harmed by it. Human rights norms however protect an individual's autonomy and right to privacy, which may include engaging in conduct that the majority may eschew as immoral, but where there is no harm to others. For example, human rights jurisprudence leaves no doubt today that majority public morality, if so inclined, cannot justify criminalization of private homosexual conduct by consenting adults. In essence, promoting public morality in the absence of harm to others is not a "legitimate purpose" for criminalization.

Protecting health is a legitimate purpose, as is protecting harm to others that may occur or be risked because of someone's drug use. But criminalization of drug use to protect someone from harming his or her *own health* does not meet criteria of necessity or proportionality.

Governments have many non-penal measures to reduce harms to someone who uses drugs, including offering substance abuse treatment and social supports. While the state has an important role in protecting health, it should not do so by punishing the person whose health it seeks to protect. As to proportionality—arrest, incarceration, a criminal record with possibly life-long consequences—these are an inherently disproportionate government response to someone who has done nothing more than partake of recreational drugs. Criminalization can also disrupt the ability of individuals to secure their right to livelihood and housing, and it can separate families and parents from their children. The state can encourage people to make good choices around drugs without punishing them.

Criminal sanctions for drug possession and personal use have counter-productive health consequences. Imprisoning people who use drugs [does little to protect their health](#), and fear of criminal sanctions can deter individuals who use drugs from accessing health services and treatment, subject them to stigma and discrimination, and increase the risk of infection (e.g., by HIV and other blood-borne infections such as hepatitis). Individuals have a right to obtain lifesaving health services without fear of punishment or discrimination.

But Human Rights Watch research in many countries—including the [US](#), [Ukraine](#), [Russia](#), Thailand, [Canada](#), [Kazakhstan](#), [Greece](#), and [Bangladesh](#)—has shown how criminal laws relating to drug use and possession for personal use, and related law enforcement practices, drive people away from lifesaving information and health services. In some countries, many people who inject drugs do not carry sterile syringes or other injecting equipment, even though it is legal to do so, because possession of such equipment can mark an individual as a drug user and expose him or her to punishment on other grounds. Many do not seek treatment or attend harm reduction services, again, for fear of arrest and conviction. Our research in this area is consistent with the findings and recommendations of other leading experts working on the right to health, to freedom from torture and ill-treatment, on drug treatment, and in particular in relation to the prevention, care, and treatment of HIV, who have called for a focus on harm reduction, including access to sterile syringes and effective drug treatment, instead of punishment.

For example, in 2010 the UN Special Rapporteur on the Right to Health in his report to the UN General Assembly on the right to health and international drug control, specifically called for decriminalization on grounds of respect for the right to health and recommended that:

... human rights be integrated into the international response to drug control, through use of guidelines and indicators relating to drug use and possession, and that the creation of an alternative drug regulatory framework should be considered. Additionally, Member States should ensure that harm-reduction measures and drug-dependence treatment services are available to people who use drugs, especially focusing on incarcerated populations. [*They also should reform domestic laws to decriminalize or de-penalize possession and use of drugs, and increase access to controlled essential medicines \[emphasis added\].*](#)

With respect to drug use by children, as a party to the Convention on the Rights of the Child, Ireland has obligations to take appropriate measures—legislative, administrative, social, educational—to protect children from the illicit use of narcotic drugs and psychotropic substances. But, in line with international standards, criminal penalties should not be imposed on children for drug use or possession.

Drug use in some situations causes or threatens to cause serious harm to others, and states have a legitimate interest in protecting third parties from harm resulting from drug use. In such circumstances, states may impose proportionate penal sanctions on harmful behavior that takes place in conjunction with drug use. Thus, a state might choose to criminalize driving a car or

flying a plane while under the influence of drugs. It might choose to arrest a person who seriously neglects or abuses a child, where drug dependence is a factor in the neglect or abuse. It might make drug use an aggravating factor in an assault. But in such cases the conduct or offense being punished with criminal sanctions is not simply using drugs, but directly causing or risking harm to others while using drugs.

2. Other Human Rights Impacts of Drug Policy Dependent on Criminalization

In addition to the concerns outlined above regarding criminalization of personal drug use and possession, it may be useful for the Committee to consider some of the findings of our research over the past two decades on global drug policy more generally:

- **National and international responses to drugs have often involved large-scale abuses and discriminatory practices in the name of enforcing criminal laws or ensuring “treatment” of people who use drugs.**

In countries around the world, we have documented how state enforcement of criminal drug laws has resulted, directly or indirectly, in serious and sometimes widespread and systematic human rights violations. Drug control policies, and accompanying law enforcement practices, have targeted vulnerable or disfavored minorities, reflecting and exacerbating systemic discrimination against them. Low-level drug offenders in the United States and other countries serve disproportionately long prison terms or even, in countries such as Iran and Singapore, face the death penalty. A step further, military and police forces engage in extrajudicial killings, enforced disappearances, torture and ill-treatment, and arbitrary detention. To cite only a few examples:

- The United States has the world’s largest reported incarcerated population (2.2 million people in adult prisons and jails), in significant part due to harsh sentences for drug offenses. US drug law enforcement is also marred by deep, discriminatory racial disparities, disproportionately affecting African Americans. Aside from the obvious harms associated with imprisonment, the [consequences](#) of obtaining a criminal record are considerable and can affect access to future employment, education and even social services such as housing.
- In [Greece](#), police in Athens subject people who use drugs (many of whom are also homeless and/or people who sell sex to support their use or for basic necessities) to arbitrary and abusive stops and searches, and arbitrary detention. These practices interfere with the ability of drug users and those dependent on drugs to access health information, medical care, and other services, as well as obstruct the work of service providers. People who use drugs are excluded from government and municipality-run homeless shelters, and no alternative housing is provided.
- In [Mexico](#) the drug-related homicide rate exploded after 2007, with tens of thousands of people being killed. The US provided more than \$2 billion in funding to Mexico to

combat drugs during that time. Yet the Mexican security forces deployed in the country's "war on drugs" have themselves often been [involved](#) in torture, extrajudicial killings, and enforced disappearances.

- In [Canada](#), [Kazakhstan](#), [Bangladesh](#), and [Ukraine](#), police have violently mistreated people who use drugs. In [Tanzania](#), police and quasi-official vigilante groups have brutally beaten people who inject drugs.
 - In [Cambodia](#), [Laos](#), and [Vietnam](#), people who use drugs are held in government-run centers where they are often abused in the name of "treatment."
 - [Indonesia](#), and several other countries—including [Singapore](#), Malaysia, [Iran](#) and China—impose the death penalty for drug offenses, in violation of international standards that limit the death penalty's use to the "most serious crimes."
- **The heavy emphasis on criminalizing the drug trade has dramatically enhanced the profitability of illicit drug markets, fueling the operations of groups that commit abuses, corrupt authorities, and undermine democracy and the rule of law.**

A 2011 [analysis](#) by the United Nations Office on Drugs and Crime (UNODC) found that illicit drugs constitute the largest income source for transnational crime, accounting for about half of transnational crime proceeds. Organized criminal groups from Mexico and [Colombia](#) to [Afghanistan](#), among others, obtain vast wealth from various facets of the illicit drug trade. We have repeatedly documented how many such groups and individuals commit serious crimes, including massacres, targeted killings, rape, torture, abductions, extortion, and forced displacement. They may engage in these crimes to perpetuate their control over the drug market or to further a political agenda. The funds from the illegal drug trade often enable them, through corruption, to evade justice and even secure the complicity of state agents in their crimes.

This was the central point raised by the governments of Mexico, Colombia and Guatemala in their October 2012 [joint statement](#) to the UN, asking for a review of the current drug control regime: "Despite the efforts of the international community over decades," drug use "continues to increase globally, generating substantial income for criminal organizations worldwide," said the governments, pointing out that those resources enabled criminal organizations "to penetrate and corrupt institutions of the States.... As long as the flow of resources from drugs and weapons to criminal organizations [is] not stopped, they will continue to threaten our societies and governments." But the current heavy emphasis on criminalization, rather than stopping that flow of resources, seems to be only making the business more profitable.

- **Restrictive drug policies impede medical and scientific use of controlled substances in numerous countries, condemning millions to needless suffering from pain and other symptoms.**

Controlled substances play a critical role in any healthcare system. At present, 12 medicines that are made of or contain controlled substances are on the World Health Organization (WHO) Model List of Essential Medicines, a list of medicines that should be available to all who need them. These medications are used such diverse fields of medicine as analgesia, anesthesia, drug dependence, maternal health, mental health, neurology, and palliative care.

A wealth of research from countries around the world, however, suggests that controlled substance regulations often interfere with the availability and accessibility of this group of medicines, especially strong analgesics. Regulations are frequently far more restrictive than required by the UN drug conventions, complicating and deterring their use. Human Rights Watch has documented the existence of needlessly restrictive regulations in more than a dozen countries, including Armenia, Guatemala, [India](#), [Kenya](#), [Mexico](#), Morocco, [Russia](#), [Senegal](#) and [Ukraine](#).

[According](#) to the International Narcotics Control Board (INCB)—the body responsible for monitoring the 1961 Convention— “approximately 5.5 billion people, or three quarters of the world’s population, live in countries with... inadequate access to treatment for moderate to severe pain.” Due to limited access to essential medicines, the WHO estimates that tens of millions of people around the world, including around 5.5 million end-stage cancer patients and one million people with AIDS, suffer from moderate to severe pain each year without treatment. Human Rights Watch has documented the egregious impact on patients of these regulatory restrictions. We have found that people with untreated severe pain often describe their pain in exactly same terms as victims of torture—that is, as so intense that they would do anything to make it stop. The failure to provide access to palliative pain relief in those circumstances [interferes](#) with the right to the highest attainable standard of health and in some circumstances can amount to a violation of the prohibition on cruel, inhuman, and degrading treatment.

3. Recommendations to the Committee

Human Rights Watch recognizes that reform of existing strategies for drug control may raise legitimate concerns about unintended social or health costs, such as a significant increase in drug abuse. However, rather than be driven by fear and speculation, we urge the Irish government to implement reforms based upon evidence of effective ways to reduce the harms to others that can accompany drug use and drug control. In considering how Ireland can reform current drug policies in ways that also enhance respect for human rights standards, we recommend that Ireland:

- **Decriminalize personal use and possession of drugs for personal use.**

Criminalization is not necessary to protect people who use drugs: governments have many non-penal measures to encourage people to make good choices around drugs, including offering substance abuse treatment and social support. Governments can also criminalize negligent or dangerous behavior (such as driving under the influence) to regulate harmful conduct by individuals who use drugs, without criminalizing drug use itself.

As noted, in Portugal, as the Committee is aware, decriminalization—in conjunction with comprehensive harm-reduction strategies—has had positive results; rather than substantially increasing, drug consumption reportedly dropped in some categories—as did recidivism and HIV infection—and fewer people suffered the severe consequences of being caught up in the criminal justice system.

- **Consider broader reforms to reduce criminal regulation of drug production and distribution and encourage other countries to do the same.**

Criminalization of the drug trade carries enormous human rights costs on a global scale, dramatically enhancing the profitability of illicit drug markets and fueling the growth and operations of groups responsible for large-scale violence and corruption. Finding alternative ways to regulate production and distribution and cutting into illicit drug profits would allow governments to weaken the influence of such groups and reduce the various abuses—killings, disproportionate sentencing, torture, and barriers to access to health care—that governments often commit in the name of fighting drugs.

- **Ground approaches to treatment and care in human rights, avoiding abusive administrative sanctions and ensuring patients have access to needed medications.**

In moving towards decriminalization, Ireland should avoid creating new human rights problems (for example, it should avoid creating systems of mandatory treatment that would compound abuses), and should support access to voluntary, community-based drug treatment with the involvement of competent nongovernmental organizations. They should also ensure that anyone with a legitimate medical need for controlled medications like morphine or methadone has adequate access to them.

- **Support reform of global drug policies along these lines during the upcoming 2016 UNGASS on Drugs**

Should Ireland move forward with reform, it will set an important example at the upcoming 2016 UNGASS on Drugs. We would strongly encourage the country to be an active participant at that session in pressing for reform of global drug policies.

Once again, thank you for the opportunity to submit these comments, and we are available to provide further information or copies of reports, or discuss in further detail any of our research and recommendations on drug policy and human rights with the committee or representatives of the Irish government. We look forward to continuing discussion of these and other matters.



**Dublin North East Drugs & Alcohol Task Force Ltd
The Mornington Centre, 44a Malahide Road, Artane, Dublin 5**

Submission to the Oireachtas Committee on Justice, Defence and Equality in relation to arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use

The Task Force board welcome the fact that the Oireachtas committee are seeking submissions in relation to arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use.

The board of the Task Force recognises that there is a need for a national public debate in relation to the current approach to addiction at national policy level where in the Irish context it is primarily treated as a criminal issue rather than a public health issue. The Task Force agrees that the national debate should not centre on decriminalisation of drugs which would be divisive. It should be treated as a review of public health strategy where the emphasis should be placed on preventing and tackling addiction rather than punishing it.

The factors influencing addiction stem from individual, relationship, community and societal factors. Sanctions for possession are counterproductive, it is necessary to act across multiple areas at the same time. This approach is more likely to sustain prevention efforts over time than any single intervention. Individual factors that increase the likelihood of becoming an addict include age, education, income and history of abuse. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviours that ultimately prevent addiction. Specific approaches may include education and life skills training. The Task Force provide an education bursary for substance misusers in recovery.

Relationships may increase the likelihood of addiction. A person's closest social circle: - family, partners and peers influence behaviour. Prevention strategies at this level may include parenting or family-focused prevention programmes and mentoring and peer programmes designed to reduce conflict, foster problem solving skills and promote healthy relationships. The Task Force provide Strengthening Families Programmes which are evidence based and very successful.

The third level concentrates on community settings such as schools, workplaces and neighbourhoods in which social relationships occur. Prevention strategies at this level are typically designed to impact on the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighbourhoods, as well as the culture, processes and policies within schools and workplace settings. The Task Force provide drug awareness programmes for schools and parents in our area.

The fourth level looks at the broad societal factors that help create a climate in which substance misuse is encouraged or inhibited. These factors include social and cultural norms that support substance use as an acceptable practice. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

A change in legislation decriminalising drugs such as cannabis for personal use needs to be rooted in the broad public health policy which recognises all factors influencing addiction. It is also crucial to highlight the distinction between decriminalisation and legalisation. Drug possession for personal use would still be an offence, albeit a civil rather than a criminal offence. A Commission along the lines of the Commission for Dissuasion in Portugal would need to be set up. It would also be necessary to stress that criminal behaviour arising from drug possession will still be prosecuted. This is similar to the way that people are not prosecuted for being in possession of alcohol for their own use but are charged for offences arising from their behaviour while under the influence e.g. drunk driving, assault, criminal damage and domestic violence. Similarly drug dealers and gangland crime will continue to be targeted as normal as the Task Force recognises and have serious concerns about the intimidation and violence that is impacting on people's lives as a result of the illegal drugs trade.

Sanctions for possession of certain amounts of drugs for personal use have led to users and their families being stigmatised. It has created a barrier to employment, training, housing, travel and insurance. It causes significant harm to an individual's future prospects given that under Irish Law the person carries a conviction for their whole life and the requirement to disclose previous convictions never lapses.

Decriminalisation has occurred in 25-30 countries including Mexico, Jamaica, Chile, Germany, Switzerland, Australia and Belgium. Evidence supports its introduction. Mexico was one of the countries that moved towards the 'decriminalising' of drugs, electing instead, to adopt a more humane approach, by treating those caught with 'personal consumption', as patients and not criminals. Campaigners had long argued that criminalisation only enriched drug cartels; triggered savage turf wars; corrupted state institutions and filled prisons with addicts who presented no real threat to society.

In Australia they found that, the States that had implemented decriminalisation, had shown a capacity to keep individuals out of the criminal justice system. They also found that 'the individuals given criminal penalties were more likely to suffer negative employment, relationship and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system than the South Australia (non-criminalised) individuals.'

While acknowledging that these are complex issues members of the Task Force believe that a change in national drugs policy is required and would broadly support the decriminalisation of drugs. However they also would like to highlight the fact that what may be effective in other jurisdictions may not necessarily be appropriate to the Irish context. In addition any change in national policy will be ineffective without a commitment from government to provide adequate resources to ensure that those most affected have access to appropriate services.

Taking into consideration these issues the Task Force recommend that any change in national policy must be based on a wider debate within a framework of Human Rights, Criminal Justice and Public Health which is informed by evidence from the Irish context and from other jurisdictions in terms of the impact of any changes may have and the outcomes for individuals, families and communities most affected.

The Task Force are also recommending that Local Drugs and Alcohol Task Forces be given a lead role at local and national level in facilitating further debate, discussions and consultations.

David McVicker

We ought to decriminalise

The first Irish drug conviction occurred in 1964. At that time the drug issue was minuscule. Today, approximately 250,000 people are using various illicit drugs in our society.

If in criminalising the intention was to grow the situation to it's current volume and corrupt the whole of society through that process (the power, terror and dominance of organised crime and the many thugs so willing to retail drugs), we have done well. If not, then "Heuston, we have a problem..." and that problem has been naive policy.

Decriminalisation of drug users will cast light on what is an underground situation. It will be the first step in undoing the mess that failed policy has created. Steps which will allow society to gain some controls on this social phenomenon. What we currently do is counter-productive and is in need of complete reform.



FTAI

Family Therapy Association of Ireland

For the attention of:

Joint Committee on Justice, Defence and Equality

**REVIEW OF IRELAND'S APPROACH TO THE POSSESSION OF LIMITED QUANTITIES OF
CERTAIN DRUGS**

Dear Members of the Committee,

The Family Therapy Association of Ireland is the representative body of Family Therapists in Ireland.

Our members provide therapy to the public on an individual, couples and family basis to help people work with many issues, including the issue of drug usage. We have many members in the Health Services, in CAMHS teams and in teams working in the area of addiction. Because of this, we see ourselves well-placed to offer an opinion on how the committee might proceed toward a decision in relation to Ireland's approach to the possession of limited quantities of certain drugs and what supports might be needed to be put in place to back up this decision.

Yours sincerely,

Peter Caffrey

*Chairperson,
Family Therapy Association of Ireland.
7TH August 2015*



FTAI

Family Therapy Association of Ireland

7TH August 2015

Dear Members of the Committee,

I write on behalf of the Family Therapy Association of Ireland. (FTAI). We are a professional accrediting association representing over 250 accredited Systemic Family Therapists. We work with families, couples, and children.

FTAI recognises the need to develop a comprehensive approach towards drug usage in Ireland. FTAI holds that this approach should be based on what is identified as best practice internationally, and that this identification of best practice should be evidence based in terms of treatment and criminal justice approaches. In this regard, we note that the examination of the research base which has emerged around the Lisbon report would be an important part of assessing the validity of this approach here.

Having said this, FTAI recognises the responsibility of Government in formulating strategies for tackling the issues of drug usage in Ireland today. Emerging patterns of recreational drug usage, coupled with rapidly changing views in society with regard to this usage, requires creative responses from Government. This inevitably involves taking calculated risks and reviewing the outcomes of these strategies.

FTAI acknowledges that not criminalizing people for possession of small amounts for personal usage has many clear advantages. We wish to highlight two such points in this submission.

Firstly, it tackles an issue relating to the pressure on the Court system at present. It also acknowledges the value of keeping young people, in particular, out of the Court system. By removing the pressure on police to prosecute in such circumstances, it also creates the possibility that interaction with An Garda Síochána might be seen as more positive. This could be very supportive of work that the Gardai are trying to achieve through their Diversionary Projects.

Secondly, it acknowledges the primary responsibility that people have to regulate their own usage of recreational drugs. However, a part of this acknowledgment of people being 'experts in their own lives', is acknowledging that people should be listened to when they declare their usage to be problematic and wish to seek treatment. In other words, making treatment much more widely available and better funded is the inevitable corollary of this proposed relaxation in legislation. In this regard, we in FTAI are anxious that the primary motivation for any move away from the Courts should not be a money saving exercise, but should involve facilitating meaningful investment in an alternative approach which would provide properly resourced treatment for drug users.

We support the offer of treatment within 72 hours as referred to on Page 3 of the document. FTAI would welcome a costing of how much it would take to provide such a level of support here in Ireland, and a commitment to provide it. This would be a necessary component of taking on this Lisbon model, even on a pilot basis. However, such approaches as those being discussed here need to be put into the wider context. FTAI also wishes to emphasise the indisputable truth about drug usage. Drugs destroy communities, destroy lives, destroy families; and this damage can extend through generations. This is where the resources need to be directed. There are articulate voices who can always speak around issues such as advocating some level of decriminalization. But we

must never forget our obligation to speak on behalf of those who are caught in the web of addiction; who are voiceless and marginalized in Irish Society, and whose communities are ravaged by drugs. Their situation must be at the epicentre of any decision we take on this matter

FTAI further recognises that meaningful treatment includes individual treatment, but goes beyond this to incorporate the family system of the user. There is considerable evidence of the efficacy of Family Therapy approaches as a very successful treatment model when working with issues of drug usage; especially amongst young people. C.L. Rowe's review of these approaches in the *Journal of Marital and Family Therapy* in 2012 is one such example. In the light of the Registration standards recognised throughout the European Community for Psychotherapy, we draw a distinction between Family Support and Family Therapy. We urge the wider use of Family Therapy as a part of the treatment team. Such Family Therapy includes, but goes far beyond, offering family support. It recognises the need to engage with the whole family system to provide therapeutic support for the drug user. Family Therapy also helps the members of that family system to deal with what they have experienced in the past and what the future may hold as a result of the impact of drugs on their lives. This would involve the recruitment of Family Therapists to the treatment teams, as only properly trained and registered Family Therapists could provide Family Therapy in this context.

FTAI members are affiliated to the Irish Council for Psychotherapy and can provide psychotherapy at the level recognised by the European Association of Psychotherapy. This standard would be essential if a European model of treatment is being offered, as is being suggested here. There would be a cost factor, but the cost of this, and other treatment modalities, would be offset by the proposed reduction in the use of an expensive Court system.

We ask you to consider these matters when deciding how to proceed.

Yours Sincerely,


Peter Caffrey

*Chairperson,
Family Therapy Association of Ireland.*

Maria Langan

A submission of opinion to the Committee on Justice, Defense and Equality's review of Ireland's approach to the possession of limited quantities of certain drugs.

The following proposal is compiled on information gathered from a personal and professional interest on the use of and effect of certain drugs, deemed illegal in Ireland, on the individual, their families and the society. Personally, I am a 30-year-old Irish female who has had considerable exposure to certain 'drugs' mainly through socializing with friends, music culture, arts and festivals. I have watched loved ones battle addictions through substance abuse. Professionally, I am a Registered General Nurse, achieved my BSc Honors Degree in Ireland in 2007 and have worked in Ireland, London and Melbourne in the capacity of a General Nurse and Critical Care Nurse in both the public and private sector. I am currently employed as an Intensive Care Nurse in one of London's major NHS Trusts.

Law Reform

Firstly, I would like to applaud the committee for their efforts in visiting Portugal and taking this matter seriously. This 'War on Drugs' is not working and the only people that seem to benefit from it are the people employed by the judicial system. I daren't say the Gardai. Even though they may hit their arrest targets, their energies could be focused better elsewhere.

I am no expert on politics, but what I have witnessed is that political agenda takes precedent over science and evidence, whether its by not educating voters (who have been swayed by media) to the actual facts in order to keep votes or to keep big business happy. This was evident in the sacking of Professor David Nutt, the chief government advisor in the UK Parliament by the then Labour Government because he presented them with evidence that they were not willing to listen to. I invite you to watch one of his many informative lectures 'Beyond Politics: Putting Science at the Heart of Drug Policy' (2014). This government, then headed by Gordon Brown went ahead with reclassification of Cannabis from Class C to Class B and ignored the scientific evidence presented to him on the basis of political ideology. There is also the work of ex-police chief constable Tom Llyod (2013) (whom I recommend you become familiar with if not already so) and his efforts to inform the public, minus the media propaganda and hysteria, of the real costs and damage this 'war on drugs' is causing. I would like to quote him on saying that "*this is not a war on drugs, it's a war on people*"!

It is evident in the Oireachtas' report from its visit to Portugal that the data collected clearly suggests that criminalization of an individual for possession of illegal drugs is not beneficial to the individual or the greater society. And their approach to decriminalization is clearly working for the greater good. The result of continuous persecution and criminalisation of individuals for possession of drugs for personal use, a non-violent crime is ridiculous. It's a complete waste of Garda time. And its causing people to resent the Gardai, who if put to better use by using resources to put more effort into fighting violent crime, we may see them be granted the respect they deserve for putting themselves in the vulnerable positions they are placed in. There are already laws in place to charge someone with antisocial behaviour, if needs be, regardless of the substances they choose to ingest.

Not every person who takes drugs is an addict! Likewise, not every person who drinks alcohol is an alcoholic. There are many individuals/professionals out there who come home in the evening and enjoy a joint of cannabis, or go out on a Saturday and enjoy an ecstasy pill or a line of cocaine and maybe in the right setting enjoy an LSD trip or when in season a few magic mushrooms for whatever reason, medicinal, spiritual or recreational. They do not become addicts, and use of the majority of the fore mentioned substances does not lead to addiction or destruction of society. The majority of people has control over their lives and should be allowed autonomy and sovereignty over their own bodies and consciousness to explore these altered states, the same way one might enjoy alcohol responsibly.

One could say that the most unpleasant effect of using these illegal substances is actually getting caught by the law! This law that is in place to 'protect' us is actually doing more harm than good. It is clearly obvious that just because something is illegal, it does not hinder one's curiosity and want to use a substance. It just creates an unsafe environment for the person to do so. Not only are people being exposed to criminal activity but because these substances are not regulated it is unclear what exactly is being sold or labeled as a particular substance, never mind the dosage. This may lead to overdose, and the secrecy surrounding the activity may hinder efforts for the necessary medical treatment to be obtained. What 18 year old wants their parents to find out that they've taken 4 ecstasy pills that they were unaware were double the standard dose or worse yet an unknown substance. Then if and when they receive medical treatment, the substance may not be able to be identified further delaying efforts in finding an effective treatment.

The law and the people that put and keep this law in place have blood on their hands, blood of the victims to violent crimes, who have seen themselves at the mercy of the criminal drug-lords. Drug-lords, who are there to provide a

service to the public because there is a want in the market. They do not care for the law or the potential threats from law enforcement. Take a look at the Mexican drug-lord Joaquin 'El Chapo' Guzmán who was able to bribe his way out of escaping from a maximum-security prison, for the second time! He took to Twitter to gloat about his achievement. The law means nothing to the people on top, and as long as they have the power, everyone underneath them will suffer.

Drugs are here to stay; they always have been and always will be. Cannabis, psilocybin, mescaline and *N,N*-Dimethyltryptamine (DMT) have been used as sacred and medicinal substances by native and indigenous cultures for thousands of years. Current research into the use of psychedelics, their induced spiritual states and reported god like experiences by Rick Strassman, the scientist who conducted the very first research on the experiences of people under the influence of DMT in his ground breaking study back in 1992, has suggested in his new book *DMT The Soul of Prophecy, A New Science of Spiritual Revelation in the Hebrew Bible* (2014), after careful dissection and review of the Hebrew bible, that these induced states could be the basis of established religions.

Like anything, there will be some dangers and misuse. We have a mass misuse of food in society leading to increased morbidity and mortality. Avena, Rada and Hoebel (2008) found that sugar is far more addictive than cocaine. Is the best answer to place sanctions on one's choice of diet? Do we ban sugar? No. We educate, regulate, and provide services for people who need assistance. Everything in life carries dangers and the best way to eliminate dangers associated with these certain drugs is to remove the added risks that prohibition places on them and educate people to use responsibly or not use at all. Look at the positive result we've seen with tobacco use and the significant drop in people smoking. We need to remove the media fuelled propaganda and hysteria. People need to be informed of the science and facts to make informed choices.

Decriminalization alone will still allow for the above-mentioned violence by drug-lords, uneducated misuse and sale of contaminated, unknown substances. That is why all these drugs, need to be legalized and regulated, and non-biased education provided to people. People should have the right to know what they are taking (like we know what's in our bottle of beer or wine) and make informed choices on whether they would like to take a substance or not. It's a means of risk management and should result in fewer overdoses and death. There's the all too familiar depiction of the guy on a night out shouting about how 'drugs are bad' and calling users 'druggies', this after he himself has downed 10 pints of beer, without even being aware that he is a druggie himself. We can thank the alcohol industry for their very clever advertising.

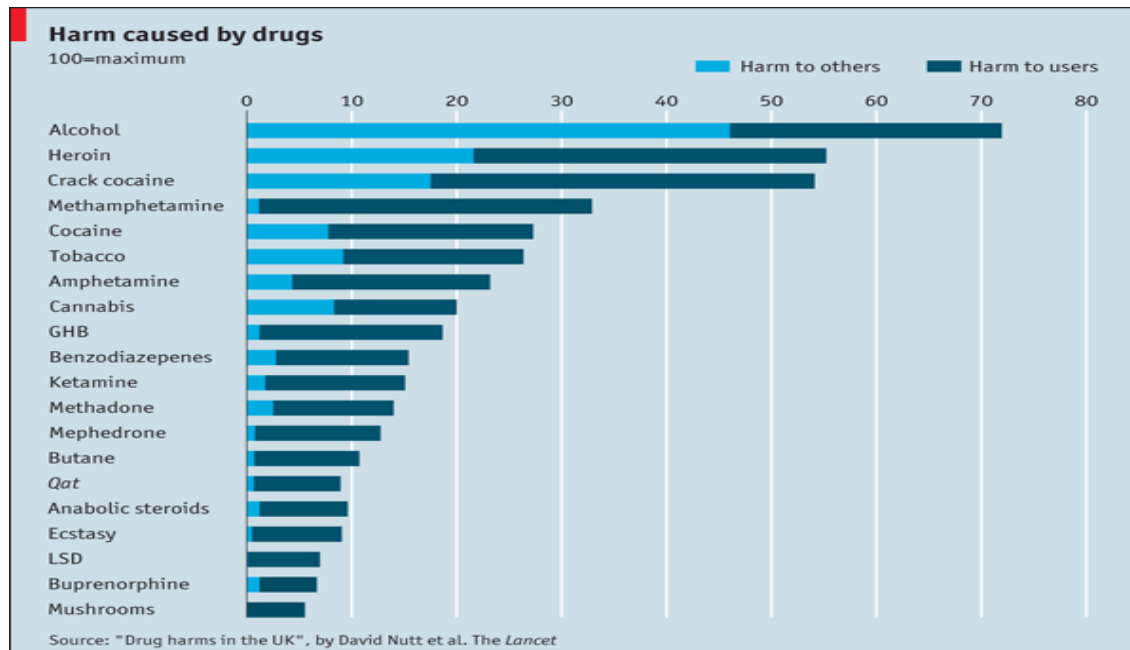


The laws in place to 'protect' us are not reflected in the harm these certain drugs cause in society. I am fully aware of the complications that legalization poses. It's difficult to imagine ever walking into a store and buying heroin, although, it is already a drug that is available on prescription, under the name Diamorphine. But for someone who has sought after and bought it off the street, there should be harm reduction implementation. If decriminalization is the first step in harm reduction, I agree with the notion of providing a safe environment for intravenous drug users to get and use clean equipment. There should also be testing kits available to allow people (intravenous and non-intravenous drug users) to test the substance that they have just bought to inform them of contamination and dose. If these were readily available to users it might have the dealer step up their game in providing a clean up-to-standard substance.

The hysteric media done well to highlight the case of one young girl who on a night out in Dublin died after taking a substance, what she thought was ecstasy. When people buy and take ecstasy they expect to be taking Methylenedioxy Methamphetamine (MDMA), but what we seen in this case, correct me if I am wrong, that the substance was in fact Paramethoxymethamphetamine (PMMA). Somebody who has purchased ecstasy with the intent of taking MDMA and unaware that the substance is PMMA subsequently is unaware of the toxicity. Information available on Drugs.ie tells us that PMMA is more toxic at lower doses, and can take longer to take effect than MDMA. The effects are less euphoric too. All these put together, may lead the individual to think that they have taken a weak or dud pill and may lead to the consumption of more, which may prove fatal. Fatal cases are preventable, and not by telling people 'drugs are bad'. That line does not work.

Clubs and festivals, who's patrons are mainly fueled by drugs such as alcohol, MDMA, LSD, cocaine or cannabis, should not be punished by assuming the encouraged use of drugs, for acknowledging drug use and providing

education, testing kits and safe havens to go to if having a bad experience. This idea should be embraced and have educated staff present to provide information on how to deal with suspected 'bad trips' or overdoses. The secrecy around drug taking needs to end in order to reduce the potential harms. It'd be interesting to survey The Order of Malta or St. John Ambulance to see what substance is the main cause of casualty on Ireland's streets at weekends and at festivals. I have my suspicions if the chart below is anything to go by.



Addiction

I would like to reference the work of Bruce K. Alexander (2010) titled *Addiction: the view from Rat Park*. In summary, the numerous experiments in the 1960s of rats kept in isolated cages with no social stimuli, only given the opportunity to continuously dose themselves with various drugs such as heroin, morphine, cocaine or amphetamine gave rise to the opinion that these drugs were highly addictive and fueled the government agenda at the time to promote this 'war on drugs'. What they didn't take into account was the mental abuse and suffering that these rats, once highly sociable mammals, were exposed to in these isolation chambers.

Put these rats in Rat Park, a highly social and interactive environment and the results were quite the opposite. The rats, which had every opportunity to continue 'using' what were deemed as highly addictive substances chose not to, instead chose to interact and bond with their rat friends and acquaintances. This gives rise to a very different view of addiction. It does not view the substance in question as the cause of addiction, but rather the social isolation or lack of

'bonding' as Johann Hari phrases it in his very information TED talk: Everything you think you know about Addiction is wrong (2015). Society's current view of substance abuse holds the substance to blame, rather than the trauma the individual has been exposed to that has led to the addiction. Trying to eradicate the substance will not eradicate the addictive behaviour. Efforts are being lost, and should be aimed at fixing social agenda and helping the individual see past their trauma.

Based on anecdotal evidence I possess there also seems to be an air of hypocrisy in how the law is enforced. One might see someone being arrested and convicted for possession of a Schedule 2 drug compared to someone being arrested, cautioned or the charge dropped for possession of a Schedule 1 drug, the difference begins between the two offenders only their socioeconomic background. I feel this hypocrisy only widens the gap in society and is very unfair to the party who was not privileged enough to be awarded a second chance.

Rescheduling to take account of medicinal value

So, Oireachtas I have applauded you for taking the time to consider reviewing this immensely important topic. But now, I have to fault you. The Misuse of Drugs Act revised in 2015. How is the scheduling of these drugs based on scientific evidence? The Oireachtas had the opportunity a few months ago while reviewing the Act to explore and update itself on the plethora of scientific research, which supports the medical benefit and use of the majority of the substances, listed as Schedule 1.

First off, to conclude that Cannabis, a Schedule 1 substance, is of no medical value is completely incorrect and should be challenged in court. Cannabis has been used for thousands of years as a medicine, the first known reference to it in 2900 BC by the Chinese Emperor Fu Hsi (Deitch, 2003). It was used as an effective medicine up until the 1930s when the likes of aspirin and morphine became a more popular substitute (Eddy, 2010). The use of Cannabis was discredited and it was referred to in its more derogatory term Marijuana, which was racially and politically motivated (Holland, 2010).

The present day view of Cannabis or as they like to call it 'Medical Marijuana' (essentially the same thing as recreational marijuana) is that it has many medical benefits and has been legal for medical use in Israel since 1992. We can thank Prof. Lumir Hanus, Professor of Medicinal Chemistry and Natural Products at the Hebrew University of Jerusalem for his excellent work in studying the Endocannabinoid System in the human body and for isolating the first known endocannabinoid neurotransmitter, anandamide (Hanus, 2007). His predecessor,

Raphael Mechoulam, is the gentleman who is most famous for isolating tetrahydrocannabinol (THC) and cannabidiol (CBD). I have not planned on giving an anatomy lesson, but the Endocannabinoid System has shown to have receptors that play a role in hormone balance in every major organ and system of the body (Sulak, 2015).

Unlike opium, cannabis does not have receptors that effect respiratory rate so cannabis does not possess the same risks as the Schedule 2 opiates/ opioids or benzodiazepines in causing respiratory arrest, which essentially leads to death. Cannabis toxicity is extremely rare. Cannabis does however affect the respiratory system by causing bronchodilation, which is effectively a treatment for asthma (Grassin-Delyle et al, 2014). Pletcher et al (2012) conducted a study over 20 years and found that smoking cannabis does not possess the same harms as smoked tobacco, even though cannabis and tobacco share many of the same toxic chemicals (Taskin, 2013). Hashibe et al (2006) and Tashkin (2013) found no strong evidence to link smoked cannabis with an increased risk of respiratory cancers.

These are just a few examples of its benefit to the human body as a medicine. The following shows how it positively effects the Central Nervous System by acting as a neuroprotector (Hampson et al, 2000), which makes it quite useful in aiding recovery from traumatic/ acquired brain injury (Nguyen et al, 2014) and managing symptoms of Multiple Sclerosis and Parkinson's Disease (Lotan et al, 2014). I have read a report issued by MS Ireland (2013) in which they quote the then minister Alex White as saying that the government were at

“quite an advanced stage in preparing regulations to allow for very limited availability of cannabis for medical purposes”.

This would suggest that the Irish government already know that cannabis is a medicine yet the law does not reflect this and Ireland's medical cannabis users are forced to go underground to seek medicine that is not of the best quality or strain that may be most suitable to their needs and also exposing them to criminal activity, risk and danger.

The production and availability of Sativex also brings into question the hypocrisy in the UK laws. Sativex, essentially Cannabis extract, containing both THC and CBD, manufactured by GWPharma in the UK, granted a license to do so by the UK government, and sold to patients at an extortionate price, even though the current UK law lists cannabis as Schedule 1, a substance recognized as having no medicinal value. Where is the consistency? What is so wrong with allowing people the opportunity to grow their own preferred strain of the crop and enjoy the benefits reaped from the satisfaction of growing such a beneficial plant? Also,

using the plant as a whole, by means of eating the leaves raw by juicing or adding to smoothies, cooking with it or smoking it. It is a super food, like we have seen hemp (the male species of the plant which does not produce the bud and THC content) being advertised as a super food in recent times (Drohan, 2014).

I will go on to mention the massive benefits children suffering childhood epilepsy and experiencing chronic, debilitating seizures have experienced from taking oral cannabis extracts (Press et al, 2015). Cannabis has been known to be an effective treatment for seizures in children since the 1947 (Loewe and Goodman, 1947(cited by Davis and Ramsey, 1949)) but governments, doctors and pharmaceutical companies, opting to treat seizures with more dangerous drugs such as barbiturates and benzodiazepines, ignored this.

Cannabis has also got potential in treating cancer. It has been recognized for a while as medicine that minimizes the negative effects caused by chemotherapy such as pain, discomfort, nausea, loss of appetite, insomnia, and lessens the need for opiate use which also carries side effects of respiratory depression, nausea and constipation. Cannabis, stimulates appetite, relieves nausea and pain but also makes one feel relaxed and aids sleep, this is recognized by the American Cancer Society (2015).

But what has also been researched is cannabis' anti-tumor effect and its ability to trigger cell death in mutant cancerous cells (Guzman et al, 2001) (Shrivastava et al, 2011). This is supported with countless anecdotal evidence easily accessed by a Google search. This should not be a Schedule 1 drug! It should be legalized and made available to people.

I hear you ask, what about the risk of induced psychosis or schizophrenia? One could suggest that prohibition of the substance has inadvertently led to the rise of psychosis induced by cannabis. Due to border control in place by Customs, the influx of cannabis into Ireland from countries where it can grow naturally outdoors is extremely difficult. This has led to the rise of grow houses to meet demand, where the cannabis is exposed to intense treatment to cut the growing time and increase potency to maximize profit. Profit is put before quality. You may be familiar with the term Skunk, a manufactured strain of cannabis with high levels of THC and virtually no CBD. Natural strains of cannabis produce a balanced amount of THC to CBD. CBD is shown to counteract the negative effects of THC that some people report e.g. anxiety (Henquet and Keuppper, 2010). In balanced strains, the overall experience is more pleasurable. Prof. Val Curran, Professor of Psychopharmacology at University College London and co-founder of Channel 4's Drugs Live and an expert in the field of cannabis study, and her team has carried out extensive research on the use and effects of skunk compared to more balanced strains of cannabis (Morgan et al, 2010). Findings

suggest that skunk leads to cognitive impairment rather than balanced strains of cannabis.

The link between cannabis with schizophrenia has been studied for years and still remains controversial (Bossong and Niesink, 2010). Environmental and genetics factors need to be considered. Did the person already have a genetic predisposition to developing schizophrenia (Malone, Hill and Rubino (2010)? Is it related to the rise in use of skunk? Are these symptoms present in more balanced (THC: CBD) strains of the plant (Morgan and Curran, 2008)? Is there evidence of a substantial rise in the incidence of schizophrenia to match the claimed rise in use of cannabis? Are the numbers relevant? A longitudinal study (over 20 years), only published this week (August 3, 2015), observed a population of young adult men from adolescence to mid 30s to see if chronic cannabis use during adolescence impacted physical and mental health later in life. Findings suggest chronic marijuana users are not more likely than late increasing users, adolescence-limited users, or low/nonusers to experience physical or mental health problems in their mid-30s (Bechtold et al, 2015).

With regards the exposure to young adolescents, who is the more likely to sell cannabis to a youth? A 16-year-old drug-dealer, who's been giving an ounce of the herb 'on tic' from a local drug-lord, or a responsible licensed vender? Removing cannabis from the street and placing it in a controlled outlet will lessen exposure to youth. It is mind boggling that people refuse to see this.

In regards to the issue of cannabis exposure to a developing brain, please ponder the following study, carried out on a population of neonates who were exposed to cannabis throughout their time in the womb, their mothers, strict Rastafarian, who smoked heavily throughout pregnancy. The 24 neonates were compared to 20 neonates never exposed to cannabis. On day 3, there were no significant differences between neonates, at 1 month however, the neonates who had chronic exposure to cannabis use scored better at autonomic stability, quality of alertness, irritability and self-regulation (Dreher, Nugent and Hudgins (1994). Though, the better scoring at one month may be secondary to environmental factors, the fact that there was no difference to those exposed and not exposed at day 3 is of importance. This study is relevant for those who might seek to use cannabis to control hyperemesis during pregnancy.

The above mentioned issues of possible involvement of certain strains of cannabis with psychosis highlights the fact that cannabis though beneficial as a medicine, enjoyed by the majority of recreational users to enhance creativity, thinking, writing, music, sex and appetite is not perfect. Nothing is perfect. Consuming too much of anything can cause harm. Drinking too much water can

cause death. Nothing goes without side effects. This is evident in the numerous prescription drugs administered to the Irish public each day. For example, Metformin licensed as an oral hypoglycaemic, increases the risk of myocardial infarction. It is still taken up to 3 times a day by its user. The oral contraceptive pill can increase the risk of deep vein thrombosis, pulmonary embolism, stroke and breast cancer, yet it is prescribed to a large proportion of the female population. I could go on. Please familiarise yourself with the risks involved with prescription antidepressants and the negative side effects people experience when trying to come off them, death being a possibility of uncontrolled withdrawal from benzodiazepines. Yet all these drugs are licensed.

Irish society is well aware of the effect of too much alcohol. One could ponder that by introducing cannabis or MDMA into the mix, it might see a reduction in the amount of alcohol consumed and a reduction in harm to the individual and society as evidence in the above image, the chart compiled by Prof. Davitt Nutt et al, a reflection of the harms caused by the listed drugs on the individual and society. Colorado reports having a significant drop in alcohol associated road traffic accidents since it legalized cannabis (Brady and Li, 2014). Not to mention the millions of dollars they have taken from the pockets of drug dealers and placed back into the society. Irish society would only dream of finding a commodity to result in such revenue. It's a shame that it has not been considered. I would like to highlight the Oireachtas report on the value of illegal drugs seized and destroyed in 2014, near 90,000,000e. I pity the ones who find this something to be proud of. They are obviously not looking at the bigger picture. How much revenue would this alone generate for the state and the economy, this being only a fraction of the total amount, the remainder of which is nestled comfortably in the pocket of some drug-lord in Spain.

Transform, Getting Drugs Under Control have put together an interesting document titled: How to Regulate Cannabis: A Practical Guide (Transform Drug Policy Foundation, 2014).

Next up I would like to discuss the work of the organization MAPS (The Multidisciplinary Association for Psychedelic Study), founded in 1986 by the well published Dr. Rick Doblin to study the medical uses of psychedelic drugs and cannabis. MAPS, is an independent organization, funded by donations and grants. The prestigious Beckley foundation and in more recent times the Wellcome Trust have offered their name and funding in support. The research conducted by MAPS includes positive results for MDMA (Methylenedioxy Methamphetamine) assisted psychotherapy for treating Post Traumatic Stress Disorder in victims of war, sexual abuse, violent crime and other traumas (Bouso et al, 2008), (Mithoefer et al, 2010), (Oehen et al, 2012). MAPS, who's sponsored research continues, have devised a \$20 million action plan to have MDMA

licensed by the Food and Drug Administration and available on prescription by 2021. Ireland should take note.

The study of psychedelic drugs, though deemed controversial by mainstream agenda, has been absolutely beneficial to psychiatry and neuroscience. The study of LSD (Lysergic acid diethylamide), a Schedule 1 substance, assisted in the discovery of the neurotransmitter Serotonin, and the study of both was quite beneficial in understanding psychotic states (Geyer and Vollenweider, 2008). LSD had been in use by psychiatrists for treatment of alcoholism right up until its prohibition (Dyck, 2006).

Extensive study into Psilocybin, a Schedule 1 compound, found in magic-mushrooms had proven it to be beneficial in tobacco cessation, having significantly better rates of cessation compared to nicotine therapy (Griffiths et al, 2014). It has also been shown to be beneficial to cancer patients experiencing distress related to the illness (Grob, Bossis and Griffith, 2013). The most recent study found positive results in psilocybin-assisted therapy for alcohol dependence (Bogenschutz, 2015). The authors' state:

"Participants exhibited significant improvement in drinking, with large pre-post effect sizes, as well as significant changes in psychological measures relevant to drinking. Importantly, much of the improvement occurred following the administration of psilocybin, at which time participants had already received 4 weeks of psychosocial treatment and 4–6 hours of assessment."

Dr. Ben Sessa, a consultant psychiatrist in treating addiction in adolescents and adults in Bristol, and co-founder of the conference on psychedelic use and study, Breaking Conventions, told the Psychedelic Press (Alford, 2015):

"These results add favourably to the growing body of contemporary research with psilocybin. Psilocybin is increasingly shown to be a safe and efficacious compound as an adjunct to psychotherapy for a wide range of psychiatric conditions, from anxiety disorders such as OCD, existential worries associated with end-of-life issues and trauma-based problems to – now with these studies – addictions."

He, Dr. Sessa, has just announced the conduction of a MAPS sponsored study into the use of MDMA assisted therapy to treat alcoholism.

Contrary to sensationalized belief that psychedelics kill brain cells, a 2013 study to measure the effects of psilocybin on mice, conditioned to fear certain stimuli, resulted in them not only getting over their fear, but also demonstrated cell growth and regeneration in their brains (Caltow et al, 2013). These findings are backed up in human trials. Brain imaging of volunteers injected with

psilocybin, carried out by neuroscience departments to include King College London and the Imperial College London, found that the brains of participants under psilocybin grew new links under previously disconnected areas, temporarily altering the brain's entire organizational framework (Petri et al 2014). The researchers state:

"The brain does not simply become a random system after psilocybin injection, but instead retains some organizational features, albeit different from the normal state."

Professor David Nutt, who was involved with the study, relates this to a previous study of his, published in 2012, which found that in people under the influence of psilocybin brain chatter across traditional areas of the brain is muted, including in a region thought to play a role in maintaining our sense-of-self (Carhart-Harris et al, 2012). In depressed people, it is believed, the connections between brain circuits in this sense-of-self region are over-connected. Negative thoughts and feelings of self-criticism become obsessive and overwhelming. Loosening those connections and creating new ones, could provide intense relief. A study lead by the already cited Ronald Griffith backs this claim. It found that a year after receiving a single dose of psilocybin, nearly two-thirds of the 36 volunteers said the experience continued to increase their sense of well-being or life satisfaction (Griffith et al, 2008)

To relate these findings back to prohibition, the law itself is making it extremely difficult and expensive for these studies to be carried out. These psychedelic substances, to include cannabis, MDMA, LSD, psilocybin, mescaline and DMT all play a major role in not only helping us advance in neuroscience, there is so little that we know about the brain and Central Nervous System, but these substances have also proven extremely beneficial for treatments in psychiatry, a field that we are failing at in terms of long-term prescriptions of antidepressants and benzodiazepines, substances that are physically addictive and extremely difficult to cease.

The vast amount of positive information available on the internet, for people seeking to cure themselves of their ailment, regarding these substances are going to cause a want in people to try them out, regardless of the laws in place. This will lead to people obtaining these substances and dabbling with them in uncontrolled environments leading to all sorts of misuse and misguidance. If prohibition of these drugs was abolished, organisations like MAPS, who already provide 'trip guidance' in the form of harm reduction at festivals, would be able to set up licensed treatment centers with trained psychotherapists to provide assisted therapy and follow up.

The law that is claimed to protect us is actually causing more harm than good. The sooner the people that make and enforce the law update themselves on what's going on in the world of science and the world that they serve the better place this world will be for each one of us.

Conclusion

I completely agree that decriminalization, though only a first step is the way forward on this issue. Traditionally opposing political parties need to put their differences aside and look at the facts and science presented before them in order to do what's best for the public they serve. The media hysteria towards these substances needs to end in order for non-biased education to be provided. It is the government's duty to provide accurate information to the public, not provide them with information they think the public wants to hear. The notion of 'encouraging drug use' needs to be left out; the unwitting people need to understand that drug use is very wide in the community among all walks of life and professions. Drugs are a massive part of societies; they always have been and always will be, dating back thousands of years. Criminalizing someone for using a certain substance is not only discriminative and dehumanizing but is a major invasion of privacy and sovereignty over one's self.

The Oireachtas needs to take the approach of harm reduction, regulation and education. The current Misuse of Drugs Act 2015 needs to be reviewed and amended in order for it to be lawful and accurate. It is not evidence based at present. The scheduling of each of the substances listed (I have only mentioned a few) needs to be reviewed against the current literature and evidence of medical use. Only then can this act, and the people implementing this act, be taken seriously.

Oireachtas, by you already highlighting the flaws in the law and showing willingness to overcome the issues portrayed, use this opportunity to take things a step further and welcome the medical use of such substances. The global laws regarding these substances are going to change for the better in the foreseeable future, you have the chance now to explore their use by talking to the expert doctors and scientists and lead the way.

America had an agenda for criminalizing these substances and commencing this so called 'war on drugs' but what they have achieved by doing so is oppression and devastation on a global scale. This oppressive and destructive war on drugs needs to end.

Resources

Breaking Conventions. <http://2015.breakingconvention.co.uk>
Global Commission on Drugs. <http://www.globalcommissionondrugs.org>
Drugs.ie. <http://www.drugs.ie/pma>
Drugs Science, Independent Scientific Committee on Drugs. <http://www.drugscience.org.uk>
Imperial College London Centre for
Neuropsychopharmacology. <http://www1.imperial.ac.uk/departmentsofmedicine/divisions/brainsciences/psychopharmacology/>
Law Enforcement Against Prohibition (LEAP) <http://www.leap.cc>
MAPS Multidisciplinary Association for Psychedelic Study. <http://www.maps.org>
NORML Ireland. <http://www.norml.ie>
Oireachtas. <http://www.oireachtas.ie/parliament/>
Reset.me. <http://reset.me>
Students For Sensible Drug Use. <http://ssdp.org>
The Beckley Foundation. <http://www.beckleyfoundation.org>
Transform Drug Policy Foundation. <http://www.tdpf.org.uk>
University College London Clinical Psychopharmacology Unit. <http://www.ucl.ac.uk/cpu>
Wellcome Trust. <http://www.wellcome.ac.uk>

Recommended Viewing

Breaking the Taboo (2011) http://www.filmsforaction.org/watch/breaking_the_taboo_film/

Clearing the Smoke: The Science of Cannabis
(2011) http://www.filmsforaction.org/watch/clearing_the_smoke_the_science_of_cannabis_2011/

Medical Cannabis and its Impact on Human Health
(2011) http://www.filmsforaction.org/watch/medicinal_cannabis_and_its_impact_on_human_health/

Weed
(2013) http://www.filmsforaction.org/watch/dr_sanjay_gupta_weed_documentary_full_hd/

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Rachael Keogh

The following submission is being presented in favour of altering the present approach in sanctions for possession of certain amounts of drugs for personal use. Addiction worldwide has been recognised as a health issue, from organisations such as the WHO right through to nation states like Portugal. This badly needed shift in perspective has brought real change for a large section of society who up to fifteen years ago had been treated as criminals. My views and opinions are based on my own lived experience of addiction and the criminal justice system in this country. I do not claim to be an expert in anything other than my own story. I do however believe that there is a lot to be learned from reflecting on those who have experienced addiction and drug services first hand. Therefore in the following pages I will outline for you a brief description of what happened to me when I became involved with drugs and subsequently the criminal justice system. What I hope will materialize through this is the ineffective nature of trying to address a complex issue such as addiction through a moral lens. I don't for one second contend that what I did in order to get drugs and feed my addiction, or indeed what others do is right, just or even in many cases moral. What I do contend is that when you view the people who carry out drug related crimes as sick, people who are in the grip of a physical compulsion to get and take drugs and in need of medical help and adequate treatment, then it alters how we should really treat these people. I hope to draw your attention to issues which I feel are not just applicable to my own story but have moulded the lives of many of the women with whom I spent time with in jail. Issues such as the revolving door which fronts prisons worldwide, for the chronic drug-user like I had been, once you go in once chances are you will be back again. What I hope will emerge through outlining my own story is that when I went to prison I was very sick, I stayed sick in prison and when I

got out I was worse than when I went in. I do all of this in order to further a cause which I believe will change the lives of not just drug addicts but whole communities in Ireland which have been ravaged by the drug problem. It is possible to imagine other ways of dealing with this problem at many levels and I believe that the Portuguese government are pioneers in this field. It is my hope that in demonstrating some of the pit falls which I encountered throughout my addiction and attempts to become drug-free it will be possible to imagine how a system such as the one currently in place in Portugal might have led to a very different outcome.

I grew up in Ballymun which was a working class area in Dublin and like many other areas of the city drug use was the norm not the exception. I was eleven years old when I first began smoking cannabis along with most of the other children in my community. My addiction progressed extremely quickly and by the time I was thirteen I was smoking heroin. There was very little education or indeed awareness in relation to the dangers of drugs and a lot of the children who innocently took drugs with me are unfortunately now dead. By the time my family found out about my problem I had already established a drug habit. I was physically addicted to heroin and at this point even though I was very aware of what was right and of what was wrong I began to steal to feed my addiction. I had been a model student in school and my teachers had high hopes for my future. I was the last person any-one thought would end up a drug-addict. My family brought me to a very well known treatment centre and there they were informed that I was "too young to be an addict" and that I was "going through a phase". However as much as I wanted to stop taking drugs I found that I could not and it was at this point that I was expelled from school. This had an enormous impact on me and I was already beginning to feel very dislocated from my community which only fuelled my drug-use. After my family were turned away from the treatment centre my family decided to bring

me abroad for treatment. However I could not speak the language and on return to Ireland my addiction progressed even further. It was at this point that I became known to the Gardai for non violent petty crime. I had being given a J.L.O for possession of stolen goods and by the time I was fifteen I was sent to Mountjoy Women's Prison. So at this point what is clear is that medically I was 'too young to be an addict' yet in the eyes of the criminal justice system I was old enough to be incarcerated for drug related crime. I had never committed a crime until I began using drugs.

This turned out to be the first of many subsequent visits to Mountjoy which became the hallmark of a life plagued by chronic drug addiction. Far from acting as a deterrent to committing crime, prison simply became a normalised part of life in active heroin addiction. Over the years prison was to serve a number of purposes for me, it became my school on maintaining my addiction, my respite, my oasis from the streets, unfortunately all of these things only served to further the downward spiral that characterises addiction, reasons been that there were simply no alternatives. In no way do I claim that going to prison caused my addiction, it did however exacerbate the symptoms. In the 1990's Mountjoy prison was over-crowded which meant that I could serve my sentences crammed into the recreational room with up to five other women. Once I had established a network with other inmates I could then access drugs which were for the whole time that I had being incarcerated readily available to use. When I was fifteen I was exposed to needle sharing and I was given many intravenous hits of heroin by other more experienced drug-user's. I made many other drug contacts that gave me lots of information on how to commit crimes for drugs. I was shown how to use many different types of drugs properly and although I had never been a violent person I was exposed to terrible violence and I was also bullied by other inmates. At the age of

fifteen when other children were developing personal and social skills I was being pushed by the criminal justice system into a terrifying situation that, once I had crossed that line I no longer had anything to fear. The worst thing that could have happened, happened. I felt as though I was being punished for something that I genuinely had no control over because the physical and psychological component of addiction was so potent and overwhelming. This indeed turned out to be true as prison remained a part of my life for the next decade.

There is no need to recount in detail what took place over the next decade. My experience in many ways is a simple one and mirrored by thousands of other drug addicts worldwide. I remained addicted, I committed the crimes necessary to feed that addiction and I returned to prison time and time again. This is not a new story or indeed even a very interesting one but what is interesting is that perhaps another story could have unfolded, a story that seems to be unfolding in the lives of Portuguese drug addicts by placing them under the umbrella of the healthcare system instead of the criminal justice system. If you stand outside of the moral question of whether I should have gone to prison or not and simply ask over that decade what did prison achieve, did it lead to anything worthwhile for anyone involved? Then this raises real questions about how we are currently dealing with drug addicts in this country. All the time you hear people refer to the revolving door of prison, but how many of us have really reflected on why it is that way? Why do drug addicts go back to jail time and time again? Why don't they change, learn their lesson, just say no.

It seems important having highlighted the nature of the so called 'revolving door' to reflect on what this actually looks like in a person's life, what affects it

has and how it can continue to affect them even if they achieve drug free status. I have often reflected back over these years of my life, the many stories I heard, the many women I met who like myself were addicted to drugs and have often questioned why are so few of these women with me in recovery today. Is it something to do with our experiences in jail or the effect that an extensive or otherwise criminal record has on you personally and professionally that has kept these women trapped in a vicious cycle of drugs crime and jail. It is beyond doubt that my life has suffered as result of my actions when I was a child. I believe that the affects of prison in relation to addiction continue to hamper you long after you been released. Perhaps this explains why I meet so few of the women with whom I spent time in jail have managed to break the cycle of addiction. When one begins to reflect on the role of prison in these terms it raises questions as to whether the punishment outweighs the crime. A punishment which for all intensive purposes failed to act as the deterrent it was intended to be.

It is at this point that we need to examine the other big hole in how we as a country deal with addiction, namely drug services. Throughout the period when I was being intermittently incarcerated for drug related crime, my addiction had gotten to a point where I genuinely wanted to stop. However what I was to discover mirrors the experience of millions of addicts worldwide that an honest desire to stop is simply not enough. The problem is not that simple. I don't claim to understand addiction in its entirety, what I do understand and have firsthand experience of is the power of addiction to drive a person to seek and take their drug of choice as an incredible cost to themselves and often times society at large. I don't believe that it is even necessary for this topic to be overly examined, a brief walk through the centre of our capital will outline for anyone that the people who engage in drug use

can't simply just stop doing it. Drug-user's injecting openly on our streets reflects a preoccupation with law and order rather than the well-being of these people. Otherwise we as a country might have safe hygienic consumption rooms where drug-user's can go to use drugs if they choose away from the glare of the rest of society and with their dignity intact. Drugs have become I would imagine for many and from my own experience an integral part of their lives and I believe in this respect we should as a society ask the question of what is right with addiction as opposed to what is wrong with addiction. What are drugs providing for these people that our communities and society can't? I do not know even one person who told me that they aspired to be a drug addict which I find tragic when I reflect on the many I know who subsequently died. Many are using drugs I believe not because they want to but because they need to.

Between the years of 1995-2006 I personally made many attempts to become drug-free as this was something that I desperately wanted and needed. However because of the lack of support available reducing my heroin intake was near impossible, this was made more difficult by to the criteria in place to access the already limited availability of detoxification beds. There-fore I spent a long time on methadone maintenance whilst receiving little to no complimentary therapies. All of this meant that it was impossible to achieve my goal of becoming drug free. In order to access a detoxification bed I would have to be on a methadone program but not on any more than 50mls. I believe that these are inappropriate criteria for detoxification. Often times drug-user's are being forced to take methadone, a drug that they do not necessarily need, in order to access treatment beds. For example if they are addicted to prescription medication, over the counter or are poly-substances users they are put on methadone without certainty of ever accessing treatment. Another

barrier I encountered was that I had to be from the right catchment area in order to be referred for detoxification by a certain doctor. I know that for a lot of drug-user's their postal code did not fall under these catchment areas which prevented them from ever receiving support. On three occasions I had to leave Ireland in order to access treatment. There were however points through-out my addiction that I was lucky enough to access a detox bed, rehabilitation and aftercare which were instrumental in my personal recovery and were successful in many ways. However due to a lack of continuum of care in relation to adequate housing, re-integration back into the workplace and general society many times these interventions proved to be absolutely futile and I am sure a waste of every-one's time and of course the tax-payers money. Taking all of this into consideration and in reflecting over my personal journey of been in and out of prison and receiving legal aid, the amount of time that was wasted in holding cells and going through general administration I cannot help but wonder that if I had grown up in a country where the conduct or activity of drug-use had being removed from the sphere of criminal law. Where there was no fear of accessing treatment by being exposed as a criminal or of been demonized. Where society viewed addiction as a healthcare issue and provided the relevant treatment, then maybe my own life and that of many others who I know might have somehow being very different.

In conclusion of my submission I believe that we cannot waste any more time and that we must radically assess our current policies in relation to drugs right across the board. Particularly in relation to criminalizing drug-user's for possession of small quantities of drugs and for minor non violent drug related crimes. I suggest that we follow in the footsteps of Portugal and deal with our drug problem as a health issue as opposed to a criminal issue. I urge the committee to reflect back on Ireland's first major policy document in the area

of Drug misuse, the 1971 Report of the Working Party on Drug Abuse, which included the opinion that ‘persons who have become dependent on drugs ... should be regarded as sick people in need of medical care to be treated with sympathy and understanding’. It recommended, among other things, that statutory controls to be contained in comprehensive, new, anti-drug legislation should not unduly infringe on individual civil liberties; that there should be a system of scaled penalties for varying types of drug offence; and that the courts should have the power to commit convicted drug abusers to a treatment facility rather than to a conventional prison.

Despite this and enormous expenditures on criminalization and repressive measures directed at reduction, supply and consumers of illegal drugs, the evidence now shows that we have completely failed to effectively curtail supply or even consumption.

I suggest that we replace drug policies and strategies driven by social ideology and political convenience with responsible policies and strategies which are underpinned by health, security and human rights .

It cost over 70.000 euro each year to keep one person in prison, excluding education and training. 27 counsellors from Merchants Quay Ireland have being given access to some prisons in an attempt to assist 73% of the prison population who currently suffer from addiction. I feel that these methods are not adequate enough to rehabilitate and reform people to a state that can integrate them back into society. I firmly believe that prison merely exasperates the problem of addiction, adding to existing feelings of deprivation, social dislocation, powerlessness and marginalization, and makes it much more difficult to get work or access courses due to convictions. We need to invest in those communities who are worst hit by the drug epidemic. To tackle the structural inequality that has become part of everyday life in

Ireland. Offering education, training, amenities, opportunity , jobs, social mobility and life choices. It is no secret that addiction for many people is a way of coping with stress, trauma, social immobility and powerlessness and is a solution to their emotional psychological and social problems. I believe that in order for a drug-user to be motivated to become drug-free the simple rewards of life need to outweigh the effects produced by drugs. There-fore offering training, education and work may be the ideal solution in building confidence and self-esteem for the drug-user and supporting them back to normal living. Stigma, shame and fear create a wall between the drug user and their family from getting the help they need. We need to eliminate this stigma attached and the only way to do that is to inform people that addiction is a sickness. Not just an individual sickness, but a societal one that applies to just about anyone.

It is in my opinion and experience that the prison economy is a revolving door system that many drug user's find near impossible to break from once they have crossed those lines. Prison exposes drug users to more crime, drugs, and makes them susceptible to the sharing of needles and drug paraphernalia and drug pathologies such as HIV and hep C. Portugal decriminalized the drug user in 2001. 15 yrs later not one person has gone to prison. Drug rates and HIV and Hep C rates have decreased. Drug related crime has decreased and they have cut the addiction problem in half. I am not advocating a free for all of drugs. Nor am I advocating that people who commit violent acts of crime should be excluded of punishment. I am simply proposing a much more humane, pragmatic and realistic approach to the drug problem. Instead of putting money into the symptoms of addiction such as policing, arresting, detention, and prison, we could, like Portugal free up enormous amounts of

money which could be re-allocated into the prevention, rehabilitation and treatment of the National Drug Strategy.

At present our primary intervention for drug use is long term methadone maintenance. With approximately 9996 methadone users to a mere 297 GP'S involved in administering it. We still only have 37 detoxification beds for an estimated 20,000 drug addicts. Access to drug services is limited and subject to enormous waiting lists. Often the window of opportunity for change is brief for the drug-user, and barriers to access change limit this even further. Building more rehabs and less prisons would be a sound economic investment in the future of our young people.

Regulation and criminalisation is clearly not working, it is simply pushing the drug problem further underground and resulting in our Government failing to recognise the true nature of the problem. And until we begin to tackle those structures within our society which reproduce generation after generation of drug addicts in our communities it is here to stay.

Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed, Shane Butler, Administration, 39(3), Autumn 1991, pp.210-235.
<http://www.drugsandalcohol.ie/6544/1/508-0443.pdf>

Submission to the Committee on Justice, Defence and Equality on its review of Ireland's approach to possession of limited quantities of certain drugs.

Introduction:

My name is Annmarie Condra and I work part time as a psychotherapist. In working with my clients I have encountered several people who are experiencing or have experienced addiction problems. I have also had some personal experience of addiction and the damage it does and I know a number of people who have unfortunately lost the battle with addiction, I know many more who are winning that battle on a daily basis and living content, successful lives in recovery. I have also been the victim of a number of petty crimes may be addiction related. I have no affiliations to any agencies; my submission is based on my own understanding and opinions on addiction.

My understanding of your review is that it is based on a trip to Portugal which the committee undertook in February of this year. This review looked at the outcomes of steps taken by the Portuguese authorities to deal with their drug problems. The committee explored these steps taken and the outcomes with a view to initiating similar changes in Ireland and is now seeking submissions on the findings. In light of this I will keep my submission to the topics outlined in the report of that visit. I would like however to take the opportunity to suggest that the committee looks at other programmes which have been successfully introduced internationally and should not limit the strategy taken in Ireland to a copy of the strategy in Portugal, examples of other programmes are New Zealand, Ecuador and Uruguay. There are many other examples. The committee should seek to find solutions that are suitable to the culture and demographic of Ireland, some may be in line with what Portugal have done and some may not.

In preparation for this submission I read "Taking Control: Pathways to Drug Policies That Work", published by the Global Commission on Drug Policy in advance of the UN General Assembly Special Session on Drugs scheduled for 2016. I will reference this document.

Responsibility:

A shift has begun internationally to move away from the idea of "a war on drugs" with a justice led solution. More and more countries, including Portugal, have started to view their drug problem as a public health problem. Drug law and the enforcement of such law fuels crime. According to latest figures provided by the Drug Prevalence Survey 6% of the population used cannabis in the last year. That is in excess of 250,000 people. All of this cannabis was imported illegally, sold illegally and generated no revenue for the state.

In addition to this there are the crimes committed by people addicted to drugs in order to pay for those drugs. These are the crimes that the average citizen is victim of or hears about. The daily robberies which we hear about and the ever increasing number of murders happening in Ireland. Shifting responsibility for the use and abuse of drugs from a justice issue to a public health issue could address some of these problems. It would move the focus from criminalising people suffering from a mental health issue to providing the supports and services for their recovery. This is a policy endorsed by the Global Commission and is one of its recommendations.

Decriminalisation not Legalisation.

“Ending criminalisation is a prerequisite of any genuinely health-centred drug policy” the Global Commission states in its report. The Portuguese model sets defined quantities which although still illegal are treated like a traffic offense. I believe this is a good starting point. Although I personally believe that the ultimate solution would be to follow the lead of Uruguay and New Zealand and allow the legally regulated distribution of lower risk drugs. This would reduce the criminality innate in the distribution of drugs currently and also allow the state to benefit from the proceeds through licensing and taxation. These proceeds could be funnelled back into a public health programme aimed at treating those addicted and also educating children about the harms.

However I appreciate that this may be a leap to far for the population and if this is the case, then the Portuguese model is at least the beginning of a change in how we view those addicted to drugs. In Spain the cultivation of small scale amounts of cannabis is permitted and this is definitely something that should be considered. This would allow recreational cannabis users to grow their own. Thus reducing the foothold that organised criminals have over the supply chain. It would not however address the supply of the more hard-core and damaging drugs i.e. heroin, cocaine etc...

Funding

The latest crime figures release by the CSO for the three quarters up to and including Q1 2015 states that there were 15,552 instances of controlled drug offenses. Of these 11,189 were for possession. Give that the subsequent report on the quality of crime statistics published by CSO shows a systemic under reporting it is likely these figures are higher. Also given it could be expected that a reduction would occur in other areas of crime, burglaries etc... There may be some ability for the Department of Justice to contribute in addition to the Department of Health and National Lottery.

As stated previously a controlled regulated market would allow for licencing fees and taxation which would contribute to cost of any public health strategy.

Treatment

There is a very simple fact that needs to be accepted. Not all drug users are addicts, just as not all drinkers are alcoholics. Many of the people using drugs are using those drugs recreationally. Therefore forcing people who are found to be in possession of drugs into treatment is not the answer. It is a waste of the time and resources of those working in the area of treatment and also of the user, who may be an employed person carrying out responsibilities, children, community work and whose placement on a treatment programme would be detrimental to their lives.

The provision of support and treatment services should be made available to all but should not be imposed on all. An assessment could be carried out to determine whether or not the person requires treatment.

Also no one treatment model works for all addicts, therefore there should be a diverse range of treatment services and supports available within the community. The must include the provision of both residential and day treatment programmes, support groups, counselling, job placements and

educational opportunities. Drug addiction affects all areas of the addict's life and therefore a holistic approach that addresses all areas is required.

Breaking the cycle

The idea of "positive discrimination" is a good one. This could possibly be linked to the CE scheme offered by the Department of Social Protection in some way or a similar scheme introduced. Again, though, it must be remembered that many people who possess drugs already have employment.

No criminal record

The committee might consider whether the retrospective removal of criminal records is an area that might be looked especially if this measure is to be introduced going forward.

Education

An education programme about the impacts and effects of all drugs (including alcohol) should be devised at primary school level. If we look at the success of the "Green cross code" and "don't be a litterbug" campaigns we can see that educating children from a young age is effective in changing mind-sets. This education programme must be fact based rather than fear based.

Conclusion

I have taken the time to compile and submit this document as I am concerned about the current regime we have for dealing with drugs in Ireland and its continued exasperation of the problem. Working in Dublin city centre I can no longer ignore the ever increasing and saddening numbers of addicts that sit on the footpaths begging for money. I have no figures but I know that I have noticed a significant increase. Walking from Rathmines to Trinity I used to pass maybe 2 homeless people. I now pass maybe 6. Anyone regularly walking around the city centre must have noticed this. This is a direct result of the state's continued treatment of a mental health issue as a criminal issue.

I feel that it is important that the committee do not make a rash decision but rather take time to look at evidence from around the world, not just one country, in addition to speaking with organisations working with people in addiction. Also talk to people in addiction and recovery, what do they think would help? What helped them?

The fact that dialogue on this issue has been opened is a welcome and positive step. I thank you for taking the time to read this submission. I hope I have provided some valuable feedback on the issues.

Annmarie Condra

Links:

<http://www.globalcommissionondrugs.org/new-report-world-leaders-call-for-ending-criminalization-of-drug-use-and-possession-and-responsible-legal-regulation-of-psychoactive-substances-2/>

http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2012/N_NACD_bulletin6.pdf

U-Casadh Policy Submission on Decriminalisation of Drug Possession for Personal Use

The U-Casadh Project was established in 2008 by former prison officer, Stephen Plunkett, to work with ex-prisoners aged 24 and over, and their families, in order to reduce recidivism and improve the lives and employment prospects of its service-users. The project is based in Ferrybank, on the border of counties Waterford and Kilkenny. It predominantly services the needs of Waterford City.

Since November 2013, U-Casadh has been operating as the Sponsor of a Community Employment (Drugs Rehabilitation) scheme with a maximum of 25 participants. It is funded by the Department of Social Protection. As participants can be referred by the drugs services, as well as the Probation Service, this has broadened the service-user cohort. Participants also need only be over 18 years old, or over, to attend the scheme – so this has also reduced the age profile.

The project operates a '3 Phase' approach for individuals who access the service.

- Phase 1 looks at stabilising the individual in terms of substance-misuse and/or criminal behaviours and providing psycho-educational, therapeutic supports towards healthier/safer choices.
- Phase 2 focuses on training and education. This often occurs 'in-house', though service-users may also be referred to outside training providers.
- Phase 3 focuses on Employment/Entrepreneurship progression for individuals who are stable in relation to their substance use and who are not actively engaging in criminal/anti-social behaviours. Some service-users are supported towards finding employment in the community, ideally with empathetic employers (who have an awareness regarding the person's background). Other service-users find the option of self-employment more attractive or more realistically achievable – when taking criminal convictions into consideration. With that in mind, the project secured Regional Development Funding to renovate a building for the purpose of creating a Social Enterprise Centre, where our service-users, as well as members of the wider community, can develop business ideas in a safe, 'incubator' environment.

U-Casadh also provides an outreach and prison in-reach service, funded by the Probation Service. The project worked with 176 individuals in 2014. At the beginning of 2015, the project received an employment based research scholarship from the Irish Research Council. The researcher is carrying out research surrounding impact measurement in the criminal justice third sector.

The authors of this submission are:

Conor Fell: Carrying out an Employment-based Masters-by-Research Scholarship in U-Casadh through the Irish Research Council, titled 'Impact measurement in the Criminal Justice Third Sector'. B.A. Degree (Hons) Criminology.

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Context

As is true for all political developments concerning deep rooted social issues, that are common in all states within the global community, there is a context apparent which must be established in order to understand political developments at a national level. This being the case, the context within which the current debate surrounding decriminalizing illicit drugs must be set out. In doing so it can be shown that the decriminalization of drugs is not an overtly radical idea, rather a pragmatic culture shift which is very much to the forefront of global discussions taking place concerning the failure of traditional approaches in combating the social fallout of illicit drugs supply and demand. Using this context when aiming to gain public support for a cultural shift in dealing with those found in possession of illicit drugs for personal use, it maybe an effective tool.

The use and supply of illicit drugs is a global issue, which is governed by an international drug control system that has developed over many years. This includes a range of international conventions, to which most countries are signatories. These seek to restrict access to psychoactive substances that are considered likely to be misused and result in significant harms to users and society, while still permitting their use for medical and scientific purposes. This international legal framework asks for unauthorised drug possession to be penalised, according to the seriousness of the offence, with prison or other criminal penalties (United Nations, 1961, 1971, 1988). Notwithstanding at a global level there has been a dramatic shift in the thinking concerning the war on drugs. The London School of Economics, in its report 'Ending the War on Drugs' (2014), is damning in its assessment of the failure of the war on drugs. The report points out that it has failed in its objectives based on its own terms of reference (LSE Expert Group, 2014). The fallout for this has had severe consequences, both intended and unintended. The culture of mass incarceration in the U.S is cited as being largely attributable to its failure (Collins, 2012, Bewley-Taylor, 2012). The

approach of the global war on drugs, set out in numerous UN strategies and adopted from the US approach, has resulted in a drastic overemphasis on policies aimed at suppressing the supply of illicit substances and encouraging the pursuit of highly repressive demand reduction policies. These extend a full spectrum of policy measures, from military intervention to the criminalisation of consumption (as a means to deprive supply of its demand).

The report points out that states appear set to push forward with a new variety of responses to the issues surrounding illicit drugs in innovative ways, designed to meet their various national and regional needs. Collins (2012) stresses that this new global drug strategy should be based on principles of public health, harm reduction, illicit market impact reduction, expanded access to essential medicines, minimisation of problematic consumption, rigorously monitored regulatory experimentation and an unwavering commitment to principles of human rights.

From a European perspective there has also been a significant change in approach surrounding discussions relating to the social fall out from the war on illicit drugs as it has been practiced. The 'European Monitoring Centre for Drugs and Drug Addiction (2015), Alternatives to punishment for drug-using offenders report', has examined current approaches across Europe that are aimed at reducing the social harm caused by illicit drugs, through alternatives to punishment and incarceration for the possession or consumption of drugs. The report cites the recent academic criticism of the deterrence model and its effects on those caught up in addiction and personal use. Despite the UN convention, although emphasizing the punishment of the consumption of illicit drugs, they also allow for the treatment and rehabilitation of drug users found in possession of illicit drugs rather than deterrent or retributive responses (United Nations, 1961, as amended, Article 36(1)(b)). Holloway et al (2008) suggest that these alternatives to punishment may be implemented to solve a range of issues, including, reducing stigma, proportionality, harm reduction, reductions in drug related crime and the prevention of disease. The EMCDDA report (2015) examines the approaches that are in action across Europe currently. The EMCDDA use four main categories, namely, decriminalization, depenalization, alternatives to prison and alternatives to punishment. Variations of each of these approaches are in operation to some degree in most European countries. The EMCDDA report suggests that the evaluations of such approaches are inconclusive and few countries in Europe have chosen to adopt widespread rehabilitative approaches, with most opting for simpler policies of decriminalisation or depenalization, namely, alternatives to prison, but not alternatives to punishment.

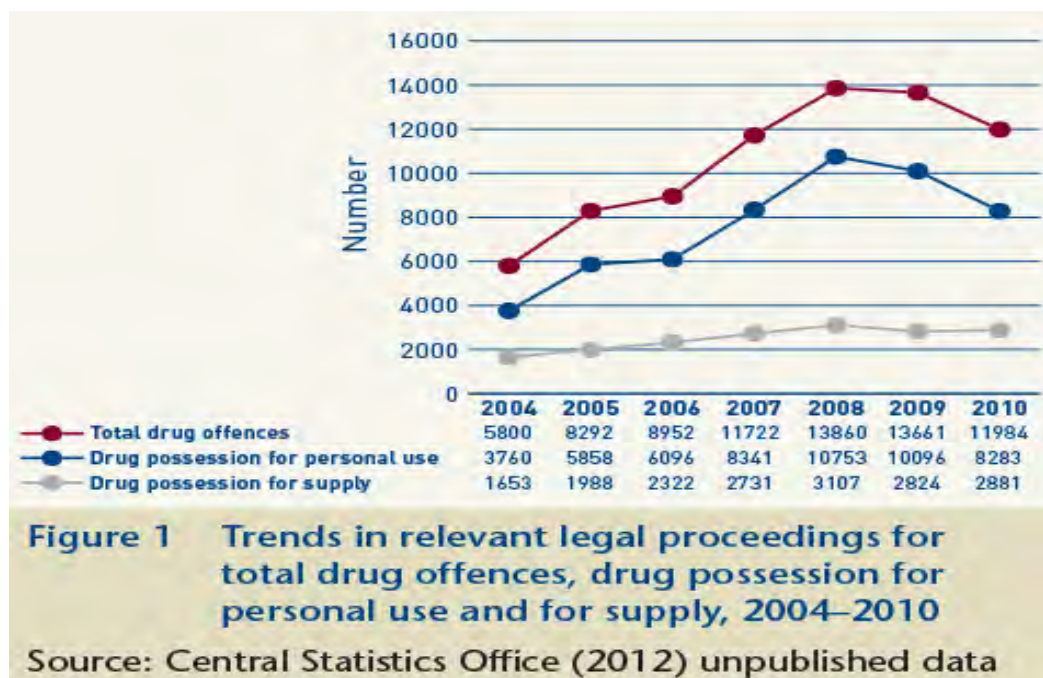
Portugal on the other hand has introduced wholesale shifts in relation to introducing decriminalization as has been cited by the visiting committee. The implementation of the Portuguese drug strategy in 1999 represented a cultural shift centered on humanism and pragmatism. It is humanist in that it views drug abusers or addicts as people to be treated through the ministry of health and pragmatic in that it acknowledges the limitations of punishment and incarceration for drug possession and consumption offences, thereby alleviating the burden on the Criminal Justice System. The results of the implementation of these policies have been laid out in the visiting committee's report and speak for themselves. The EMCDDA also notes that a number of other countries can be seen to be moving towards the implementation of a similar system of decriminalization. This clearly shows that rather being the implementation of a radical approach to dealing with the drug issue the Portuguese model is in fact a progressive move that is apparent across Europe and in the wider context globally.

It is interesting to note that while the headline will almost certainly surround the concept of decriminalization, the legality of decriminalizing drug use on a personal level is only one of 13 objectives in an overall strategy that aimed to change a culture in relation illicit drug use (Allen, Trace and Klien, 2004). This suggests that a wholesale implementation of the relevant facets of the system are adopted. One of the most positive moves of the Portuguese model is the positive discrimination, regarding the employment of those processed through the system. This allows an individual to access employment from sympathetic employers who in turn receive a tax break with the employee given leave in order to attend treatment. From our experience employment is an essential factor in the rehabilitation and integration process. For this reason this element of the strategy is perhaps its most fundamental to allowing people move on with their lives and away from addiction. This should also be represented in the forthcoming spent convictions bill, in that the legislation should complement any moves towards the introduction of the decriminalization strategy.

Crime Data

As can be seen from the chart, below (Central Statistics Office, 2012), legal proceedings for drug offences relating to possession for personal use far outstrip those for possession for supply. In fact, in 2010: "Possession offences accounted for 69.1% of total drug offences" (Connolly, 2012). This is clearly a massive drain on policing resources, as well as being a huge burden on the criminal justice system. It also has the effect of focusing resources on drug-users rather than drug-suppliers (at more than a 2:1 ratio), thereby criminalising people with addictions while leaving Gardai with

fewer resources available for the apprehension of drug-dealers/traffickers.



Figures from the Probation Service of Ireland (2013) showed that of persons under 20 on a Probation order - “87.1% were reported by their supervising Probation Officer to have misused at least one ‘identified substance’”

Earlier research into drug and alcohol misuse by adult offenders by the Probation Service of Ireland (2012) found that 89% admitted to drug and/or alcohol misuse, with 20% of those admitting to solely using alcohol and the rest either using a mix of drugs and alcohol or using drugs exclusively.

Drug Use Data

Heroin use in Ireland is at roughly double the European average (Gantly, 2011). In 2012, 52% of people entering treatment for drug problems reported opiates (predominantly heroin) as their primary problem drug (Health Research Board, 2014).

Research into daily consumption levels by heroin users in Ireland showed consumption at an average of 2.35 bags per day, at an average cost of €45.72 (Keane, 2013) - with an average price per gram of €116.71 (Connolly, 2014) [1?].

Research in Switzerland, where pharmaceutical grade heroin (diacetylmorphine) was prescribed to users (with no dosage limits imposed by the service-provider), showed that the mean daily dose was

491.7 mg, with most users 'maxing out' at between 300 and 500 mg per day (Uchtenhagen et al, 1999). It is worth noting that Irish research on the purity of heroin available in Ireland shows a mean purity of 47% in 2010, 30% in 2011 and 24% in the first 3 months of 2012 (Connolly, 2014) [2?].

While finding reliable data on benzodiazepine misuse is difficult, due to the fact that it is so commonly prescribed, it is known that the numbers of people entering treatment with benzodiazepine addiction identified as their main problem more than doubled between 2003 (76) and 2008 (167). The numbers presenting with benzodiazepine as an additional problem increased by more than 50% over the same period – 982 in 2003 and 1562 in 2008. Benzodiazepines were also implicated in 31% of all deaths by poisoning between 1998 and 2007 (Bellerose et al, 2010).

Substance Misuse Policy – Impact on Suicide Rates

A 2004 study (Burgess et al) which looked at data from 100 countries, including Ireland, between 1950 and 2003 from the World Health Organisation database, examined the impact of national mental health policies versus the impact of national substance misuse policies on suicide rates. The research showed that: “Contrary to the hypothesized relationship, the study found that after introducing mental health initiatives (with the exception of substance abuse policies), countries’ suicide rates rose.”

The study defined the relevant policies as:

National Substance Abuse Policy: “A specifically written document of the government or Ministry of Health containing goals of prevention and treatment activities related to the use, abuse and dependence of alcohol and prescription and non-prescription (including illicit) drugs.”

National Mental Health Policy: “A specifically written document of the government or Ministry of Health containing the goals for improving the mental health situation main directions for attaining them.”

Trauma & Addiction

The Adverse Childhood Experiences study (Centers for Disease Control and Prevention, 1997), an American study with 17,000 participants, found that survivors of childhood trauma/abuse showed an increase of 4600% in relation to IV drug use (as well as a 500% increase in problem alcohol use

in adulthood).

Mental Health & Addiction

While Irish data on Dual Diagnosis (the co-existence of mental health and addiction issues) is limited, one study showed 45% prevalence of substance abuse (drugs other than alcohol) in clients who also have mental health difficulties (MacGabhann et al, 2004). Unfortunately, one of the key findings of the Irish report was that “Dual diagnosis is not clearly understood as a concept nor is it formally recognised in mainstream addiction and mental health services, nor is it formally recognised in national policy in Ireland”. Other key findings were that:

- “Only 21% of services indicated they had a policy on dual diagnosis but there was no consensus on what policies were in place “
- “Access to services is limited because of exclusion criteria which operate in both addiction (58%) and mental health services (43%).”
- “The majority (75%) of service providers agreed that a fully integrated service would provide the most effective management of dual diagnosis.”

Recommendations

Part of the process of developing the following recommendations to the Committee involved having a series of focus group meetings with our service-users. Our service-users have a great deal of experience of drug use, addiction, mental health issues, childhood and adult trauma, attempted suicide and self-harm, conviction for drug (and other) offences and incarceration. While many of the group members were concerned that decriminalisation may 'glorify' drug use (a concern which was also voiced in Portugal prior to the changes in their system), all felt that replacing the trauma and stigma of entering into the criminal justice system, when found to be in possession of illicit drugs for personal use, with the option of entering into a therapeutic treatment process would be hugely beneficial to the individuals in question, as well as to the wider community.

Members of the group also spoke about the fact that they had been discriminated against in relation to housing and employment, due to the fact that they had a conviction for possession of drugs for personal use. They also spoke about the fact that this limited their ability to travel to certain countries to seek employment or to visit family members.

Based on a combination of feedback responses from the focus group and our own thoughts, based

on our research and experience in the field, we make the following recommendations to the Committee:

- That the current legislation relating to possession of controlled substances for personal use be changed in favour of the 'decriminalisation model', as detailed in the Committee's report.
- That a certain amount of flexibility be built into the legislation and operation of the model. As people often find it difficult to move from active addiction to recovery, it needs to be acknowledged that individuals may relapse after entering into, or completing, treatment programmes.
- That sufficient resources be made available to provide quality addiction treatment, available in all communities. Residential treatment is expensive and has limited success with providing individuals with the skills they need to maintain their recovery when they have returned to the community.
- That the Committee consider that the threshold amount of heroin (1g) would be a very low estimate for 10 day's supply for personal use in the Irish context. Many of the former heroin users in our focus group felt that this amount would suffice for considerably less time (2-3 days). We feel that the data, above, relating to heroin use in Ireland would support that claim.
- That the committee consider adding benzodiazepines to the 'Threshold Quantities' list. We understand that there may be issues with this as it is a prescription drug, however, methadone is mentioned, presumably in terms of non-prescription use (as prescribed users would not be committing an offence by having it in their possession). On the ground, and in speaking to our focus group, we see that there is a serious problem with benzodiazepine misuse and its associated behaviours.
- That the committee consider that we are currently punishing a large cohort of the drug-using population who are, in many cases, 'self-medicating' in order to cope with childhood traumas, abuse and/or mental health issues. As the committee's report indicates, this situation needs to change.
- That the committee consider establishing state bodies similar to the Portuguese SICAD (General-Directorate for Intervention on Addictive Behaviours and Dependencies) and Commissions for Addiction Dissuasion (as mentioned in the committee's report). We feel that it would be essential for a robust, dedicated structure to be put in place under any new decriminalisation model.
- That the Committee consider, as proposed in their report, developing a model of 'positive discrimination', in terms of employment, for individuals who have been found in possession

of illicit drugs for personal use and who have engaged with the treatment services. U-Casadh's philosophy on relapse and recidivism prevention has always been based around meaningful 'activity with purpose'. We have found that this is the most important element in a person's continuing rehabilitation and integration, after the initial stabilization stage. Identifying empathetic employers, who will take on one of our service-users in the knowledge that they have a history of substance misuse and/or a criminal record is a challenge which we embrace. The introduction of tax break incentives for employers of this cohort would greatly improve the individual's chances of gaining employment – integrating the person into the wider community and supporting them in becoming a greater asset to society and the exchequer. U-Casadh are currently developing the www.worldofwork.ie website, which, inspired by the work of the UK charity, Clean Sheet (www.cleansheet.org.uk) will develop a database/directory of empathetic employers who would be interested in hiring from our pool of service-users. Service-users will be added to the employment pool/panel when they are drug-free (or stable on methadone), desisting from criminal behaviours and suitably trained/educated to meet the current employment market demands. We will be piloting this programme in Waterford & South Kilkenny shortly and plan to roll it out nationally, with support-workers in each county.

Treatment Recommendations

We feel, based on our research and experience of working directly with people in active addiction, that an integrated, consistent community-based, holistic approach in terms of the treatment of individuals under the proposed model needs to be taken. With that in mind, we make the following recommendations:

- That interventions/treatments be community-based, as much as possible, with only individuals on the extreme end of the addiction spectrum being referred to residential treatment. Residential treatment can be very beneficial in some cases, however, as mentioned, above, all people in addiction must continue to live in their communities, where drugs are freely available and where they will come into regular contact with friends and/or family members who are continuing to use. It is vital that people in addiction learn to live a drug-free life in their day-to-day environment. Residential treatment is not a 'silver-bullet' for 'curing' addictions, nor is it cost-effective.
- That SMART Recovery Facilitator Training be rolled out nationally. SMART Recovery is a science-based (cognitive-based) model of group facilitation for all addictions. The Bray

Community Addiction Team are currently engaged in the roll-out of this training in parts of the East and South-East. It would provide a professionally facilitated, consistent approach to group work on addictions. While it is not intended to replace the 12 step fellowships (Narcotics Anonymous, etc.), it gives an alternative to the large cohort of people who wish to work towards recovery, but who find it difficult to engage with the philosophy of the fellowships for religious, or other, reasons.

- That the new system is able to deal with the co-existence of mental health and addiction issues (dual-diagnosis). At the Dual-Diagnosis Conference in Waterford (2013) it became clear that co-morbidity is more the rule than the exception, when alcohol misuse is included. Currently, dual-diagnosis clients are 'bounced around' between the dedicated mental health and addiction services being advised that they need to deal with their mental health issue before their addiction(s) can be treated or vice versa.
- That all workers in the new system be provided training in working with clients suffering from PTSD. The Seeking Safety training, which can be run over 2 days, would be one option.
- That all workers in the new system be trained in Suicide Prevention (ASIST) and Self-Injury/Self-Harm (STORM). Both of these courses are currently provided by the Suicide Resource Offices.

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NATIONAL ORGANISATION FOR THE REFORM OF MARIJUANA LAWS IRELAND LIMITED

NORML IRELAND Submission

7th of August 2015

"Review of Ireland's Approach To The Possession Of Limited Quantities Of Certain Drugs"



NORML IRELAND supports Legalisation & Decriminalisation of cannabis for medicinal and personal use. We are working towards the removal of all penalties for the private possession of cannabis by adults, cultivation for personal use, and the casual nonprofit transfers of small amounts. NORML works toward the development of a legally controlled market for cannabis. Which can be of benefit to our economy and society rather than a drain on it.

NORML supports the removal of all penalties for the private possession and responsible use of marijuana by adults, including cultivation for personal use, and casual nonprofit transfers. This removes the consumer -- the marijuana smoker -- from the criminal justice system, while maintaining criminal penalties against those who sell or traffic large quantities of the drug.

NORML IRELAND believes all drugs, including cannabis, can be abused. Our cannabis policies should discourage irresponsible use, including use by adolescents. The best way to prevent drug abuse is with honest, credible and factual drug education. Only in a climate in which cannabis is viewed from a public health perspective, instead of a criminal justice perspective, can prevention efforts be effective.



NATIONAL ORGANISATION FOR THE REFORM OF MARIJUANA LAWS IRELAND LIMITED

NORML IRELAND Submission

7th of August 2015

"Review of Ireland's Approach To The Possession Of Limited Quantities Of Certain Drugs"

Impacts of Cannabis Legalisation and Decriminalisation

By any objective standard, marijuana prohibition is an outstanding failure. Despite an international war on drugs, today marijuana is more prevalent than ever before, access to marijuana is easier than ever before, the drug is on average more potent than ever before, and there is more violence associated with the illegal marijuana trade than ever before. The criminal prohibition of marijuana has not dissuaded anyone from using marijuana or reduced its availability;

However, the strict enforcement of this policy has adversely impacted the lives and careers of millions of people who simply elected to use a plant to relax or heal themselves, that is objectively safer than alcohol.

NORML believes that the time has come to amend criminal prohibition and replace it with a system of legalisation, taxation, regulation, and education.

As Countries all over the world begin to debate the question of legally controlling marijuana, many lawmakers are posing questions to NORML international regarding what effect, if any, such a policy change may have upon the public's use of cannabis and/or young people's attitudes toward it.

The following paper reviews various studies** that have examined this issue in regions that have either

- a) Regulated marijuana use and sales for all adults.
- b) Decriminalised the possession of small quantities of marijuana for adults.
- c) Medicalised the use of marijuana to certain authorised individuals; or
- d) Deprioritised the enforcement of marijuana laws.

This paper also proposes general guidelines to govern marijuana use, production, and distribution in a legal, regulated manner.

**This paper expands upon the studies initially referenced by NORML in its paper, Marijuana Decriminalisation & Its Impact on Use.



NATIONAL ORGANISATION FOR THE REFORM OF MARIJUANA LAWS IRELAND LIMITED

NORML IRELAND Submission

7th of August 2015

"Review of Ireland's Approach To The Possession Of Limited Quantities Of Certain Drugs"

Rethinking the Consequences of Decriminalizing Marijuana

http://norml.org/pdf_files/NORML_Rethinking_Decriminalizing_Marijuana.pdf

The Case For Legalisation / Regulation

Regulation = Controls

Controls regarding who can legally produce marijuana

Controls regarding who can legally distribute marijuana

Controls regarding who can legally consume marijuana

Controls regarding where adults can legally use marijuana and under what circumstances is such use legally permitted

Prohibition = the absence of controls – This absence of control jeopardises rather than promotes public safety. Prohibition abdicates the control of marijuana production and distribution to criminal entrepreneurs, such as drug cartels, street gangs, drug dealers who push additional illegal substances Prohibition provides young people with easier access to marijuana than alcohol (CASA, 2009)

Prohibition promotes disrespect for the law, and reinforces ethnic and generation divides between the public and law enforcement.

What would marijuana regulation look like?

NORML IRELAND recommends the adoption of the:

Cannabis Regulation Bill 2013

AN ACT TO PROVIDE FOR THE REGULATION OF CANNABIS FOR MEDICINAL AND RECREATIONAL USE AND FOR THAT PURPOSE TO ESTABLISH THE CANNABIS REGULATION AUTHORITY; TO PROVIDE FOR THE LICENSING OF THE CULTIVATION, SALE AND TRANSPORT OF CANNABIS; TO PROVIDE FOR OFFENCES; AND TO PROVIDE FOR RELATED MATTERS.



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Section 15 provides that there will be three categories of cultivation licence:

- (a) Licence for the Commercial Cultivation of Cannabis;
- (b) Licence for the Home Cultivation of Cannabis; and
- (c) Licence for the Cannabis Social Club Cultivation of Cannabis

Section 17 sets out the requirements which must be satisfied before a licence for the Home Cultivation of Cannabis may be granted. The maximum number of plants which may be cultivated under this licence is six plants. (this should be changed to 6 Flowering Plants) or 12 - 18 plants v between growing and flowering. There are many models of regulation; depending on the substance being regulated these regulations can be very loose (apples, tomatoes) or very strict (alcohol, tobacco, prescription drugs)

FOR EXAMPLE : The alcohol model of regulation:

Commercial production is limited to licensed producers (though non-retail, home production is also allowed)

Quality control and potency is regulated by the state, and the potency of the product is made publicly available to the consumer

Retail sale of the product is limited to state licensed distributors (liquor stores, restaurants, bars, package stores, etc.)

The state imposes strict controls on who may obtain the product (no minors), where they may legally purchase it (package store, liquor store, etc.), when they may legally purchase it (sales limited to certain hours of the day), and how much they may purchase at one time (bars/restaurants may not legally service patrons who are visibly intoxicated, states like Pennsylvania limit how much alcohol a patron may purchase at a licensed store, etc.).

The state imposes strict regulations prohibiting use in public (no open container in public parks, or beaches, or in an automobile) and/or furnishing the product to minors



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The state imposes strict regulations limiting the commercial advertising of the product (limits have been imposed on the type of marketing and where such marketing may appear)

A regulatory scheme for marijuana that is similar to the scheme described above for alcohol would be favourable compared to the present prohibition.

Ideally, such a regulatory scheme for marijuana would maintain the existing controls that presently govern commercial alcohol production, distribution, and use – while potentially imposing even stricter limits regarding the commercialisation, advertising, and mass marketing of the product.

NORML Ireland recommends:

An extended process of consultation which would build a model of cannabis legislation in Ireland that will work for and benefit our community. This Model needs to be built on an inclusive and research based process. Drawing from the mountains of scientific research and worldwide experience with cannabis legislation.

NORML Ireland requests to engage with this process.

We would like to draw your attention to the following:

Written submission to:

The Joint Committee on Justice, Defence and Equality: by legal@norml.ie

Legal director of NORML Ireland Lee Evans (National Organisation for the Reform of Marijuana Laws)

Distinguished members of the committee we understand that your specific remit is to gather and assimilate the differing contentions as to the highly emotive topic of changing the societal stance as to drug possession and consumption. We, at NORML Ire, believe that we can help the committee members in ascertaining the benefits that can be found simply by lowering our current stance on the cannabis plant. We will show that the current and notorious conception of cannabis is an erroneous belief and that the benefits of regulating the consumption of the plant is beyond refute.



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In our submission we will examine three distinct avenues which, when analysed, will show that the empirical evidence suggests that decriminalising cannabis provides a benefit to society that are impossible to fathom.

These are;

- (1) The predominant perception of cannabis which is shown by more advanced and recent scientific findings to be erroneous, (scientific findings)
- (2) An examination as to the extent cannabis can be used for the effective treatment of many ailments,
- (3) A comparative analysis of the sociological effect cannabis decriminalisation has had on analogous jurisdictions.

All findings of fact will be footnoted and sections divided.

www.norml.ie/useful-links

150+ World Cannabis News Articles Published Since 3rd Jul '15 (older ones in Archive)

www.forum.norml.ie/forumdisplay.php?22

Videos, Films & Documentaries (Here you will find educational videos, films & documentaries about Cannabis & Hemp.)

www.forum.norml.ie/forumdisplay.php?31

Cannabis: Is legalisation right for Ireland? Cannabis Thesis by Ciaran Wallace.

[www.files.norml.ie/Cannabis Thesis by Ciaran Wallace.pdf](http://www.files.norml.ie/Cannabis%20Thesis%20by%20Ciaran%20Wallace.pdf)

Cannabinoid Research: Links to Research Articles & Patents! (135 Links)

www.forum.norml.ie/showthread.php?884

NORML IRELAND Submission

7th of August 2015

"Review of Ireland's Approach To The Possession Of Limited Quantities Of Certain Drugs"

**DOES THE LAW OF
CANNABIS PROHIBITION
MAKE SENSE?**



ORGANISED CRIME WAS CREATED FROM PROHIBITION. WHILE NOT EXCLUSIVE TO CANNABIS PROHIBITION, CRIMINAL GANGS ARE FUELLING CRIME WHICH IS FUNDED FROM THE PROCEEDS OF THE CANNABIS BLACK MARKET. A MARKET WHICH MANY RESPONSIBLE USERS DO NOT WANT TO CONTRIBUTE TO. MEXICAN CARTELS ARE ESTIMATED TO HAVE LOST 1 BILLION DOLLARS A YEAR FROM COLORADO LEGALISATION.



IRELAND SPENDS €176,000,000 PER YEAR ON DRUG ENFORCEMENT. CANNABIS TAKES UP A LARGE PROPORTION OF THIS BILL PAID FOR BY YOU, THE TAXPAYER. THE COST OF CRIMINAL RECORD TO SOCIETY IS INCALCULABLE, OVER 100,000 CRIMINAL RECORDS FOR CANNABIS SINCE PROHIBITION BEGAN. THESE PEOPLE ARE LESS LIKELY TO GET A JOB, NOT ALLOWED WORK WITH CHILDREN AND IN MANY CASES CANNOT WORK AND LIVE ABROAD.



ONE OF THE MOST EGREGIOUS OUTCOMES OF CANNABIS PROHIBITION IS THAT MANY SICK PEOPLE CANNOT LEGALLY ACCESS THE MEDICINE THAT WORKS BEST FOR THEM. FOR MANY SERIOUSLY ILL PEOPLE, CANNABIS IS THE ONLY MEDICINE THAT RELIEVES THEIR PAIN AND SUFFERING, OR TREATS SYMPTOMS OF THEIR MEDICAL CONDITION, WITHOUT DEBILITATING SIDE EFFECTS. MARIJUANA HAS BEEN SHOWN TO ALLEVIATE SYMPTOMS OF A HUGE VARIETY OF SERIOUS MEDICAL CONDITIONS INCLUDING CANCER, AIDS, AND GLAUCOMA, AND IS OFTEN AN EFFECTIVE ALTERNATIVE TO SYNTHETIC PAINKILLERS.



NORML IRELAND Submission

7th of August 2015

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DESPITE CANNABIS BEEN AN ILLICIT DRUG UNDER THE MISUSE OF DRUGS ACT 1977, THE MARKET IN IRELAND HAS FLOURISHED IN THE LAST HALF CENTURY. IN 1965 THERE WERE ONLY TWO DRUGS CHARGES, IN 2008 IRELAND SAW 23,404 CONTROLLED DRUG OFFENSES. PROHIBITION ENCOURAGED PEOPLE TO SEE THE LAW AS WHIMSICAL AND UNIMPORTANT, INSTEAD OF SOMETHING GOOD AND PROTECTING. IT DID NOTHING TO ENCOURAGE THE RESPECT AND OBEDIENCE THE LAW DESERVES.

THE MORE WE KNOW ABOUT A DRUG, THE BETTER WE CAN DECIDE A TYPE OF REGULATION TO CONTROL THE DRUG. CANNABIS PROHIBITION HAS PREVENTED MANY SCIENTISTS FROM STUDYING THE DRUG. EVEN WHEN WE CAN STUDY CANNABIS MANY OF THE SAMPLES OBTAINED ARE FROM THE BLACK MARKET, USUALLY SPRAYED WITH ADDITIVES AND OTHER MATERIALS TO ADD WEIGHT. THIS GIVES AN INACCURATE RESULT AS TO THE EFFECTS CANNABIS HAS ON HEALTH.

UCD SCHOOL OF ECONOMICS PROFESSOR RON DAVIES ESTIMATED IN NOVEMBER 2014 THAT A (CONSERVATIVE) NET BENEFIT OF CANNABIS LEGALISATION WILL COME TO €562,000,000 PER YEAR, MONEY WHICH CURRENTLY ONLY CRIMINALS ARE GETTING.

**Submission of Tim Murphy to the Joint Committee on Justice, Defence and
Equality in relation to the matter of altering the present approach to sanctions for
possession of certain amounts of drugs for personal use**

***Executive Summary:** This submission emphasises from the outset the failure of current Irish drug policy and refers to the alternative policy options of legalisation and decriminalisation. Although I am an advocate of drug legalisation as the best possible drug policy, in this submission I focus, as required, on decriminalisation—the matter of whether the present approach to sanctions for possession of certain amounts of drugs for personal use should be altered. My submission does not pretend to be anything like an exhaustive survey of the relevant issues but instead seeks to emphasize what I consider to be general points that are particularly important to the debate. The submission discusses the sanctions for possession of certain amounts of drugs for personal use in light of the legitimate scope of criminal law, and it argues that these sanctions represent a misuse of criminal law. This argument is supported with reference to the multifarious contexts of drug use and the crucial distinction between drug use and drug misuse, and also with reference to the evolving moral perspectives surrounding drug policy discourse and practice. The benefits of decriminalisation are then discussed and I conclude by recommending very strongly that the Committee consider including support for drug decriminalisation in its report to the House.*

1. Introduction

1.1. I am an Irish legal academic who is making a submission because of a long-standing engagement with the legal and policy questions surrounding drug law reform in Ireland, particularly while I lectured at University College Cork Law Faculty between 1992 and 2005. Among my relevant publications is a book, *Rethinking the War on Drugs in Ireland* (Cork University Press, 1996), in which I presented an argument for the full decriminalisation (i.e. legalisation) of psychoactive drugs currently prohibited by law. I have

also published work on the criminogenic nature of drug prohibition; Dutch drug policy; and socialist perspectives on drug law reform. In the 1997 General Election I stood as an Independent candidate in the Cork South-Central constituency on a cannabis legalisation platform. I have presented publicly my ideas on drug law reform on several occasions, including an invited keynote address at the Association of Health Boards in Ireland Annual Conference, and a presentation to the National Crime Forum, both in 1998.

2. *The Failure of Drug Prohibition*

2.1. At the heart of drug prohibition is an ideal-typical perspective on drug use that Govert Frank van de Wijngaart (*Competing Perspectives on Drug Use: The Dutch Experience*, Rijksuniversiteit te Utrecht, 1990) describes as the “deterrence perspective”, a perspective that is linked historically to a strategy of intervention in dealing with social problems based on differentiation and exclusion. It is associated with a positivist world-view, particularly the idea that human beings are essentially responsive organisms, acted upon by external forces. In the deterrence perspective, drugs are the primary cause of “drug problems”. The models of drug use in this perspective include the “medical model”—holding that certain drugs are dependence-producing and that such dependence constitutes a “disease”—and the “moral-legal model”—condemning certain drugs as dangerous and their use as wrong. Typically and in the Irish case (in the legislative and regulatory framework originating with the Misuse of Drugs Act, 1977), systems of drug prohibition give legal expression to this perspective by criminalising the production, supply and possession of specific drugs.

2.2. The aim of the system of drug prohibition is to reduce—in some versions, to eliminate—both the supply of, and the demand for, specified drugs. In Ireland and elsewhere the system has failed to achieve this goal—indeed, by all accounts the supply of, and the demand for, prohibited drugs has increased over the course of the past forty or so years, the “heyday”, one might say, of drug prohibition. Moreover, it has long been observed and argued that drugs do not cause many of the problems associated with drug use but rather these problems are caused by the system of prohibition itself. For example,

drug prohibition allows for no regulation of drug quality or safety, as is the case for legally available drugs such as drugs available on the free but regulated market (e.g. alcohol, nicotine) and drugs available only on medical prescription (e.g. depressants, opioids and morphine derivatives, stimulants). Prohibition also blocks many types of educative initiatives that might encourage and assist safer consumption of currently illegal drugs. And of course by criminalising certain drugs, prohibition not only criminalises automatically all illegal drug users in the community, it also facilitates control of the market for those drugs by often unscrupulous individuals and groups, which in turn engenders a whole range of other types of criminal activity. It is therefore unsurprising that that it was in the course of the Joint Committee's hearings on the effects of crimes carried out in communities by gangs that the matter of drug prohibition came under scrutiny.

3. *Legalisation v. Decriminalisation*

3.1. Given the ongoing failure of drug prohibition, and given the increasing awareness of its deleterious effects, alternative policy approaches are now being implemented in several jurisdictions throughout the world. The choice of alternative options is usually framed in terms of “legalisation” v. “decriminalisation”, where the former denotes a free but regulated market for drugs akin to the market for alcohol, nicotine, and drugs available on medical prescription, and the latter a system where a person found in possession of drugs for personal use is not given a criminal conviction but may be given another sanction or, in cases of perceived problematic use, may be directed to drug treatment services. Although this is the accepted nomenclature it is worth noting that better terminology would be “full decriminalisation” for “legalisation” and “partial decriminalisation” for “decriminalisation”.

3.2. In my view, full decriminalisation or legalisation, with different regulatory regimes for different drugs, is by far the best drug policy approach. I set out my arguments as to why I believe this to be the case in my book, *Rethinking the War on Drugs in Ireland* (Cork University Press, 1996), and I stand completely by these arguments

now, nearly 20 years later. However, I appreciate that this is not the place to reiterate those arguments because the question regarding which the Joint Committee seeks submissions is very specific—the matter of altering the present approach to sanctions for possession of certain amounts of drugs for personal use. In other words, the Joint Committee has opened a debate in Ireland about the prospect of partial decriminalisation—or simply “decriminalisation”, as it is better known and as I shall refer to it henceforth in this submission. This is a development for which I believe the Joint Committee should be warmly congratulated. It is not the ideal policy approach but it would be a significant improvement on the current system—and possibly of course, with time, a stepping-stone toward the implementation of full decriminalisation.

3.3. Decriminalisation would be a significant improvement on the current system because it would bring Irish drug policy closer to the alternative ideal-typical perspective on drug policy identified by van de Wijngaart (see paragraph 2.1 above), namely the “normalisation perspective”. This perspective is linked to integrative or “normalising”, rather than exclusionary, strategies of social policy. It is founded on a world-view associated with interpretative and transactional epistemologies. These knowledge-systems, embracing forms of ambiguity and relativism, regard the individual primarily as an agent acting meaningfully in given social contexts, contexts that in turn have the potential to construct meanings of multifarious types. In the context of drug use, this means that the individual and social circumstances and consequences of drug use are regarded as far more significant than the substances themselves. The first of the two models of drug use in the normalisation perspective is the “psychosocial model”, in which drug use is regarded as behaviour that would not persist unless it serves some meaningful function for the individual user in a given social context. The second model—the “sociocultural model”—incorporates the variable social and psychological considerations of the psychosocial model but goes further to highlight socio-economic and environmental conditions as the reasons for psychological demands and stresses of various types that may be relevant to understanding drug use. In sum, the normalisation perspective recognises the roles of psychological, social and cultural factors in understanding all forms of drug use.

4. *The legitimate scope of criminal law and drug possession for personal use*

4.1. As stated in paragraph 2.2, the current legislative regime has failed to reduce either the supply of, or the demand for, prohibited drugs, or to create anything like the “drug-free” society to which prohibitionist rhetoric sometimes alludes. A key part of this failed legislative regime targets drug users by imposing sanctions, including incarceration and enduring criminal convictions, for possession of drugs for personal use. This strategy of punishing drug users is hugely significant in terms of the total number of drug convictions—according to the Citywide Drugs Crisis Campaign (*Decriminalisation: A New Direction for Drugs Policy*, 2013), figures from the Central Statistics Office indicate that in 2012 almost 72% of convictions for drug offences were for possession of drugs for personal use. In addition to constituting this very high proportion of drug convictions (with the attendant substantial law enforcement, legal aid, judicial proceedings and incarceration costs), in my view the offence itself, possession of drugs for personal use, constitutes a misuse of criminal law.

4.2. There is extensive and ongoing debate about the proper purpose of the criminal law. Should criminal law, for example, be oriented primarily toward retribution or deterrence or rehabilitation or perhaps some other goal? Or, if it should combine one or more of these goals, what weight should be given to each? Whatever one’s view of this debate, it is well established that the legitimate *scope* of the criminal law includes only behaviour that is harmful in particular ways. Generally, criminal matters are “public wrongs”, where an individual or group causes deliberate and direct harm to other individuals or groups or to society. Cases of “victimless” crimes, where no direct harm is caused to any other by the perpetrator, have typically been justified on the grounds of protecting the individual from himself or herself, or on the basis of indirect harm caused to others, or on the view that the activity is wrong morally. However, sanctions for the possession of drugs for personal use fail to meet properly any of these criteria. Such possession and use does *not* inevitably bring about dependence or “addiction” that is harmful to the user or to others; and, given the range of very different legitimate moral views on the matter, the test of immorality is not a very helpful one—indeed, in this case

and in many others it is precisely a lack of consensus that is causing the enforcement of morality by the criminal law to lose ground steadily.

4.3. Two types of issues are raised in paragraph 4.2, namely medical and moral-legal issues, and these correspond precisely to the models underlying the deterrence perspective on drug use (paragraph 2.1 above). Paragraph 5 addresses further the contexts of drug use and the (“medical”) distinction between drug use and drug misuse, and paragraph 6 discusses the evolving moral perspectives surrounding drug policy discourse.

5. *Distinguishing between drug use and drug misuse*

5.1. All drugs are relatively safe to use, and to suggest that using any of them leads inevitably to problematic use, or to describe any of them as *intrinsically* “dependence-producing” or “addictive”, is inaccurate and misleading. Although this claim may be counterintuitive to some, it is by no means novel. It is, in fact, the conclusion of most research on the subject. Drugs—which are, after all, inert substances—only have the *potential* to be dangerous. This distinction is crucial. As one writer, for example, remarks of heroin, cocaine, cannabis, and LSD: “If used responsibly, with due precautions, no harm will come. In contrast, a careless or reckless user may meet disaster” (Richard L. Miller, *The Case for Legalizing Drugs* (Praeger, 1991), p. 25). The most influential work underlying this understanding of drug use is Norman Zinberg's *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use*, published by Yale University Press in 1984. Zinberg's central idea (p. 5)—developed after careful and extensive interviews with users of cannabis, heroin, and LSD—is that “in order to understand what impels someone to use an illicit drug and how that drug affects the user, three determinants must be considered: drug (the pharmacologic action of the substance itself), set (the attitude of the person at the time of use, including his personality structure), and setting (the influence of the physical and social setting within which the use occurs)”. The effect of any drug, in other words, is not a constant; instead, it is a variable within certain limits, depending on the interrelationship between the personality of the drug-taker, the context or environment in which the drug is consumed, and the drug itself. In simple terms, if ten adults were selected randomly and

each were to consume, under controlled circumstances, five pints of Guinness, the effect of this drug use would be different on each individual; if the drug were consumed in this way every day for a month or a year, the longer-term effects and consequences would again be very different for each individual.

5.2. Zinberg's drug-set-setting analysis challenges the many myths surrounding the idea of "addiction"—a term long abandoned by leading authorities such as the World Health Organisation in favour of references like those to the "syndrome" of drug "dependence"—and it also brings into focus the insights offered by the normalisation perspective and its models of drug use. In particular it acknowledges that drug use typically serves some meaningful function for the individual user in a given social context, and it emphasises socio-economic and environmental conditions as reasons for psychological demands and stresses of various types that may be relevant to understanding drug use. The Joint Committee's insightful report of June 2015 on the impact of the current Portuguese approach to the possession of certain drugs refers (p. 3) to how, in some cases, "mothers and fathers were using drugs as an aid to coping with the stresses and strains of everyday life", and this is precisely what a non-punitive, health-oriented analysis of drug use is likely to emphasise. On a broader social scale, in Ireland we are all too well aware of how certain vulnerable and disadvantaged communities have been particularly susceptible to problems associated with, in particular, heroin. With greater understanding now than ever before of the role of socio-economic and environmental conditions in problematic drug use, who can seriously consider maintaining punitive policies that exacerbate the problematic dimensions of drug use? Crime and punishment have their place in any social system but to prioritise them where health promotion and care as well as socio-economic reform are needed is surely not only unreasonable but also unjust.

5.3. The sanctions administered in Ireland for possession of certain amounts of drugs for personal use make no distinction between use and misuse. It seems evident that many convictions for possession of drugs for personal use *include many convictions in cases where safe use only, and no misuse or harm, is involved*. Who or what can justify this absurd application of the criminal law? And who or what can justify not focusing on

identifying instances of misuse and addressing them as part of the general health promotion strategy of the state? This legal situation is preposterous in the extreme and requires urgent reform.

6. *Drugs and morality*

6.1. A good deal of support for prohibitionist drug policies has traditionally come from the idea that to consume certain drugs is wrong morally. This ideology makes little sense and originates ultimately in historical developments underpinning modern drug prohibition that have no coherent foundation in science or medicine or moral philosophy. I have discussed these developments in Chapter 2 of *Rethinking the War on Drugs in Ireland*, titled “Drug Prohibition in Historical Perspective”, and outlined there how the genesis of drug prohibition is to be found in changing perceptions of the use of two drugs—alcohol and opium—during the nineteenth century. I will not reiterate here the social, economic and political background to the moralistic condemnation of certain drugs, but mention must be made of the fact that this condemnation is now nowhere near as common as it was in the past. I believe that the Joint Committee’s opening of a debate about the prospect of drug decriminalisation in Ireland reflects changing social and moral perceptions and values regarding drug prohibition—and certainly regarding the imposition of criminal sanctions on individual drug users. One way of conceptualizing this is to think of a shift in the customary or “living” law of Irish society.

6.2. Any human society or community does a whole host of things in particular ways, including the customs, practices, well-known and accepted procedures, and mutual expectations that establish the jural relationships and entitlements particular to that community. This is the customary law or “living law” of the community—it is the moral tradition that constitutes the commonly accepted moral rules of a community, some of which, but rarely if ever all of which, may be written down or even formulated in speech. The socio-cultural concept of tradition is one way of understanding how living law is handed down in communities: just as children learn language so too they learn the morality—the customs or living law—of their particular community. The living law

preexists—and continues on an ongoing basis to exist separately from—all types of formal and state law, so the particular sociological understanding of “law” in the living law approach is not of law as posited or laid down in the way a constitution, statute, code, or other set of rules are posited or laid down.

6.3. The living law of Ireland in relation to drug use and drug policy appears to have changed considerably in recent years—this is reflected, for example and albeit to varying degrees, in surveys, polls, media opinion and social attitudes—and the Joint Committee’s opening of this debate may be said to reflect that change, which is as it should be. The Joint Committee’s report on Portuguese decriminalisation refers to a process in which the first step was to transfer much responsibility for drug policy from the Portuguese Justice Department to the Health Department, and it suggests (p. 5) that when authorities in Portugal were tasked originally with formulating a different approach to more effectively tackle the drugs problem which was so damaging to its society, it was believed that the proposed solution of civil/administrative sanctions for drug use could only be successful “with a change in the mindset of society”. The “mindset of society” refers to the living law and it is rarely uniform or unanimous, but I respectfully suggest that the mindset of many people in Portugal had changed long before drug law reform came about. All law reform must be “marketed”, so to speak, and there are, I understand, fears in Ireland among reform-minded individuals and groups that the wider society may not readily accept the idea of decriminalisation. Certainly, the whole of society will not, but support for a humane health-centred approach to drugs as opposed to the failed existing policy is in my view greater than is sometimes thought. It seems to me that the worldwide trend of the successful implementation of more humane drug policies, including recent unexpected developments in the United States, is not going unnoticed even by many of those previously entrenched in prohibitionist ideology.

6.4. Many anti-prohibitionists make the comparison with the legal changes relating to LGBT concerns in many jurisdictions, in which people’s entitlement to the expression of their sexuality and gender identities is being recognized after protracted struggles that have been in turn supported by shifts in communal moral laws. Another such example is

changing attitudes toward legal reforms in relation to assisted dying. These shifts are not unanimous or universal and legal change may not occur in many jurisdictions for a considerable period of time or in some cases perhaps not at all, but it is time for Irish state drug law to at least *begin* to come into line with the living law. It is very encouraging that in 2016 the UN General Assembly will be holding a Special Session (UNGASS) on drugs, in which UN member states, including Ireland, will openly debate the range of possible drug policy approaches—again, this reflects a shift in the living law of the *global* community relating to drugs and drug policies and is a hugely positive development.

7. *Decriminalisation in practice*

7.1. The abolition of criminal sanctions for the possession of drugs for personal use would have a wide range of positive implications. Given the high proportion of drug convictions that fall into this category, the high expenditure relating to law enforcement, legal aid, judicial proceedings and incarceration for these convictions could be diverted to socially useful purposes, including the provision of drug education and other health promotion drug strategies as well as treatment services for problematic drug use. Some of the very serious problems with Ireland's overburdened prison system could also be addressed. Moreover, decriminalisation would acknowledge the reality of safe personal drug use. The unreasonableness of the current law undermines the authority of the legal system, and the alignment of authority with reasonableness represented by decriminalisation would be very welcome and positive. If introduced in conjunction with a system of positive discrimination regarding employment, as described (p. 4) in the Joint Committee's report on Portuguese decriminalisation, the benefits of decriminalisation in Ireland could be enhanced further.

7.2. The Joint Committee's report on Portuguese decriminalisation lists (p. 5) among the outcomes of that legal reform as including no increase in drug consumption; the authorities keeping at least the same level of intolerance towards drug trafficking, both internal and international; Portugal not becoming a destination for drug consumers; a

decrease in the number of crimes directly related to drug misuse; drug users no longer being looked upon or treated as criminals; drug users becoming less dependent on traffickers and police discretion, something especially true when it comes to people with less resources; the end of thousands of criminal cases for drug consumption that cost time and money with absolutely no gain; and because it is easier to know who is buying drugs, “it is easier to know who is selling them”. The only problem raised by this list relates to the paradox intrinsic to drug decriminalisation measures. In the Netherlands, with the permitted retail “coffee-shop” outlets in its system of cannabis decriminalisation, the paradox is referred to as the “back-door/front-door dilemma”. In the words of one coffee-shop owner: “It presents a lot of problems for us ... Someone comes to the front door and asks for [cannabis], we can supply them. Someone comes to the back door and wants to sell us some ... and we are breaking the law buying from them, they are breaking the law supplying us ... Of course they don’t [arrest us], but the point is they could” (Quoted in Whynne-Jones, “Where the Grass is Greener”, *The Independent on Sunday*, 14th December 1997). In any system of decriminalisation people can demand and possess drugs for personal use, but, unless explicitly or implicitly tolerated, suppliers may still be sanctioned by law enforcement measures. In the longer term this approach may prove unsustainable. Ultimately, however, while that potential long-term unsustainability is worth bearing in mind, it does not detract from the unanswerable case for drug decriminalisation.

8. *Summary: Recommendation for action by the Government that I would like the Committee to consider for inclusion in its report to the House*

8.1. I recommend very strongly that the Committee consider including support for drug decriminalisation in its report to the House. While the Portuguese system has much to commend it, in my view it would be beneficial if the Committee also gathered information about other decriminalisation systems. This would likely improve the quality of any report to the House including support for drug decriminalisation. Moreover, it could feed positively into Ireland’s participation in the UN General Assembly Special Session (UNGASS) on drugs next year.

In conclusion, I thank the Joint Committee for the opportunity to contribute to this important discussion.

7 August 2015

Tim Murphy, BCL, LLM, PhD

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Carlos III de Madrid*

Students for Sensible Drug Policy, Ireland

**The Future of Drug Policy
Reform in Ireland**

**Submission to Oireachtas Joint Committee
on Justice, Defence and Equality**

**Fri. 7th of
August 2015**

Forward

'Students for Sensible Drug Policy' (SSDP) is an international grassroots organisation that began in the USA in 1997¹ to improve student and general public opinion about drug policy trends and initiatives.

This has been motivated by the fact that drug policy has failed to protect young people from the harms of drugs but instead has criminalized millions of young people around the world while putting money and power directly into the hands of criminal enterprises all while adding contaminants and unregulated potencies to dominate a volatile market without restrictions on who can or can't buy any particular substance. To end this destructive paradigm, we encourage young people to educate themselves in exercising their rights and building on our capacity to facilitate drug policy reform.

There are now hundreds of branches of SSDP all over the world including UCC, NUIG, DCU, AIT and CIT in Ireland. SSDP are united to facilitate informed public understanding that the drugs issue is not some temporary global phenomenon that is going to magically disappear if we keep pumping money and resources into its prohibition, but substance use is deeply embedded in our culture and human condition.

Contemporary prohibitionist drug laws implemented in most countries are not only outdated but are incredibly counter-productive and deeply inhumane. We believe in taking an evidence based approach to communicate and implement sensible drug policies in modern society.

SSDP Ireland consists of representatives from universities all across the country and we have worked relentlessly to develop our organisation which is at the forefront of facilitating drug policy reform in Ireland. Over the past 5+ years² of our collective history we continue to successfully develop capacity to meet our primary goals of raising public awareness about the harms caused by the criminalisation of people who use drugs and to increase the collective voice of young people who suffer from and are increasingly marginalized by misguided and ill-informed political decision-making.

Recently, our association met with the Minister for Drugs Strategy, Mr. Aodhán Ó Riordáin, as well as many other experts *in situ*, as well as interacting directly with the public by conducting peer-reviewed surveys and various other interviews, events, debates and generally increasing our capacity to facilitate drug policy reform by holding a visible public and on-campus presence. We have been vocal and active supporters of the Portuguese model of decriminalisation since our inception and we are delighted to have the opportunity to submit this proposal in support of extending the Portuguese drug policy model to Ireland.

In addition to this we also provide suggestions for the future beyond decriminalisation and address that the many problems of drugs can not be addressed by decriminalisation alone. To achieve this we invite more people to join current SSDP chapters or to contact us to begin the journey of starting your own network and improving our common initiative.

¹ <http://ssdp.org/resources/a-brief-history-of-ssdp-slideshow/>

² <http://www.rabble.ie/2014/04/03/taking-on-the-drug-war-on-the-home-front/>

Context

Contemporary drug policy in Ireland is implemented in accordance with the Misuse of Drugs Act 1977, which is a derivative of the 1961 United Nations (UN) Single Convention on Narcotic Drugs. The 1961 Convention aimed to eradicate drugs and was ratified by 181 countries worldwide including Ireland.

Considering that humans have been using psychoactive substances (i.e. drugs) for 10,000s of years, contemporary prohibition is a relatively new attempt at dealing with a long history of an intertwined anthropogenic identity with substance use. Recent decades have shown us that natural human demand for substance use across countless different cultures and demographics will not be prohibited by fears of criminalisation, arrest and stigma. All of which are currently associated with drug culture in Ireland and most other parts of the world.

In Ireland there are 47 drug-related deaths per million per year, which is above the European average which ranges between 3 (Portugal) and 120 (Estonia)³. Drug-related deaths may be prevented by alternative sanctions to drug use, as experienced in Portugal. The State must carefully balance drug control with their obligation to protect the life of their citizens, particularly vulnerable groups such as young people. It must be considered that drug-related deaths could drastically fall by decriminalising the personal possession of drugs and shifting from a criminal justice to public health approach.

The decriminalisation of drugs should not be seen as encouraging drug use, and programmes supporting demand reduction and prevention are essential. Policy-makers may consider the following:

- Early intervention for primary and secondary school children and more open dialogue around drugs, rather than the tired message of “just say no”.
- Training in harm reduction and safe-use among third level students and young adults.
- Allowing for drug-testing facilities and drug monitoring as a public health initiative.

The Current Approach

Linking the supplier through the consumer has been a favourable tool used to mitigate drug trafficking in recent history. However, it has proven to be ineffective and morally unjust. Rather than criminalize people for the possession of drugs and estimating the statistics of users, we would be in a much better position to tackle the harms associated with drug use by understanding personal substance use from the perspective of public health.

For example, if a doctor or other health professional was able to communicate honestly and openly with drug users, knowing they would not be criminalised or unduly stigmatised for their choices, perhaps people might be able to come to better terms with their substance use.

³ http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf

Through our constant efforts at eliminating drug culture in Ireland with the force of the law, our attempts have inadvertently created international criminal networks. This has become so prolific that entire nation states (eg. Mexico, Afghanistan) have been undermined and corrupted by drug money, with disastrous consequences for the local population. More locally, young people who may have had difficult upbringings and who turned to substance use in lieu of social networks, or drug dealing as an escape from financial instability have fallen into the hands of criminal networks and as a result are increasingly hardened and at-risk of committing serious criminal offenses for the lures of power, money and status within various subcultures.

The prohibitionist “Just say no” drug policy model of the 1970’s should not be taken as an unalterable fact in modern Ireland where substance use is glorified and even aggressively marketed on one hand (eg. via sports, peers, licenced pharmaceutical drugs) but shunned and silenced on the other. Drug culture in Ireland has undertaken immeasurable shifts since contemporary drug laws were first implemented and the harms being done due to these outdated laws can no longer be ignored. Whether we like it or not, drug use is here to stay; with cannabis being used among 49% of Irish students surveyed in the past 12 months and ecstasy at 32%⁴.

Our current approach of prohibition is not lowering these figures, but instead it is facilitating the mass criminalisation of our youth.

The Situation in Portugal

As stated in the Irish Government's official committee's report on the Portuguese approach of decriminalisation (2015):

“Fifteen years have passed and:

- a) drug consumption has not increased;*
- b) the authorities kept at least the same level of intolerance towards drug trafficking, both internal and international;*
- c) Portugal did not become a destiny for drug consumers;*
- d) the number of crimes directly related to drug addiction has decreased.*

At the same time:

- a) drug consumers are no longer looked upon or treated as criminals, not only by the authorities, but also by society (including their own families);*
- b) they became less dependent on traffickers and police discretion, being especially true when it comes to people with less resources;*

⁴ Bingham, O'Driscoll & de Barra, National Student Drug Survey 2015.
<http://www.irishexaminer.com/ireland/half-of-students-have-used-cannabis-339579.html>

c) the end of thousands of criminal cases for drug consumption, that cost time and money with absolutely no gain;

d) by being easier to know who is buying drugs, it is easier to know who is selling them”

Portugal’s bravery and forward thinking 15 years ago has given us an unprecedented insight into a model that has essentially removed any perceived risk associated with the decriminalisation of drugs. As outlined in the committee’s report, the Portuguese people have seen a remarkable increase in public and social health due to their proactive approach to drugs since their shift in drug policy reform 15 years ago and Ireland could most certainly benefit hugely from implementing a similar model.

Reducing the Harms from Drugs

Harm reduction is an approach that goes hand in hand with decriminalisation of possession of drugs. This approach aims to accept the fact that some people will choose to consume drugs, and as such it makes sense to try and reduce the harm to the user by implementing sensible policy around consumption rooms, drug testing and treating drug use as a public health issue.

All illegal drugs are subject to contaminants and unknown purities and qualities. Rather than continuing with the “just say no” rhetoric, it is essential that authorities share health advice on what drugs in Ireland are currently contaminated and what drugs are less dangerous than others, which is particularly relevant since many users are not aware of the quality or strength of the drug they are consuming. The type and prevalence of contamination varies greatly depending on the drug in question and has been reported on countless times in Ireland:

- **Ecstasy (MDMA):**

- In 2012, the HSE issued a warning regarding a substance containing MDMA and PMMA, believed to have been involved in the death of two young men in Kinsale. PMMA’s prevalence seems to have dipped since, while ‘super-strength’ ecstasy is believed to have been involved in the recent death of Ana Hick.⁵

- **Cocaine:**

- A study of cocaine in Ireland between 2010 and 2012 found that the average purity of cocaine in 2011 was 19%. It was also stated that 49% of samples contained levamisole⁶. Levamisole suppresses the production of white blood cells, leading to neutropenia and agranulocytosis. With the increasing use of

⁵ <http://www.irishexaminer.com/ireland/strong-ecstasy-pills-suspected-in-teen-death-331487.html>

⁶ Boyle, Michelle and Carroll, Lynn and Clarke, Karen and Clarke, Paula and Coyle, Hugh J and English, Henry and Goff, Miriam and Kane, Eugene and Killoran, Sarah and O’Connor, Kristen (2014) What’s the deal? Trends in Irish street-level heroin and cocaine 2010-2012. Drug Testing and Analysis, 6 (9). pp. 953-958.

levamisole as an adulterant, a number of these complications have been reported among cocaine users ⁷.

- **Cannabis**

- Herbal cannabis has often been found to be sprayed with glass, paint, sand, lead and other chemicals to increase its weight and profits for unscrupulous dealers.

Harm reduction can begin with decriminalisation of possession for personal use, which removes the fear of legal repercussions for someone who wants to try and discover what the purity and contents of their drug are. For example, in every major city in the Netherlands, there is a place you can bring ecstasy tablets for testing without fear of arrest. These testing locations will test the tablet and provide the user with information regarding the strength and purity of the sample⁸. These testing facilities provide a place for consumers to check their drugs in an attempt to curb overdoses and hospitalisations which arise as a result of people consuming drugs of unknown purity and strength.

Aside from the many physical harms caused by prohibition, it is also evident that being criminalised can have a serious negative impact on the life of a person who uses drugs. Is a person who uses drugs to be punished and vilified for their decision? Surely harm reduction should also seek to reduce the societal harms caused by being criminalised.

It has also been shown that many people who develop drug problems come from the disadvantaged areas of our society. Drug addiction is increasingly being shown as being driven heavily by a person's environment^{9,10}. If this is the case, then people are indirectly being punished for the environment or area they grew up in. This is grossly immoral and is something that needs to be heavily considered.

Conclusion

At SSDP Ireland we endorse the decriminalisation of personal possession of all drugs to achieve the following:

1. To end the criminalisation of people in Ireland for the possession of small amounts of drugs. This is currently restricting people's possibilities for travel and limiting their employability, productivity and full integration into society.
2. To enable police and legal resources to focus on more serious crime and to transfer financial savings from criminal justice into education and health.
3. To allow for more harm reduction and education around drug consumption rooms, drug purity testing and heroin-substitute therapy.

⁷ Centers for Disease Control and Prevention (CDC) (December 2009). "Agranulocytosis associated with cocaine use - four States, March 2008-November 2009". *Morb. Mortal. Wkly. Rep.* 58 (49): 1381-5. PMID 20019655.

⁸ <http://www.drugs-test.nl/>

⁹ <http://tedmed.com/talks/show?id=309156>

¹⁰ https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong?language=en

Beyond Decriminalisation

While we at SSDP Ireland feel that decriminalisation is incredibly important and should be implemented in Ireland as soon as possible, it is important to note the limitations of decriminalisation. Decriminalisation does not solve the problem of the black market for drugs, nor the issue of contamination of drugs at source. At SSDP we feel it is time for the Irish government to continue to take a lead on issues of social reform and to make proactive decisions like Portugal successfully implemented 15 years ago. As such, we firmly believe that it is time for Ireland to explore the option of full regulation of the drugs market like in the State of Colorado or in Uruguay. This is the only way to really cripple the black market drug trade, to control who can purchase drugs, and to ensure people who use drugs are not using contaminated drugs of unknown strength and purity.

This decision would require a lot more work than decriminalisation and needs a large infrastructure of education and strict and informed regulation which would take time and careful investigation. However, the potential benefits all across our society are huge.

The only reliable example of legalisation at this point in time is regarding cannabis. Colorado has recently legalised the sale and consumption of cannabis, and the results have so far been overwhelmingly positive. With job creation, increased tax revenue, reduced workload for police and vast reduction of the black market being the main factors. Worries like increased use have so far not been seen. Conversely, policy makers have a better understanding of the market size and demographics now and are in a stronger position to implement proactive policies that improve public health.

Unfortunately, cannabis is currently the only drug whose legalisation in other states we can study. However, it is important to look beyond cannabis and to deal with each illegal drug according to its unique properties and average user profile. Only by regulating each drug based on these factors can a government truly start to reduce its country's drug demand, right from the user to the criminal gangs importing the drugs from abroad. This would be a bold step by the Irish government, but like the smoking ban and the recent gay marriage referendum it could prove to be another proud achievement where we were world leaders in a difficult and important field.

Signed,

Students for Sensible Drug Policy, Ireland.

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Submission to the Committee on Justice, Defence and Equality on its review of Ireland's approach to the possession of limited quantities of certain drugs

This is a joint submission to the Justice, Defence and Equality Committee of the Houses of the Oireachtas on behalf of [Harm Reduction International](#) ('HRI'), the [International Drug Policy Consortium](#) ('IDPC'), [Release](#), and [Transform Drug Policy Foundation](#) (hereinafter 'Transform'). All four organisations advocate for evidence-based drug policies based on the principles of harm reduction, human rights and public health.

Founded in 1996, Harm Reduction International (HRI) is a leading non-governmental organisation working to reduce the negative health, social and human rights impacts of drug use and drug policy by promoting evidence-based public health policies and practices, and human rights based approaches to drugs.

IDPC is a global network of 134 NGOs that focus on issues related to drug production, trafficking and use. IDPC promotes objective and open debate on the effectiveness, direction and content of drug policies at the national and international level, and supports evidence-based policies that are effective at reducing drug-related harm. Our global membership has expertise and experience on the wide spectrum of drug policy issues. IDPC also runs the global "[Support Don't Punish](#)" campaign, which calls for drug policy reform and the scale-up of harm reduction services for people who use drugs.

Release is the UK's centre of expertise on drugs and drug laws, providing free and confidential legal and drug services to people who use drugs and/or those caught up in the criminal justice system. The organisation also campaigns for reform of the UK's current drug policy, with a specific call for the end of criminal sanctions for possession offences. As part of our campaigning work we produced '[A Quiet Revolution: Drug Decriminalisation Models Across the Globe](#)', which looks at 21 jurisdictions that have adopted a non-criminal justice approach to possession of drugs. As a result of this research Release is considered to be one of the leading experts on decriminalisation.

Transform is a UK-based charity and think tank producing policy analysis on, and advocating for, an end to the failed, enforcement-based 'war on drugs' for almost 20 years. Transform operates in the UK and internationally and has been awarded Consultative Status with the UN Economic and Social Council. It is regularly called upon to support parliamentary committees, carries out high-level advisory work for governments around the world, and serves as a key technical coordinator and advisor for the Global Commission on Drug Policy.

We thank the Committee for the opportunity to provide evidence in support of the Government's proposals to end criminal sanctions for drug possession offences. We would also like the Committee to note that we support the submission of our colleagues at CityWide in Dublin.

Clarifying the differences between decriminalisation and legalisation

There has historically been conflation of the terms *decriminalisation* and *legalisation* which can hinder productive debates on the matter. Therefore, it is important to clarify the differences between the two:

- **Decriminalisation** – has usefully been defined as ‘the removal of sanctions under the criminal law, with optional use of administrative sanctions’.¹ These administrative penalties can include fines and compulsory education about the harms of drug use. Under decriminalisation models, the personal possession and use of small amounts of drugs are still unlawful, but not criminal; some models allow cultivation of cannabis for personal use.² All activities associated with the production and supply of a controlled drug remain subject to the criminal law.
- **Legalisation is technically the process by which a product becomes legal and is often conflated with regulation. Regulation is the legislative framework for the operation of the legal production, supply, and purchase of a product.** Ultimately, under such a model all drug-related offences are no longer controlled within the sphere of criminal law, but production, supply and use are regulated through administrative laws, as is the case for tobacco or alcohol.³

Fundamentally, under a decriminalisation model, drug possession and use do not result in a criminal record or arrest as the matter is treated as a public health issue rather than a criminal justice one. Decriminalisation in no way implies that drug use is not a serious issue, or one that should be ignored or allowed to proliferate in society.

The jurisdictions that have decriminalised either all drugs or cannabis are not confined to any one region. A number of countries in Europe and Latin America have taken the decision not to treat drug use as a criminal justice issue, whilst states in Australia and the United States of America have a long history of decriminalising cannabis for personal use.⁴

The evidence in favour of ending criminal sanctions for possession of controlled drugs

Major national and international bodies have found no link between the severity of punishment and the level of drug use in society:

- Release launched a report in 2012 looking at 21 jurisdictions that had decriminalised possession of all, or some, drugs and found no increase in prevalence of drug use.⁵
- The World Health Organisation (‘WHO’) agreed: *“there is no clear link between punitive enforcement and lower levels of drug use ... moves towards decriminalisation are **not** associated with increased use,”* while the United Nations Development Program (‘UNDP’)

¹ Hughes CE, Stevens A. *What can we learn from the Portuguese decriminalization of illicit drugs?* British Journal of Criminology, 2010; 50:999–1022

² Rosmarin A & Eastwood N, ‘A Quiet Revolution – Drug Decriminalisation Policies in Practice Across the Globe’, Release, United Kingdom, 2012, www.release.org.uk/sites/default/files/pdf/publications/Release_Quiet_Revolution_2013.pdf

³ Ibid.

⁴ Rosmarin A & Eastwood N, ‘A Quiet Revolution – Drug Decriminalisation Policies in Practice Across the Globe’, Release, United Kingdom, 2012, www.release.org.uk/sites/default/files/pdf/publications/Release_Quiet_Revolution_2013.pdf

⁵ Ibid

states: *'longitudinal and comparative analyses suggest that there is no clear link between more punitive enforcement and lower levels of drug use.'*^{6 7}

- In its 2014 policy paper *Drugs: International Comparators*, the UK Home Office found that, *"Looking across different countries, there is no apparent correlation between the 'toughness' of a country's approach and the prevalence of adult drug use"*.⁸
- Irish drugs law have failed to impact on elevated levels of national drug use; between 2002/03 and 2010/11 lifetime prevalence of illicit drug use rose nearly 50%, while past year prevalence also increased over the same period.⁹
- Portugal decriminalised the possession for personal use of all drugs in 2001 while at the same time significantly increasing investment in health and harm reduction programmes. In Portugal, lifetime use for cocaine, ecstasy, amphetamine and cannabis now sits significantly below the EU average, and well below the levels seen in Ireland, which are above the EU average for each substance.¹⁰

Bans on harmful substances are created with the intention of reducing their use and therefore protecting people from their harms. Given that no link exists between criminalisation and lowered levels of drug use, the current criminalised status of drug possession could be seen as a serious and unnecessary infringement on the personal liberties of Irish citizens.

Recent amendments to Ireland's drug laws also support findings that criminalisation does not impact on use:

- After introducing a blanket ban on new psychoactive substances (NPS) in 2010, lifetime NPS use in Ireland amongst 15 to 24 year olds rose from 16% in 2011 to 22% in 2014.¹¹

Release, IDPC, HRI and Transform support Ireland's exploration of decriminalising the possession and use of all drugs on the basis that ending the use of criminal sanctions for such activity has shown to have better health, social and environmental outcomes:

- Punishing people who use drugs, both recreational users and those with serious addiction issues, is neither just nor proportionate. Criminalisation has a significant negative impact on the individuals who are targeted and fails to produce improved public health outcomes, lowering neither drug use nor its attendant harms. A comparative study of Western Australia's policy of criminalisation and South Australia's regime of administrative penalties for cannabis

⁶ WHO. *Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations*. World Health Organisation, July 2014, p.6

www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf

⁷ United Nations Development Programme. *Perspectives on the development dimensions of drug control policies*. UNDP: Vienna, March 2015. p.6

www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf

⁸ Home Office. *Drugs: International Comparators* 30th October 2014, p.51, www.gov.uk/government/publications/drugs-international-comparators

⁹ Drug Use in Ireland and Northern Ireland - Drug Prevalence Survey 2010/11: Regional Drug Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) Results pg. 60-61 http://www.dhsspsni.gov.uk/bulletin_2.pdf

¹⁰ European Monitoring Centre for Drugs and Drug Addiction. *European Drug Report 2015: Trends and Developments*, pp. 76-79 <http://www.emcdda.europa.eu/publications/edr/trends-developments/2015>

¹¹ Flash Eurobarometer 330 – TNS Political and Social. Youth attitudes on drugs: an analytical report. TNS Political and Social commissioned by the European Commission, July 2011. P.85 http://ec.europa.eu/public_opinion/flash/fl_330_en.pdf and Flash Eurobarometer 401 – TNS Political and Social. Young people and drugs: a report. TNS Political and Social commissioned by the European Commission. p.T6 http://ec.europa.eu/public_opinion/flash/fl_401_en.pdf

possession, found that individuals given criminal penalties were more likely to suffer negative employment, relationship, and accommodation issues as a result of their cannabis conviction. People given criminal sanctions were also more likely to come into further contact with law enforcement than people who faced administrative penalties, potentially contributing to recidivism rates.¹²

- In the UK, the scarring impact of a conviction for cannabis possession has been shown to reduce lifetime average annual earnings by 19%.¹³
- Previous drug possession convictions act as a barrier to employment for individuals, and for those who have a history of problematic drug use it can also prevent reintegration into society. A UK study carried out in 2008 by the *UK Drug Policy Commission* found that almost two-thirds of employers believed those with a history of drug use to be untrustworthy, and expressed concerns about safety in the workplace if they were to hire them.¹⁴
- In spite of this, 27.2% of Irish citizens aged 16-54 have used drugs in their lifetime, resulting in a lottery effect where more than a quarter of citizens violate drug laws and an unlucky minority, often those who are poor and/or young, are punished.¹⁵ Unpublished research by Release has shown that 93% of those found in possession of drugs by the Metropolitan Police were from lower socioeconomic groups.¹⁶

The stigma of criminalisation prevents vulnerable drug users from accessing required services. Drug use is a public health issue and should not be subject to criminal sanctions:

- Multiple studies have shown the negative impact of stigma attached to drug use in preventing access and engagement with harm reduction and treatment services.^{17 18}
- Ireland has a drug-induced death rate of 58.5 cases per million, more than triple the EU average of 17.3 cases per million and more than sixteen times greater than Portugal's 3.0 cases per million.¹⁹ Decriminalisation has allowed Portugal to address drug use outside the criminal justice system and operate a pragmatic approach rooted in harm reduction and the needs of vulnerable drug users; deaths due to drug use have decreased significantly – from approximately 80 in 2001, to 16 in 2012.²⁰

¹² McLaren J, Mattick RP. *Cannabis in Australia: use, supply, harms and responses*. Sydney: National Drug and Alcohol Research Centre, University of South Wales, 2007; p.560.

¹³ Bryan M. et al. *Licensing and Regulation of the Cannabis Market in England and Wales: Towards a Cost-Benefit Analysis*. Institute for Social and Economic Research, University of Essex, November, 2013, pp.92-93

¹⁴ UK Drug Policy Commission. *Working Towards Recovery: getting problem drug users into jobs*. London: UK Drug Policy Commission, 2008, www.ukdpc.org.uk/resources/Working_Towards_Recovery.pdf

¹⁵ Drug Use in Ireland and Northern Ireland - Drug Prevalence Survey 2010/11: Regional Drug Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) Results pg. 60
http://www.dhsspsni.gov.uk/bulletin_2.pdf

¹⁶ Daly. M, 'Rich People Are Officially Less likely to be Busted For Drugs', 2014, https://www.vice.com/en_uk/read/class-drugs-release

¹⁷ Radcliffe, P. and Stevens, A. Are drug treatment services only for 'thieving junky scumbags'? Drug use and the management of stigmatised identities. *Journal of Social Science and Medicine*, October 2008; 68 (7): 1065-1073.
<http://www.sciencedirect.com/science/article/pii/S0277953608002980>

¹⁸ UK Drug Policy Commission, *Dealing with the stigma of drugs: A guide for journalists*, London: UK Drug Policy Commission, 2012

¹⁹ European Monitoring Centre for Drugs and Drug Addiction. *European Drug Report 2015*, p. 80

²⁰ Data for year 2001 taken from Hughes, C. E. and Stevens, A., 2012, op. cit., p. 107; data for year 2012 taken from Instituto da Droga e da Toxicodependência, 2013, op. cit., p. 64.

- Portugal has reduced the rate of new HIV infections among injecting drug users from 1,497 new cases in 2000 to 78 in 2013, with a fall *every single year* since decriminalisation.²¹

Decriminalisation reduces criminal justice costs and can help divert law enforcement expenditure towards more serious criminal activity:

- Portugal has reduced the number of criminal drug offences from approximately 14,000 per year in 2000 to an average of 5,000 to 5,500 per year after decriminalisation.²² This has led to a significant reduction in the proportion of individuals with drug-related offences in Portuguese prisons -- in 1999, 44% of prisoners were incarcerated for drug-related offences; by 2008, that figure had reduced to 21%.²³ This has resulted in a major reduction in prison overcrowding in Portugal.
- Expenditure on low-level drug busts could be more cost-effective if re-routed towards treatment. The UK's National Treatment Agency (NTA) estimated that every £1 spent on drug treatment saves society £9.50 through crime reduction, economic and social reintegration and reduced health expenditure. The NTA also estimated that 4.9 million crimes were prevented in 2010-2011 by drug treatment.^{24 25}
- Cannabis decriminalisation in the state of South Australia has been shown to result in savings, with conservative estimates from 1995 putting the figure at between AU\$500,000 and AU\$1 million despite the fact there was low adherence to fine payments. This does not take into account the potential extra tax revenue generated through people engaging in employment as a result of not being damaged by a criminal record.²⁶
- When California introduced decriminalisation of cannabis possession in 1976, it estimated that criminal justice savings in the first six months of the policy being implemented was over \$12 million, compared to the same period of the previous year.²⁷ Today that equates to \$50 million when inflation is taken into account.

The decriminalisation of drugs possession and use is endorsed by numerous international bodies

Decriminalising drugs is increasingly recognised as a pragmatic policy response that effectively begins to manage drug use where punitive measures have failed:

- A growing number of UN bodies have voiced their support for decriminalising the possession and use of all drugs, with both the Joint UN Programme on HIV/AIDS (UNAIDS) and the WHO doing so in 2014.^{28 29}

²¹ European Monitoring Centre for Drugs and Drug Addiction. *Data and Statistics: Infectious diseases – HIV*.

<http://www.emcdda.europa.eu/data/stats2015#displayTable:DRD-33> (last consulted 22/06/15)

²² Hughes CE, Stevens A. What can we learn from the Portuguese decriminalization of illicit drugs? *British Journal of Criminology* 2010;50:1008.

²³ Ibid: p.1010.

²⁴ National Treatment Agency for Substance Misuse. *Treat addiction, cut crime: how treatment and recovery services reduce drug-related offending*. NHS, 2012. p.6 <http://www.nta.nhs.uk/uploads/vfm-crimepresentationvfinal.pdf>

²⁵ <http://www.fead.org.uk/docs/storyofdrugtreatment0809.pdf>

²⁶ Single E, Christie P, Ali R. The impact of cannabis decriminalisation in Australia and the United States. *Journal of Public Health Policy* 2000;21(2):167

²⁷ Ibid

²⁸ World Health Organisation. *Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations*. World Health Organisation, July 2014. p.91.

²⁹ UNAIDS. *The GAP Report*. UNAIDS: Vienna, 2014. P.71

http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

- The UNDP has stated that member states should “*address abuses that interfere with access to comprehensive harm reduction services, including laws criminalizing drug use and possession of small amounts of drugs for personal use and drug paraphernalia ... tak[ing] advantage of flexibilities available in the drug conventions on penalization of possession and use of controlled substances, including decriminalization of drug use and possession of small amounts of drugs for personal use*”.³⁰
- The UN General Secretary, Ban Ki-Moon, declared in 2015 that countries should “*consider alternatives to criminalization and incarceration of people who use drugs and focus criminal justice efforts on those involved in supply. We should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies*”.³¹
- The head of the United Nations Office on Drugs and Crime (UNODC) has stated: “*we must ensure that drug users are treated with respect, not marginalized or discriminated against,*” and that, “*drug users should be treated as patients and not criminals*”.³²
- UN Women has stated, “*member states should avoid ... criminalizing the most vulnerable in the chain of drug production and drug trafficking, including the possibility of decriminalizing drug use and low-level, non-violent drug offenses*”.³³

Recommendations for the development of an effective model of decriminalisation

As stated, our organisations support Ireland’s exploration of a non-criminal justice response to drug use and possession for personal use. In the development of any such model there are numerous key variables to consider in order to ensure that the policy achieves its fundamental aim of diverting people away from the criminal justice system, with a view to improving health and social outcomes for communities, including people who use drugs. Appropriate thresholds and sanctions should be rigorously explored to ensure the decriminalisation model has the intended effect. The points raised below are a brief consideration of the key factors:

- Many, though not all, decriminalisation models use maximum-quantity thresholds to distinguish between possession and trafficking offenses. In practice, these thresholds should be meaningful and encapsulate what is a realistic amount for personal use; for example, Mexico’s decriminalisation model allows for possession of just over 5 grams of cannabis, while Jamaica’s allows for over 56 grams. When the threshold is too low, as in the case of Mexico, the policy has little practical effect and is considered to be a ‘hollow’ model of decriminalisation as people routinely carry greater amounts for their personal use. Thresholds should take into consideration and include the different types of consumption levels for personal use, including problematic use or those who buy larger quantities to limit their contact with the black market.

³⁰ “Addressing the Development Dimensions of Drug Policy’. United Nations Development Programme. *Perspectives on the development dimensions of drug control policies*. UNDP: Vienna, 2015. p.34.
<http://www.undp.org/content/dam/undp/library/HIV-AIDS/Discussion-Paper--Addressing-the-Development-Dimensions-of-Drug-Policy.pdf>

³¹ United Nations Office on Drugs and Crime. Secretary General Ban Ki-Moon’s Message for 26th June 2015. UNODC, 26th June 2015, www.unodc.org/drugs/en/sg/secretary-general-message-2015.html

³² Fedotov, Yuri. *Addressing the global scourge of illicit drugs*. Reuters, March 11th 2013, <http://blogs.reuters.com/great-debate/2013/03/11/addressing-global-scurge-of-illicit-drugs/>

³³ UN Women, ‘A Gender Perspective On The Impact Of Drug Use, The Drug Trade, And Drug Control Regimes’, 2014
[https://www.unodc.org/documents/ungass2016/Contributions/UN/Gender and Drugs - UN Women Policy Brief.pdf](https://www.unodc.org/documents/ungass2016/Contributions/UN/Gender%20and%20Drugs%20-%20UN%20Women%20Policy%20Brief.pdf)

- Where the threshold has been set, there should be continual evaluation as to whether it is sufficient for the intended purposes of decriminalising possession for personal use. In the Australian Capital Territory, a 2013 amendment was passed that increased the threshold for cannabis possession from 25 grams to 50 grams. Though the legislation did not state a rationale for this change, in practice the old law meant that people who bought 1 ounce (28 grams) of cannabis – a common purchase unit – were handed a criminal sanction, despite the amount being for personal use.³⁴
- It is worth noting that the evidence from countries that have adopted thresholds indicates that the threshold levels put in place do not have any correlation to levels of consumption, and so should not be used as a tool of deterrence i.e. imposing a lower threshold will not encourage lower prevalence rates.
- Thresholds should not be the sole determinative factor in deciding whether an individual is in possession of drugs for their own personal use or in possession with the intention to supply. As is currently the case, police should be able to look at all the evidence to assist them in making the correct determination.
- Different decriminalisation models have different non-criminal sanctions. These include: fines; community-service orders; warnings; education classes; suspension of a driver's or professional licence; travel bans; property confiscation; associational bans; mandatory reporting; termination of public benefits; administrative arrest; or no penalty at all. From the experience of other jurisdictions, the sanction in place appears to have very little or no correlation to levels of use.
- We would advise against having street fines as a sanction as there is a real risk of 'net widening' whereby more people get caught up under the new scheme than under the old criminal justice model. This is largely driven by the fact that there is a financial incentive for forces to issue fines, or it is an easy mechanism for police officers to demonstrate their effectiveness. In this scenario, more police time and money is dedicated to low-level offences.
- A more effective health-based approach to sanctions should be adopted for those caught in possession of drugs for personal use. For example, a brief education intervention providing harm reduction advice and highlighting drug risks (similar to the driving awareness courses offered to a speeding driver in the UK as a way of avoiding points on your license) could be offered, whilst those whose use is considered problematic could be encouraged to engage in a more in-depth intervention.

If decriminalisation is inadequately devised or implemented, it will have only marginal impacts, even potentially creating new problems such as net-widening. Decriminalisation should ideally form part of a wider policy reorientation and resource reallocation away from harmful punitive enforcement and towards public-health-oriented and human-rights-based approaches targeted at people who use drugs, particularly young people and people who inject drugs. It can be seen as a part of a broader harm reduction approach, as well as a key to creating an enabling environment for other public health interventions.

³⁴ Australian Capital Territory Act, *Crimes Legislation Amendment Act 2013 (No. 2) (No. 50 of 2013) - Section 171A (7), definition of simple cannabis offence , paragraph (b)*, http://www.austlii.edu.au/au/legis/act/num_act/claa2013250o2013347/

The above is a very brief outline of some of the factors and variables to consider in developing a model of decriminalisation. Our organisations would be delighted to provide additional written and/or oral evidence, or other technical assistance, in any future development of Ireland's policy.

(August 2015)

Irish Council for Civil Liberties (ICCL)

Submission to the Houses of the Oireachtas Joint Committee on Justice, Defence and Equality

on the review of Ireland's approach to the possession of limited quantities of certain drugs

6 August 2015

Background

The drug policies promoted universally over the last decades by some countries have been embraced globally. The United Nations Office on Drugs and Crime (UNODC) and its intergovernmental body the Commission on Narcotic Drugs (CND) have been the stewards of the process. However, if it ever did, the choir is no longer singing from the same music sheet. Mainstream drug policies are at present under robust scrutiny.

Reformists advance that scientific knowledge defies mainstream approaches that, *a fortiori*, do not achieve the intended objectives. They claim that current policies perversely bring about considerable and unnecessary human suffering, ignoring that upwards of 80% of persons with serious drug problems are victims muffling their suffering due to severe trauma and abuse, often sustained during childhood. Some also claim that the vast majority of people who expose themselves to drugs do not become addicted and discontinue use or remain occasional or recreational users.

They also argue that current policies are extremely costly and that the bulk of the resources spent on law enforcement should be invested to far better results in harm reduction, prevention and education, and in improving health care and treatment of persons suffering from substance use disorders. Examples of policies adopted in certain countries seem to bear this out.

Alongside part of the scientific community and a number of civil society organisations, some governments also call into question the rationale behind and the effectiveness of those policies. Certain nations or states are legislating away from the so-called "war on drugs". This growing trend to some extent hints at a return to the situation before the "war" begun: decriminalised use, tolerance of recreational or non-problematic use, affirmation of the public health dimension and primacy of the medical response to substance use disorders that, in certain cases, may involve the prescription or medical administration of certain substances otherwise considered drugs of abuse. Education, prevention and harm reduction are part and parcel of these trends.

Problem or high-risk use is defined by the European drugs observatory (the EMCDDA) as "recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms".

It is broadly acknowledged that a drug free world is unattainable. People's desire to alter their mental state or consciousness cannot be suppressed through criminal policy.

Some argue that current drug policies adversely affect the enjoyment or effectiveness of a range of fundamental rights. Certain of the questions that arise from a human rights approach to drug policy are explored later in this short paper.

It should be emphasised that nothing in this submission should be interpreted as denying that substance use disorders exist or that drug use can be dangerous and can cause severe harm. Recreational drug use and self-medication are not advisable and do entail risks. However, the danger may even be greater for persons minded to take drugs if they acquire street drugs which are unreliable, of uncertain composition and unknown potency, and therefore with unpredictable effects.

Certain interferences with peoples' fundamental rights can be justified in a democratic society in order to achieve the legitimate goals of drug policies. It is necessary for example to protect children and preserve public health. Such interferences must, and mostly are, based in laws that meet human rights requirements. Nevertheless, some argue that the proportionality test required by human rights law would fail if drug policies are not capable of achieving the objectives they are intended for or if they can be shown to aggravate rather than resolve the situation.

These arguments have to be weighed against the duties of the state to protect people, in particular children and other vulnerable groups, and to preserve and promote public health. And also against the legitimate and desirable law enforcement measures the state should take to those ends.

Human rights – preliminary remarks

Within a Council of Europe context, States have submitted to the jurisdiction of the European Court of Human Rights. The Court oversees the application of the European Convention on Human Rights through its adjudications in individual or interstate complaints about human rights violations. In doing so and subject to the principle of subsidiarity, it falls to the Court to tease out the boundaries of human rights and the modalities for their protection.

However, the Court has not had the opportunity to pronounce itself in drug-related cases to an extent that would allow drawing out principles to outline or inspire drug policy. In addition, the case law of the court can, and does evolve with time. On the other hand, the position adopted by the Court in cases not related to drugs or drug policy offers some guidance that might usefully be borne in mind when examining drug policy from a human rights perspective.

In general, human rights entail negative obligations for the state: not to interfere with a right. In certain circumstances, they also bring about positive obligations for the state: to act in order to protect. This may involve taking reasonable steps to facilitate or secure the enjoyment of rights or to prevent, minimise or redress third party interferences.

Human rights sensitive drug policy should be evidence or science-based. While the state has a recognised, albeit variable, margin of appreciation, human rights based policy should not be ideology or prejudice driven, nor should it be judgmental. There is a strong case for redesigning drug policies if it is true that they are not achieving their objectives and, instead, have significant unwanted, undesirable or even unacceptable effects, all the more if they impinge on the enjoyment of human rights.

This approach may also contribute to shaping drug-related aspects of foreign policy and international cooperation.

Right to life (Art 2 ECHR)

There are around 200,000 drug related deaths every year across the world (ten times more than the number of victims of terrorism). Europe counts some 16,000 drug-related deaths per year, half of them within the European Union, with opioids leading among the primary illicit drug of concern. According to the EMCDDA, the drug-related death rate in the European Union ranges from around three per million inhabitants per year (Portugal) to more than 120 (Estonia). **Ireland stands halfway between these two extremes, with almost four times the overall European Union average.** Certain states in the U.S. register up to 300 drug-related deaths per million inhabitants per year.

Such considerable variations may be explained in part by policy choices. Even if unintended, some of these deaths might be preventable through different or adjusted drug policies. Subject to weighing carefully the tangible impact of policy changes against the duties of the state to protect people, in particular children and other vulnerable groups, and to preserve and promote public health, policy makers might wish to consider whether the number of drug-related deaths can be reduced by:

- Shifting the emphasis of drug policy from criminal justice to public health and health care;
- 'Good Samaritan' provisions to protect persons who alert to a drug overdose or drug-related health complication;
- Adopting policies on the use of opioid overdose reversal medication, including "take home" distribution of that medication and training on its use;
- Providing safe drug-injecting facilities or spaces, and offering on-site health monitoring for people who inject.

The degree or intensity of the shift of drug policy from criminal justice to public health may need to be decided on the basis of empirical observation (including evolution in the number of drug-related deaths) and adjusted through an incremental or dynamic approach. This may have significant implications if more lives can be saved by steering users clearly away from dangerous and unreliable street drugs. Policy makers might therefore wish to assess whether drug-related deaths can be reduced by:

- Decriminalising the use of drugs and their possession for own consumption;
- Programmes for the medical prescription and/or administration by health care professionals of certain (medical quality) drugs.

At the same time, attention should be paid to ensure that these measures are not misinterpreted as encouraging people who would otherwise not use drugs to take them. Policy makers may consider prevention also in terms of:

- Measures designed to keep drugs away from children to the maximum extent possible (in line with the approach followed in respect of tobacco and alcoholic beverages);
- Drug-related education and awareness raising about the risks and dangers of drugs starting from young age and reinforced for persons who use or are at risk of using drugs and in places where drugs are likely to be used;
- Training on safe (or safer) drug-taking practices;
- Making drug-testing or drug-checking material available among people who use or are at risk of using drugs, or in places where drugs are likely to be used.

Policy makers might also consider the extent to which the preceding observations might apply to custodial settings where preventable drug-related deaths occur.

A number of countries around the world retain capital punishment for drug-related offences. As Ireland and other Council of Europe member states have done, it appears judicious from a human rights perspective to discontinue support for international drug-enforcement cooperation activities that may directly or indirectly lead or contribute to, or be understood as condoning, the arrest and execution of persons for drug-related offences.

Prohibition of torture and inhuman or degrading treatment or punishment (Art 3 ECHR)

Persons with drug problems suffer considerably and their health is eroded by street drugs and by drug-taking practices. There is transmission and high prevalence of HIV, Hepatitis C, etc. among the drug using population. Compounded by the stigmatisation that goes along with substance use disorders or drug addiction, these and a range of other conditions can be perceived by the persons suffering them as inhuman or degrading. These consequences are largely avoidable even if people continue using drugs.

Policies focussing on drug use as a health problem rather than through criminal policy might strike a better balance in terms of addressing these human rights concerns. Policy makers might wish to consider whether the following may contribute to reducing suffering resulting from problematic use of drugs and related medical conditions and stigmatisation and associated debasing feeling:

- Prioritising treatment both in cases of problematic use or 'addiction' and in cases of drug-related health incidents;
- Responding to drug use, whether problematic, recreational or occasional, as a health issue and a matter between doctor and patient (subject as appropriate to relevant public health guidelines and arrangements for delivery of health care and social services), devoid of moral, ideological or criminal law policy constraints.

In exploring the consequences of the primacy of the medical dimension of access to and choice of palliative, substitution or maintenance treatment for problematic drug users, policy makers may wish to consider:

- The place for medical heroin and other medical quality drugs in the range of supervised or unsupervised treatment options available to doctors.

As already mentioned in respect of the right to life, a human rights approach may involve decriminalising the use of drugs and their possession for own consumption. Policy makers may also wish to consider whether drug policy could contribute to reducing preventable suffering associated with communicable disease and other medical conditions, especially to the extent that it might be felt as inhuman or degrading, through:

- Prevention policies and awareness raising activities among persons who use drugs, including training on safer use;
- Safe drug-injecting facilities or spaces, offering on-site counselling and health assistance for people who inject;
- Syringe and needle exchange programmes accessible to people who inject drugs, and distribution of disinfecting or sterilising material.

Preventive measures should not be misconstrued as to the actual risk that drug use involves and the damage that it can cause. Efforts should be made to avoid people having a false sense of acceptance to drug use or of security. Education is therefore a fundamental component of prevention policies.

Drug use may be the result of lack of access to wanted palliative treatment or failure to respond to the real or perceived somatic or mental health needs or conditions of the user. These needs may be related to undisclosed traumatic experiences (e.g. abuse suffered during childhood that renders a person more vulnerable to problematic substance use). Policy makers might wish to examine the degree to which suffering might be reduced or prevented, especially if it can reach the inhuman or degrading threshold, and non-medical use of prescription drugs or use of illegal drugs reduced if:

- Doctors have greater prescription freedom subject only to professional standards, without a criminal policy inspired gatekeeping role and associated sanctions for doctors perceived as over-prescribing psychoactive substances.

Policy makers might also consider the extent to which the preceding observations apply to custodial settings and the modalities for their application in those settings.

Many countries retain harsh, unusual, inhuman or degrading punishment for drug use, contrary to human rights requirements and to the idea that substance use disorders are a medical condition not a vice, depravation or crime, complacency or self-indulgence. Consequently, a country's foreign policy might rightly consider the human rights dimension and the reasonable means available to it to discourage such treatment and promote change towards human rights sensitive policies abroad.

Prohibition of forced labour / slavery (cf. Art 4 ECHR)

Drug policies that stigmatise, marginalise and exclude users often push them into the hands of persons who exploit them sexually or otherwise in situations that are tantamount to forced labour, sometimes modern slavery. If these situations are avoidable through different policies, they raise questions from a human rights perspective. Policy makers may wish to consider certain of the preceding reflections also in this context.

Although not under the potential scope of Article 4 of the European Convention on Human Rights, it is worth noting that working conditions and work-place environments may also be conducive to drug use. This may occur because of work-related stress, unreasonable performance objectives or demands, or an excessively competitive atmosphere. Performance enhancement drugs can lead to problematic use. Policy makers may wish to consider response that minimise risks in such situations.

Right to liberty and personal freedom (cf. Art 5 ECHR)

According to UN estimates, widespread drug use continues world-wide. Up to around 7% of the population take drugs at least occasionally, and around 1% of the population are problematic users. Some researchers estimate that upwards of 80% of persons with serious drug problems are attempting to muffle their suffering due to severe trauma and abuse, often sustained during childhood.

Those proportions would represent around 30 million occasional drug users within the European Union, and some 5 million problematic drug users. However, the EMCDDA reported only 1.25 million drug offences in the European Union last year, of which 781,000 were cannabis use and a further 223,000 involved use of other drugs; cannabis supply amounted to 116,000 recorded offences, with supply of other drugs accounting for 86,000 and other offences 42,000 criminal cases.

These figures suggest, in the first place, that the application of criminal law to drugs is uneven and therefore risks being discriminatory. If use were punished systematically, it would mean criminalising within the European Union the equivalent of seven times the population of the Republic of Ireland, or more than once its population if only problematic users were targeted. Policy makers might wish to consider whether drug-related criminal law:

- Fails its vocation of general non-discriminatory application, while drug trafficking continues to be rampant despite considerable law enforcement efforts;
- Fail its purpose of preserving public health given the scale of the drug problem and the reported collateral damage of drug policy;
- Fails its purpose of protecting children.

Drug policy in many cases leads to the deprivation of liberty for persons who suffer from substance use disorders, i.e. a medical condition that should receive a medical response (unless there is a danger to others). Policy makers might consider whether:

- Legal provisions that allow for the detention of people because of their condition (addiction), or actions aimed at the procurement of the drugs they are addicted to, or possession of those drugs for own consumption are out-dated.

Paradoxically, the wording of Article 5.1.e of the ECHR appears to sanction deprivation of liberty of “alcoholics, drug addicts and vagrants”. This wording, included in the original 1950 text of the Convention and yet to be amended, now appears antediluvian, especially when other provisions in the Convention can be relied on, if necessary, to justify deprivation of liberty for reasons *other* than problematic drug use.

Right to private life, freedoms of thought, expression, association (cf. Arts 8, 9, 10, 11 ...)

Some argue that the rights to private life, freedoms of thought, expression and association are or may in some cases be interfered with as a result of prevailing drug policies, depending on the motivation of the user or modalities of application and impact of drug policies. This could be the case for example when drugs are done as a means of protesting or expressing discontent, or as a way of dissociating oneself from mainstream society or culture.

As regards more particularly the right to private life (Article 8 ECHR), arguably it extends to enjoying an experience of one's choice, including those that alter one's mental perceptions or state of consciousness, especially if it does not transcend to the public or endanger others.

The interdiction of such activities (in terms of their mind-altering power) would be contrary to Article 8 of the European Convention on Human Rights, unless provided for in law “in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”. The objective pursued would have to be demonstrably necessary in a democratic society and the interference proportionate. In order to manage the risk, the response would have to be prevention, education, awareness, empowerment, self-determination, etc., not criminal law.

Policy makers might wish to consider whether these arguments could be used when exploring the human rights dimension of drugs. While the human-rights based discussion has not yet taken place to an extent that would allow drawing guidance, policy makers might wish to take these matters into account as elements that may shift the balance in favour or against a particular approach, and explore whether:

- The ‘right to private life’ contention is pertinent in respect of (decriminalisation of) use and possession intended for own consumption;
- This argument could carry even more weight in respect of the home-growing of cannabis plants for personal consumption in cases where there is no likely impact, visibility or risk beyond a purely personal sphere, especially if this activity does not involve risk to children or to public health.

Prohibition of discrimination (Art 14 and Protocol 12 ECHR)

It is broadly accepted that drug laws are not applied equally across social groups and categories, affecting far more people in disadvantaged communities. This is apparently the case despite drug use being roughly the same across communities or even when there is higher prevalence among more affluent or mainstream ethnic groups. This is not something that policy makers should ignore.

Some also argue the discriminatory character of policy decisions that subordinate the treatment of substance use disorders to criminal policy or related moral considerations, as compared to other self-inflicted conditions (e.g. tobacco-related cancer, alcohol-related diseases, diet-related hypertension, certain cases of diabetes, extreme sport-related injury or even suicide attempt) that remain a purely medical matter. This bias can affect access to and the modalities of palliative, substitution or maintenance treatment for substance use disorders. Policy makers may wish to consider whether current drug policies that hinge around criminal law and repression:

- Have an unnecessary, undesirable or discriminatory impact on the delivery of health care for persons suffering from substance use disorders;
- Place the persons concerned in significantly less favourable conditions for access to and quality of treatment than people who suffer from other self-inflicted medical conditions.

Concluding remarks

The objective of this ICCL submission is to identify some questions that may help legislators consider the drugs phenomenon from a human rights perspective. It is not narrowly circumscribed to the question of possession of limited quantities of certain drugs, because of the interconnection between different aspects of drug policy.

The content of the submission draws inspiration from emerging Council of Europe human rights standards in this area and, in particular, from the work of the Council's "Pompidou Group".

Given its acknowledged expertise, the ICCL would respectfully suggest that you might consider inviting a senior representative of the Council of Europe's Pompidou Group to give evidence before your Committee.

The Irish Council for Civil Liberties remains at the entire disposal of the Joint Oireachtas Committee on Justice, Defence and Equality should any further questions arise.

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Submission to the Oireachtas Justice Committee regarding the decriminalisation of Cannabis.

From: Community Awareness of Drugs (CAD)

Established in 1983 Community Awareness of Drugs is a voluntary organisation and registered charity that provides drug education and training programmes for parents guardians community workers and vulnerable young people.

1 While we fully understand that people would have an interest in decriminalisation of cannabis – we in Community Awareness of Drugs CAD) are concerned that use would escalate as perception of harm diminishes with relaxed laws. That in turn would mean more people using a very harmful substance.

The terrible truth about cannabis: Expert's devastating 20-year study finally demolishes claims that smoking pot is harmless. Professor Wayne Hall.

Read more: <http://www.dailymail.co.uk/health/article-2782906/The-terrible-truth-cannabis-British-expert-s-devastating-20-year-study-finally-demolishes-claims-smoking-pot-harmless.html#ixzz3i8BJIa6>

One in six teenagers who regularly smoke the drug become dependent on it,

Cannabis doubles the risk of developing psychotic disorders, including schizophrenia,

Cannabis users do worse at school. Heavy use in adolescence appears to impair intellectual development

One in ten adults who regularly smoke the drug become dependent on it and those who use it are more likely to go on to use harder drugs,

Driving after smoking cannabis doubles the risk of a car crash, a risk which increases substantially if the driver has also had a drink,

Smoking it while pregnant reduces the baby's birth weight

By [BEN SPENCER, SCIENCE REPORTER FOR THE DAILY MAIL](#)

PUBLISHED: 23:02 GMT, 6 October 2014 | UPDATED: 07:08 GMT, 7 October 2014

2 In our view, one does not relax the laws when you are dealing with a harmful substance - you need to continue to raise awareness about its harmfulness. There are thousands of studies testifying to its harm

3 We will take it that the committee accepts the scientific literature on the matter. So would use go up. The literature is confusing.

4 Alternative to decriminalisation.

CAD believe we should expunge convictions instead of introducing decriminalisation. We believe that this could happen over time when the young person / or not so young person is in a healthier place. This would mean the person would not be carrying charges going forward perhaps interfering with travel plans or employment opportunities.

5 Use may go up – clear proof of misuse of data

- In Portugal, a scientific paper by Cordosa, Santos & Duarte (2009) based on 2008 data found that reported lifetime use of all illicit drugs increased from 7.8% to 12% after decriminalisation.
- Lifetime use of cannabis went from 7.6% to 11.7%
- Cocaine use more than doubled from 0.9% to 1.9%
- Ecstasy nearly doubled from 0.7% to 1.3%
- Heroin rose from 0.7% to 1.1%

This study was undertaken by the Portuguese Focal Point for the European Monitoring Centre for Drugs & Drug Addiction.

6 On the other hand, other papers report that the Portuguese System is working, has not been linked to increased use – it's quite confusing.

There is one paper called 'A resounding success or a disastrous failure – re-examination of the interpretation of evidence on the Portuguese decriminalisation of illicit drugs'. Hughes CE and A Stevens - Drug and Alcohol Review (Jan 2013) 31, 101-113. In this paper the researchers found **clear proof of misuse** (of data) p109. They drew on the two most divergent accounts and **found selective use of the evidence base**. What hope do we have when it comes to deciphering the literature on this subject matter!

7 If use goes up, problem use becomes more likely. What problems have we encountered already here in Ireland?

- Physical ill health – cannabis smoke produces three times more cancer causing chemicals and five time more poisonous carbon monoxide than tobacco smoke. Cannabis smokers inhale smoke and hold it in their lungs for a longer period of time than tobacco smokers.
- Mental ill health – more psychosis 'Skunk' more stronger than 'hash' and more popular lately.
- Impaired learning in schools, colleges, training workshops or workplaces – our fear would be that this would become more commonplace by vulnerable young people.
- Dependence would continue to grow.

- Road Traffic Accidents – Cannabis is currently in second place behind alcohol when implicated in Irish RTAs. It usually appears in top three alongside alcohol and benzos.
- The question is will use escalate? We believe it will.
- Parenting related to drug use is likely to become more difficult as parents will be told by their young people that the government have taken a u turn on the use of cannabis! It's no longer illegal. (We believe this is what the young people will surmise from the relaxed laws) Will young people see it as a signal that it is ok to use ?
- Is illegality a significant deterrent to use. Workshops we have run in the past with young people asked them why young people might give up using cannabis. One of thirty reasons they gave was the fact that they did not want to come to the attention of the law. They wanted to travel.

8 Prevalence – the war on drugs is not lost - more use licit drugs

Just over one in four adults aged 15-64 (27%) reported taking any illegal drugs at some point in their lives compared to 90% who had ever used alcohol.

One in fourteen (7%) had used an illegal drug in the past year compared to 85% who had used alcohol

One in 30 (3%) had used an illegal in the last month compared with 71% who had used alcohol

Among those aged 15-24 use in the last year was highest (15%) This age group also reported the highest use of cannabis (13%) amphetamines (1.5%) ecstasy (1%) magic mushrooms (1%) and LSD (1%).

Source National Advisory Committee on Drugs Prevalence Survey 2010/2011.

(if you take the 13% reporting cannabis use – that means 87% of respondents did not use cannabis – how is this a failed policy?.

9. Later this year we will have complete data on what is happening in the US with regard to both decriminalisation and legalisation. Former Policy Advisor to the White House will speak at our conference in October – Kevin A Sabet. The findings are far from positive.

10. At the same conference we will hear about the UK's experience when they declassified. Again this was a negative experience which had to be reversed.

End

Bernie Mc Donnell

Director of Services

Community Awareness of Drugs

www.cadaboutdrugs.ie

087 2464995

Ps apologies I did not have time to reference this document. This was my initial intention. Many thanks for the opportunity to submit.

End

Bernie Mc Donnell ☐

The terrible truth about cannabis: Expert's devastating 20-year study finally demolishes claims that smoking pot is harmless. Professor Wayne Hall.

Read more: <http://www.dailymail.co.uk/health/article-2782906/The-terrible-truth-cannabis-British-expert-s-devastating-20-year-study-finally-demolishes-claims-smoking-pot-harmless.html#ixzz3i8BJla6>

One in six teenagers who regularly smoke the drug become dependent on it,

☐ **Cannabis doubles the risk of developing psychotic disorders, including schizophrenia,**

☐ **Cannabis users do worse at school. Heavy use in adolescence appears to impair intellectual development**

☐ **One in ten adults who regularly smoke the drug become dependent on it and those who use it are more likely to go on to use harder drugs,**

☐ **Driving after smoking cannabis doubles the risk of a car crash, a risk which increases substantially if the driver has also had a drink,**

☐ **Smoking it while pregnant reduces the baby's birth weight**

By [BEN SPENCER, SCIENCE REPORTER FOR THE DAILY MAIL](#)

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Introduction

1. This document is a submission to the Joint Oireachtas Committee on Justice, Defence and Equality on the topic of Ireland’s approach to the possession of certain amounts of drugs for personal use. The submission is made on behalf of the Ana Liffey Drug Project (ALDP).
2. ALDP is a national addiction service which works from a low threshold, harm reduction ethos. We work with individuals, families and the broader community to limit the harm caused by drug use in Ireland. We also lobby for the continued implementation of evidence based drug policy in Ireland, such that all stakeholders can work together to limit the public and private harms associated with drug use. More information on the organisation and our work is available online at www.aldp.ie.
3. This submission has been prepared in line with Fact Sheet 5 on *Making Submissions and Presentations to Oireachtas Committees*.

Factual Information

4. This section contains factual information concerning decriminalization which ALDP believes may be of use to the Committee in its deliberations.

Defining Decriminalisation

5. As a starting point, it is helpful to consider what is meant by ‘decriminalisation’. For the purposes of this submission, decriminalisation is taken as referring to the “*elimination of a*

*conduct or activity from the sphere of criminal law*¹". Thus, it is not the case that decriminalisation necessarily results in the abolition of sanctions. Rather, it is simply the case that such sanctions are no longer administered through the criminal justice system. A practical example of such a policy approach in action is that which was studied by members of the Committee on its recent mission to Portugal. As a policy approach, decriminalisation is generally applied to offences related to drug consumption, such as possession for personal use.

6. Decriminalisation is to be distinguished from *legalisation and regulation*, both of which envisage much farther reaching reforms than merely removing possession for personal use from the ambit of the criminal law. For example, legalisation contemplates the removal from the sphere of criminal law of all drug-related offences: use, possession, cultivation, production, trading, and so on², such that a legal market is created. Regulation refers to the control of that market.
7. It is also to be distinguished from *depenalization*, which is the effective non-enforcement of extant criminal sanctions, rather than their removal. Depenalization can either be the result of a *de facto* policy approach of enforcement bodies, or in circumstances where there have been judicial pronouncements from superior courts on the legitimacy of sanctions for certain drug offences, resulting in a situation where prosecution of certain offences becomes unenforceable in practical terms. An example is the situation in Argentina following the *Arriola* decision, in which the Supreme Court held that legislation criminalizing possession for personal use was unconstitutional³. Similar results have also been seen in recent years in a number of countries, including Colombia⁴ and Germany⁵.
8. It is important for the Committee to be aware that decriminalisation is not a novel policy approach. As Rosmarin and Eastwood note:

"Some countries have had decriminalisation policies in place since the early 1970s; others never criminalised drug use and possession to begin with.

¹ Jelsma (2011), 9.

² *Ibid.*

³ Rosmarin and Eastwood (2012); 16

⁴ *Ibid.*; 22

⁵ *Ibid.*; 24

However, in the past 10 years, a new wave of countries have moved toward the decriminalisation model, suggesting growing recognition of the failures of the criminalisation approach and a strengthening political wind blowing in the direction of an historic paradigm shift.”⁶

The Variables in Decriminalisation

9. As a preliminary matter, it should be noted that the Ana Liffey Drug Project has been in contact with our colleagues in Citywide and are aware that other groups will make submissions addressing the international evidence concerning decriminalisation, and it is not proposed to recite that evidence here, save to note that decriminalisation (and, for that matter, any other single drug policy issue) is not a panacea. It is the view of the Ana Liffey Drug Project that eradicating problematic drug use, while attractive in the abstract, is not attainable in reality. Drug use is, and always will be, a population level health issue for society to manage, not a discrete problem to be solved. *Per the Global Commission on Drug Policy:*

“A stale political declaration in 2016 that promises to ‘solve the drugs problem’ and make the world ‘drug-free’ is not going to be the answer the world needs. We reiterate that the international community needs to come to terms with the reality that easy answers to solve the drug problem do not exist.”⁷

10. Given that this is the case, it is important that a society chooses policy approaches that are both effective in limiting harm and cost effective when compared to the alternatives. In this context, the realistic policy choices are between varying models of decriminalisation and not between decriminalisation and criminalization. *Per the Global Commission on Drug Policy again:*

“Criminalization of drug use and possession has little to no impact on levels of drug use in an open society. Such policies do, however, encourage high risk behaviours such as unsafe injecting, deter people in need of drug treatment from seeking it, divert law enforcement resources from focusing on serious criminality, reduce personal and government funds that might otherwise be available for positive investment in people’s

⁶ Rosmarin and Eastwood (2012); 11

⁷ Global Commission on Drug Policy (2014); Taking Control: Pathways to Drug Policies that Work; 7

lives, and burden millions with the longlasting negative consequences of a criminal conviction”⁸

11. Thus, whether or not societies should decriminalize drug possession for personal use is somewhat of a moot point, given that such behaviours are both costly and ineffective to deal with through the criminal law. As the London School of Economics has recently noted:

“The immediate task is for international policymakers to accept that a more rational and humble approach to supply-centric policies is required. If prohibition is to be pursued as a means to suppress the supply of certain drugs deemed incompatible with societal well-being, 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 reduced. After this, additional spending is wasteful and likely damaging. Further, there is a clearly emerging academic consensus that moving towards the decriminalisation of personal consumption, along with the effective provision of health and social services, is a far more effective way to manage drugs and prevent the highly negative consequences associated with criminalisation of people who use drugs.”⁹

12. In implementing decriminalisation as a policy response, there are a number of variables which policy makers can adjust to find a solution which suits their particular jurisdiction. Rosmarin and Eastwood note the following, among others, as such variables:

- a. *Threshold limits*, i.e., the quantity of a substance one may possess before a criminal response results
- b. *Types of administrative response*. Clearly, decriminalisation does not necessarily imply a lack of consequences. There are a range of administrative responses which can be imposed, including *“fines, community-service orders, warnings, education classes, suspension of a driver’s or professional licence, travel bans, property confiscation, associational bans, mandatory reporting, termination of public benefits, administrative arrest, or no penalty at all.”*¹⁰

⁸ *Ibid.*

⁹ ‘*Ending the Drug Wars*’. Report of the LSE Working Group on the Economics of Drug Policy (2014). London: London School of Economics; p. 13

¹⁰ Rosmarin and Eastwood (2012); 12

- c. *The roles of the judiciary and police.* The criminal justice system is administered by the policing and judicial functions. As the police force will remain the state body which is most likely to come into contact with people in possession of drugs, they necessarily have a role even in the context of a framework where the simple possession of drugs is decriminalized.
- d. *The roles of medical and social services.* Equally, decriminalisation necessarily implies a shift of responsibility from law enforcement towards health and social care.

The Irish Context

13. Save for section 16 of the Misuse of Drugs Act 1977 ('the 1977 Act'), which prohibits the use of opium, there is no offence of drug consumption in Irish law. Simple possession in Ireland is legislated for by way of section 3 of the 1977 Act, which covers only drugs which are controlled for the purposes of the Act. In this context, it is interesting to note that the Criminal Justice (Psychoactive Substances) Act 2010, which addresses psychoactive substances which are not controlled for the purposes of the 1977 Act, did not create a crime of possession. Thus, possession of such substances has never been criminalized in Ireland; in considering decriminalisation, insofar as the discussion is limited to possession and consumption offences, what is effectively being considered is the altering of the system of drug control such that those offences which are currently captured by section 3 are no longer dealt with through the criminal justice system. This presents a number of core issues which the Committee should consider in its deliberations.
14. First, consideration will need to be given to formalizing the level of possession which determines whether an offence is mere possession or is indicative of possession for sale or supply pursuant to section 15 of the 1977 Act. In doing so, care must be taken to ensure that any level chosen does not unintentionally result in a more restrictive regime than is currently in place. For this reason, the views of the Gardai, the DPP and the judiciary should be canvassed to establish what level of possession is (generally) currently accepted before the assumption that a person is in possession for the purposes of sale or supply is triggered.
15. Second, consideration will need to be given to what sorts of sanctions should be administered, in what manner and by what bodies. There is little point in moving towards decriminalisation if

the system which replaces the criminal law is expensive and inefficient. In this regard, it is submitted that the focus of any decriminalisation process should be the health of those found in possession of controlled substances, rather than any ancillary matter such as revenue generation through fines, etc. Within this, it should be recognized that decriminalization can help to build relationships at community level between state and community actors. As Magson notes:

“The revised role of the police in supporting rather than criminalising problematic users in states like Portugal has helped to strengthen the relationship between the public and the state and this approach feeds into longstanding UK endorsement of community policing principles and the use of the criminal justice system to rehabilitate as well as punish offenders”¹¹

16. Third, while it is recognized that the current submission is limited to decriminalisation, the Committee will recognize that decriminalisation is not the only option open to legislators. Legalisation and regulation for certain substances might also be considered; arguably, such approaches could provide a revenue stream to the state for treatment services, whereas decriminalisation maintains the *status quo* of a hidden drugs economy. For the avoidance of doubt, this comment is offered by way of observation only, and should not be interpreted as support or opposition to such approaches.

17. Finally, and importantly, the overall effects of decriminalisation as a policy should be considered. The Ana Liffey Drug Project works with active drug users, many of whom have multiple and complex social and medical needs. In our experience, the threat of criminal sanctions achieves nothing in terms of reducing or discouraging drug use among this group, nor does it lead to any greater public amenity. However, it does serve to further isolate and stigmatise this group. In 2012, almost 72% of convictions for drug offences were for possession in the context of personal use¹². While such convictions are unlikely to lead to imprisonment, they require significant resource allocation in the context of policing, prosecution and legal representation. Further, a criminal conviction carries with it a lifelong categorization for a

¹¹ Magson, J. (2014). *‘Drugs, Crime and Criminalisation. Assessing the impact of drug decriminalisation policies on the efficiency and integrity of the criminal justice system’*; p. 48

¹² Central Statistics Office, cited by Citywide (2015).

person which can impact on future opportunities; it is not a sanction the state should implement lightly. Finally, the criminalization of possession offences does not only affect drug users, but also those who work with them. Section 19 of the 1977 Act places a statutory obligation on service providers not to knowingly permit certain activities on their premises, including possession. This necessarily affects the way in which addiction services engage with those who use their services, and not in a manner which is conducive to building the trust necessary to an open and honest therapeutic relationship.

Conclusion

18. In conclusion, the Ana Liffey Drug Project welcomes and commends the leadership that has been shown by the Committee in examining this area and:
 - a. Supports the implementation of decriminalisation as a policy, noting that the alternative policy of criminalization is both expensive and ineffective
 - b. Notes the negative effects that a criminalization policy has on both those who use drugs and the services like ALDP that work with them
 - c. Notes that there are a range of variables which can be considered by policy makers in how best to implement a decriminalisation policy, and that decriminalisation is not a sole option
 - d. Recommends that the focus of all drug policy, including an implementation of decriminalisation, should be on health, and that drug policy should not act as a barrier to living a life without drugs, if that is the person's choice.

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Union of Students in Ireland
Aontas na Mac Léinn in Éirinn

**Union of Students in Ireland
submission to the Oireachtas
Joint Committee on Justice,
Defence and Equality**

Drug Policy Review

“[The committee]... is inviting public submissions on its drug policy review, and in particular, if an alternative approach to the possession of small quantities of illicit drugs for personal use should be considered... The Committee is keen to hear from interested organisations and individuals in Ireland on whether a similar approach to the classification of small quantities of drugs should be considered here.”

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Foreward

The Union of Students in Ireland (USI) (Aontas na Mac Léinn in Éirinn) is the national representative body for third-level students' unions in Ireland. USI is the sole national representative body for students in Ireland. Founded in 1959, USI now represents more than 354,000 students in over forty colleges across the island of Ireland. The goal of the USI is to work for rights of students and a fair and equal third level education system in Ireland.

Prior to making a submission to the Oireachtas Joint Committee on Justice, Defence and Equality on drug policy review, USI engaged in a consultation process with member organisations and students' unions to ascertain their views. On July 17th 2015, USI National Council ⁽ⁱ⁾ formally adopted a stance that called for USI to support a call for decriminalisation of drugs, with a view to taking a similar approach to the one Portugal took in 2001.

The Current Irish System

Contemporary drug policy in Ireland is implemented in accordance with the Misuse of Drugs Act 1977, which is a derivative of the 1961 United Nations Single Convention on Narcotic Drugs.

The current Irish system processes 'personal use' cases in the justice system. As a result individuals are given a conviction which lasts a lifetime. This is particularly concerning for USI, as college is often a time for exposure to drugs for many students. According to the National Drugs Survey 2015, "around 75 per cent of over 300 Trinity respondents... said they had used illegal drugs, while 5 per cent said they had purchased illegal drugs on the dark web." ⁽ⁱⁱⁱ⁾ If a student gets a conviction for personal use, this can have lifelong implications. It can prevent a student from accessing a visa to certain countries, a job which requires Garda vetting, certain types of insurance, and can impede them from availing of further education or training. A criminal conviction also limits an individual's chances of social mobility, which results in students becoming dependent on the state.

"Around 75 per cent of over 300 Trinity respondents... said they had used illegal drugs, while 5 per cent said they had purchased illegal drugs on the dark web."

Our current system is broken, and the prohibitionist approach of 'just say no' is no longer working. Policies of prohibition exacerbate social problems. Ireland currently has one of the highest drug related death rates in the EU and the prevalence of drug use in Ireland

ranks within the highest across various drugs. In 2006, we ranked above all other countries with heroin use. ⁽ⁱⁱⁱ⁾ Citizens who have drug addiction(s) are stigmatised and segregated from society. Drug use cannot be tackled by policy measures which are only aimed at controlling the supply of illicit drugs.

It is futile to only have supply reduction strategies in place of more cost-effective and evidence based investments in harm-reduction and education. USI is calling for The Committee to recommend the introduction of a system similar to one introduced in Portugal on July 1st 2001.

Case Study: Portugal ^(iv)

During the early 1970s in Portugal, the Justice Department was assigned to deal with the drug problem, an approach similar to those in other jurisdictions at present, including Ireland. However, it became apparent that, outside their use of illegal substances, not all drug users were engaged in criminal behaviour and that the criminalisation of drug users and addicts was counterproductive as it prevented them from seeking help. It was noted that drug abuse was not confined to any particular social class but was a universal problem. It was also noted that not all addicts were using illicit drugs and were addicted to prescription drugs.

To criminalise rather than treat this group of people was ineffective as a method of tackling drug use

The first step was to remove responsibility for this matter from the Justice Department and re-assign it to the Health Department. When this decision was taken, the State established SICAD (General-Directorate for Intervention on Addictive Behaviours and Dependencies) and Commissions for Addiction Dissuasion.

On July 1st 2001, Portugal decriminalised drug use, acquisition and possession of illicit drugs when conducted for personal use as part of a comprehensive new policy. ^(v) This quantity of personal use amounted to up to 10 days' supply for personal use. The policy also included a significant expansion in drug treatment, including methadone maintenance, to help dependent users get away from injecting heroin. While it is no

longer a criminal offence to possess drugs for personal use, it is still an administrative violation, punishable by penalties such as fines or community service. The specific penalty to be applied is decided by the 'Commissions for the Dissuasion of Drug Addiction', which are regional panels made up of legal, health and social work professionals.

The provision of funding for this service is split: 60% of funding is provided by the State in the Health Budget and 40% from the National Lottery. This approach results in significant cost to the Health Budget, this approach has actually resulted in a reduction in costs to the State in Portugal. This is due to the reduction in costs associated with police time, criminal investigations, legal aid costs and court time as well as the reduction in the number of HIV/AIDS cases thereby reducing the cost to health services.

Each of the 18 districts throughout Portugal has a Commission, with 4 covering the islands. This ensures that all treatment is available locally and the person in need of treatment is more likely to attend and complete the programme. This also allows a person undergoing treatment to hold down a full-time job and without risk of dropping out of a treatment programme or trying to manage their addiction and recovery themselves. This local availability has resulted in a more successful outcome. This policy is focused on the treatment of the individual and not the criminalising the person suffering from a drug addiction. In order to break the cycle and allow drug addicts the opportunity to move away from a life of drugs 'positive discrimination' for gaining employment was introduced. This system offered employers' tax breaks to employ recovering addicts and the State would pay the employee an amount equal to the minimum wage.

The employer was required to release the employee for their treatment/counselling until their programme had concluded. In many cases, these employees gained full time employment and did not go back to using drugs.

Decriminalisation of Drugs

"Decriminalisation (sic) is defined as the removal of sanctions under criminal law, with optional use of administrative sanctions (e.g. provision of civil fines or court-ordered therapeutic responses" ^(vi)

USI is calling for the decriminalisation ^(vii) of drugs and for investment into treatment and health facilities along with education about drug use and risk for young adults and those of school age.

As has been previously noted, college is a time where students feel freer to express themselves and experiment with drugs. In relation to recent cannabis use alone (defined as being within the previous 12 months), the statistics from the National Student Drug survey show:

- 49% of respondents had smoked 'normal-strength' cannabis weed
- 44% had smoked 'high-potency' weed
- 26% had smoked 'high- potency' cannabis resin
- 25% had smoked low/medium cannabis resin
- 7% had consumed cannabis oil

Other findings relating to recent use (previous 12 months) for other substances were:

- 98% of respondents consumed alcohol
- 61% had taken prescription drugs ^(viii)
- 33% indulged in weekly binge drinking (6 or more drinks in a session)
- 32% had ingested ecstasy (MDMA) tablets
- 25% had taken MDMA in powder form
- 20% had ingested cocaine

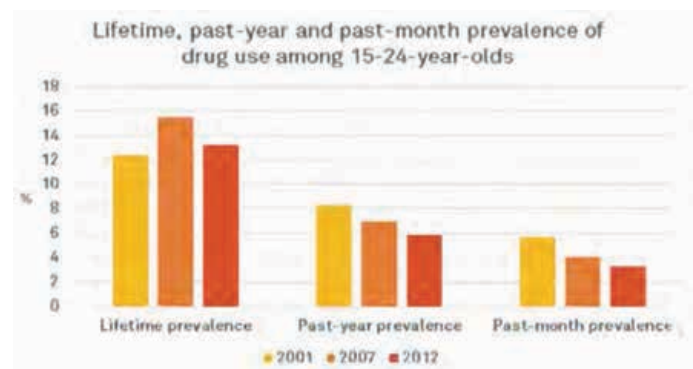
- 13% had purchased legal highs or research chemicals
- 11% had taken LSD
- 11% had taken ketamine

From these results, it is clear that students are not averse to taking drugs. Drug consumption is deeply embedded in the social and recreational cultures of young people.

USI has evidence of a student in NUIG, receiving a criminal conviction for a minor drug offence and this conviction then having an impact her ability to obtain a visa to pursue studies abroad in Canada. If minor offences were decriminalised was in place, she would not have received the criminal conviction which impeded her ability to further her studies abroad. There is concern of how this conviction will impact her as she goes through life, in terms of seeking work and her ability to travel.

There is evidence ^(ix) to suggest that since decriminalisation in Portugal in 2001, drug use for people aged 15-25 has gone down rapidly [see Table 1].

TABLE 1



Despite virtually eliminating all punishments for personal drug possession, rates of drug use haven't skyrocketed in Portugal like some predicted. As this chart shows, use had gone up slightly when measured in 2007 (a trend in line with other, comparable countries), but has since gone back down. In fact, by two out of three measures, adult drug use is now lower than it was in 2001. This gives more credence to the idea that criminalising people is an unnecessary (not to mention inhumane) way of trying to stop them taking drugs.

While decriminalisation will prevent individuals who have recreation or personal drug use from getting a criminal conviction, decriminalisation alone will not solve the current drug problem in Ireland. We need to look at economic and social policies if we wish to make significant progress on drug problems. As in Portugal, decriminalisation must go hand in hand with programmes aimed at education, and drug addiction recovery and treatment. There must be particular emphasis on after-care and social re-integration for former users of illegal substances. Evidence from decriminalisation in Portugal indicates reductions in problematic drug use, drug-related harms and criminal justice over-crowding. Fears of Ireland becoming a haven for drug users can be dissuaded; the Portuguese approach "has not resulted in an increase in drug-taking nor has it resulted in Portugal becoming a destination for drug tourists." ^(x)

USI believes there is a need for health professionals, parents and educators to acknowledge the fact that young people often engage in drug use, and at the very least will be exposed to drug use at some point in their lives. We need wider society to foster informed and responsible conversations about drugs and drug use, something we believe can only happen if decriminalisation of drugs is introduced.

Education at second and third-level is crucial in terms of informing students about drugs and the consequences taking drugs may have on their future

Ultimately, USI understands that young people and students experiment with drugs. It is important for young people and students to understand about that substances they are putting in their body, and to be able to have a conversation about drugs in an informed and responsible manner. USI does not want to see students lose out on the possibility to travel, whether that be for further study or personal development, due to a minor drug infraction. Having a criminal record for drug misuse can also result in employment and other opportunities in a student's future being unavailable. USI believes that decriminalisation will allow students, who are guilty of minor offences under the current laws, the opportunity of a second chance, along with allowing wider society to open up in conversations surrounding drug use and seeking help.

Footnotes and References

(i) National Council is USI's executive body, consisting of one representative from each Member Organisation and USI's full-time and part-time officers. It is convened at least four times a year for the purpose of directing the overall work of the national union, amending the schedules to the constitution and determining interim policies responsive to events.

(ii) Heaphy, Edmund. "Respondents to Survey Use Drugs, with Majority Unconcerned About Its Impact." *University Times*. 5 Aug. 2015.

(iii) EMCDDA, "The State of Drug Problem in Europe",

(iv) Summary from Report of Visit by a Committee Delegation to Examine the Impact of Portuguese Approach to the Possession of Certain Drugs.

(v) In Portugal, possession for supply remains a criminal offence.

(vi) Hughes, Caitlin Elizabeth, and Alex Stevens. "What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?" p. 3.

(vii) It is important to note that decriminalisation is not legalisation. The sale or importing of drugs will still be illegal. Individuals caught breaching these laws along with theft, assault, intimidation in relation to drugs will still be prosecuted under the criminal justice system.

(viii) The survey did not indicate that the question was being asked as to how many respondents took prescription drugs illegally, so caution must be taken when reading this particular result.

(ix) Murkin, George. "The Success of Portugal's Decriminalisation Policy – in Seven Charts."

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To whom it may concern,

I would like to start this letter stating the position I hold on the matter of prohibition of drugs, and that is, that I completely disagree with it. I would like to explain my reasoning for my opinions of thinking in this letter. I have many different reasons why I think prohibition of any substance is a self-fulfilling prophecy, wasteful of resources and unhealthy to the society. Changing these outdated laws would bring economical and health benefits paired with a very positive and forward thinking attitude shift.

First, I would like to point out how the prohibition of illegal substances came about. It all started in United States of America in the 1970s when President Nixon launched the "war on drugs". But it wasn't as simple as that the American people had a drug use problem. It all really started a little while before that when the image of marijuana was tainted by oil and paper companies because of the threat that this cheap herb posed to both of these industries¹. After corporations started the battle with marijuana, Nixon was definitely the one to finish it. Certain experts were appointed by the American Government to find out whether cannabis was as bad as these corporations claim. Despite quite surprising results that marijuana is not a "gateway drug" and it should not be classed as a Schedule I drug, Nixon (possibly having his own agenda) kept on pushing this conception that marijuana is dangerous and discharging anyone who dared to disagree with him².

Secondly, let me point out one fact that the prohibition (of any substance) does not work. Prohibition as a social engineering tool does not work. We have a perfect example of this when The United States decided to ban alcohol in the 1920s. All that this decision achieved was chaos, disobedience and home-made moonshine sold on the black market³. We can see America making the same mistake with the "war on drugs". As a nation they have wasted numerous resources, such as money, man-power and time and the results are nothing but appalling⁴. Overcrowded prisons, staggering crime rates and addiction rates which have not subsided⁵. Global prohibition followed the America's aggressive example, but why are we following something that has not yielded any positive results?

It naturally follows to investigate the opposite. Does legalisation work? I know complete legalisation would be the most drastic change we could implement with regard to the drug laws. We, as a nation, may not decide that legalization is the best idea, and we may settle

¹ <http://www.deathandtaxesmag.com/181675/history-of-marijuana-prohibition-policing-pot-weed-laws/>

² http://www.alternet.org/story/12666/once-secret_%22nixon_tapes%22_show_why_the_u.s._outlawed_pot

³ <http://www.1920-30.com/prohibition/>

⁴ <http://www.countthecosts.org/sites/default/files/Economics-briefing.pdf>

⁵ <http://www.thewire.com/national/2012/10/chart-says-war-drugs-isnt-working/57913/>

somewhere in between with decriminalisation. Regardless, of how far we decide to go with this reform I believe that any step is a step to the right direction.

Back to the point of whether legalisation/decriminalisation works. I would like to point out three examples in support of my view that decriminalisation does work. First of all let's consider the country that the delegation of Committee members visited just recently – Portugal. A country that had infinite access to hard drugs through its colonies and a country that had just overthrown a totalitarian regime was ready to experiment with anything, and it did. Resulting in one of the biggest populations of heroin addicts in Europe, Portugal decided to implement a very radical change and to decriminalize all of the illegal substances⁶. Fourteen years later, Portugal has one of the lowest addiction rates in Europe and they have experience a huge decline in newly diagnosed HIV cases⁷. The second example I would like to put forward in support of decriminalization is the country we all know well for its famous coffee shops – Netherlands. They have shown the whole world that having marijuana legal does not mean that the country is full of criminals or drug addicts. My third example is the State of Colorado, who decided very recently to change their drug laws and have succeeded so well that they had to give tax back to the tax payers⁸.

I have many more points that I would be able to expand on, if given the opportunity. Unfortunately, I have not had enough time (because of the deadline) to explain my views fully in this letter. But I have many great and forward thinking ideas with regards to this law reform.

Thank you for your time,

Yours faithfully,

Karolina Simonaviciute

⁶ <http://m.mic.com/articles/110344/14-years-after-portugal-decriminalized-all-drugs-here-s-what-s-happening>

⁷ <http://www.tdpf.org.uk/blog/drug-decriminalisation-portugal-setting-record-straight>

⁸ http://www.huffingtonpost.com/2015/02/04/colorado-pot-taxes-back-to-residents_n_6612292.html

Association for Criminal Justice Research and Development

ACJRD SUBMISSION
TO
THE OIREACHTAS JOINT COMMITTEE
ON
JUSTICE, DEFENCE AND EQUALITY

**Review of the approach to the possession of
limited quantities of certain drugs**

August 2015

ACJRD seeks to promote reform, development and effective operation of the Criminal Justice System.

Registered Office: The Spade Enterprise Centre, St. Paul's, North King Street, Dublin 7 • Registered Company no. 340129 • Registered Charity no. CHY 15012. Tel: +353 (0)1 6174864 • Fax: +353 (0)1 6174895 • Email: enquiries@acjrd.ie • Web: www.acjrd.ie. Association for Criminal Justice Research & Development Ltd, is a company limited by guarantee not having a share capital, registered in Dublin, Ireland.

ACJRD SUBMISSION ON THE REVIEW OF THE APPROACH TO THE POSSESSION OF LIMITED QUANTITIES OF CERTAIN DRUGS

1. Introduction

The ACJRD

[1.1] The Association for Criminal Justice Research and Development (ACJRD) is a non-governmental organisation dedicated to promoting the reform, development and effective operation of the Irish criminal justice system. In particular, the ACJRD encourages innovation in criminal justice and seeks to facilitate interdisciplinary dialogue between agencies and practitioners in the sphere of criminal law.

[1.2] The ACJRD's membership is varied, but is largely comprised of individuals who have experience working within the criminal justice system and who have a strong interest in criminological matters. These include probation officers, legal and criminological academics, social workers, members of the Gardaí, prison officers, mental health professionals and practising lawyers.

[1.3] The ACJRD's approach and expertise is therefore informed by the hands-on experience of practitioners and agencies who deal with all aspects of the criminal justice system, enhanced by the contribution of people with diverse experiences, understandings and practices.

[1.4] **The views expressed in this submission are those of ACJRD in its independent capacity and are not those of the ACJRD members' organisations or their employers.**

2. Executive Summary

- i. Further empirical data may be required with respect to the Portuguese approach to the possession of limited quantities of certain drugs as listed in some questions at section 3.
- ii. Literature Review and Research both nationally and internationally suggests that
 - a. Treatment is key for drug addiction and there is a correlation between treatment and reduced crime rates.
 - b. Any proposed decriminalisation must be done within a health and wellbeing promotion framework
 - c. Adolescents are already a particularly vulnerable group with respect to addiction requiring Early Intervention and Protective/Preventative measures and will require a singular focus in the context of any proposed decriminalisation of certain drug use that explores the support of Multidimensional Family Therapy (MDFT).

3. Questions arising regarding the Committee delegation Report

Lisbon June 2015

The June 2015 report suggests some questions that may be answered by literature available to the Committee from the Portuguese approach to the possession of certain drugs and it may be helpful in the context of exploring this discussion to list those questions here:

1. Where can data on the less positive/negative results of the Portuguese policy to be found? e.g.
 - a. Overdose tracking during the period for measurement of impact of the programme.
 - b. Feedback/evidence from other stakeholders e.g. the police, field social workers, hospital doctors, community activists and street people.
2. Is there empirical evidence available to support the comment ‘...not all drug users were engaged in criminal behaviour ...criminalisation of addicts was counterproductive as it prevented them from seeking help’ [p.3, Responsibility para 1]
3. What metrics were employed in determining ‘personal use’ quantities might be [p.3, Decriminalisation not Legalisation para 1] given that this concept could be subjective to the individual user
4. What were the resource implications in Portugal of reporting to Commission for Addiction Dissuasion 72 hrs after being found with up to 10 days’ supply of drugs for personal use?
 - a. What data is available on the number of users who report within the specified time period?
5. Does the Portuguese State have power to require treatment and follow-up treatment?
 - a. What are the consequences if a drug user does not report and/or refuses treatment?
 - b. Is there a practice of detoxing users who are incarcerated?
 - c. Are those drug users who have been detoxed given the opportunity for follow-up treatment?
6. Where can the empirical data be found that supports the statement that ‘in many cases these employees gained full time employment and did not go back to drugs’[p.4, Breaking the Cycle para 2]
7. Has there been some statistical analysis of the Outcome in Portugal over 15 years [p.5] where advocates of the Portuguese approach make statements including: drug consumption has not increased, there is the same level of tolerance, the treatment centres did not become drug consumer destination, there has been no increase in drug related crimes, the drug consumers had become less dependent of traffickers and police discretion and it has become easier to know who is buying and selling drugs i.e. is there empirical data that demonstrated:
 - a. Specific measurements of the numbers of individuals treated annually
 - b. Recidivism rates of those treated
 - c. Academic comparison to a similar control group that did not partake in treatment
 - d. Other objective measures of success for their programme.

4. Literature Review and Research

Previous ACJRD Papers

[4.1] As with society in general, some ACJRD members favour a harm reduction methodology with respect to the possession of limited quantities of certain drugs whereas others become concerned about views that drug use is primarily a medical problem that should be uncoupled from a criminal sanction framework. Therapists raise concerns about the profound effect that cannabis has on adolescents and their families.

[4.2] ACJRD visited this harm reduction policy discussion during its Annual Conference entitled *Preventable Harm - Criminal Justice, Communities & Civil Society* in 2013, with papers from Professor and Senator John Crown and Professor Catherine Comiskey, Trinity College Dublin respectively entitled “Harm reduction or abstinence from drugs?” and “Harm Reduction is good but is it good enough?” Outcomes from workshops at that conference explored “From harm reduction to total abstinence: a continuum of care in drug treatment” by Tony Geoghegan, CEO, Merchants Quay and “Evidence based harm reduction practices – addressing issues of chronic addiction in the community” by Kerry Anthony, MBE, CEO, DePaul Ireland. A link to that literature from an Irish Context is listed in the Reference Section at the back of this document.

[4.3] In ACJRD’s submission to The Oireachtas Joint Committee on Justice, Defence and Equality on *The Effects of Gangland Crime on the Community* the link between gangland crime and drugs was demonstrated in a manner that is reflected in the Portuguese experience.

Factual Research Evidence from Ireland

[4.3] It is known from the National Advisory Committee on Drugs and Alcohol (NACDA) (2012) general population survey of a large representative sample of 5,134 15 to 64 year olds that in the period 2010/11 in Ireland, just over 27% of those surveyed reported using any illegal drugs in their lifetime. Cannabis was the most commonly used illegal drug with 25% of the adult population having ever used the drug. Lifetime prevalence rate for any illegal drugs was highest among those aged 25-34 years (42%) followed by the 35-44 (29%) and 15-24 (27%) age groups. Clearly based on this evidence use of illegal drugs is widespread and across all age groups and the impact of a potential criminal record on the employment for a person who uses drugs is considerable.

[4.4] The scale of the prevalence of the number of persons who use opiates was last estimated in 2006 (NACDA, 2009). It was found that the number of people who use opiates is growing and spreading from the capital city to the regional areas. At that time the number estimated to be using opiates in the study year was over 20,000 or 7.2 persons per 1,000 of population. Given that the current National Drug Strategy embraces a harm reduction philosophy there is clearly a risk of harm to these 20,000 individuals under current legislation (National Drug Strategy, 2009-2016).

International Evidence from Ireland

[4.5] International evidence based on drug treatment outcomes studies from the United States over a 30 year period, England and Wales over a five year period, Australia over an eleven year period and

Ireland over a three year period (Comiskey 2015) clearly demonstrates that treatment for opiate use works but it is not sufficient on its own and more is needed in terms of rehabilitation and recovery for people who use drugs.

[4.6] National and international evidence has consistently demonstrated that access to drug treatment works not only in terms of reducing drug use but also reducing levels of crime and improving social functioning. The ROSIE study in Ireland followed a cohort of over 400 opiate users entering treatment for a period of three years and found that acquisitive and other crime rates reduced significantly during the three year period and the average number of crimes committed also reduced (Comiskey et al, 2009).

Harm Reduction Policy within the context of Promoting Health and Wellbeing

[4.7] A study carried out by Youth Work Ireland, Cork (2011) highlights that problem drug use is a consequence of social inequality and proposes that social interventions rather than a medical or legal approach offer the best outcomes.

[4.8] High levels of alcohol consumption in pregnancy has been reported by an international birth study led by researchers in Cork who found Ireland had the highest proportion of drinking during pregnancy at 80% per cent of women in Ireland drank at some point in their pregnancy compared to 65 per cent in the UK, 38 per cent in Australia and 53 per cent in New Zealand. Family Therapists report that they have to regularly contact An Garda Síochána in relation to young people (age 14-16) purchasing alcohol in shops, garages and pubs without being asked for identification.

[4.9] Reported absence of support by some adults in respect of current regulation prohibiting access by young people to alcohol and to adult venues demonstrates a need for promoting health and wellbeing if a policy for decriminalising certain drugs was to be pursued.

Adolescent Addiction

[4.10] Family Therapists working within Adolescent Addiction Service have a particular interest in advocating for Early Intervention and Protective/Preventative measures when it comes to young people in particular.

[4.11] Statistics from within the HSE for 2013 show that:

- The numbers of young people attending the service of school going age who were out of education was high compared to previous years at 28 out of 31 young people under age 16years old (90%). (Fact Sheet attached).
- The number of young people who had previous/current contact with Child and Adolescent Mental Health Services (CAMHS) was higher than in other years at 73%. (average over the past eighteen years 65%).
- The extent to which to which substance misuse featured within families was also high (68%)
- 26% had a parent who was linked to Adult Addiction Services.
- There was a rise in the number of young people who were linked to social work services at 29% (N=15)
- 12% (N=6) subject to Child Protection Notification System.

- All attendees were known to a number of services.

[4.12] Therapists report that issues of self-harm, indebtedness, poor school attendance, lack of motivation, memory loss and mental health concerns are often minimised by young people who view these issues to be separated from their substance use. Other substances used include Alcohol, Benzodiazepines, Amphetamines, Cocaine, Solvents and Heroin.

- The majority of young people 92% (N=49) were seen by Family Therapist only
- 8% (N=4) had Psychiatric Assessment
- 4% (N=2) received medication for treatment of ADHD.

[4.13] The changing profile of drug use presents challenges to services in terms of establishing a broad range of treatment responses and greater emphasis on inter-agency working, family involvement, community support in addition to medical intervention and providing opportunities for employment.

[4.14] A survey by the Family Support Network of Ireland highlights that intimidation and threats of violence are increasing among families where members have drug related debts (Connolly J. 2010).

[4.15] A study comparing Multidimensional Family Therapy (MDFT) with CBT and enhanced service as usual (ESAU) revealed that MDFT produced better outcomes for young people who presented with increased levels of substance use combined with psychiatric co-morbidity (Henderson, *et al*, 2010). These findings are corroborated by randomised controlled trials carried out in the Netherlands comparing MDFT and CBT (Hendriks, *et al*, 2011). MDFT is a family based therapy approach used with adolescents who are engaging in substance misuse and other behaviours. The approach involves intervening within the major domains of a young person's life, including family, peers, school, leisure and work (Liddle, *et al*, 2005). Within both studies it is identified that young people with more severe problems seem to benefit from family based treatments due to the fact that the approach encompasses a wider range of risk factors and involves parents and other family members in addition to significant other people.

5. Conclusions

It is recommended that the when the Oireachtas Joint Committee on Justice, Equality and Defence when it makes a decision with regard to their Review of approach to the possession of limited quantities of certain drugs it should consider:

- The need for more empirical evidence on the Portuguese experience and from other jurisdictions (if not already available).
- The stated national drug policy philosophy on harm reduction.
- National evidence on the scale of the prevalence of drug use among certain sections of the population but also in the general population as a whole
- International and national evidence on the benefits of treatment to those who use drugs and to the wider community in terms of the reduction in crime
- The need to resource and support a robust approach to health and wellbeing, in particular in the context of vulnerable young people

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And by:

Denis Murray M.A. Family/Systemic Psychotherapist, Registered with FTAI/ICP & EAP Adolescent Addiction Service, HSE Dublin Mid-Leinster South Western Area

And by:

ACJRD members

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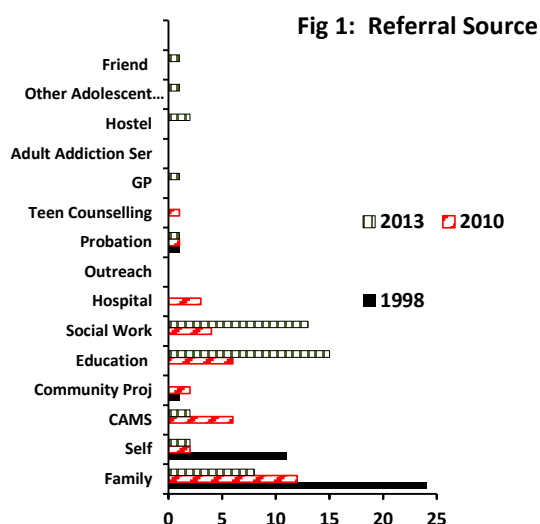
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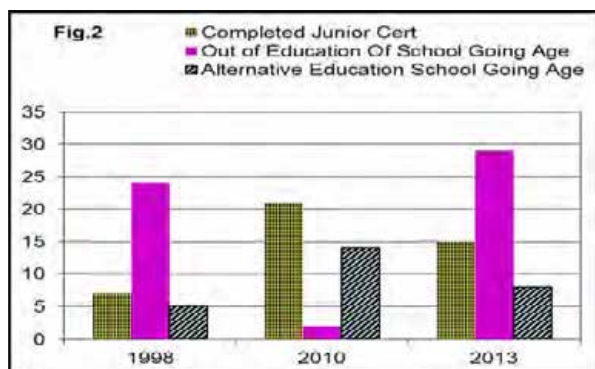


Adolescent Addiction Service Fact Sheet 2014

In 2013 the Adolescent Addiction Service worked with 53 young people and their families of which 68% (36) were new referrals with a mean age of 15 years (range 13–18 years). The majority (63%) were male. Referrals were received from a broad range of services with Alternative Education Projects representing (33%) followed by Social Work (29%), Family (18%), Self (5%), CAMHS (4%), Hostel (4%), School (4%) and friend, GP and other Adolescent Substance Misuse Treatment Service all at (2%). See Fig. 1 for a comparison with other years. In addition to direct work with young people and families the service also engaged consultations with other professionals and services about young people for whom there were concerns in relation to substance misuse.

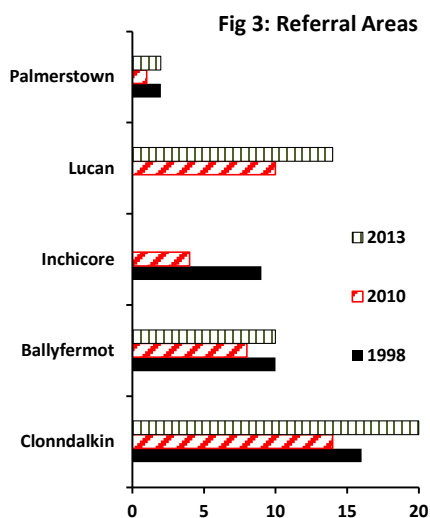


The numbers of young people attending the service of school going age who were out of education was high compared to previous years at 28 out of 31 young people under age 16years old (90%). See Fig 2 for comparison with other years. Also the number of young people who had previous/current contact with Child and Adolescent Mental Health Services (CAMHS) was higher than in other years at 73%. The extent to which to which substance misuse featured within families was also high (68%) and significantly 26% had a parent who was linked to Adult Addiction Services. There was a rise in the number of young people who were linked to social work services at 29% (N=15) with 12% (N=6) subject to Child Protection Notification System. All attendees were known to a number of services.



In terms of referral areas there was a shift in 2013 in that for the first time since 1997 no referrals were received from Inchicore. In contrast referrals from Clondalkin continue to rise (44%), followed by Lucan (32%), Ballyfermot (20%) and Palmerstown (4%). See Fig 3.

Cannabis/weed continues to be the primary substance of use (87%) which represents a 7% increase on 2012. Some young people view weed to be less harmful than cigarettes and quote various information sources in support of their position. The issues of self-harm, indebtedness, poor school attendance, lack of motivation, memory loss and mental health concerns are often minimised by young people who view these issues to be separated from their substance use. Other substances used include Alcohol, Benzodiazepines, Amphetamines, Cocaine, Solvents and Heroin. The majority of young people 92% (N=49) were seen by Family Therapist only while 8% (N=4) had Psychiatric Assessment with 4% (N=2) receiving medication for treatment of ADHD. There is a trend among some young females engaging with older men through contact on internet sites. A further trend has been the number of Non-Irish Nationals attending the service particularly from Lucan area. In most cases young people attending the service had established patterns of substance use prior to referral and as a consequence many struggle to maintain abstinence.



Nathan Douglas

Drug policy

There is only one question that's needed to be asked when you think about drug policy: what is the objective of drug policy? Your first answer might, and probably will, be "To minimise the usage of drugs." That is the wrong answer.

To explain why, you need to think "Why do we want to minimise the usage of drugs?" The answer to that question is "Because drugs cause harm." That means the objective of drug policy is not to minimise the usage of drugs, but to minimise the harm that is caused by the usage of drugs. That objective will change the approach to the usage of drugs, radically.

There are many harms caused by the usage of drugs, harms which obviously differ depending on the drug in question. There are currently two approaches to minimising these harms; criminalisation (or prohibition), and regulation by the state. The difference in the approaches can be seen in comparing two relatively harmless drugs: LSD and paracetamol. LSD is banned outright[1] (due to its negative effects, which can include anxiety, nausea, megalomania and paranoia, especially at larger doses) [2]. Paracetamol, a painkiller, is legal to possess, produce, import or export in Ireland. This is despite it causing possibly fatal liver damage [3], which can occur at the relatively low dose of 10g [4], which is 2.5x the maximum recommended daily dose. There were 255 deaths with paracetamol mentioned in the death certificate in the UK in 2009 [5] (there is no published figure for Ireland).

I am not suggesting that LSD should be sold in the local Spar, or that paracetamol should become a controlled substance; I am highlighting the difference in reaction to the harmful effects caused by each of the drugs. LSD possession is criminalised, whereas the reaction to paracetamol's liver damage is to reduce the size of packs. This regulation has had very beneficial effects: in the UK, suicides from paracetamol

were reduced by 22% the year after pack sizes were reduced, liver transplants fell by 30%, and large overdoses were reduced by 20% [6]. Regulation is never considered for non-medical drugs, unfortunately.

The hope in criminalising drugs is that this in itself will reduce harm that comes from drug usage, as it reduces demand for illegal drugs. This will not work, because as we have seen, there will always be demand for illegal drugs (heroin and cocaine would not exist otherwise), and while that demand exists, there will be harm caused by the usage of such drugs. None of these harms are reduced by prohibiting them, and in fact, prohibition can exacerbate them, or create new ones entirely.

It is useful here to imagine the result of criminalisation of alcohol, and compare it to the current regime. If it was criminalised, this would be the result: 14 year old children could walk into a bar, be handed a drink of unknown contents, and drink it. There is absolutely no quality control for this drug, so the dealers and producers would have little reason to include control the quality of the drug they produce, and it would no doubt contain impurities. These impurities would cause much harm. Methanol, a common contaminant, causes permanent blindness if as little as 10ml is ingested, and can be fatal if 30ml is ingested. This is smaller than a single shot of vodka. Even if the alcohol contained no impurities, and was just watered down in an effort to increase profit margins, this would also cause serious problems.

Knowing that the amount of ethanol they ingest varies, people would drink more than they normally would to make up for the shortfall in concentration. Wanting to get drunk, but not run afoul of the law, people would drink legal but much more unsafe alternatives, like Sterno or industrial alcohol. At the same time, with alcohol dealers having an incentive to make their customers addicted to their products, and with alcohol being heavily addictive, they would sell higher strength alcohol and try to move their customers to more addictive drugs like heroin. With strength (not necessarily concentration) being the main determinant of price, dealers will also increase the potency of their drugs. Prohibition would give gangs a financial basis to flourish, and the rate of theft, murders, assaults, drug addiction and smuggling

would increase, which also increases policing costs.

As you can see, this does not compare at all with the current situation that surrounds alcohol:

At present, children can not legally buy alcohol, nor can they have it bought for them, as there is a law requiring people to be 18 before they can buy it, and they are also required to produce ID to do so [7]. The contents of any drink a person can legally buy are completely known, and safe, as is any product that can be legally sold. Sold alcohol does not contain any contaminants, so it does not cause blindness or death in small doses. The amount of ethanol in any drink is exactly as expected. Guinness does not actively try to get their customers addicted, nor do they sell more addictive drugs. There are no alcohol gangs, and as such the usage of alcohol does not create opportunities for theft, assaults or smuggling.

What I outlined in the paragraph above about criminalisation of alcohol is not hyperbole: everything described either happened during alcohol prohibition in the United States from 1920 to 1933, or happens now with illegal drugs: drug dealers do not care about ID, and happily sell to those underage. MDMA (ecstasy) tablets are regularly contaminated with PMA or PMMA, both of which can cause fatal hyperthermia at common MDMA dosages [8]. MDMA dosages are typically two to three times that of PMA. The inclusion of PMA/PMMA is a direct result of criminalisation: Safrole is a common precursor of MDMA [9]. Due to its illegality, safrole and other precursors are heavily watched by law enforcement agencies. Hundreds of tons of the oil have been destroyed [10, 11, 12]. These destructions forced producers to move to different precursors, like anethole. PMA is synthesised from anethole [13].

there were no deaths in the UK where the person died had either of PMA or PMMA in their bodies until 2011. There was 1 in 2011, and 29 in 2013 [5]. This is 67% of those who died with MDMA in their bodies.

Substances used to dilute cocaine include an insecticide and worm killer [14], and the average purity of UK cocaine is at most 30% [15]. In 2013, Martha Fernback took

500mg of MDMA. The powder was 91% pure, and Martha died [16]. 100mg is a common dose for MDMA [17]. With cannabis being illegal, many users moved to synthetic cannabis [18], and symptoms of use include vomiting, hallucinations, confusion, high blood pressure and seizures [19].

THC is the main psychoactive component of cannabis, and the amount of THC in cannabis trebled from 3.4% in 1993 to 12.3% in 2012 [20].

In the USA from 1920 to 1921, the year prohibition started, thefts increased by 9%, homicides 13%, assaults 13%, drug addictions 45% and police department costs by 11.4%. Here in Ireland, the presence of RAAD and other republican drug enforcers who kneecap and execute drug dealers, and are sometimes executed themselves [21, 22], show a similar effect. A feud between rival gangs killed up to 16 people and led to many stabbings, shootings and pipe bomb attacks [23, 24].

Criminalisation does not solve any of those problems in any way, and neither would decriminalisation. Regulation by the state is the only answer to prevent these from occurring. I did not talk above of any problems emanating from drug use itself if the drugs are pure and taken at common dosages, like alcohol or heroin addiction, withdrawal or death.

Drugs are criminalised because they can be and are dangerous. Strangely, this logic is only applied to drugs, and to nothing else; any sort of thrill-seeking outside of drug use is legal and regulated. Skydiving is legal, as is bungee jumping, scuba diving, river rafting, rollercoasters, rock climbing. The list is endless. Here, every activity is regulated rather than banned. I don't know why.

It isn't just adrenaline related activities that can cause harm. Horse riding causes much harm. In the US, there are 11500 cases of traumatic head injury every year related to horse riding [25], 10 deaths and 100 road traffic accidents every year in the UK, and it has been estimated there is a serious adverse event every 350 rides. This is actually 30x more than MDMA, which has serious adverse event event 10,000 exposures.

Driving is another dangerous activity: 190 people died on Irish roads in 2013 [26],

and yet it is not illegal. Instead, to minimise the number of deaths, the government requires every driver to be trained in how to drive, and be able to prove that they are so trained.

Again, I am not saying horse riding or driving should be classified as a controlled substance, just highlighting the differences.

Even with some drugs being criminalised, there are things that can be done to reduce harm. To reduce the number of impurities ingested and keep the concentrations of drugs constant, drugs can be tested using kits bought from the Internet, or kits brought to festivals, raves and the like. This is done at festivals by Dancesafe [27], and by the Dutch government at raves in the Netherlands [28]. Onsite education, water stations and the like can also be used. Water stations are used at festivals to provide the correct amount of water intake for MDMA-using festival-goers. Unfortunately, the reactions to these measures is frequently exactly the opposite to what it should be: they are shut down [29], because it is believed that making drug use safer encourages people to take more drugs.

This is a ridiculous suggestion; we can apply it to the activities above to see why.

"Seatbelts should be banned, because if drivers know they will be protected in the event of a crash, they will be encouraged to drive, and cause more accidents."

"We must not provide any driving licenses or associated testing, because that will encourage people to drive."

"Bicycle helmets must be criminalised, because their existence encourages cycling, and cycling is dangerous."

"Parachutes must be illegal to possess, and we will not create any standards for them, because that will encourage people to skydive, which can cause death."

These are obviously ludicrous suggestions, but they are the arguments used in the debate surrounding drugs.

I have not yet mentioned tax intake from the sale of drugs, because it is the least important effect. If the government received tax from sales, they could use the

resulting tax to pay for the effects of legalisation. As an example the state of Colorado in the USA pulled in \$53 million dollars from the tax on cannabis alone after legalisation, and it is earmarked for school construction, among other projects [30].

In summary, drug use, possession, production and sale should be legalised, not to make it legal, but so it can be regulated by the state to the high standards set for every other product on the market, rather than be subject to no control whatsoever, and to reduce crime heavily.

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**IPRT Submission to the Committee on Justice, Defence and Equality on Ireland's approach
to the possession of limited quantities of certain drugs
August 2015**

Introduction

The Irish Penal Reform Trust (IPRT) is Ireland's leading non-governmental organisation campaigning for the rights of everyone in the penal system, with prison as a last resort. IPRT is committed to reducing imprisonment and the progressive reform of the penal system based on evidence-led policies. IPRT works to achieve its goals through research, raising awareness, and building alliances.

IPRT's vision includes ensuring that the principle of imprisonment as a last resort is at the centre of Government policy, as well as making clear the links between criminal justice policy and wider social policy. IPRT therefore welcomes the invitation from the Joint Committee on Justice, Defence and Equality for written submissions in relation to arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use.

Decriminalisation vs. Legalisation

We note that the Committee has specifically limited its considerations to the issue of *possession of limited quantities of certain drugs*; specifically, the decriminalisation (as opposed to legalisation) of possession of limited amounts of certain drugs and the use of civil/administrative rather than criminal sanctions to respond to the current offence of possession of controlled substances. We understand the proposed **decriminalisation** to be a reform of the law that would abolish criminal sanctions (including imprisonment) in respect of the act of possession of a controlled substance, but would continue to enforce a prohibitionist regime by shifting the responses and sanctions for possession to a civil or administrative context.

A criminal justice issue - or a social and health issue?

In respect of the offence of simple possession for personal use, Ireland's approach to date has been to rely on the criminal justice system to tackle what is, in fact, a public health issue. Using a criminal justice response to tackle a chronic relapsing condition such as drug addiction is counter-productive, both for the individual and for the community, and does little or nothing to tackle the root causes of drug use or abuse. This approach carries significant financial costs, and is not based on strong evidence of effectiveness in reducing the numbers of repeat possession offences.

Criminal Law on Possession

Under the *Misuse of Drugs Acts* where an individual is found in possession of cannabis, imprisonment is an available penalty on a third or subsequent conviction (on summary conviction a prison sentence of no longer than 12 months is available and on conviction on indictment a prison sentence of not more than three years is available). Possession of a controlled drug other than cannabis may carry a sentence of no longer than 12 months of on summary conviction and a prison sentence of not more than seven years on indictment.

The Social Harm of Imprisonment

The strongest reason for a move away from the use of imprisonment as a response to repeated offences of possession is that short term imprisonment is an ineffective and counter-productive measure. In the words of the Scottish Prisons Commission, “*prison may sometimes do good, but it always does harm*”. Prison represents a serious restriction on the rights of the prisoner, quite apart from the deprivation of liberty; it carries with it profound negative social impacts on the prisoner, on his or her family and on his or her community, and often the consequences of even a short period of imprisonment are permanent for both the prisoner and those close to him or her. Losing contact with family, employment and social or community services, even for a short period can have long-lasting negative effects. In short, imprisonment for less serious offences compounds the cycles of disadvantage – poverty, homelessness, addictions, mental health issues - which are often at root of offending in the first place¹.

IPRT strongly believes that a focus on addressing the causes of drug use would be more effective and more efficient than expending resources on criminalisation and imprisonment.

Impact on Prison System

In 2012, *Release* (national centre of expertise on drugs and drugs law, London) reported² on the impact of decriminalisation on the Portuguese criminal justice system, both in respect of recorded offences and prison overcrowding:

*“On the criminal justice side, Portugal has reduced the number of criminal drug offences from approximately 14,000 per year to an average of 5,000 to 5,500 per year after decriminalisation. This has led to a significant reduction in the proportion of individuals in Portuguese prisons for drug-related offences – in 1999, 44 per cent of prisoners were incarcerated for drug-related offences; by 2008, that figure had reduced to 21 per cent. This resulted in a major reduction in prison overcrowding in Portuguese prisons.”*³

¹ Irish Penal Reform Trust (2012) *Shifting Focus: The Vicious Circle of Social Exclusion and Crime*, Dublin. Available at: <http://www.iprt.ie/contents/2276> [Accessed 7 Aug 2015]

² *A Quiet Revolution: Drugs Decriminalisation Practices Across the Globe*, Rosmarin & Eastwood, 2012 http://www.release.org.uk/sites/default/files/ereader/quiet_revolution/index.html#/30

³ Ibid at page 32

The Irish penal estate has grown significantly since the mid-1990s, including during times of falling crime rates, yet some prisons continue to hold numbers beyond their capacity and the problem of overcrowding remains a continuing concern.

The Irish Prison Service Annual Report 2014 provides figures which show that in 2014 there were 761 sentenced committals for “*controlled drugs offences*”⁴. While the report does not provide further data as to the nature of the offences within that category, it may be noted that 546 (70%) of these were serving sentences of less than 12 months; and 407 (53%) were for less than 3 months⁵. This suggests that the majority fell at the lower end of the scale in respect of seriousness, and the cohort is likely to include repeat possession offenders. Where offenders are committed to prison for repeat possession offences this adds to an already overcrowded prison system and can place increased pressure on stretched resources.

Ireland has one of the highest rates of committal to prison in the European Union, due to the overuse of short custodial sentences. While the daily prison population rate is 83 per 100,000, Ireland’s rate of committals (number of people committed to prison) is 375 per 100,000, while the rate of release is 379 per 100,000⁶. The *flow of entries and releases* from Irish prisons puts severe strain on the prison system in a number of discrete areas:

- **Admissions:** administrative and assessment (including medical) resources.
- **Accommodation:** 5 of Ireland’s 14 prisons regularly operate above recommended capacity.
- **Security:** transience in the prison population, caused by high rates of committal on short sentences, increases the risk of illegal drugs entering the system and creates an unstable environment in which it is more difficult to maintain good order.
- **Rehabilitation:** significant resources are expended on securing accommodation and linking prisoners due for release with community treatments, including methadone clinics.

Decriminalisation may also have the effect of reducing the number of drug users circulating within the prison system, thus potentially reducing the numbers of those exposed who may not have been using controlled substances before incarceration. The Connolly Report noted that:

*“A number of explanations were also advanced during interviews as to how illicit drugs entered the areas. Factors mentioned included {...} the influence of prison where people had developed addictions and/or met people who would subsequently introduce them to drug-dealing...”*⁷

⁴ This data is not disaggregated further into offence type

⁵ See Appendix V of the Report http://www.irishprisons.ie/images/pdf/ar2014_english.pdf

⁶ Aebi, M.F. & Delgrande, N. (2015). *SPACE I – Council of Europe Annual Penal Statistics: Prison populations. Survey 2013*. Strasbourg: Council of Europe.

⁷ Connolly, Johnny and Donovan, Anne Marie (2014) *Illicit Drug Markets in Ireland*, National Advisory Committee on Drugs and Alcohol, Dublin.

Diversion of drug possession offenders away from the criminal justice system into appropriate community-based treatments and alternatives would reduce some of the strains on the prison system, which would be able to instead divert resources into management of longer-term prisoners and those who have committed more serious offences.

IPRT believes that short-term and low risk offenders could be safely and efficiently removed from the criminal justice system, thus reducing some of the pressure on strained prison resources.

Drug-related Deaths

IPRT does not have the relevant expertise to propose drug treatment approaches. However, evidence suggests that community-based approaches are preferable to prison. An Irish research study found an increased risk of mortality among prisoners within days and weeks following their release from prison; many of these deaths were drug related. This was thought to be caused by the altered tolerance to drugs which an individual may develop while in prison⁸. Of 105 deaths examined, the vast majority (88.6%) were male, aged between 20 and 29, unemployed (83.8%), and living in unstable accommodation (20%) or homeless (9.5%).

Since 2012, the Inspector of Prisons has conducted investigations into deaths of prisoners which occur in prison and on temporary release; these reports are made public. IPRT notes the number of drug-related deaths of prisoners on temporary release documented in the Inspector of Prisons investigation reports. Of the six published reports on deaths that occurred on temporary release in 2014, four were due to suspected overdoses⁹. One of these deaths was of a 20-year-old female serving a sentence of 5 months¹⁰.

Financial Cost

Using the full force of the criminal justice apparatus is an expensive response to personal drug possession and potentially diverts resources away from the provision of services in the community, health and education that could go some way in preventing drug-related offending in the first place.

The average cost of one prison place in Ireland is approximately €69,000 per annum. This figure represents the actual cost of holding a prisoner for one year (excluding education spend) and does not include police time¹¹, criminal investigation, legal aid costs or court

⁸ Walsh, Simone and Lyons, Suzi (2010) Drug-related deaths among recently released prisoners. *Drugnet Ireland*, Issue 35, Autumn 2010. p. 25.

⁹ See Office of the Inspector of Prisons (2014/2015) *Report on the death of Prisoner A – 2014; Report on the death of Prisoner B – 2014; Report on the death of Prisoner G – 2014; Report on the death of Prisoner G – 2014*. Available at: <http://inspectorofprisons.gov.ie/en/IOP/Pages/WP14000001> [Accessed 7th August 2015]

¹⁰ See Office of the Inspector of Prisons (2014) *A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of prisoner A on 15th January 2014 while on temporary release*.

¹¹ According to the National Drugs Strategy “The Gardai advise that about 20% of drugs crime relates to supply offences and 80% to possession”

time. A recent study¹² by the National Advisory Committee on Drugs and Alcohol highlights that possession offences take up a significant amount of court time, and calls for alternative approaches to handle possession cases. Views have also been expressed that decriminalisation may also free up Garda time to concentrate on investigating and prosecuting the crimes that cause the most harm, rather than targeting low level possession offences:

“An issue highlighted by the National Drug Strategy Steering Group, ... relates to the use of resources by the Garda Síochána, particularly in relation to the prioritisation of drug-related crime and, in particular, the time being allocated by the Garda Síochána to personal possession of cannabis offences. The view was expressed that this time might be more usefully spent on more serious offences, such as supply offences.”¹³

CityWide Drugs Crisis Campaign has also noted that by directing problematic drug users into treatment programmes rather than the criminal justice system, decriminalisation would reduce criminal costs and allow money to be redirected towards tackling organised crime.¹⁴

The Committee Report¹⁵ notes that the Portuguese approach resulted in a reduction in costs for the State. This was reportedly due to the reduction in costs associated with police time, criminal investigations, legal aid costs and court time¹⁶ as well as the reduction in the number of HIV/AIDS cases thereby reducing the cost on the health budget. The prison environment is a high-risk environment for the transmission of communicable diseases, namely HIV, Hepatitis C, and Tuberculosis (WHO, 2007) mainly due to structural conditions within prison systems such as over-crowding, lack of sanitation and limited access to healthcare services (WHO, 2009). Again highlighting the links between prisons, prisoners and communities, communicable diseases tend to spread more rapidly among groups that experience high levels of socioeconomic disadvantage, many of whom may subsequently enter the prison system (Northern Dimension Partnership in Public Health and Social Wellbeing (NDPHS), 2008). As a result, prisoners become more susceptible to communicable diseases because they have no control over their environment or the individuals they interact with (WHO, 2009).

The Commission on English Prisons Today has stressed the importance of what it calls ‘justice re-investment’, a policy decision and related practices that seek to “*re-balance the criminal justice spend by deploying funding that would otherwise be spent on custody into community based initiatives which tackle the underlying causes of much crime*”. The Commission states very clearly that it understands this process as investing in ‘alternatives’ **outside** of the justice system, and not within it. This understanding reflects IPRT’s view of

¹² Connolly, Johnny and Donovan, Anne Marie (2014) Illicit Drug Markets in Ireland, National Advisory Committee on Drugs and Alcohol, Dublin

¹³ Ibid.

¹⁴ CityWide Drugs Crisis Campaign (2013) *Decriminalisation: a new direction for drugs policy?* Dublin.

¹⁵ Joint Committee on Justice, Defence and Equality, June 2015, page 4

¹⁶ According to the Courts Service Annual Report 2014, almost 18,000 drugs matters came into the District Court in 2014. See:

[http://www.courts.ie/Courts.ie/library3.nsf/%28WebFiles%29/76D5C7C737385EFF80257E91002F3D7A/\\$FILE/Courts%20Service%20Annual%20Report%202014.pdf](http://www.courts.ie/Courts.ie/library3.nsf/%28WebFiles%29/76D5C7C737385EFF80257E91002F3D7A/$FILE/Courts%20Service%20Annual%20Report%202014.pdf)

the need to develop effective interventions in Ireland, separate from the criminal justice system.

IPRT views the proposed introduction of the Portuguese model (if properly researched, resourced and operationalised) as one which potentially represents an innovative and cost-effective diversion of drug users out of the criminal justice system.

Breaking the Cycle

Crucially, the Portuguese approach ensures that no criminal record will result from contact with the *Commission on Dissuasion*, recognising the crucial point that having a criminal record for drug misuse may produce insurmountable obstacles to employment and other opportunities. Obstacles to education, employment or training are counterproductive to a person's recovery and rehabilitation. The purpose of this provision is to allow the person the opportunity to turn their life around, and acknowledge efforts to move on from the behaviour. The strong words of the Argentinian Supreme Court in the *Arriola* case illustrate the principle:

*'Criminalizing an individual [for drug use] is undeniably inhumane, subjecting the person to a criminal process that will stigmatize him for the rest of his life and subject him, in some cases, to prison time.'*¹⁷

In Ireland, CityWide have also found that:

*'Criminalisation does not act as a deterrent when someone decides to use drugs but it does cause significant harm to an individual's future prospects as the requirement to disclose previous convictions never lapses.'*¹⁸

Securing employment or training is crucial to breaking the cycle of drug use and offending. Along with enacting effective spent convictions legislation in Ireland, IPRT believes that this approach would remove a significant barrier to the successful reintegration of those found to be in possession of drugs.

Conclusion

- IPRT believes that a focus on addressing the root causes of personal drug misuse would be more effective and more efficient than expending resources on criminalisation and imprisonment.
- IPRT believes that low risk offenders, including those found in possession of drugs for personal use, could be safely and efficiently removed from the criminal justice system. This would reduce some of the pressure on prison space and resources.

¹⁷ The judgment is only available in Spanish however a summary of the findings is available at: <http://druglawreform.info/en/country-information/latin-america/argentina/item/235-the-arriola-ruling-of-the-supreme-court-of-argentina>

¹⁸ CityWide Drug Crisis Campaign (2013) *Decriminalisation: a new direction for drugs policy?* Dublin.

- Moves to decriminalise certain drug-related offences must be met with investment in evidence-informed substance misuse services, treatment and interventions in the community.
- Securing employment or training, and the ability to rebuild a life after committing an offence, is crucial to breaking the cycle of offending. Along with enacting effective spent convictions legislation, removing those found in possession of drugs for personal use from the criminal justice system could remove existing significant barrier to rehabilitation.
- IPRT views the introduction of this model (if properly researched, resourced and operationalised) as one which has strong potential to represent an innovative and cost-effective response to drug use. IPRT strongly recommends the diversion of drug users away from the criminal justice system and towards drug treatment and services.

Peter McVerry Trust is a voluntary organisation with charitable status. It has over 30 years experience in working with homeless young people who present with complex low threshold needs. In responding to these needs the Peter McVerry Trust has developed a range of services to directly address homelessness and to offer supports in relation to issues such as problematic drug/alcohol use, criminal justice issues, challenging behaviour and mental health issues.

Current service provision includes adult homeless and housing services, drug treatment services, drop-in, housing first and street outreach services and under 18s residential care. Although all services offer support in relation to problematic drug/alcohol use, specific drug treatment services include two Drug Stabilisation and Recovery Services and a Tier 4 Residential Community Detox Service with a national remit. This service provides a methadone detoxification programme and the only residential cannabis cessation programme in the country. The service is over-subscribed. We also provide visiting drug stabilisation clinics across all of our homeless services. In 2014, PMVT services provided support to 4,460 people. The organisation has a wealth of experience of offering support to those who use illegal drugs both through choice and by necessity as a result of addiction.

The impact of criminalization

We regularly see the impact of criminalization on young people who have had troubled histories and who often use drugs as a way of temporarily escaping emotional and psychological trauma. With the current criminal justice approach to possession, a young person who receives a criminal conviction will be less likely to gain employment and is restricted in terms of travel. For those who receive a custodial sentence, the possibility of employment becomes even more remote and the likelihood of more long-term drug use is increased.

Value for Money

Treating addiction in the community or in residential settings is a better short and long term investment than criminal justice interventions. The cost associated with policing and prosecuting possession of small amounts of certain drugs is enormous and for the majority of those prosecuted does reduce the risk of re-offending. This money could be better spent investing in services to address and reduce drug use as a health issue. Increased investment in treatment options will provide better outcomes for individuals and be more cost effective than criminal justice interventions. In particular, saving achieved by decriminalization of possession of limited amounts of certain drugs could be redirected to the following interventions:

- a national funding stream for all Tier 4 services with a national remit;
- residential stabilisation beds for homeless persons;
- increased drug free aftercare beds for those completing residential treatment programmes;

- providing more local treatment services that do not require clients to travel long distances to access supports.

Treating addiction as a health rather than a criminal justice issue

Many of those with whom we work are caught in addiction and there are times when they express a strong desire to access treatment and address the addiction. Some give up on the possibility of escaping addiction to drugs and have resigned themselves to an ongoing cycle of addiction, crime and incarceration. Providing treatment in such circumstances is a humanitarian response. Changing the approach to the possession of limited quantities of certain drugs to focus on treatment interventions would provide greater opportunities for young people to be supported to address their drug use and avoid the risk of moving into addiction thereby benefiting both the individuals themselves and the communities in which they live.

Dear Sir/Madam,

I am writing to you on behalf of the a working group of social workers, working in the Addiction services, who are members of Irish Association of Social Workers, the professional body for social workers in Ireland. We would like to bring a few issues to the attention of the Committee which we would ask them to consider when drafting any strategy in this area.

1. That given the high risk to the welfare of children as outlined in other reports, such as in Hidden Harm - we believe that drug treatment services should actively prioritise treatment (either outpatient or inpatient) for people who have children. This prioritisation should be put on a legislative footing.
2. That within the homeless services, that special accommodation be found for mother's who are undergoing drug treatment, especially those with infants and young children. Such placements would need to be appropriately supported.
3. That the number of short term beds which are set aside for stabilization purposes be increased.
4. That Domestic violence services offering emergency accommodation offer placements to those with drug issues and who are in treatment and thus actively seeking to address their usage issues.
5. That homeless services set aside a residential service(s) admitting those who have entered in to Drug treatment residential programmes and have successfully completed same.

Thank you for the opportunity to make a submission in this area and if required we are happy to talk to the issues above to the Committee in more detail.

Kind Regards,

Dónal O'Malley

Chairperson

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Committee on Justice, Defence and Equality

Submission on review of Ireland's approach to the possession of limited quantities of certain drugs

Merchants Quay Ireland (MQI) is a national voluntary organisation providing a range of care and treatment services for homeless persons and drug users. MQI provide drug treatment services across the continuum of care which includes the following:

- Crisis contact services and health promotion services offering information and harm reduction programmes in Dublin and four midlands counties.
- Structured pathways programmes with a strong emphasis on personal development, basic education and independent living skills linked to methadone treatment and counselling support
- Residential detoxification in a fully medically supervised therapeutic programme
- Drug free residential drug treatment programmes with a strong emphasis on group therapy and one to one counselling
- National Prison Based Addiction Counselling Service
- Aftercare and Social Housing supports

In 2014, we worked with over 5,000 drug users and people who were homeless. For more information visit www.mqi.ie

Decriminalisation:

Merchants Quay Ireland view addiction as primarily a health and social issue and as such believe that it is best dealt with in the health and social care system. It is our firm belief that diverting drug users from the criminal justice system into drug treatment services is the best and most effective means of addressing the drugs problem. In this regard there is strong evidence, both from Irish and international research, that engagement in drug treatment leads to significant and sustained reductions in drug use and drug related crime and anti social behaviour. In addition, the British Home Office's cost benefit analysis on drug treatment provision estimated that for every €1 spent on drug treatment there was a €3 saving in criminal justice costs and that the saving rose to €9 when health and social costs were taken into account.

We see the decriminalisation of the possession of a limited amount of certain drugs as a positive mechanism for diverting people from the criminal justice system into the health and social care services. We know that, unfortunately, many problematic drug users over the course of their drug use come into contact with the criminal justice system and acquire criminal convictions, either directly or indirectly related to their drug use. Currently, in Ireland there is no facility for criminal convictions to become 'spent'. The absence of such a facility runs contrary to the spirit of the

National Drug Strategy and specifically the rehabilitation pillar which places an emphasis on reintegration into society. It is almost universally accepted that the best outcome for drug users engaged in crime or anti social behaviour is their rehabilitation and reintegration into the community. This rehabilitation is hampered by the lack of any Rehabilitation of Offenders Act in Ireland. Such an Act would provide ways to ensure that the burden of the requirement to disclose a previous conviction is minimized for the very many ex-offenders who simply want the chance of lawful employment, while maintaining a requirement to disclose where there may be a particular risk of harm. Ireland remains one of only two or three jurisdictions in Europe that does not have a rehabilitation of offenders provision in place.

In summary we would highlight the following points in relation to decriminalisation:

- Decriminalisation would direct problematic drug users into treatment programmes rather than the criminal justice system.
- Increase the numbers of drug dependent people accessing treatment and significant reductions in the transmission of HIV and Hep B & C.
- Criminalisation does not act as a deterrent when someone decides to use drugs but it does cause significant harm to an individual's future prospects as the requirement to disclose previous convictions never lapses
- In 2012 almost 72% of convictions for drug offences were for possession of drugs for personal use.
- Decriminalisation would reduce criminal justice costs and money could be redirected towards tackling organised crime.
- In 2012 the cost to the taxpayer of imprisoning one person for a year was €65,404 (excluding education & training costs)

**Submission to the Committee on Defence,
Justice and Equality regarding Ireland's approach
to sanctions for the possession of limited
quantities of certain drugs.**



7 August 2015

Submission by:

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Introduction

The Irish Hospital Consultants Association (IHCA) makes this submission in response to an invitation from the Joint Committee on Justice, Defence and Equality. The IHCA represents 85% of Consultants working in acute hospitals and Mental Health Services in Ireland. It is the single representative body that speaks solely on behalf of Consultants.

The authors of this submission, on behalf of the IHCA, include Consultant Psychiatrists working within the HSE Addiction Services in Dublin. The submission includes significant input from Dr Bobby Smyth, Consultant Child and Adolescent Psychiatrist, and Dr Eamon Keenan, Consultant in Adult Addiction Psychiatry. These two Consultants have a cumulative thirty five years' experience in addressing addiction issues in Ireland. We are commenting on the proposed legislation intended to decriminalise the possession of small quantities of illicit drugs.

Factual Information

At present a person found in possession of a drug scheduled in the Misuse of Drug Act can be prosecuted for that drug possession in the Criminal Courts. Increasingly, Gardaí appear to be adopting discretion regarding people caught in possession of small quantities of drugs such as cannabis. For example, in the Global Drug Survey in 2014 it is reported that only 17% of respondents who were found in possession of cannabis by Gardaí ended up going to court. It appears to be the case that many young people who do end up in court avoid a criminal conviction as judges also use discretion. However, this use of discretion by Gardaí and Judges creates a system which is inherently unfair, as some people do still end up with criminal convictions while the majority avoid same.

The countries with the longest experience of alternative approaches to drug possession are the Netherlands and Portugal. In addition in the United States of America, marijuana is now legal or in some form decriminalised in 27 states and the District of Columbia. Prior to embarking on a formal approach of decriminalisation in Ireland it would be prudent to examine the impact of these measures in those jurisdictions. We are very concerned that much of the public discussion on this topic in Ireland has been profoundly imbalanced, with positive experiences of other countries being greatly exaggerated and adverse consequences being ignored.

Netherlands

In 1976 the Dutch adopted a formal written policy of non-enforcement for violations involving possession or sale of up to thirty grams of cannabis. In 1995, in response to domestic and international pressure because this threshold was perceived to be too high, the threshold for possession was lowered to five grams. In their review of the Dutch cannabis policy MacCoun and Ruter (2001) examined two distinct phases. The first of these related to 1976 to 1983 which reflected the period of the depenalisation (or decriminalisation). The second period was from 1984 to 1996 when there was de facto legalisation and commercialisation of the sale of cannabis via coffee shops.

Examination of prevalence data on use of cannabis and other drugs caused them to conclude that the policy of depenalisation did not increase the prevalence of cannabis use among young people relative to changes which were observed in neighbouring European countries. However, they did detect a significant escalation in use of cannabis following the commercialisation of sale and availability of cannabis via the expanding network of coffee shops during the second period.

Portugal

In 2001 Portugal introduced a new law which significantly changed the legal response to drug users. They ended criminal sanctions for drug possession for personal use. However, and quite unlike the Netherlands, they persisted with a significant consequence for people who were found in possession of drugs as they were referred to the “Commissions for the dissuasion of drug addiction (CDTs)” The changes to Portuguese drug policies seemed prompted by an epidemic of heroin injection in the late 1990s, similar to that which was seen in Dublin. Again like Dublin, it seemed to largely affect people in deprived communities in large urban centres. Drug related criminal activity and HIV infections were seen to be major social problems and the public demanded a response from politicians.

While there appears to be an international desire among enthusiasts of liberalisation of drugs policy to view the decriminalisation approach adopted by Portugal as an unqualified success, there are very divergent views on its impact. This relates in large part to the limited quality of the data on the extent of the problems prior to the revised legislation (Hughes & Stevens, 2012). Secondly, they relate to the rapid fluctuations which occur internationally in drug use and drug related harms. As a consequence of this reality it is difficult to attribute causality in the Portuguese situation. We simply do not know what would have happened in Portugal if it had persisted with the more traditional criminalisation of drugs policy.

The Cato report was written by a constitutional lawyer Glenn Greenwald and concluded that it was a resounding success. In stark contrast, the APLD report was written by Dr Manuel Pinto Coehlo, a Portuguese addiction specialist, concluded that it was a disastrous failure. Both reports have been objectively reviewed and both appear highly selective in the data which they chose to report and imbalanced in their respective conclusions (Hughes & Stevens, 2012). Both reports are often quoted in international discussions, especially the Cato report by Greenwald.

Following decriminalisation, efforts were made to assess its impact on rates of drug use and drug related harms. Unfortunately, much of the baseline data on the pre decriminalisation period is of poor quality and it is difficult to draw firm conclusions on many measures. In addition to the decriminalisation policies, a National Drug Strategy was developed in Portugal in 2000, again adapting many of the same principals which were employed in the Irish Strategy. The fact that many changes were implemented in Portugal at the same time makes it difficult if not impossible to discern the specific impact of single elements of the overall strategy, such as decriminalisation.

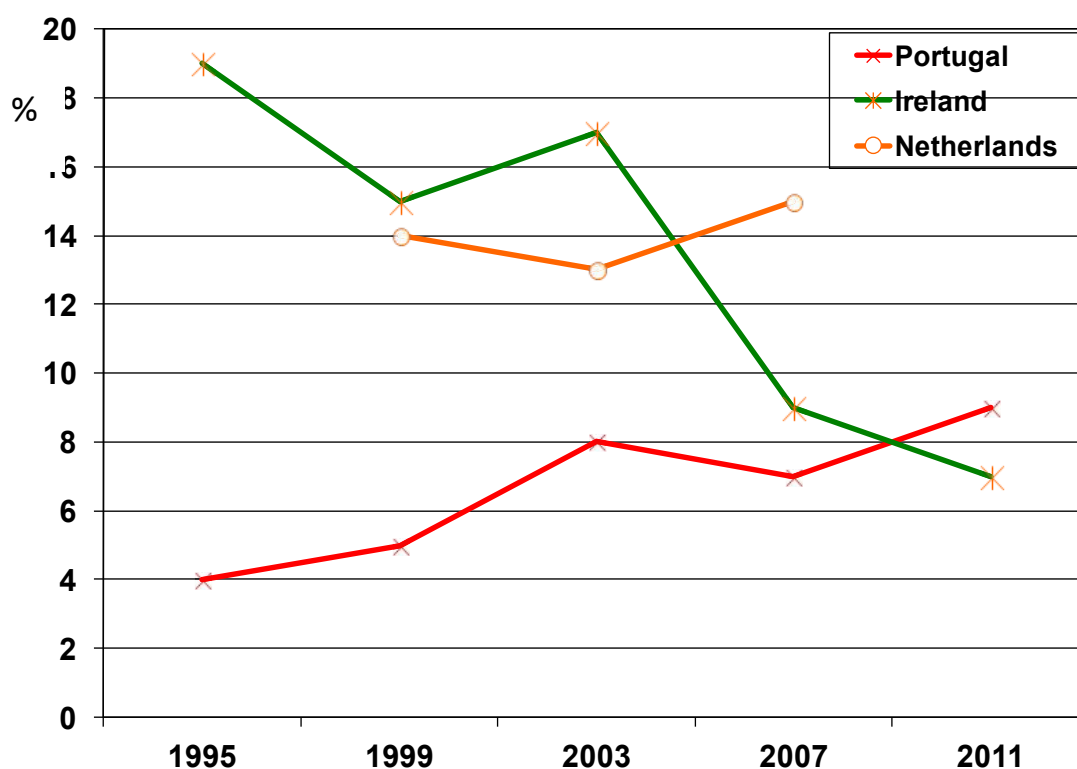
The evaluation of the Portuguese experience of decriminalisation indicates that there was a reduction in opiate related deaths, blood borne viral infection and drug related crime. However, as shown by Hughes and Stevens (2010), drug treatment access in Portugal expanded considerably post-reform. This increased access to treatment is likely to have contributed significantly towards the reduction in opiate related deaths due to the fact that more opioid users can gain access to

treatment interventions such as Opioid Substitution Treatment that has proven efficacy in reducing opioid related deaths.

It is also argued that the policy of decriminalisation resulted in more people entering treatment. Two factors may have contributed to this increase in treatment entry. Firstly, CEDT mandated that about one third of the people referred to these committees had to enter treatment as they were deemed to be addicted to the possessed substance. Secondly, it is suggested that the decriminalisation of drug use made people more willing to seek help from health professionals.

There is evidence that some measures of the level of drug related harm deteriorated after the new policy was introduced in Portugal. There was an escalation in deaths linked to substances other than heroin. There was also an escalation in cannabis use among teenagers, as shown in Figure 1 below. This highlights the fact that in Ireland with no decriminalisation the rates of cannabis use among teenagers fell while the rates in Portugal have increased to higher than the Irish levels over the last 15 years.

Figure 1. Past Month Cannabis Use among 15-16yo schoolchildren from ESPAD Surveys 1995-2011. (Netherlands did not participate in ESPAD in 1995 or 2011)



United States of America

The situation in the United States varies significantly from State to State with particular reference to Cannabis. In some states, Cannabis use has been decriminalised, in some states Cannabis is available for medicinal use and in other states Cannabis has been legalised completely. There is a constantly

evolving picture in the United States but this does allow us an opportunity to examine how these different approaches impact on rates of use and attitudes among young people over time.

Research is emerging on this issue on a regular basis and it would be advisable from a legislative point of view to monitor this research on an ongoing basis. For example Miech and colleagues (2015), in the *International Journal of Drug Policy*, highlighted decriminalisation as a risk factor for future use and acceptance of cannabis among young people. Another research study by Johnson and colleagues (2012) reported an increase in Cannabis involved driving since 2007 when legislation was introduced to decriminalise cannabis. That same study found no increase in other drugs that remained illegal. Cannabis production and sales has become a multi-billion dollar industry in the United States and a concern exists that decriminalisation is simply one step along the way to cannabis legalisation and production.

Potential Impact of Decriminalisation on Addiction Treatment Services in Ireland

The response to addiction in Ireland changed dramatically in Ireland during the 1990s. There was a move away from abstinence based treatment approach towards harm reduction approaches. The dominant driver behind this policy change was the extremely dramatic escalation in heroin dependence which was witnessed in teenagers and young adults in Dublin. This heroin epidemic reached its peak in the mid-1990s.

The first National Drug Strategy in Ireland was established in 2000. It underpinned the move in the treatment approach towards harm reduction. The supply reduction pillar remained largely within the remit of the Department of Justice and the prohibition based approach persisted. Since that time there has been a dramatic reduction in the incidence of new cases of heroin dependence in Dublin. For example, during the period 1996-1997 there were 180 children under the age of 18 presenting to addiction services dependent on heroin each year (Smyth & O'Brien, 2004). This number has fallen to less than 10 per annum in 2013-14.

Unfortunately, many of the thousands of people who became addicted to heroin in the 1990s remain in contact with treatment services. There are approximately ten thousand people on methadone maintenance treatment in Ireland, and the vast majority of these are in the Dublin area. The HSE Addiction Services in Dublin deal almost exclusively with heroin dependence. These Services have suffered larger cutbacks in staffing than that seen across the HSE treatment service in general. For example, the HSE Addiction Services in Dublin Mid Leinster experienced a twenty percent reduction in frontline clinical staff in the areas of nursing, counselling and outreach in the three years from 2010-2013.

The probability that decriminalisation will lead to increase in treatment entry is to be welcomed. However, it also requires proactive planning by treatment commissioners and treatment providers. The latter group needs to be resourced to respond appropriately to this escalating demand. At present there are tremendous discrepancies in addiction treatment access across Ireland. For example, data from the general population survey (NACD, 2012) when cross matched with the National Drug Treatment Reporting Systems (Bellerose, Carew, & Lyons S, 2011), indicates that drug users in Dublin are five to ten times less likely to enter treatment in any given year compared to their counterparts in the Southeast of Ireland. This appears more likely related to the fact that services in Dublin find themselves overwhelmed in responding to an aging cohort of opiate

dependent patients who have enormous co-existing psychological and psychiatric morbidities and ever increasing physical health needs. These discrepancies and variations in service provision nationally must be addressed as a matter of urgency. These Services are failing to respond to the current level of need. This need will escalate if a policy of decriminalisation is adopted in Ireland.

Harms associated with criminalising people who use drugs

Obtaining a criminal record for use of a drug brings with it significant adverse consequences for individuals. It complicates their ability to travel abroad and may completely prevent emigration to some countries. It may also interfere with a person's ability to obtain work in Ireland.

Benefits of a criminal sanction for drug use.

The possibility of obtaining a criminal record must act as a deterrent to drug use for some people. When a person is presented with the option of use of a drug, there are a range of pros and cons for that person. One of the many disadvantages of drug use is the possibility of a criminal prosecution. We simply do not know how large a factor this is in causing most people to choose to avoid drug use most of the time. The fact that a significant minority of people chose to use drugs regularly does not mean that the possible criminal sanction is not acting as a deterrent for those who chose not to use, or chose not to continue using.

The motivations underlying human behaviour are tremendously complex. There are many apparent paradoxes. For example, the General Population survey found that only 48% of people who reported past use of cannabis believed that it should be legalised for recreational use. Most people with penalty points for speeding accept the need for speed limits on our roads.

Conclusions

We do not need to rush into the introduction of decriminalisation of drugs and the emerging situation in the USA gives us an opportunity to learn from the experience elsewhere. Nobody can predict with any certainty what will happen if Ireland does chose to decriminalise drug use. We can be fairly certain that there will be both societal benefits and costs.

The International Narcotics Control Board (INCB) of the United Nations should be consulted on such a move given their central role in providing a comprehensive and balanced approach to international drug control conventions. The 2014 report of the INCB highlights their role and availability to consult governments on technical matters relating to drug control systems.

The dramatic rates of increase of cannabis use among teenagers over the last two decades in Portugal which have followed decriminalisation, along with the emerging evidence from USA, suggests a cautious approach to this controversial topic may be wise.

On balance the IHCA is neutral on the option of decriminalising drugs for personal use. We have nevertheless opted to make a submission on this important issue as we are very concerned at the lack of balance in the debate to date. We also have strong views, based upon the evidence, regarding how decriminalisation might be enacted if it does occur.

If Ireland does opt to decriminalise drug use, we see no qualitative distinction between the various scheduled drugs. They all pose substantial risks to the individual users and can bring adverse

consequences for people around the drug user. Therefore, we see no reason to decriminalise one particular drug or group of drugs, while continuing to criminalise other classes of drugs. Doing so may mislead people into thinking that some drugs are safe and others are harmful.

If Ireland does opt to decriminalise, we believe that we should do so in a manner somewhat similar to Portugal. Specifically, we argue that there should continue to be a sanction for drug use, albeit not a criminal sanction. This delivers an unambiguous message to individuals that our society disapproves of this risky activity, much in the same way that we manage excessive speed by drivers on our roads. That sanction could be a simple civil sanction such as a fine. A system of consistently enforcing fines may well be a more effective deterrent than the tremendously inconsistent approach in operation at present.

While steps should be taken to improve access to addiction treatment across Ireland and address the current imbalances in access which exist in any case, it will be even more important to do this if drug use is decriminalised, as the numbers seeking treatment are probably going to increase.

Ends

IHCA

7 August 2015

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Submission to Oireachtas Committee regarding ‘Decriminalisation’ of currently illegal drugs.

I am writing this submission as Coordinator of UISCE – Union for Improved Services, Communication & Education. We are an advocacy group for drug users and users of drugs services.

We are based in the North Inner City where we have developed strong links with community, statutory and voluntary sectors. We have been at the centre of developing a network of other drug/service user reps through SURF (Service User Representative’s Forum). We are also engaged with many drug user activists through INPUD (International Network of People who Use Drugs) and its European branch EuroNPUD.

We very much welcome this opportunity to contribute to a possible change in Irish drugs policy that is more respectful of human rights, and more effective in redirecting resources towards more holistic and certainly less harmful approaches to the drugs issue.

The committee will have seen through their own research and from other submissions that there a number of models operating elsewhere that decriminalise personal possession of illegal drugs.¹ Perhaps the most pertinent case is that of Portugal where ‘dissuasion committees’ operate.

While the Portuguese model is desirable in many ways, it maintains the sanctioning of criminalisation albeit in a different form. Because Portugal provides perhaps the most discussed model, it is a useful starting point.

The use of dissuasion committees should be reserved for under 18s primarily. It should not be used in cases of simple possession for adults unless their use of drugs (including alcohol) is a factor in other offences such as public order and traffic offences, and in cases of larceny where the effect of drugs or the cost of a drug habit is a factor. In cases like these a dissuasion committee can have a valuable input. However, referring all cases of possession to such committee is not an effective use of resources. There needs to be

¹ Rosemarin & Eastwood ‘A Quiet Revolution: Drug Decriminalisation Policies In Practice Across The Globe (Release – 2012)

more filtering to ensure that drug use that is un-problematic (the majority) is not diverting resources away from people who may appreciate an intervention.

The case of tobacco:

As much as 20% of the cigarettes smoked in this country are un-taxed, and many are counterfeit, illegal cigarettes. It appears the strategy of the customs and the gardai does not target the consumers of these products whatsoever, and rightly so. In fact, there is probably a deficit in harm reduction information that targets this specific consumer group. A similar parallel can be drawn with illegal alcohol.

To treat other substances differently reflects a moral rather than a rational bias. More importantly, such a standpoint and policies fuel stigma and undermine human rights. Notwithstanding the legacy of demonising drugs and drug users, and an inability to see drug use outside the narrative of 'vice', like their forbearers did with 'dirty books' like Ulysses, there is now widespread support for a move towards decriminalisation.

Possession of any substance by an adult for personal use should be ignored, unless it is a significant factor in the committing of an offence. The introduction of bye laws about consuming drugs in public places could be introduced to complement decriminalisation. In other words, possession of personal drugs should only be noted as an adjunct to other offences

It needs to be considered whether drugs found on a person should be returned or confiscated

Drugs policy needs to be framed within a harm reduction strategy that recognises the criminalisation of drug users is a direct harm to them, and exacerbates other harms linked to drug use as well as further marginalising people further. Although it may provide ammunition for those who oppose any deviation from the law and order approach, a decriminalisation approach necessitates an acceptance of drug use and of drug users. Attempts to stop drug taking by imposing criminal sanctions and social stigma have not been successful, and are often counter-productive.

There has been much discussion about the issue of decriminalisation, spurred by the example set by Portugal. It is particularly significant that Citywide who have provided a network and strong leadership to communities supports decriminalisation.

The drugs issue is multi-faceted. While any progress towards decriminalisation deserves our commendation, it is not simply a recalibration of our overall response from a legal to a medical or social paradigm. The economic dimension needs to be highlighted. It is disadvantaged communities that pay the highest cost in terms of drugs harms and criminalisation.

Decriminalising drug users should be reflective of our aspiring to be a more inclusive, egalitarian society that respects the human rights of all its citizens.

Finally, I would like to thank you all again for this opportunity to be part of the discussion as we attempt to make Irish drugs policy more progressive and respectful of human rights. There is bound to be opposition, and while our response – on behalf of people who are still using drugs may be predictable, I am sure you will give it due consideration.

While it can be argued that the drugs issue affects every town and village in Ireland, I would ask that you afford the experts with long-standing track records in the drugs area particular attention: Citywide, Merchant's Quay, Ana Liffey all come to mind. For us, the human rights cannot be compromised, suspended or postponed. We earnestly hope for positive change that will eventually gain popular support. Although decriminalisation may happen soon, we cannot wait for layperson to be convinced.

Please do not hesitate to contact me should you require

Yours sincerely,

Ruaidhri McAuliffe
Coordinator
UISCE

Neil Mannion

Decimalisation of drugs in Ireland

A nation is defined by the laws it places on its peoples. It is to be expected that a society will change and differ if not improve from the one preceding it decades previously, in that vein the laws placed by the older society will doubtlessly contain aspects viewed unfitting or even immoral by those of the later society. To ensure we are not ruled by laws we have inherited we must consistently review our laws with modern values and knowledge and change as we find accordingly.

While I lack any expertise in this area which could give weight to my argument I hope to express my reasoning for the process of decriminalisation by following the general layout below.

1st Historical failures of criminalisation

2nd Modern failures and impracticality's of criminalization

3rd Specifically show the failures in Ireland

4th The benefits of decriminalisation

5th Final Word

- 1) In terms of a nationwide prohibition occurring in history from which we can learn from we need look no further than the remarkably applicable American prohibition (1920-1933), an infamous example of self-defeating actions. The law imposed to prevent alcohol consumption, and therefore decrease the crimes and social degradations assumed to stem from it, instead merely gave previously inconceivable revenue streams to organised crime and strengthened the mafias' foundations so that the effects can still be seen today. Whether right or wrong this prohibition can be seen as the imposition of a law due to the strong moral desires of a minority on a majority either apathetic or strongly against it. From the origin there was only ever one outcome.

"When Prohibition was introduced, I hoped that it would be widely supported by public opinion and the day would soon come when the evil effects of alcohol would be recognized. I have slowly and reluctantly come to believe that this has not been the result. Instead, drinking has generally increased; the speakeasy has replaced the saloon; a vast army of lawbreakers has appeared; many of our best citizens have openly ignored Prohibition; respect for the law has been greatly lessened; and crime has increased to a level never seen before."⁽¹⁾

The failures of this prohibition era are not only well known and documented on an academic level but also hold a place in modern memory being found to inspire drama in both movies and television and in literature, both historical and fictional. When involving crime and noir from the era inevitably one must mention the criminals funding stemming from the prohibition act, this failure is a constant source of inspiration for success including even classics such as "the great Gatsby").

It is truly a wonder that such an analogous situation and learning experience is ignored despite its relevance. It sadly proves those who refuse to learn from history are doomed to repeat it, as I hope to show has been done.

- 2) On a global level there are few ways to judge the current process as a success. The war on drugs has left an estimate of over 100,000⁽²⁾ dead in Mexico while leading the cartels to become one of the regional powers. In the middle-east opium poppies have become a source of income for the Taliban⁽³⁾ while Russia is estimated to have a future epidemic on their hands with over 2 million⁽⁴⁾ addicts. With the growing interconnected age international purchasing of drugs for personal use is becoming easier than ever. Communication over the dark-net and payment using cryptocurrencies are a new and trying challenge for authorities who struggled with the old.

It is therefore no surprise that abroad many countries have begun to augment their laws. Uruguay has taken the lead in Latin America having just legalized cannabis possession for personal use while Argentina and Brazil have lessened enforcement and sentencing for personal use.

Central America Ecuador is beginning to see drugs as a health concern rather than a crime and is to allow cross the board personal use. Colombia which has bared the brunt of other countries policies has begun to demand the US repeal its current laws.

The most recent developments occurring since I began writing this include approval of medical marijuana by Australian senators with support by prime minister Tony Abbott⁽⁵⁾ while UK police have admitted that they have given up enforcing small scale cannabis farms and Sara Thornton (who leads the national Police chiefs council) stated that they had “never been a top priority”.

All the While more and more American states have begun the process of decriminalisation. Despite being the foundation for the war on drugs (as well as the largest area of demand) the USA has relatively quickly shown a growing distance from its previous stance with President Obama providing an official pardon to over 100 prisoners related to drug charges.

Understanding the changing standing in the world is important for Ireland. For starters it is an indicator that we too may wish to rethink our moral grounding on our current stance but importantly and regardless of ones opinions on drug use itself is the realization that as more absolute bans on drugs end the more difficult it will become to prevent the entrance of drugs from the ever-growing international safe havens.

Consider that even while the world was nearly unified (if only officially) against certain illicit drugs it failed to prevent the (black) markets desires. It can only be assumed how difficult it will become in the relatively close future when an entire continent will have legal streams of transfer they must manage to prevent it travelling to countries where the ban is still active, all of this is under the assumption they will be willing to spend their resources on ensuring our laws, which they have discarded, are maintained.

- 3) While I am sure others will make a case for a moral cause to decriminalise, if not legalise marijuana and other illicit drugs I will offer a simpler and more practical point, irrelevant to the validity of marijuana's legal/illegal state which is that the laws have not decreased drug use while increasing risk to drug users and society.

Ireland has shown to not be an exceptional case and follows the global and historical trends. As elsewhere marijuana constitutes the vast majority (63%)⁽⁶⁾ of drug use and possession and sales. As such marijuana consumers disproportionately are affected by rules aimed to diminish other, more destructive drugs. Ireland shows a steady marijuana use rate equivalent to the rest of Europe⁽⁷⁾⁽⁸⁾. Due to the direct method of production and sale marijuana differentiates from other illicit drugs in that it can be purchased with less likelihood of providing funding towards major organised crime⁽⁹⁾.

According to the 2015 EMCDDA report⁽¹⁰⁾ the estimated lifetime and previous year drug use percentage figures stood at

	Last year (15-64)	Last year (15-34)	Lifetime
Cannabis	5.7	11.7	23.3
Cocaine	1	1.9	4.6
Amphetamines	0.5	1	3.5
Ecstasy	0.6	1.4	3.6

Excluding Cannabis usage and assuming the absolute limits of overlap we are still left with the bare minimum figure of 4.6% of the European Union having experience with drug usage. Assuming Ireland followed the European average we would still have to arrest a significant percent of the population to enforce such laws fairly and evenly. To the extreme limit if one was to in prison all (again ignoring cannabis) these people as law breakers then Ireland would have the highest prison population per capita in the world, over 3⁽¹¹⁾ times higher than the current record holder, the USA where 48.6% of the prison population is due to drug offences and tough laws brought in during the war on drugs.

As stated earlier that it is becoming more difficult⁽¹²⁾ to separate old illegal with new legal high we should look at the current situation. According to the most recent European Drug report Irish youths had the highest (9%)⁽¹³⁾ level of usage of legal drugs with a prevalence of 9.7% with young adults (15-24) meaning that even with our current laws drugs are easily available. I believe one should consider this as evidence that as we try to ban newer drugs we merely cause the creation of new drugs to fill the void in the market (9%) these new drugs however lack the history which other drugs have gained over time which allows a certain level of knowledge and control for users. Consider the difficulty of trying to treat a patient reacting to one of the new and ever changing legal highs compared to having a few known and studied drugs with a documented medical history. For context the synthetic cathinone MDPV, which was first detected in 2008, had been found in 99 deaths at the time of its risk assessment in 2014⁽¹⁴⁾.

Despite the youth culture around drugs and accepting that drug use is drastically higher among club goers figures show that of drug related deaths only 8%⁽¹⁵⁾ were under age of 25 meaning there is a delay between fluctuations in drug use in society and noticeable/immediate effects. This latent effect shows a further insidious nature in the drug trade. This means that in the background of society there is an aging drug using population with compounding health issues, the true extend of which will not be apparent to the general public for years Drug mortality rates can be hard to quantify as along with direct deaths from overdose one must also consider somatic causes such as AIDs or depression stemming from addiction leading to suicide. A chilling fact is that under current legislation Ireland has consistently ranked among the top 5 drug induced mortality rates in Europe since 2000⁽¹⁶⁾

- 4) Drug laws have been lessened previously to good effect in Ireland. With the Heroin outbreak came a surge in HIV and hepatitis C. Europe has shown a steady decrease in HIV rates related to injected drug use⁽¹⁷⁾ with Portugal (decriminalised drugs) having noticeable decreases and only Spain having a noticeable jump. It should be noted that methadone is not a catch all answer as Ireland had in 2011 twice⁽¹⁸⁾ the number of deaths related to methadone (often in relation with other drugs) than heroin.

I find it hard to rationalize that respect for our Gardaí increases in people's eyes by the uneven enforcement of laws which affect those only by chance or by their poverty. Similarly one immediate benefit to be found will be the freeing up of valuable police resources and court time.

Depending on whether decriminalisation or legalisation occurs we could gain through taxation where previously this area has been a bottomless drain.

However I believe it is in the international aspect Ireland will most benefit. As the countries are changing their long standing positions we can choose to be at the forefront especially in Europe rather than play it safe and wait for other countries to take the brunt of external pressure or we can follow reason and be the example other countries follow suit and learn from.

If legalisation occurs the market, which has not been dampened will be able to choose controlled substances which have passed quality controls as any other drug does. No longer would purity fluctuate causing people to unsuspectingly take a quantity stronger than they were prepared for. Purity could be assured preventing poisoning and lessening the chance of overdose.

Takers will not only have a safety in knowing what they take is being made to higher standards but importantly production would also be more moral. Heroin would not fund the Taliban, cocaine would not fund southern American gangs. Drugs would be made by chemists wearing protective material in a plant rather than by the desperate, greedy or by those forced into production with no protection and god knows where.

I cannot stress that there is no reason to think we have suppressed drug use while we know (by the very of illicit material) we have provided funding to the worst among society and made have made organised crime stronger for it.

Even if we look at the situation in the most selfish and economic terms change is desirable. Ireland will be at the forefront of production and quality control for these drugs meaning that as other countries change their laws it will be our industries which have the head start and market control. All the while the money gained from these industries would be money not funding criminal organisations whether it be local criminals, Mexican cartels or Afghanistan Taliban.

- 5) To me though there is one issue at the heart of the matter. It is not the moral aspect that people should be free to choose to alter their own state of consciousness despite the hypocrisy involved in a world famous drinking culture which openly sells tobacco ban having such laws. Nor is it even that we currently have laws which cannot be enforced fairly and equally. While intellectually unpleasant these issues do not reach a scale of such that I would write this letter. One unavoidable fact is that we are repeating history at the expense of the weakest and most vulnerable for what I can only understand is stubbornness. For what reason can there be to keep such laws other than stubbornness? The belief that drug use is lowered because of them? In which case you would believe that over 23.3% of the population wish for the choice and still you refuse them their own decision. So while it is true we can wait patiently for other parts of Europe to take the first steps, so that we may follow in line behind them benefitting without having to bear the weight. I write this so those who choose us to stay as we are cannot pretend ignorance. The choice of inaction comes at a price, not merely the pride of a nation choosing hypocrisy or illogical choices, not the price of lost taxes (both those spend and those we won't gain) which are relatively small⁽¹⁹⁾, not even the price of our own citizens who suffer directly or indirectly from these laws but at price of the world's weakest. If you will not change these laws then I would ask you either tell me your logic which has you believe our current course minimizes the cost of the innocent bystanders, which somehow shows the current laws doing anything other than fund groups which who break any legal or moral code . If you cannot say that our laws decrease such atrocities then I ask you to explain why you wish to defend such laws. I believe we now have both an abundance of evidence to, even if we demonize the drugs themselves and/or the people using them, disband our current drug regulations with the confidence that they merely antagonize the situation, wasting taxes as well hours of police and legal work while increasing the profits of criminal organisations and funding their far more harmful transgressions. All the while we may reinvest a small fraction of the money to be saved, from disbanding the enforcement of the current rules, to be put to use in rehabilitation and care work. Even if one wished to punish drug users for breaking a law regardless of its ethical value we must accept that all data points such actions come at the cost of the "innocent society". Rehabilitation on the other hand decreases not only drug use but also adversities which are intrinsically linked to it. If you still believe that an individual should not have the legal right to consume certain drugs as chosen without scientific or moral consistency by the government then I ask that you should not punish them for such an action alone and instead act to minimize the numbers of those who would break such laws (regardless of their logic). If you would rather punish them than prevent their occurrence then I ask you consider the innocent you will harm as consequence. If you believe that the suffering of innocent bystanders (society as a whole) is a necessary evil for ensuring that a law is enforced I would advise you to ask forgiveness.

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Submission by Finglas Cabra Drug & Alcohol Task Force to the Joint Committee on Justice, Defense and Equality.

Introduction

The Joint Committee on Justice, Defense and Equality has decided to invite written submissions from interested groups or individuals in relation to arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use.

This call stems from a visit by a delegation of Committee members to Lisbon where an alternative approach was introduced 15 years ago.

These are some views on this matter from a Drug & Alcohol Task Force perspective on whether a similar approach should or should not be considered in Ireland. The views contained here are those that have come up in the course of our work. If some of them seem contradictory it is due to the complex nature of this aspect of policy and the difficulty many find in avoiding moralistic positions.

After 18 years of work in Finglas Cabra we would now see the need for the law on the possession of drugs for personal use to be changed so that health and social consequences of personal drug use can be given the priority in Irish public policy. How this is done is by no means straight forward and needs to be approached in a manner that does not bring about other unintended consequences.

Finglas Cabra Drug & Alcohol Task Force

Our Task Force was set up in 1997 to develop a coordinated and integrated response to what was then described as a heroin epidemic clustered in some of the most socio-economically deprived areas of Ireland.

All of the official evaluations and many academic studies of the Task Forces and the community based drug initiatives they have produced indicate that this approach to the heroin epidemic was relatively successful in stemming the tide of this epidemic. We continue to work on the legacy of this epidemic which many individuals and families in our area are living with.

Factual information for the Committee to consider

In 2013 our Task Force carried research into licit and illicit drug use patterns in the Finglas Cabra Drug and Alcohol Task Force area. As part of the field research for this study local drug users reported that they used a wide range of drugs on a daily basis and in accordance with the mood alteration being sought. These drugs were also being used in various combinations. The overall sense coming from the drug users who were interviewed was that these drugs were widely available, they were getting cheaper and they were increasing in quality. Most drugs were being purchased via mobile phone with internet coming more to the fore as a supply route. Illicit drugs can now be purchased in a similar fashion to that of ordering a pizza for delivery to your home.

Despite the current law and the dedicated efforts of our Gardaí the advent of mobile and internet communications is making access to a continually widening range of illicit drugs by a growing number of people easier. Most of these people are not criminals and should not be brought into contact with the criminal justice system. Instead they should be directed toward help if they have a drug use problem and informed about the potential risks to their health and the health of others from their drug use. The Garda currently do this if they encounter a person on the street with alcohol and small quantities of illicit drugs.

Finglas Cabra lies within the Garda Dublin Metropolitan West area. In the years from 2004 to 2011 there were 8818 offences recorded for possession for personal use (CSO). Starting at 215 offences in 2004 and peaking at 1,823 in 2009, a 75% increase over the period. A

change in the law on possession would free up the considerable amount of Garda time and resources in processing these offences. These resources could be diverted into targeting higher level drug dealers and their criminal networks. It would also make resources available for treatment and other drug related public health supports.

A change in the law would also have the effect of taking the individuals connected with these 8,818 offences away from the criminal justice system and the personal implications this may have for them if their case goes beyond a Garda warning.

A downside of changing the current law is that Gardaí would no longer have the power to disrupt retail drug dealing at local level by confiscating drugs purchased for personal use. A change in the law on possession would reduce this power and could make life difficult for residents in areas where there is high concentrations of drug dealers (such as in Local Drug & Alcohol Task Force areas).

One of the most important benefits of changing the law in regard to personal use would be its impact on reducing drug related deaths. Drug users would feel safer about getting drugs they are unfamiliar with tested. This would reduce the possibility of life threatening situations developing. The Portuguese model has allowed services of this nature to be provided at night clubs, music festivals etc.

Recommendations to the Committee

In principal the consensus of opinion within our Drug Task Force would be for the Minister to begin work on setting out how a Portuguese like model could be implemented in Ireland and the details of the law changes that this would require. With a view to seeking cross party support for its introduction in the next Dáil period.

While this is being done the Dáil committee should seek the extension of the Spent Convictions Bill (2012) to cover possession for personal use convictions and small scale supply convictions below €13,000 if there are no other convictions within a 5 year period post release.

End