

# 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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