



House of Commons
Home Affairs Committee

Drugs: Breaking the Cycle

Ninth Report of Session 2012–13

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Volume II: Oral and written evidence

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Home Affairs Committee

The Home Affairs Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Home Office and its associated public bodies.

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Key facts

- England and Wales has almost the lowest recorded level of drug use in the adult population since measurement began in 1996. Individuals reporting use of any drug in the last year fell significantly from 11.1% in 1996 to 8.9% in 2011–12. There was also a substantial fall in the use of cannabis from 9.5% in 1996 to 6.9% in 2011–12.
- The prevalence of drug use among 11 to 15 year olds has also declined since 2001. In 2010, 18% of pupils reported that they had ever taken drugs and 12% said they had taken drugs in the last year, compared with 29% and 20% in 2001.
- Around four in five adults (78%) who had taken any illicit drug in the last year thought it was very or fairly easy for them to personally get illegal drugs when they wanted them: around a third (34%) thought it was very easy and 44% thought it fairly easy. Adults who had not taken any illicit drug in the last year perceived a slightly lower level of ease of obtaining illegal drugs if they wanted them (75% perceived it to be very or fairly easy to obtain drugs compared with 78% of those that had taken drugs in the last year).
- Around 50% of all organised crime groups are involved in drugs and 80% of the most harmful groups are involved in drugs predominantly in importation/supply of class A drugs.
- Drugs account for some 20% of all crime proceeds, about half of transnational organized crime proceeds and between 0.6% and 0.9% of global GDP. Drug-related profits available for money-laundering through the financial system would be equivalent to between 0.4% and 0.6% of global GDP.

1 Introduction

Recommendations from the last Home Affairs Committee report on drugs policy

1. The last time the Home Affairs Committee looked at drug policy as a whole was in 2002, though more recent inquiries have touched on specific aspects of drug policy.¹ We decided it would be appropriate to look again at this whole matter, and see what significant changes, if any, have taken place here and in other countries since then. As part of this inquiry, we asked the House of Commons Library to produce a note, which is appended to this Report, examining the implementation of the recommendations from the 2002 report.

Drug driving

We recommend that techniques to test drivers for drug-related impairment are improved, and that all police officers responsible for testing receive the necessary training. (Para 99)

2. We welcome clause 27 of the Crime and Courts Bill, currently before the House of Lords, which introduces a new offence of driving, or being in a charge of a motor vehicle, with concentrations of specified controlled substances in excess of specified levels. It will sit alongside the offence of being unfit to drive while under the influence of drugs in the Road Traffic Act 1988. However, concerns have been expressed about the impact the Clause would have on those taking drugs which had been legitimately prescribed, especially in the case of opiate painkillers, where long-term users who suffer chronic pain might in the fullness of time end up on quite high doses to offset the body's habituation to the drug.² There were also concerns that the length of time that traces of a drug remain in the body may adversely affect some people. **The Department for Transport has set up a panel of experts to advise on those drugs which should be covered by the new offence driving with concentrations of drugs in excess of specified levels and, for each drug, the appropriate maximum permissible level of concentration in a person's blood or urine. We believe that this maximum should be set to have the equivalent effect on safety as the legal alcohol limit, currently 0.08 mg/ml.**

Increase in treatment places

We recommend that the number of treatment places for cocaine users is substantially increased. We recommend that resources are channelled into researching and piloting innovative treatment interventions for cocaine users. (Para 140)

As with cocaine, we recommend that more treatment places are created for crack users and that resources are channelled into researching and piloting more effective

1 For example, Seventh Report of 2009–10, *The Cocaine Trade*, HC 74.

2 HL Deb, 4 July 2012: Col 765–766

treatments. We further recommend that in the meantime efforts are redoubled to extinguish supply of crack cocaine. (Para 147)

We recommend that the Government substantially increases the funding for treatment for heroin addicts and ensure that methadone treatments and complementary therapies are universally available to those who need them. We recommend that the guidance on the correct dosage of methadone to be used is strengthened. (Para 161)

We recommend that the broadest possible range of treatments is made available to opiate users, and that all treatments and therapies should have abstinence as their goal. (Para 164)

3. There are currently 197,110 people in treatment for drug addiction.³ Roughly 165,000 of those will be addicted to heroin or crack cocaine (or both). The rest are being treated for addiction to cocaine, cannabis, ecstasy and other drugs.⁴ Waiting times have also improved, according to the National Treatment Agency. In 2011–12:

97% [of patients] waited no more than three weeks from referral to first appointment, up from 96% in 2010–11. In 2005 the average wait for the first appointment was nine weeks; in 2012 it is just five days.⁵

There are estimated to be 306,000 heroin and/or crack dependent users⁶ so at least half of those are in treatment at present. By contrast, it is estimated that only a fifth of heroin or crack dependent users are in treatment in countries such as the United States and Sweden.⁷ Of those in treatment in the UK, 81% are either dependent on heroin alone or a combination of heroin and crack cocaine. Cannabis and cocaine accounted for just 8% and 5% of those in treatment.⁸

Changing patterns of demand for treatment

4. Illicit drug use is, in fact, falling—according to the crime survey of England and Wales, it is at almost its lowest level since measurements began in 1996⁹—but the types of drugs that people are seeking treatment for has changed. This is especially true of the 18–24 age group, among whom heroin use has fallen sharply to about a third of the level it was at six or seven years ago. However, in the same time-period, the significantly smaller number of young people seeking treatment for problem cannabis use has risen by around a third, from 3,328 in 2005–06 to 4,741 in 2011–12.¹⁰ Cannabis was downgraded from a Class B drug to a Class C drug in 2004 and re-classified as a Class B drug in 2009. The 2012 Global

3 National Treatment Agency, *Drug Treatment 2012: Progress Made, Challenges Ahead* (September 2012), p 6

4 Ibid, p 5

5 Ibid, p 7

6 Ev 122, para 2.1

7 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 231

8 National Treatment Agency, *Drug Treatment 2012: Progress Made, Challenges Ahead* (September 2012), p 6

9 Home Office *Drug Use Declared* (2nd edition), (September 2012), p 7

10 National Treatment Agency, *Drug Treatment 2012: Progress Made, Challenges Ahead* (September 2012), p 8

Drug Survey which measured the prevalence of drug use from a self-selecting, and therefore probably unrepresentative, sample of 7,700 UK drug users found that a third of respondents had taken prescription drugs in conjunction with illicit drugs¹¹ and that 19% of 18–25 year olds had taken a ‘mystery white powder’ without being sure of what it contained.¹²

5. The Royal College of Psychiatrists also notes the growth in the use of “club drugs”¹³, abuse of over-the-counter medications and prescription medications, and internet sourcing, arguing that these trends should inform the future development of drugs policy.¹⁴ The Club Drug Clinic at the Chelsea and Westminster Hospital was opened in September 2011, and is the country's only open-access clinic for the users of club drugs. By March 2012, it was treating more than 200 patients.¹⁵ The Angelus Foundation highlighted the importance of such a clinic

One of the difficulties is that a lot of these new substances are addictive and they have awful side effects, and the kids have nowhere to go to get help, absolutely nowhere. That is something else that we need to look at. The parents are just bemused and bewildered [...] one of the toxicologists said there has been an increase in the incidence of hanging. There have been a lot of young deaths associated with that, and they suspect that it may be attributable to some of these substances. The fact is we don't know what the long-term harms are because there is no research, but there is a whole generation of kids waiting to go down the drug route and cost the taxpayers a fortune.¹⁶

The criminal justice benefits of treating those dependent upon heroin or crack cocaine as a priority are obvious. Dr Bowden-Jones, who runs the club drug clinic, told us that club drugs have very low rates of associated criminality, and that the majority of people who came into the Club Drug Clinic were working and had family networks and social networks.¹⁷ However, the priorities for the provision of drug treatment must include the health of the dependent user, as well as the reduction of local crime rates. The introduction of Health and Wellbeing Boards, which we discuss below, will provide for treatment places to be allocated at a local level.

6. The Government is already aware that there is a change in need. Its 2010 Drug Strategy notes that groups of people “who would not fit the stereotype of a dependent drug user” are presenting for treatment in increasing numbers. These individuals are often younger

11 The Guardian, *Recreational drug users take medicines to control side-effects, survey finds*, (March 2012)

12 The Guardian, *Truth about young people and drugs revealed in Guardian survey*, (March 2012)

13 That is, drugs which are used predominantly by teenagers and young adults in social settings such as nightclubs. This includes ecstasy, methamphetamine, LSD, ketamine, GHB and Rohypnol among others. The common feature of these drugs is the social setting in which they are used, not their psychoactive properties or associated risks.

14 Ev 143

15 Q168

16 Q113

17 Q178

and are more likely to be working and in stable housing.¹⁸ The Government must ensure that provision for these individuals is appropriate and responsive to their needs.

7. The establishment of Health and Wellbeing Boards under the Health and Social Care Act 2012 provides an opportunity to tailor drug treatment services more closely to local needs. It is important that local provision should not develop into a “postcode lottery”, where the availability of drug treatment is inadequate in those areas where drug use is not generally regarded as a significant problem. On the other hand, there is the risk that interventions by central Government which are intended to promote equality of access to services could stifle Boards’ localised decision-making. **We recommend that the Government continue to monitor the decisions of the Health and Wellbeing Boards as to allocation of treatment places, recording each request, monitoring waiting times to enter treatment and assessing the success rate of those dependent on different drugs. The Government should publish this information in an easily accessible and understandable format and consider developing a league table of Health & Wellbeing Boards’ performance on local drugs provision while taking care in selecting assessment criteria not to introduce perverse incentives into the decision making process. This will allow Boards to benchmark their provision against each other, having due regard to local need.**

Treatment in prisons

We recommend that appropriate treatment forms a mandatory part of custodial sentences and that offenders have access to consistent treatment approaches within the prison estate as well as outside it. This should include strictly supervised methadone treatment in the first instance, as the most effective treatment available. (Para 169)

8. There are positive developments which we have identified in individual prisons but there are also still a number of issues with treatment for drug dependence within the prison service and we expand upon those in detail below. However, we use this opportunity to note the need for services which also address alcohol dependence. The annual report of Her Majesty’s Inspectorate of Prisons recently found that the provision of alcohol treatment was variable: in one prison where 30% of the population had an alcohol problem directly related to their offending, prisoners were unable to access an accredited alcohol or drug programme.¹⁹

Prescribing diamorphine (heroin)

We recommend that a proper evaluation is conducted of diamorphine prescribing for heroin addiction in the UK, with a view to discovering its effectiveness on a range of health and social indicators, and its cost effectiveness as compared with methadone prescribing regimes. (Para 178)

18 Home Office, *The drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* (2010), p 6

19 Her Majesty’s Inspectorate of Probation Annual Report 2011–12, p 60

9. The Government's 2010 Drug Strategy stated that it would "continue to examine the potential role of diamorphine prescribing for the small number who may benefit, and in the light of this consider what further steps could be taken, particularly to help reduce their re-offending." A 2010 study found that treatment with supervised, injectable heroin leads to significantly lower use of street heroin than does methadone. It recommended that "UK Government proposals should be rolled out to support the positive response that can be achieved with heroin maintenance treatment for previously unresponsive chronic heroin addicts."²⁰ When medical heroin was prescribed regularly in Switzerland, half of those who received treatment were also in regular employment.²¹ There have been six studies in the UK over the past 15 years, all showing the benefits of prescribing diamorphine in the small number of cases where chronic heroin users do not respond to traditional treatment.²² Diamorphine prescribing is still rare despite evidence of its effectiveness.²³

10. New evidence which has emerged in the decade since our predecessor Committee's Report on drugs suggests that diamorphine is, for a small number of heroin addicts, more effective than methadone in reducing the use of street heroin. It is disappointing therefore that more progress has not been made in establishing national guidelines for the prescription of diamorphine as a heroin substitute. We recommend that the Government publish, by the end of July 2013, clear guidance on when and how diamorphine should be used in substitution therapy.

Education and prevention

We acknowledge the importance of educating all young people about the harmful effects of all drugs, legal and illegal. Nonetheless, we recommend that the Government conducts rigorous analysis of its drugs education and prevention work and only spends money on what works, focussing in particular on long term and problem drug use and the consequent harm. (Para 211)

11. We highlight this recommendation as an issue which still requires attention – this is the strand which seems to have the lowest priority in the Government's 2010 Drug Strategy. The Strategy, which aims to reduce demand, restrict supply and support and achieve recovery, announces that the Government will establish a whole-life approach to preventing and reducing the demand for drugs that will:

break inter-generational paths to dependency by supporting vulnerable families;

provide good quality education and advice so that young people and their parents are provided with credible information to actively resist substance misuse;

use the creation of Public Health England (PHE) to encourage individuals to take responsibility for their own health;

20 Strang, et al, 'Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial'. *The Lancet*, vol. 975 (2010)

21 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, (2010), p 73

22 King's College London Addictions Department, *RIOTT*, (<http://www.kcl.ac.uk/iop/depts/addictions/research/drugs/riott.aspx>)

23 Ev w336; Ev w362

intervene early with young people and young adults;
consistently enforce effective criminal sanctions to deter drug use; and
support people to recover.²⁴

12. Despite this, the UK annual reports to the European Monitoring Centre for Drugs and Drug Addiction reveal that public expenditure on drugs education decreased from £5.4 million in 2006–07 to £0.5 million in 2010–11.²⁵ In addition, central government support for the national Continual Professional Development training for drug education has been cut, and the Tellus Survey, which collected school-level data on young people's drug use amongst other health and well-being measures has been stopped.²⁶ We consider this issue in more detail below (see paragraphs 62 to 81).

The aims of drugs policy

13. There are a number of harms associated with the recreational use of drugs, whether legal or illegal.²⁷

- a) Direct damage to the health of drug users, the nature and severity of which varies enormously from drug to drug, depending also on dose and purity. Ketamine, for example, can cause severe and irreversible damage to the bladder; cocaine use accelerates the development of coronary artery disease and can precipitate acute cardiovascular events; and ecstasy (MDMA) can in some cases lead to severe hyperthermia or sudden death.
- b) Health risks associated indirectly with drug use, particularly intravenous drug use, including the spread of blood-borne viruses such as HIV and hepatitis C and the impact of drug-related violence, which is a particular problem with alcohol. Some drug addicts turn to sex work to fund their habit, thereby exposing themselves to additional risks to their health and personal safety.
- c) Acquisitive crime—mostly robbery and burglary—committed by addicts to fund their habit.
- d) Crime associated with the production, importation, distribution and supply of illegal drugs, much of which is serious and organised. International drug trafficking is also associated with people trafficking, terrorism, the clandestine trade in firearms, political corruption and a wide range of other major, global, criminal threats.

24 Home Office, *The drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* (2010), p 9

25 That is, public spending on drugs which is classified as "education". There may be other sources of expenditure on drugs education which are classified differently. See Ev 117 [Mentor written evidence]

26 Ev 118, para 3.4 [Mentor]

27 The Drug Equality Alliance argued that there are no such things as "illegal drugs" (Ev w239). In this Report, we use the term, which we believe is readily comprehensible to the ordinary reader, to describe controlled drugs within the meaning of s. 2 of the Misuse of Drugs Act 1971. The Act restricts the import, export, supply, possession and (in the case of cannabis) cultivation of such drugs.

- e) Social exclusion: not all drug users are addicted and not all addicts are unable to function as a productive member of society but, at its worst, addiction (or other forms of problem drug-use) can result in behaviour which can be destructive to the individual and others. This can include criminal behaviour, excessive risk-taking and an inability to care for children, maintain employment, or participate fully in society.
- f) Issues with the environment: the destruction of the rainforest through the clearing of areas to plant coca leaf, the introduction of the harsh chemicals used in the making of different drugs into the local eco-system and the impact of aerial fumigation on soil and ground water.

14. Drug use can lead to harm in a variety of ways: to the individual who is consuming the drug; to other people who are close to the user; through acquisitive and organised crime, and wider harm to society at large. The drugs trade is the most lucrative form of crime, affecting most countries, if not every country in the world. The principal aim of Government drugs policy should be first and foremost to minimise the damage caused to the victims of drug-related crime, drug users and others.

2 Global drugs policy

History of international drugs control

15. The first international drugs control treaty was the 1912 International Opium Convention, which gained widespread adherence after the First World War after it was incorporated into the Treaty of Versailles and connected treaties. Other international agreements aimed at limiting the international supply of narcotics were concluded between the wars and in 1946, ownership of these agreements passed from the League of Nations to the newly-created United Nations. In 1961, the first UN Single Convention on Narcotic Drugs (later amended by the 1972 protocol) was agreed. It covered opiates, cannabis and drugs derived from the coca plant. The 1971 Convention on Psychotropic Substances expanded the coverage to include psychoactive drugs such as amphetamines, barbiturates, benzodiazepines, and psychedelics. The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances established legal mechanisms to support the earlier conventions such as restrictions upon precursor chemicals and asset seizure and extradition relating to drugs offences.

16. The International Narcotics Control Board (INCB) is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. It was established in 1968 in accordance with the 1961 Convention. Its role is to ensure that adequate supplies of drugs are available for medical and scientific uses and that the diversion of drugs to illicit channels does not occur. It also identifies weaknesses in national and international control systems and contributes to correcting such situations and is responsible for assessing chemicals used in the illicit manufacture of drugs, in order to determine whether they should be placed under international control.²⁸

17. Established in 1997, the United Nations Office on Drugs and Crime (UNODC) is the lead United Nations entity for delivering legal and technical assistance to prevent terrorism, the illicit trade in drugs and international crime. Based in Vienna, UNODC operates 54 field offices around the world, covering more than 150 countries, including an office in Bogota, which we visited while we were there. UNODC relies on Member States to fund efforts to tackle crime, drugs and terrorism worldwide. They also receive financial support from multi-donor trust funds, other United Nations entities, international financial institutions, private foundations and other organizations. Their 2010 annual report notes that “in 2009, as a consequence of the global financial crisis, UNODC experienced a sharp decline of 26% in general purpose income.”²⁹ Their budget for 2009 (the latest year for which data is available) was US\$243 billion.³⁰

28 <http://www.incb.org/incb/en/about/mandate-functions.html>

29 United Nations Office on Drugs and Crime Annual report 2010, p 63

30 Ibid, p 64

The unintended consequences of drugs policy

18. In 2008, the then-executive director of the United Nations Office on Drugs and Crime, Antonio Maria Costa, described the five unintended consequences of the international drug control system:³¹

- a) The development of a huge, highly profitable, criminal black market, in which hundredfold increases in price from production to retail are not uncommon.
- b) Policy displacement, specifically the redirection of public resources from public health programmes to law enforcement.
- c) Geographical displacement—also known as the “balloon effect”—whereby tough measures to tackle the production and supply of drugs in one area result in increased production and supply elsewhere (even if the overall result is a net decrease). Mr Costa cited the shift in Andean coca production from Peru and Bolivia to Colombia in the 1990s as an example, but during our visit to Bogota (four years after Mr Costa gave his speech), we saw evidence that tough enforcement measures in Colombia were pushing production and supply back in the opposite direction.
- d) Substance displacement,³² which occurs when effective measures to combat the supply of or demand for one drug results in increased supply of or demand for another. We saw examples of this in Florida, where a stepping-up of law-enforcement action against the supply and use of cannabis had been followed by a growth in so-called “pill mills”, medical clinics operating at or beyond the border of legality to supply excessive quantities of psychoactive drugs, such as oxycodone.
- e) The exclusion and marginalisation from the social mainstream of those who use illicit drugs. This fifth unintended consequence is the way we perceive and deal with the users of illicit drugs. A system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalized from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when they may be motivated to want it.

Current international drugs policy

19. Drug Policy is an issue which affects almost every country in the world, whether as source, transit or consumer countries. According to the UNODC, the largest consumer region is North America (44% of total retail sales), followed by Europe (33%), although no region is spared. Patterns of consumption are constantly changing. In recent years, cocaine use has declined in North America and grown in Europe, whereas heroin use has stabilised or fallen in Europe but has increased in some transit countries. Sources of drugs are spread around the world—cannabis is cultivated widely, but with concentrations in Africa and the

31 United Nations Office on Drugs and Crime, *Making drug control fit for purpose: Building on the UNGASS decade* (2008), p 10-11

32 The term, “balloon effect” is also sometimes used to describe substance displacement.

Americas; Asia is the largest source of opiates; cocaine is produced almost exclusively in South America and synthetics are produced in Europe, Asia and North America.³³

20. The supply and transit of drugs is a major threat to the governance structures of the countries concerned. The Mexican drug wars, which have resulted in more than 50,000 deaths since the mid-2000s, are an extreme example of the toxic mix of armed conflict and political corruption that affects several countries in South and Central America, Africa and Asia.³⁴

21. In 1998, the UN held a General Assembly Special Session (UNGASS) on drugs at which they agreed a number of ten-year targets. None of these targets was successful. In a response to the 2008 UNODC World Drugs Report, the Transnational Institute said

The world today is not any closer to achieving the ten-year targets set by the 1998 UN General Assembly Special Session (UNGASS) on drugs. These goals were “eliminating or significantly reducing the illicit cultivation of coca bush, the cannabis plant and the opium poppy by the year 2008.” Instead global production of opiates and cocaine has significantly increased over the last ten years. According to the United Nations Office on Drugs and Crime (UNODC) global illicit opium production doubled from 4,346 tons in 1998 to 8,800 tons in 2007. This is mainly due to the massive increase in opium production in Afghanistan. The estimated global cocaine production increased from 825 tons in 1998 to 994 tons in 2007, an increase of 20%.³⁵

22. The continuing illegal trade in drugs is leading some world leaders to question the viability of the criminalisation of users. In 2009, three former Latin American presidents—Fernando Henrique Cardoso of Brazil, César Gaviria of Colombia (whom we met informally during our visit to Colombia), and Mexico's Ernesto Zedillo—announced that the war on drugs had failed and that it was time to discuss alternative approaches. This was followed by a 2011 Report which called for the decriminalisation of drugs. The Report was produced by the Global Commission on Drug Policy, an independent body funded by a number of private sources, including George Soros's Open Society Foundations, the Drug Policy Alliance (an organisation which campaigns for drug-law reform in the USA) and Richard Branson's Virgin Unite. The Report was signed by those same former presidents, as well as Ruth Dreifuss, former President of Switzerland; George Papandreou, former Prime Minister of Greece; Kofi Annan, former secretary-general of the United Nations; George P. Shultz, former US Secretary of State, and Paul Volcker, former Chairman of the US Federal Reserve. Since then, a number of current Latin American Presidents have called for reform. It is important, however, to put this campaign in perspective as despite continued debate on the potential benefits and disbenefits of decriminalisation over the last decade and more, in the majority of countries it is the settled policy of governments that illicit drug use will remain criminalised for the foreseeable future.

33 United Nations Office on Drugs and Crime, *World Drug Report* (2012), p 66

34 Stockholm International Peace Research Institute, *Maritime Transport and Destabilizing Commodity Flows* (January 2012), p 1

35 The Transnational Institute, *Rewriting history: A response to the 2008 World Drug Report*, (June 2008), p 1 (<http://www.tni.org/briefing/rewriting-history>)

23. In March 2012, we travelled to Bogotá, Colombia, to meet President Juan Manuel Santos, Minister of the Interior Germán Vargas Lleras, and National Defence Minister Juan Carlos Pinzón Bueno. President Santos told us that in his opinion the war on drugs was the source of many of Colombia's problems—terrorism, corruption and criminal violence. He also stated that after a period of collective denial, the Colombian people had woken up to the problem and, with international support, had managed to make progress. However, they had paid a high price. The country had lost many of its best judges, police officers, journalists and politicians but had made progress by any standards. He advocated an international debate about the best way to tackle the drugs problem. He was open to the possibility that the *status quo*, or something like it, might eventually emerge as the best way forwards, but the possibility of a different approach to the war on drugs had to be considered. He was of the view that whatever the outcome, only a co-ordinated, global drugs policy would be successful. The drugs trade only thrived because it was profitable—targeting the profits of organised crime, much of which was in North American and European financial institutions, should be a central part of international efforts to tackle the drugs trade.

24. The President stressed throughout our discussion that he was not advocating the legalisation of drugs, but the establishment of a new international consensus around the best way to tackle the problem. He was, however, keen to emphasise that legalisation should not automatically be ruled out as a possible part of a global solution. He pointed out that whereas in consumer countries such as the UK, the problems created by the consumption of illegal drugs were predominantly associated with health and crime, in supplier countries such as Colombia, they were problems of national security. It was brought home to us by several of those we met in Colombia how close the country had come to falling entirely under the control of the drugs cartels; this is clearly a world away from the problems of addiction and acquisitive street crime which are associated with the drugs trade in the UK.

25. The Committee saw for itself during its visit to Colombia the effect of the drugs trade on producer and transit countries—the lives lost, the destruction of the environment and the significant damage caused to governance structures by corruption and conflicts. We recognise and sympathise with the immense suffering and slaying of innocent people which tragically has taken place over the years in Colombia and other Latin American countries, as a result of the murderous rivalry between drug gangs.

26. Bolivia has already in effect withdrawn from the 1961 Single Convention.³⁶ The country intends to re-accede the treaty in January 2013, with a new reservation that gives legal protection for the traditional use of the coca leaf (which, in its unprocessed form, is chewed and made into tea) but this will only happen if two thirds of all parties to the Convention do not express objections. Whether Bolivia would still decide to re-accede if that reservation were not accepted, remains to be seen.³⁷ The International Narcotics Control Board was critical of the move in its 2011 annual report, arguing that if other state parties were to follow the mechanism of denunciation and reaccession, “the integrity of the

36 Babor et al, *Drug Policy and the public good*, (Oxford University Press, 2010), p 16

37 The Transnational Institute, *Fact Sheet: Coca leaf and the UN Drugs Conventions* (October 2012) (<http://www.tni.org/briefing/fact-sheet-coca-leaf-and-un-drugs-conventions?context=595>)

international drug control system would be undermined and the achievements of the past 100 years in drug control would be compromised”.³⁸

27. We believe it is important that countries remain inside the Single Convention on Narcotic Drugs of 1961, rather than entirely outside it. We therefore believe that Bolivia should be allowed to re-accede to the Convention, with the reservation they require for traditional practices. We recommend that the UK Government support this position and encourage other countries to do likewise.

28. The UN General Assembly has recently approved a resolution to hold a General Assembly Special Session to review current policies and strategies to confront the global drug problem. The session will take place at the beginning of 2016 after an intense preparatory process which will begin next year. The draft resolution, which was presented by Mexico, was co-sponsored by ninety-five United Nations member countries including various countries in Latin America and the Caribbean and in the European Union, as well as Japan, China, Australia, and the United States.³⁹

The impact of globalisation on the drugs trade

29. In 1999, the then-Secretary General of Interpol was quoted by UNESCO as saying

Globalization and its many manifestations mean that borders of all sorts are becoming increasingly difficult for governments to define, let alone maintain. International drug trafficking has been aided by the explosion in computer and telecommunications technology and by world-wide transport systems. These same facilities, as well as advances in the banking and services sectors also benefit money launderers. There is no doubt that the illegal trade in narcotics is being regular economy on a national as well as an international level. This situation makes combating of the drug trade on a financial front all the more difficult.⁴⁰

In 2007, trade in illegal drugs was estimated at five to six percent of overall world trade, which is slightly larger than the combined global trade in agricultural products and cars.⁴¹

30. Between 80% and 90% of globally traded goods are transported by sea. Maritime transport of goods has quadrupled in the past 40 years. The global shipping network is the dominant method of transporting illicit goods, including drugs.⁴² Part of the reason for this is the growth in the use of containerised shipping—containers conceal their cargo, they have few distinguishing features and thousands go through the world’s busiest container

38 International Narcotics Control Board Annual Report 2011 (February 2012)

39 Press Notice from Mexican Government, *La Asamblea General de la ONU aprueba resolución presentada por México sobre cooperación internacional contra las drogas*, (November 2012) Accessed November 2012: <http://saladeprensa.sre.gob.mx/index.php/es/comunicados/2149-351>

40 <http://www.unesco.org/most/sourdren.pdf>

41 Yale Centre for the Study of Globalisation (YaleGlobal), *Globalization and the Corrupt States*, (November 2007) Accessed November 2012: <http://yaleglobal.yale.edu/content/globalization-and-corrupt-states>

42 Stockholm International Peace Research Institute, *Maritime Transport and Destabilizing Commodity Flows*, (January 2012), p 1

ports each day. Despite this, the UNODC estimates that only 2% of containers are inspected.⁴³ A recent report in to trends in maritime trafficking stated

The growth in container shipping has been exploited by drug trafficking organizations whose own cargo ships were increasingly targeted by air and sea operations involving the US Coast Guard, the US Drug Enforcement Administration (DEA) and European law enforcement agencies. In 1999 a US intelligence study noted that the rapid growth in containerized sea transport offered narcotics traffickers ‘simplicity and convenience’, stating that containers were the most ‘cost effective’ method.⁴⁴

31. Also in 1999, the World Customs Organization reported that 64% of the cocaine seized globally was intercepted in maritime containers. By 2010 more than 80% of the cocaine seized on its way into Spain was in shipping containers. In 2010, the US State Department assessed it as the most cost-effective and lowest risk method of transporting cocaine to distribution centres in Europe and the USA.⁴⁵ The containers are often transported on ships which are owned by mainstream shipping companies based in EU, NATO or OECD member states and without the knowledge of the ship’s owner, operator or officers.⁴⁶

32. As a result of the prevalence in maritime transport in the trafficking of drugs, there are several joint operations involving a number of countries which cover the Atlantic, the Caribbean and the eastern Pacific. The Joint Interagency Taskforce South (JIATF-South) is based in Florida and is thought to have been responsible for more than 40 %of global cocaine interdiction in 2009.⁴⁷ JIATF-South includes personnel from the US armed forces, law enforcement and intelligence agencies, as well as representatives from Argentina, Brazil, Canada, Chile, Colombia, the Dominican Republic, Ecuador, El Salvador, France, the Netherlands, Peru, Spain and the UK. We were, however, informed that UK practical assistance by the Royal Navy had been dramatically reduced following the strategic defence spending review.

33. In Europe, the Maritime Analysis and Operations Centre (Narcotics) (MAOC(N)) performs a similar function and works closely with the US Joint Interagency Taskforce (which has observer status in MAOC). We visited MAOC’s Lisbon headquarters in March 2012. The Centre was established in 2007, and its focus is on using intelligence to guide the interception of vessels carrying cocaine and cannabis. Much of this cargo comes across the Atlantic from South America to West Africa, where it is processed and packaged for onward shipment to Europe and elsewhere. The number of maritime seizures attributable to MAOC’s work had fallen, following its early success which owed much to the Serious

43 UNODC, *Countering the world of smuggling through container control*, (May 2011) Accessed November 2012: <http://www.unodc.org/unodc/en/frontpage/2011/May/countering-the-world-of-smuggling-through-container-control.html>

44 Stockholm International Peace Research Institute, *Maritime Transport and Destabilizing Commodity Flows*, (January 2012), p 37

45 Stockholm International Peace Research Institute, *Maritime Transport and Destabilizing Commodity Flows*, (January 2012), p 37

46 Ibid, p 49

47 Munsing, E. and Lamb, C. J., ‘*Joint Interagency Taskforce-South: The Best Known, Least Understood Interagency Success*’, Center for Strategic Research Strategic Perspectives 5 (National Defense University Press: Washington, DC, June 2011), p 3

and Organised Crime Agency (SOCA) and its historically successful bilateral co-operation with Spanish and Portuguese authorities, and changes to smugglers' methods. This is despite the number of "vessels of interest" rising significantly from around 10 in 2007 to over 100 in 2010.

34. Data about maritime trafficking, maritime pollution, ship safety, vessel traffic and fisheries protection data can be combined to build a more accurate picture of trafficking flows. The Stockholm International Peace Research Institute has argued that EU Member States and institutions should create an information-sharing mechanism for lists of suspect ships and shipments that could be integrated into other EU systems as part of a wider holistic approach to maritime security and the enforcement of EU arms embargoes.⁴⁸

35. We were concerned to discover that the Maritime Analysis and Operations Centre (Narcotics) has seen a sharp fall in its rate of drug interdiction and now faces an uncertain future over its funding, 95% of which is currently provided by the European Commission. Gathering reliable intelligence about the maritime trafficking of illegal drugs is a crucial part of the international fight against the drugs trade. While recognising that this is not a matter for the UK Government alone, we urge the Government to work with both EU countries and other key international partners to ensure more effective drug interdiction in the future.

36. Policies governing trade, such as import duty and inspection regimes, regulations placed on shipped goods, and the ease of travel and contact between citizens of different countries, will have an impact on illicit trade as well as on legitimate trade.⁴⁹ Although it has less of an effect, the increasing ease of international migration has also affected the drugs trade, especially within the EU. SOCA, which conducts operations against British criminals involved in the drugs trade in other EU countries, told us that

organised criminals are entrepreneurial, agile and resilient. They operate like businesses and do not respect regional, national or international boundaries, managing the risk they face from other criminals and law enforcement, including by changing commodity, location, changing supply routings and modus operandi according to opportunity and risk.⁵⁰

37. The outcome of law enforcement action against such organisations, rather than dismantling them, can sometimes result in them simply transferring their base of operations. The Agency cautions that criminal organisations will change their operating methods or physical location in response to police intervention, citing the example of successful SOCA operations against British gangs abroad.

operational activity does not cease when arrests have been made. Such displacement often forces organised crime groups to alter their operating methods or change their physical location, therefore making themselves more vulnerable to law enforcement intervention. For example, it is known that law enforcement activity, targeting Class

48 Stockholm International Peace Research Institute, *Maritime Transport and Destabilizing Commodity Flows*, (January 2012), p 49

49 Babor et al, *Drug Policy and the public good* (Oxford University Press, 2010), p 253

50 Ev 129, para 4

A drugs and associated criminal finances in Spain and the Netherlands has resulted in some British criminals relocating from these countries. SOCA-led activity continues to put pressure on organised crime groups through a number of approaches ranging from financial investigation through to more non-traditional techniques.⁵¹

This is one example of the displacement, or ‘balloon’ effect.

The balloon effect

38. Black markets do not respect borders, so in an era characterized by globalisation the development of a global drug policy might be the most effective way to combat drug production, trafficking and consumption. The issue often faced by national counter-narcotics operations is that when one area of production or route of trafficking is disrupted, production simply shifts to other locations, and trade to other routes. The United Nations Development Programme in Colombia described the balloon effect this way:

The economic mechanism underlying the global effect is quite simple: the success of eradication in one area temporarily reduces the supply, and that translates into a price rise. Then, given that the supply function is fairly [price] elastic, higher prices stimulate people to plant crops in other places. The costs to start planting are quite low given that the majority of property rights on land planted with illicit crops are ill defined.⁵²

39. One example of this is the evolution of cocaine production and trafficking routes over time, largely in response to crop eradication policies, interdiction efforts, competition among actors and shifts in demand. We discussed this extensively with senior politicians, academics, journalists and police officers during our visit to Bogotá. Coca leaf production increased considerably in the 1980s, mainly in Peru, followed by Bolivia. Production in the mid-1990s shifted to Colombia, with a corresponding decline in the other Andean countries and the total area under coca bush cultivation thus stabilized, at a high level, in the 1990s.

40. In the 2000s, cultivation was successfully reduced by a massive eradication programme undertaken by the authorities in Colombia, which has been successful in reducing the area of cultivation within the country by almost a third.⁵³ This success has come at a high human cost. The use of crop spraying is effective against larger areas of cultivation, but much of the eradication work is carried out on the ground by officers of the Counter-Narcotics Directorate of the Colombian National Police (DIRAN). The Counter-Narcotics Jungle Company, whose training base we visited during our stay in Bogotá, trains men and women to venture into hostile territory by helicopter to dig up coca plants by hand. This is the only effective way of destroying small plantations of the bushes, which are very resilient. Officers are vulnerable to attack from cartels and guerrillas. Plantations are

51 Ev 129, para 2

52 United Nations Development Programme Colombia, *National Human Development Report, Chapter 13: Taking Narcotics Out of the Conflict: The War on Drugs*, (2003).

53 United Nations Office on Drugs and Crime, *World Drug Report* (2012), p 76

sometimes mined. We were told that, for every 30 officers attacking a crop, around 100 others were needed to defend them. Although Colombia's success in crop eradication has been partially offset by an increase in Bolivia and Peru, it has still led to an overall reduction in potential production of around one sixth between 2007 and 2010.⁵⁴ In effect, for every two bushes that are destroyed in Colombia, another one is planted elsewhere in the Andes.

41. A similar effect has been observed in the shifting of supply routes in response to effective interdiction. In the 1970s and early 1980s, cocaine was smuggled into the USA primarily using air shipments from Colombia to Florida and other destinations along the eastern seaboard. In response to increased law enforcement efforts during the 1980s and 1990s, traffickers switched to using boats crossing the Caribbean. In recent years, the route has switched to the Pacific and the Gulf of Mexico, with semi-submersibles carrying cocaine between Colombia and Mexico for onward transport overland into the US.⁵⁵ The calamitous impact on Mexico of this shift in trade routes is well documented: 12,903 people were killed in drug-related violence in the first nine months of 2011, bringing the total number of dead since 2006 to 47,515. **Targeting supply at an early stage is the most effective way of reducing supply, as larger amounts can be intercepted higher up the supply chain. Even so, we do not believe that it will be possible to reduce the overall volume of the international drugs trade dramatically only by tackling supply — it is too easy for narco-criminals to respond by diversifying their supply routes.**

42. **The global nature of the drugs trade, and the potential for displacement of drug cultivation and supply routes in response to law enforcement measures, means that the international drug trade can only ever be tackled effectively by co-operative, co-ordinated international efforts. We must recognise that no one nation can do this on its own.**

43. As well as geographical displacement, the drug trade is susceptible to substance displacement, where targeting the supply of one type of drug leads to increase in use of another. In 2011, a survey carried out by DrugScope highlighted the rapid rise in the use of ketamine since it was banned in 2006, as well as the rise of benzodiazepines. It was suggested that this might reflect a shortage of good-quality heroin from late 2010.⁵⁶ When we discussed the prevalence of prescription drug abuse with law enforcement officials in Miami, some argued that the growth of 'pill mills' in Florida has been due in part to tough law-enforcement action against other drugs such as cannabis.

44. **The potential for "substance displacement", where users switch from one drug to another in response to changes in supply, has clear implications for public policy. In particular, the Government must be mindful of the fact that tougher measures against one drug can lead to increased consumption of another. Where the drug that is being targeted is less harmful than its substitutes—and all recreational drugs are harmful to a greater or lesser extent—there is the clear potential for measures which are intended to tackle the supply and consumption of drugs to result in an overall increase in the harm**

54 United Nations Office on Drugs and Crime, *World Drug Report* (2011), p 20

55 United Nations Office on Drugs and Crime, *World Drug Report* (2012), p 78-79

56 The Economist, *The fire next time*, (November 2011) Accessed November 2012: <http://www.economist.com/node/21538765>

they cause. We recommend that, where decisions about the classification of drugs are concerned, the opinion of the Advisory Council on the Misuse of Drugs should be sought on the potential for substance displacement, and the comparative risk associated with the likely substitutes.

The environmental impact of drugs

45. The environmental impact of drugs production is rarely discussed, but it is far from negligible. Significant ecological damage is caused both by those producing the drug and those attempting to halt its production. Not all drug production is environmentally harmful, but the fact that such production is carried out clandestinely means that it is entirely unaffected by the environmental protection measures by which legitimate industry must abide.

Cocaine

46. According to the Ecologist Magazine, by 2009 cocaine production had been responsible for the destruction of two million hectares—an area the size of Wales—of Amazonian rainforest. Police officers in Colombia told us that a hectare of coca plant produces about a tonne of leaf, which produces a kilogram of cocaine base. It has also been estimated that for every gramme of cocaine produced, four square metres of rainforest are required, taking into account additional clearance for habitation, processing and supply routes. Further damage is inflicted by the introduction of precursor chemicals—including kerosene, sulphuric acid, acetone, petrol, urea and cement—into the sensitive Amazonian ecosystem. The chemical agents used in crop eradication are no less harmful to the environment, and the aerial spraying of herbicides such as glyphosate kills plants indiscriminately, potentially leaving the soil barren and contaminating the water supply.

Ecstasy

47. One of the precursor chemicals, used to make ecstasy comes from safrole, made from the roots of the endangered selasian wood tree found in the Cardamom Mountains in Cambodia. Traders illegally harvest their roots to stew in vats for up to 12 hours in order to make the oil. As well as illegally hunting local endangered animals for food and profit, the traders often cut down other trees to build fires to stew their oil, endangering the supply of cardamom which impacts negatively on the businesses of the local spice merchants. Leaks of oil into water courses can have a negative impact on aquatic life.

Cannabis

48. So-called “wild grow” sites are especially common in the USA—nearly 50,000 cannabis plants are found each year in Sequoia and Kings Canyon national parks in California. Growers routinely clear the area of its natural wildlife and treat the sites with herbicides and pesticides many of which will run off and damage local plant, aquatic and wild life. Where cannabis is grown indoors, many producers use chemicals such as hormones which are then simply poured or flushed away into the waste water system. In Miami, we saw evidence of underground grow houses which had resulted in hugely increased use of, often illegally diverted, electricity.

Methamphetamine

49. By-products of methamphetamine production which include red phosphorus and iodine, both harmful at low doses, have been found dumped into domestic water wells, mine shafts and on to farmland, contaminating water supply and soil.

50. We asked Russell Brand, a former drug user, if he thought the environmental consequences of drug production could be used to deter drug use:

No more than the industrial consequences of oil production affect people using their cars. People don't care about industry. People care about getting the resource that they require. The illegality makes no difference, the consequences in the nation of origin make no difference. [...] Of course, any illegal industry, or the cocaine manufacture in South American nations, or wherever, has a negative consequence for their nations but I don't think that that is something that individual drug addicts are going to be affected by, to be honest, because they are normally on drugs.⁵⁷

Links between drugs, organised crime and terrorism

51. According to the UNODC, the illicit drugs trade accounts for half of all transnational organized crime proceeds and is the most profitable sector. It estimates that around \$2 trillion was laundered in 2009 and that probably around 0.2% of illicit financial flows are currently being seized and frozen.⁵⁸ The Association of Chief Police Officers (ACPO) told us that around 50% of all organised crime groups were involved in drugs, including 80% of the most dangerous groups, most of whom are involved in the supply of Class A substances.⁵⁹

52. In 2011, the Child Exploitation and Online Protection Centre published a report on people trafficking in which the largest identified trend was the trafficking of Vietnamese children into the UK—37 of the 58 children identified were trafficked into the UK to work in cannabis farms.⁶⁰

53. The Advisory Council on the Misuse of Drugs (ACMD) estimates that 25 to 30 tonnes of adulterated and unadulterated cocaine is needed each year to meet UK demand. A tonne of cocaine at import could, depending on purity, equate to between seven and 14 million street deals of cocaine at £20 to £40 per deal. Between 18 and 23 tonnes of adulterated and unadulterated heroin are imported annually to supply the UK market. A tonne of heroin at import could, depending on purity equate to between 3 and 6 million street deals of heroin at £10 to £20 per deal. This equates to a total street value of heroin and cocaine which is already somewhere between £4 billion and £20 billion. But that is before further cutting agents—which may be anything from cheaper drugs which mimic the effect of the drug in question (e.g. cocaine cut with local anaesthetics) to wholly inert diluents such as talcum

57 Q250

58 United Nations Office on Drugs and Crime, *Estimating the illicit financial flow resulting from drug trafficking and other transnational organised crimes*, (October 2011), p 7

59 Ev 181

60 The Child Exploitation and Online Protection Centre, *The trafficking of women and children from Vietnam*, (2011), p 3

powder—are introduced to increase profit margins.⁶¹ In 2005, the UNODC calculated that in Europe, heroin and cocaine cost six times more per unit weight than gold.⁶²

54. The Home Office told us that the links between the drugs trade and terrorism are most apparent in Afghanistan, where the United Nations Office on Drugs and Crime estimates that the insurgency derives approximately \$150 million per annum from Afghan narcotics, and in Colombia, where criminal groups continue to support terrorist and paramilitary groups such as the Revolutionary Armed Forces of Colombia (FARC). There is also evidence of the profits from the transit of drugs in the West African region being used to fund terrorist groups such as Al Qaeda in the Islamic Maghreb (AQIM).⁶³

55. We are concerned that despite significant international efforts to disrupt supply of illegal drugs and bear down on demand, the illegal drugs trade remains a hugely profitable enterprise for organised criminals and narco-terrorists. In part this is due to the highly inflated prices of the drugs in question, inevitable in a high demand underground market, and in part due to very low production costs, arising from cheap labour costs where many workers are exploited and the fact that most illicit drugs are very simple and inexpensive to make. This ultimately causes massive harm and deaths around the world. We urge the Government to continue to factor this unintended consequence into considerations on drugs policy.

Human rights abuses

56. A number of organisations have called attention to the abuses of human rights which are committed through the implementation on international drugs policy. The International Centre on Human Rights and Drug Policy told us that human rights abuses associated with drug enforcement include extra-judicial killing, the death penalty, corporal punishment, arbitrary detention, denial of healthcare, discrimination, and violations of multiple other rights including for specific groups such as children and indigenous peoples. They argue that

While some of the most egregious human rights abuses in the context of drug control occur overseas, the UK cannot divorce itself from the international context for a number of reasons. First, the UK funds drug enforcement efforts in countries with poor human rights records; second, developments in the UK are looked to in other parts of the world; and third, almost all UN Member States have agreed to be bound by the same law enforcement based approach to drug control.⁶⁴

57. There are currently thirty-two countries or territories in the world that have laws prescribing the death penalty for drug offences but it is estimated that executions for drugs have taken place in just 12 to 14 countries over the past five years and that only 5 % of nations actually enforce mandatory death sentences for drugs in practice.⁶⁵ Those states

⁶¹ Ev 187

⁶² Babor et al, *Drug Policy and the Public Good*, (Oxford University Press, 2012), p 69

⁶³ Ev 175, para 50

⁶⁴ Ev w107

⁶⁵ P. Gallahue, 'The Death Penalty for Drug Offences: Global Overview 2011', *Harm Reduction International*, (September 2011)

that regularly enforce the death penalty in drugs cases are China, Iran, Saudi Arabia, Vietnam, Malaysia and Singapore. The Foreign and Commonwealth Office estimates that there were 590 executions for drugs offences worldwide in 2010.⁶⁶

58. Human rights abuses by the military and police officers in attempts to eradicate drug production have been widely reported. In 2011, Human Rights Watch found evidence that strongly suggests the participation of the Mexican security forces in more than 170 cases of torture, 39 disappearances, and 24 extrajudicial killings since December 2006.⁶⁷ An earlier report into extrajudicial killings in the war on drugs focused on Thailand. In February 2003, the Thai government, under then Prime Minister Thaksin Shinawatra, launched a 'war on drugs', aimed at the suppression of drug trafficking and the prevention of drug use. In the first three months of the campaign there were allegedly some 2,800 extrajudicial killings of suspected drug dealers. In 2007, an official investigation found that more than half of those killed had no connection whatsoever to drugs.⁶⁸

59. According to Human Rights Watch, compulsory drug treatment centres where users are detained (often without trial and sometimes for indefinite periods of time) exist in Thailand, Malaysia, Myanmar, China, Indonesia, Singapore Cambodia, Vietnam, and Lao PDR. People detained in drug detention centres have reported beatings, rape, denial of meals, isolation and forced labour.⁶⁹ A number of these centres are funded by international donors.⁷⁰

60. It is important, however, not to imply that it is in pursuit of such state-sanctioned drugs policies that the most egregious human rights abuses associated with the drugs trade occur. In fact the most widespread human rights abuses associated with the drugs trade are perpetrated by the organized crime gangs who profit from exploiting vulnerable communities and individuals. In Colombia, we were told that the activities of the cartels and criminal gangs (known as "BACRIM") had been responsible for numerous murders of police officers, judges, journalists and politicians over several decades. Hostage-taking had been for many years a standard tactic. As we have already noted, drugs gangs are involved in the trafficking of children into the UK as slave labour (see paragraph 52). In Chihuahua, Mexico, the authorities recently announced the discovery of mass graves of bodies showing evidence of torture.

61. The Government should not turn a blind eye to capital punishment and other human rights abuses affecting those involved in the drugs trade. In particular, we recommend that the Government ensure that no British or European funding is used to support practices that could lead to capital punishment, torture, or other violations.

66 Foreign and Commonwealth Office, *Human Rights and Democracy: The 2010 Foreign & Commonwealth Office Report* (March 2011), p 204

67 Human Rights Watch, *Neither Rights Nor Security Killings, Torture, and Disappearances in Mexico's War on Drugs* (November 2011)

68 Human Rights Watch, *Thailand's 'War on Drugs'* (March 2008) Accessed November 2012: <http://www.hrw.org/news/2008/03/12/thailand-s-war-drugs>

69 Ev w108

70 Human Rights Watch, *Torture In The Name Of Treatment: Human Rights Abuses In Vietnam, China, Cambodia, and Lao PDR* (July 2012), p 16

3 Education and prevention

Current levels of drug usage

62. From 1996, the Crime Survey for England and Wales (until April 2012, the British Crime Survey) has included questions on drug use for those aged 16 to 59. These questions ask whether respondents have ever used drugs in their life, whether they have used them at least once in the last year, and in the last month. The interviewer does not see the response to this question, which the respondent puts directly into the computer and is then encrypted. In 2011–12, 19.3% of 16 to 24 year olds had taken an illicit drug in the last year (nearly 1.3 million people).⁷¹ Overall use of illicit drugs among young people has fallen between the 1996 Survey (29.7%), and the 2011–12 Survey, due to a decline in the use of cannabis.

63. As in previous years, cannabis was the most commonly used type of drug among young people in the last year (15.7%, equivalent to 1 million young people), followed by powder cocaine (4.2%), ecstasy (3.3%) and mephedrone (3.3%). The current level of cannabis use is a little more than half its peak level of 28.8% in 1998.

64. Although not as dramatic, this change is reflected across the all age groups measured by the Survey. An estimated 8.9% of adults had used an illicit drug in the last year; this remains around the lowest level since measurement began in 1996, when the corresponding figure was 11.1%. Again, this decline can be partly attributed to a decline in cannabis use, from 9.5% in 1996 to 6.9% in 2011–12. At the same time, the levels of Class A drug use have remained steady as an increase in the use of powder cocaine has offset a decrease in the use of ecstasy and hallucinogens.

65. These findings are reflected in other surveys, such as the NHS Information Centre survey of secondary school pupils (2011), which found a risk-averse attitude among the pupils surveyed:

Among pupils who had ever been offered drugs, 75% said they had refused them at least once. The most common reasons for refusing drugs were ‘I just didn’t want to take them’, ‘I think that taking drugs is wrong’, ‘I thought they were dangerous’, or ‘I didn’t want to get addicted’.⁷²

The decline in drug use among young people, as we have already noted, has been reflected in the number accessing treatment, from 22,000 in 2010 to 20,688 in 2011.⁷³ The National Treatment Agency has maintained that this is likely to represent a genuine fall in demand rather than limited access to services.

specialist services are intervening quickly and effectively to all young people with any substance misuse problem: 98% of interventions in 2011–12 began within three

71 Statistics in this section are all taken from *Drug Misuse Declared: Findings from the 2011-12 Crime Survey for England and Wales*, 2nd edition (Home Office, July 2012).

72 NHS Information Centre, *Smoking, drinking and drug use among young people in England in 2011* (July 2012), p 9

73 National Treatment Agency, *Substance misuse among young people 2011-12* (October 2012), p 2

weeks of referral, while the average wait for a young person to start a specialist intervention for the first time was just two days.⁷⁴

Drug education in schools

66. Reducing demand is a key part of the 2010 Drug Strategy. However, not all drug education is preventative – some educational interventions, such as talking about different drugs and the different physiological and psychological effects that they can have, will not prevent drug use but are intended to minimise the harm that people do to themselves if they do choose to take drugs. Education which will actually decrease the risk of drug taking is more likely to be classroom exercises which teach behavioural and social norms rather than focussing on the harms of drugs. Annette Dale-Perera of the Advisory Council on Misuse of Drugs told us that the evidence showed that drug education did not necessarily affect drug-taking decisions but did improve people's knowledge about substances. She thought that the expectation that drugs education will prevent people using drugs was misplaced and highlighted alternative programmes which build up resistance to the use of drink or drugs as being more effective as a preventative measure.

67. Ms Dale-Perera also emphasised the importance of credibility when teaching children about drug use:

Young people often overestimate how many drugs they use or how accepted it is by their peers, and if they realise that drug use is a minority activity and is not necessarily accepted, that can be used to modify behaviour. But the kind of messages and the data presented must be given by credible sources, otherwise the young people will not believe it. So these are slightly more promising approaches than other methods, but they have to be provided by people whom the young people respect, otherwise they do not take any notice of them at all.⁷⁵

68. The Department for Education told us that the National Curriculum requires infant school children to be taught about drugs as medicines whilst junior school pupils are taught about the impact of alcohol, tobacco and drugs on the human body and how they can effect health as well as what drugs are legal and illegal. In the first three years of Secondary School (Key Stage 3), children will learn the effect drugs can have on conception, growth, development, behaviour and health. This is extended during the last two years of Secondary School (Key Stage 4) where students are taught about the effects that regular drug use can have on human health. Throughout key stages 3 and 4, Personal, Social and Health Education (PSHE) will focus on the legislation controlling drugs and the potential impact that drug use can have both on an individual and society as a whole.⁷⁶ Fee-paying schools and academies do not have any requirements to teach drug education although the Department notes that they are “expected to provide a broad and balanced curriculum and one that enables pupils to distinguish right from wrong and to respect the law.”⁷⁷

74 National Treatment Agency, *Substance misuse among young people 2011-12* (October 2012), p 3

75 Q370

76 Ev w376, para 6

77 Ibid, para 7

69. The provision of drug education in English schools has been criticised by Ofsted in a report published in July 2010⁷⁸ and more recently in research commissioned by the Department for Education⁷⁹. Ofsted found that lack of discrete curriculum time in a quarter of the schools visited, particularly the secondary schools, meant that programmes of study were not covered in full. This extended to sex and relationships education and broader education about mental health, as well as drugs and alcohol.⁸⁰

70. The research commissioned by the Department for Education found that the majority of both primary and secondary schools deliver drug education once a year or less.⁸¹ In a case study on the need for discrete curriculum time the authors describe a school that uses 20 minute tutor periods in the lunch break to deliver their Personal, Social and Health Education lessons, which teachers thought was inadequate to deliver the subject effectively. Lack of teaching materials was also identified as a problem, with a plethora of companies offering consultancy services in the area, but with no clear means of assuring the quality of this provision for schools.⁸²

71. We took evidence on drugs education from Mentor, a UK charity which focuses on protecting children from the harms caused by drugs and alcohol through evidence based programmes, and the Angelus Foundation, which is dedicated to combating the use of legal highs and party drugs in UK. They stated unequivocally that the Drugs Strategy's vision of high-quality drug and alcohol education for all young people was not happening.⁸³ Mentor went further, telling us that

We are spending the vast majority of the money we do spend on drug education on programmes that don't work.⁸⁴

They advocated the introduction of professionally-trained PSHE teachers, rather than having the curriculum delivered by a teacher who is a specialist in another subject.⁸⁵

72. Because education about the effects of drugs is expected to be preventative, many students will feel that the harms of drugs use are exaggerated. Several of our witnesses emphasised the importance of being completely truthful when talking about the effects of drugs.⁸⁶ Chip Somers, who runs Focus 12, a rehabilitation charity, told us that

It is no good just going into schools and saying, "Drugs are bad. Stop it". Because in each of those schools there will be people who are using cannabis, who are using ketamine, who are using ecstasy. Not all the schools but some of them will be. If you

78 Ofsted, *Personal, social, health and economic education in schools*, (July 2010)

79 Department for Education, *Personal, Social, Health and Economic (PSHE) Education: A mapping study of the prevalent models of delivery and their effectiveness*, (January 2011)

80 Ofsted, *Personal, social, health and economic education in schools*, (July 2010), pp 5-6

81 Department for Education, *Personal, Social, Health and Economic (PSHE) Education: A mapping study of the prevalent models of delivery and their effectiveness*, (January 2011), p 48

82 Drug Education Forum, *PSHE and Drug Education in England*, (February 2011), Accessed November 2012: http://www.drugeducationforum.com/images/dynamicImages/7881_377172.pdf

83 Q96

84 Q97

85 Q101

86 Q120;285

don't give people both the good and the bad of drug use they will not listen to you. There are lots of people in schools who are smoking cannabis and not dropping dead. You have to give both the positive and the negative side of it, and I don't think we are doing that. We are giving too much of the negative side of it and not giving honest information. People won't listen unless it is honest.⁸⁷

73. Instead of using scientific evidence to discourage drug use in teenagers, studies have shown that programmes which are focused on classroom management or teaching social skills are much more effective. Our witnesses told us about two such programmes—The Good Behaviour Game and Preventure:

- a) The Good Behaviour Game works with children from the ages of five to seven or eight. It is a tool for managing classroom behaviour. The class is divided into two teams, and each team gets a point for each instance of inappropriate behaviour by one of its members, such as leaving their seat, shouting out or otherwise being disruptive. At the end of the day, the team with the fewest points gets a reward. If both teams keep their points below a specified level, then both teams share in the reward. Witnesses told us that a study over 15 years showed that children who played the game had a 60% higher rate of university admission. The Game does not focus on drugs at all—rather it is intended to equip children with the resilience and self-control to make positive choices in life.⁸⁸
- b) Preventure is more explicitly focused on issues such as drug use. It uses psycho-educational manuals within interactive group sessions with students aged 13–16 years, focusing on motivational factors for risky behaviours and coping skills to aid decision-making in situations involving, anxiety and depression, thrill seeking, aggressive and risky behaviour (e.g. theft, vandalism and bullying), drugs and alcohol misuse. We were told that it had been shown to dramatically reduce the incidence of drug-taking among participants.⁸⁹

74. When we asked the Department for Education how often either of these programmes along with two others—Life Skills Training and Unplugged—were used in schools, we were told that they “do not monitor the programmes or resources that schools use to support their teaching.”⁹⁰ We contacted a number of local authorities and asked them to survey the secondary schools in their area, asking them whether they used Life Skills Training, Unplugged or Preventure. None of those that replied used any of the programmes. According to Mentor, it would cost £500 per student to implement a preventative education programme for all students. This is a small cost compared to the overall cost of state-funded education per student (£71,000) or their estimated cost to society of a drug user over the course of their life (£820,000).⁹¹

87 Q254

88 Q90

89 Q92

90 Ev w375, para 3

91 Q111 - 114

75. It is surprising that apparently cost-effective programmes to dissuade young people from using drugs — Life Skills Training, Unplugged or Preventure—are not more widely used in schools. While we do not wish to endorse these particular programmes over others which might be equally good but were not drawn to our attention, we believe that there is a compelling case for the use of behaviour-based interventions in schools which are proven to reduce the chances of young people taking drugs. **The evidence suggests that early intervention should be an integral part of any policy which is to be effective in breaking the cycle of drug dependency. We recommend that the next version of the Drugs Strategy contain a clear commitment to an effective drugs education and prevention programme, including behaviour-based interventions.**

76. There is strong evidence that expenditure on preventative measures is highly cost-effective. Classroom interventions which can be delivered effectively at very little cost need only to be effective in a few cases to repay their cost many times over. Failing to provide funding for the professional training and resources which are needed to deliver these programmes is therefore potentially, in the long-term, a very costly mistake. **We recommend that Public Health England commit centralised funding for preventative interventions when pilots are proven to be effective.**

Government focus on prevention and education

77. There is no real understanding as to why the levels of drug use have fallen in the past sixteen years. As our predecessor Committee found, there is little research in to what constitutes effective prevention and education and it may even be the case that prevention measures are not behind the current decline in drug use. There are suggestions that social inequality increases prevalence of drug use. Dr Alex Stevens told us that

We see a correlation between countries that have the least generous welfare states [based on levels of unemployment benefit, sickness pay and pensions: how much you can get services without access to the market and being able to pay for things] tending to have the highest rates of cannabis use among their population. There is also a correlation between the least generous welfare states having the highest rates of injected drug use.⁹²

This is supported by a number of studies, dating back to the 1960s, which show that neighbourhoods with high levels of poverty, unemployment and deprivation are also more likely to have high levels of drug use.⁹³

78. Dr Claire Gerada of the Royal College of General Practitioners also highlighted this as a reason

We know from quite a few studies, including by the Joseph Rowntree Trust, that the pathway to addiction is poverty and social inequality, and that some of the factors

92 Ev 199

93 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 43

that give children resilience include stable parenting and good education. There is a body of knowledge.⁹⁴

In 2003, the ACMD estimated that there were between 200,000 and 300,000 children in England and Wales with one or two parents who have serious drug problems.⁹⁵ According to Addaction, the children of problematic drug and alcohol users are seven times more likely to develop a problem themselves.⁹⁶ A 2010 review of prevention measures found that the interventions which have the most impact have two things in common: they focus on early intervention with the proximal social environment, either the classroom or the family, and they address issues other than drug use by focusing on social and behavioural development.⁹⁷

79. The 2010 Drug Strategy includes several preventative measures: breaking inter-generational paths to dependency by supporting vulnerable families; providing good quality education and advice and early intervention with young people and young adults.⁹⁸ A Social Justice Strategy paper produced by the Department for Work and Pensions in March announced that one of the methods to help those with drug and alcohol dependence problems was about focusing on the family.

The family is the first and most important building block in a child's life and any government serious about delivering Social Justice must seek to strengthen families. So many of the early influences on a child relate to the family setting in which they grow up. When things go wrong, we know that this can increase the risk of poor outcomes in later life. Even more importantly, we know that family breakdown and other risk factors —worklessness, educational failure, mental ill health or drug and alcohol dependency —can feed off one another, compounding their effects, and leading to outcomes that can be very damaging for those affected and costly to society as a whole.⁹⁹

80. This recognition however, does not always translate into effective support. The Crime Reduction Initiative told us that education and early intervention should be at the core of any cost effective drug strategy—every £1 spent on interventions may save between £5 and £8 for the NHS and other agencies—but they were concerned that they were seeing significant disinvestment in drug related expenditure, with local spending decisions having an adverse impact on drug education and prevention provision for young people delivered in school settings, drug treatment for young people who are already using drugs and alcohol, and support for infrastructure organisations for professionals working in the sector.¹⁰⁰

94 Q188

95 Advisory Council on the Misuse of Drugs, *Hidden Harm – Responding to the needs of children of problem drug users* (2003)

96 Sophie Kydd, Natalie Roe, 'A better future for families: The importance of family-based interventions in tackling substance misuse' *Addiction* (March 2012), pp 14

97 Babor et al, *Drug Policy and the Public Good* (Oxford University Press 2010), p 120

98 Home Office, *The drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* (2010), p 9

99 Department of Work and Pensions, *Social Justice: transforming lives* (March 2012), p 15

100 Ev w178

81. This view was supported by Mentor, who told us that new figures from the Department for Education show local spending on drug and alcohol services for young people falling by £7 million next year. At the same time, money for drug prevention, which comes to local councils via central Government's Early Intervention Grant, has been cut by 23% between 2010 and 2012.¹⁰¹

The Inter-Ministerial Group on Drugs

82. As part of an effort to co-ordinate drug policy across Departments, the Government have set up the Inter-Ministerial Group on Drugs. The role of the IMG is to bring "together Ministers across Government to drive forward and oversee implementation of the Drug Strategy."¹⁰² The following Ministers are invited to meetings of the IMG:

Home Office (Chair)	Jeremy Browne MP, Minister for Crime Prevention
Department for Communities and Local Government	Mark Prisk MP, Minister for Housing
Department for Education	Elizabeth Truss MP, Parliamentary Under Secretary of State (Education and Childcare)
Department of Health	Anna Soubry MP, Parliamentary Under Secretary of State
Department for Work and Pensions	Esther McVey MP, Minister for Disabled People
Ministry of Justice	Jeremy Wright MP, Parliamentary Under-Secretary of State (Prisons and Rehabilitation)
Cabinet Office	Oliver Letwin MP, Minister for Government Policy

Source: Home Office. Ministerial representatives will be invited from the Department for International Development, Ministry of Defence and Foreign and Commonwealth Office when there is a relevant agenda item.

However, neither attendance at the meetings nor the agendas of the meetings are published (although the agendas were made available on request following an FOI request). On 9 July 2012, the Home Office announced via a Written Parliamentary Question that

Ministerial attendance varies according to the agenda of the meeting and their availability. Other Ministers or senior officials and advisers may attend subject to the agenda. The IMG on Drugs has met 15 times since May 2010.

Prevention and education forms a key part of the drug strategy as part of the reducing demand theme. The IMG regularly discusses progress at its meetings on each of the themes of the strategy.¹⁰³

¹⁰¹ Mentor UK, *Drug prevention and early intervention agenda buried by cuts*, (October 2012) Accessed November 2012: <http://www.mentoruk.org.uk/2012/10/drug-prevention-and-early-intervention-agenda-buried-by-cuts/>

¹⁰² Inter-Ministerial Group on Drugs, *Putting Full Recovery First*, (March 2012), p 2

¹⁰³ HC Deb, 9 July 2012, c82W

As the area of prevention has no obvious lead department we make our recommendations to the Inter-Ministerial Group on Drugs.

83. We believe that the current, inter-departmental approach to drugs policy could be strengthened by identifying a Home Office Minister and a Department of Health Minister, supported by a single, named official, with overall responsibility for co-ordinating drug policy across Government. We recommend that the Home Secretary and the Secretary of State for Health should be given joint overall responsibility for co-ordinating drug policy. By giving joint lead responsibility to the Home Office and Department for Health, the Government would acknowledge that the misuse of drugs is a public health problem at least as much as a criminal justice issue.

84. We recommend that the agenda, a list of attendees and minutes of each meeting of the inter-ministerial group on drugs be published on a government website. We would also welcome work addressing the harmful effects of drug consumption.

4 Treatment

Current treatment options

85. There are three main types of treatment for drug dependency:

- a) Social or peer support such as Narcotics Anonymous, some of which use the 12-step approach pioneered by Alcoholics Anonymous. The programme is designed to help individuals re-build their lives and make amends to those they have hurt in the course of their dependence.
- b) Psychological therapies (also known as ‘talking therapies’). These therapies can be carried out either whilst the individual remains within the community or in a residential rehabilitation setting. The main psychological therapy used is cognitive behavioural therapy (CBT) which helps the drug dependent person to identify and learn to cope with the triggers for their drug taking. CBT is designed to prepare the individual for stressful situations by helping them develop a coping strategy which does not rely on drugs. As well as individual therapy, couples and family therapy is also used in treating drug addiction.
- c) Pharmacological therapy, also known as opioid substitution treatment (OST). This is only available for those addicted to opiates (usually heroin) and is a method of reducing use of illicit ‘street’ drugs and in most cases is also intended to reduce injecting. There are several different types of OST—diamorphine, which is discussed above, methadone, which is the most common type of OST used in the UK, and buprenorphine, which is the second most common type of OST used in the UK and the principal treatment in some other countries, e.g. France and Sweden.

86. The National Treatment Agency for substance misuse supports the use of all three types of treatment for drug addiction, stating that there is no single treatment which is appropriate for all individuals. Instead the National Treatment Agency funds a range of community, inpatient and residential rehabilitation services, with the majority of patients treated within the community. The National Institute for Health and Clinical Excellence (NICE) has concluded that community treatment is effective for all but the most complex cases. Although some people respond best to residential rehabilitation, there is no guarantee that this will be sustained when they return to their communities, so there needs to be an effective programme of community-based support to help people stay clean after getting off drugs through treatment.¹⁰⁴

How do we determine the most effective methods of treating addicts?

87. At the start of the inquiry, the Committee examined treatment options available to addicts. The majority of scientific studies on the effectiveness of treatment show that Opioid Substitute Therapy (OST) is the most cost-effective initial way of reducing the prevalence of injection of street-bought heroin. This reduces both the criminal justice costs

104 <http://www.nta.nhs.uk/facts-faqs.aspx>

associated with the acquisitive crime committed in order to buy heroin and the public health cost in treating diseases associated with injecting behaviour. Buprenorphine substitute prescribing also has high cost-effectiveness in these areas and potentially more generally to the extent that a greater proportion of its users may be able to sustain employment although there are less studies available as it is a more recently deployed drug. It is important to note, however, that there is a paucity of research about how effective some alternatives to OST are. Anecdotally, for example, residential abstinence-based rehabilitation can be highly effective for some patients but there have not been as many funded research studies of these forms of treatment as compared to drug based treatments. As a result of this it is difficult to draw firm conclusions on the comparative effectiveness of different treatment options on the basis of currently available evidence either in terms of long term outcomes for the patient or in terms of value for money. In addition, OST alone rarely leads to abstinence and so the National Treatment Agency uses it in conjunction with psychosocial therapy to treat individuals dependent upon drugs.

88. A number of written submissions had highlighted the importance of residential rehabilitation and emphasised that the number of residential rehabilitation places had fallen over the past few years. Many of those who have been through residential rehabilitation stated that they would not have been able to recover from their addiction had they not been able to access residential rehabilitation. However, the National Treatment Agency will only offer residential rehabilitation in the most complex cases, partly due to the lack of research into its effectiveness but mainly due to the cost and the fact that, until the Drugs Strategy 2010, national drugs policy firmly emphasised maintenance and harm reduction rather than offering patients, who want it, a route to recovery. According to the NTA

The average annual unit cost of community treatment for a heroin addict is about £2,000. The comparable annual figure for treatment that includes residential rehab is about £10,000. This includes time spent in community-based services as well as the cost of a 13-week rehab programme and the cost of inpatient detoxification beforehand.¹⁰⁵

89. A recent article in *The Lancet* examined scientific reviews of various aspects of drug policy, starting the different policy areas involved in international drug strategies.¹⁰⁶

Evidence for the effectiveness of health and social services for established drug users

	Effectiveness	Amount of research support and cross-national testing	Comments
Methadone or buprenorphine opioid substitution treatment(OST)	Good evidence for reduced mortality, heroin use, other drug use, crime, HIV infection, and	Studies done in many countries, including Australia, China, France, Germany, Indonesia,	Appropriate for opioid users only. Combination with psychosocial services enhances outcome. Cost-effectiveness is high relative to other treatment

¹⁰⁵ National Treatment Agency, *The role of residential rehab in an integrated treatment system* (2012), p 11

¹⁰⁶ Strang et al, 'Drug policy and the public good: evidence for effective interventions', *Lancet*, vol 379 (2012), pp 71-83

maintenance	hepatitis	Italy, Iran, Lithuania, Malaysia, Poland, Spain, Sweden, Switzerland, Thailand, Ukraine, UK, and USA	interventions. The evidence-base is slightly stronger for methadone. The buprenorphine evidence-base might change after release of a buprenorphine plus naloxone combination formulation
Slow-release oral morphine OST maintenance	Few studies, but produces similar benefit to methadone OST	Trial data mostly from Austria, plus exploratory studies from Australia	In Austria, slow-release oral morphine OST is used as well as methadone OST. It might have value for patients for whom methadone OST is not beneficial
Heroin (diamorphine) OST maintenance	Evidence of effectiveness in reducing or stopping use of street heroin in individuals who do not respond to oral OST	Demonstration programmes and randomised clinical trials in Switzerland, the Netherlands, Germany, Canada, and the UK	Appropriate for opioid users only. Randomised trials have consistently shown positive results with this population, but heroin OST is the most expensive form of OST and is usually reserved for dependent users who have not responded to oral OST
Oral opioid antagonists (e.g., naltrexone ¹⁰⁷) maintenance	Some evidence for reduced opioid use but compliance to treatment is a major limitation	Few studies outside of the USA	Targeted at opioid users, less than 20% of whom are willing to try this treatment. Oral naltrexone studies are of poor methodological quality and do not lend support to the potential effectiveness of the treatment
Needle exchange programme (NEP)	Observational evidence that NEPs can reduce HIV infections and enable treatment engagement	Most research done in Canada, the UK, Australia, and the USA	Targeted at injecting drug users. Might prevent HIV infections but have no evidence of reducing Hepatitis C infections. NEPs have never been assessed by a randomised clinical trial
Psychosocial treatment	Good evidence for reducing drug use, drug-related problems, and criminal activity	Studies in most high-income countries and many low-income and middle-income countries, including India, Mexico, and Peru	Appropriate for individuals using a range of drugs and administration routes. Can be combined with pharmaceutical treatment and delivered in outpatient and residential settings in group or individual formats
Behavioural family-based and couple-based	Several randomised trials show improved retention and benefit	Research evidence is mostly from the USA	Not widely applied in the USA, not tested in other cultures

107 Naltrexone helps patients overcome opioid addiction by blocking the drugs' euphoric effects although it has little to no effect on cravings.

treatment	during treatment for heroin or cocaine addiction		
Residential drug-free rehabilitation houses	Very few randomised trials. Longer duration of residence associated with better outcome, although randomised trials show equal benefit from shorter programmes with follow-up or with similar day care	Only moderate quantity of good-quality research evidence, despite long history of provision	Extensively provided around the world in different forms, some based on programmatic therapeutic communities, some based on 12-step rehabilitation and recovery, and some based around religious communities
Peer self-help organisations	Good evidence for the reduction of drug use and crime	Evidence available from a range of countries as diverse as the USA, the UK, Iran, and China	Highly cost effective. Probably the most widely available method of treatment globally
Brief interventions in general medical settings	Good evidence for reducing drug use by at-risk drug users	Evidence available from the UK, the USA, South Africa, India, Australia, and Brazil	Evidence available for a variety of substances

Source: Strang et al, 'Drug policy and the public good: evidence for effective interventions', *Lancet* 379 pp 71-83, 2012

Role of residential rehab in the treatment system

90. Many of those who have been through residential rehabilitation stated that they would not have been able to recover from their addiction by another route. The lack of effective evaluation of residential rehabilitation was highlighted in a study by Professor John Strang and others which stated that there was only a “moderate quantity of good-quality research evidence, despite [a] long history of provision.”¹⁰⁸ In contrast, evaluation on OST was extensive and worldwide.¹⁰⁹ Professor Strang told us that he was working with others to construct properly designed studies to produce a research evidence base for the future of residential rehabilitation and aftercare.¹¹⁰ This disparity in the evidence base makes it difficult to directly compare different treatment options on some effectiveness criteria although, as stated earlier, it is already clear that although OST is an easier response for local drug services and comparatively cheap in the short term, it does not usually offer a route to abstinence.

¹⁰⁸ Strang et al, 'Drug policy and the public good: evidence for effective interventions', *Lancet*, vol 379(9810, January 2012)

¹⁰⁹ Ibid

¹¹⁰ Q163

91. Community treatment is supposed to comprise of OST and psychological therapy but that therapy will likely take place less often than it would in residential rehabilitation. In fact, in the NICE guidelines on OST, it is noted that the access to psychological therapy is “limited and variable around the UK”¹¹¹ and that OST “should ideally include psychosocial care, but that methadone and buprenorphine should be provided even when psychosocial care is not available.”¹¹² The effect of these guidelines have been that local drug services were able to put heroin addicts on OST alone without any attempt to assess and treat the issues that lead to their dependence and with no attempt to support those addicts to come off OST. We took evidence from Wendy Dawson who runs a residential rehabilitation facility in Oxfordshire and has worked in a number of drugs and alcohol treatment services over the last 30 years. She told us that:

The problem was that we did not script people with an exit strategy; we just continued to script people. It is not unusual for us at the Ley Community to receive a referral from somebody who has been on methadone for over five years and has never been offered the opportunity of residential rehab.¹¹³

A number of witnesses commented on this problem of local drug services ‘parking’ addicts on OST and not having alternative treatment options in place for those patients who would clearly benefit. Chip Somers, Chief Executive of Focus 12 Rehabilitation Centre, is an ex-addict himself has been working with addiction and alcohol problems for over 26 years. While being clear that OST has an important role in drug treatment and that not everyone will be able to become drug free, his opinion was that maintaining someone on OST should not be seen as an ideal outcome:

Not everybody can achieve it [abstinence]. Not everybody can give up smoking. I think there is a really good purpose for methadone usage at a certain stage. But just to park people on methadone for four to seven years and more, it is criminal, really, just to keep people locked into that addiction because methadone usage is a dependency, you are totally dependent. It has a role but I think it gets overused and we just tend to use it as a response to everything, and we don’t do enough to intervene...I don’t think methadone usage is a good thing. I see very few people on methadone who are leading good, stable lives. Most of the people who are using methadone are also using other drugs on top. If I saw it producing good stability I would be much more in favour of it. I don’t see that. What I do see is that people who are abstinent lead good, clean and decent lives, but obviously not everybody can achieve it.¹¹⁴

92. In July 2012, the National Treatment Agency also published a report on the role of residential rehab as part of the treatment system. As well as setting out the role of rehab, the NTA analysed its effectiveness and found that residential rehabilitation is often used, not as a stand-alone treatment, but rather as part of a network of services. The NTA found that three-quarters of residents came from community-based treatment services before

111 NICE, *Methadone and Buprenorphine for the management of opioid dependence*, (January 2007), p 23

112 Ibid, p25

113 Q122

114 Q255

accessing residential rehabilitation and the majority returned for further structured support afterwards.

For every ten people who go to rehab each year, three successfully overcome their dependency, one drops out, and six go on to further structured support in the community. Of those six, two overcome dependency with the help of a community provider, at least two are still in the system, and at least one drops out. Almost two-thirds of those who drop out from residential rehab do so in the first few weeks, suggesting that referring services and receiving facilities need to ensure people are better prepared before entering residential programmes and better supported during their stay.¹¹⁵

93. However, it is difficult to assess how this picture might differ following the production of a more rigorous evidence base about the variables affecting residential rehab and the outcomes achieved. In particular, it was concerning to hear from Wendy Dawson that some of the data might be being corrupted due to inappropriate referrals and an inadequate data collection system:

...a lot of residential rehabs have been sent inappropriate referrals; by that I mean people who are not medically able to sustain any form of intervention other than hospital. It is not unusual for clients to collapse on entry and be sent to hospital. That then skews the NDTMS [National Drug Treatment Monitoring System] figures, because it looks like it has been an unsuccessful intervention. There used to be a field in NDTMS that said "inappropriate referrals". That was recently removed, which is slightly disingenuous for residential rehab because we are providing a service and what we accept is the person that has been referred to us. Most residential rehabs have a very comprehensive assessment process that our assessment teams do very rigorously. That is not always reflective of the information that is captured in NDTMS, and it is not always reflective of the information that is supplied to the residential rehab provider.¹¹⁶

94. Different treatment regimes will work for different patients. It is clear that, for some people, residential rehabilitation is the most effective treatment, backed by proper aftercare in the community. Although it is expensive when compared to treatment entirely in the community, it is cost-effective when compared to the cost of ongoing drug addiction. While we welcome the Government's focus on recovery in the Drugs Strategy 2010, we have consistently been told that there is a shortage of provision, and in particular provision for specific groups such as teenagers. We recommend that the Government expand the provision of residential rehabilitation places. In addition, we recommend the Government review the guidance for referrals to residential rehabilitation so that inappropriate referrals are minimised and amend the National Drug Treatment Monitoring System form so that where incidents of inappropriate referral do occur they can be captured and an accurate picture of the effectiveness of residential rehabilitation as a treatment option can still be obtained.

115 National Treatment Agency, *The role of residential rehab in an integrated treatment system* (2012), p 3

116 Q126

95. The NTA also highlighted the disparity of effectiveness across the residential rehab sector. The research found that more than 60% of residents of the best providers go on to overcome dependence, while the poorest struggle to enable 20% or fewer to overcome addiction.¹¹⁷ The NTA concluded that residential rehabilitation was “a vital and potent component of the drug and alcohol treatment system” and should continue to be so. It should not be seen as a separate treatment setting, or as an alternative to community treatment, but as one potential element of a successful recovery.¹¹⁸

96. Outcomes which range from 60% of patients overcoming their dependence to just 20% suggest that the quality of provision is very variable. We recommend that, in line with the publication of certain outcome statistics for National Health Service providers, publicly-funded residential rehabilitation providers should be required to publish detailed outcome statistics so that patients and clinicians can make better-informed choices of provider.

OST: Methadone and buprenorphine

97. Methadone was developed in the 1950s as a substitute for heroin. Buprenorphine was developed as a painkiller in the 1990s but it soon became clear that it was a viable substitute treatment for heroin. It is sold under the trade name subutex and is the main OST available in France and Sweden. There are criticisms of both drugs. The RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) published interviews with recovering heroin users about their experiences and found that the negative consequences of methadone were widely recognised even by those who felt that the treatment was really helping them. In addition to the embarrassment of having to stand with other drug users in a methadone queue, key dislikes included the belief that methadone is very hard to come off, prescribed methadone use is simply another addiction, and methadone gets into ‘your bones’ and ‘rots your teeth’. These concerns about methadone are repeated by Professor Nutt, who has comprehensively described the problems associated with methadone use in his work. He notes that buprenorphine was designed to address some of those problems¹¹⁹ as it does not ‘intoxicate’ and ‘sedate’ like methadone does,¹²⁰ while still acting to block withdrawal symptoms associated with heroin use. However, buprenorphine may partly for this reason retain a somewhat lower proportion of previous heroin users in treatment than methadone. Its direct cost of prescription is also greater, although this is countered by the potentially greater ability of users in treatment to hold down employment..

98. Both drugs are used by the NHS when treating opiate addicts (although primarily used for heroin-dependent patients, OST can also be used for those who are dependent on other sorts of opiates, such as fentanyl, a prescription painkiller). In 2005, 16% of those on OST

117 National Treatment Agency, *The role of residential rehab in an integrated treatment system* (2012), p 3

118 Ibid, p 11

119 Prof. David Nutt, *‘Drugs without the hot air’*, UIT Cambridge, 2012, p 167

120 Ridge et al, *Journal of Substance Abuse Treatment* 37, 2009, p 98

were using buprenorphine rather than methadone.¹²¹ The National Treatment Agency does not collect data on which OST is prescribed, though Dr Gerada told us that her experience was of 90% of patients being on methadone, 1% on suboxone (a combination of buprenorphine and naloxon, a drug that blocks the effects of opioids) and around 9% buprenorphine alone.¹²²

99. Professor Strang had undertaken an analysis as part of a wider previous study. He had identified that, after its introduction in 1999, the proportion of buprenorphine prescribing had steadily increased up to about 15% by 2005, but that it had remained steady at this proportion (about 15%) thereafter. He also noted that

The ratio between buprenorphine and methadone is approximately 1:6, but this varies considerably in different parts of the country, partly for reasons of clinical preference or judgement, I suspect, partly as a result of promotion of the pharmaceutical companies probably, and also because of legacy of concerns from earlier intravenous abuse of analgesic buprenorphine (e.g. especially across Scotland in the 1980s) so that it is much less likely to be prescribed as OST today.¹²³

100. We make no comment on the relative merits of methadone and buprenorphine. It is for the individual prescriber to decide which drug is clinically indicated for each patient. However, we note that recent pharmacological advances in opioid substitution therapy mean that there are other options to patients being “parked” on methadone are notably treatment using buprenorphine which was less widespread when our predecessor committee published its report in 2002 and that it is possible that OST could in the future become a more effective route to abstinence than it has been in the past. **Policy makers should understand the potential for more effective OST treatments and, rather than ignoring reports of the negative side effects of current OST drugs because they are available, familiar and cost-effective, should continue to keep sight of a greater emphasis on buprenorphine relative to methadone prescription to lead to better patient and societal outcomes.**

Implementation of the Government’s goal of recovery

101. The Government’s 2010 drug strategy has recovery as one of its key aims. It states that recovery has three main principles— wellbeing, citizenship, and freedom from dependence before noting that recovery is an individual, person-centred journey, as opposed to an end state, which will mean different things to different people and that local services must commission a range of services at the local level to provide tailored packages of care and support. It also notes that medically-assisted recovery does happen and that there are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime.” It qualifies this however by stating that “for too many people currently on a substitute

121 Strang, J., Manning, V., Mayet, S., Ridge, G., Best, D., & Sheridan, 'Does prescribing for opiate addiction change after national guidelines? Methadone and buprenorphine prescribing to opiate addicts by general practitioners and hospital doctors in England, 1995–2005' *Addiction*, 102, 2007

122 Ev 195

123 Ev 195

prescription, what should be the first step on the journey to recovery risks ending there.”¹²⁴ The fact that each individual will require different support and different treatment options is further demonstrated by the RSA study which found that

This wide range and diversity of available support forms and sources is vital given that heroin users inevitably have their own particular histories, needs, preferences and aspirations. Some will feel that methadone or other substitute drugs help them, whereas others will not; some will enjoy going to groups or attending NA meetings, whereas others will not; and some will want to go into residential treatment, whereas others will not. Furthermore, their wants, needs and preferences will not be static. As a result, some individuals may not want a particular form of support at one point in time, but then desire it later.¹²⁵

It is vital that the Government continue to offer a range of treatments in line with their goal of recovery.

102. The goal of recovery is a holistic (and potentially amorphous) one which does not focus solely on the physiological aspects of drug dependence but also on receiving assistance which may be needed with housing, education and employment. However, the stated goal of recovery has led to criticism from both those who believe it does not go far enough¹²⁶ and those who believe it promotes abstinence at the cost of harm reduction.¹²⁷

103. A recent study which interviewed a number of recovering heroin addicts concluded that individuals with a heroin dependence demonstrated a very strong desire to progress their recovery journeys and that there was no evidence that individuals wanted to be given prescribed substitute drugs indefinitely. They generally disliked being on prescribed medications and wanted to detoxify from them, and from heroin, as quickly as possible. However, they noted that

our study participants’ accounts clearly revealed that there is no quick or easy route out of heroin addiction. Indeed, trying to detoxify from prescribed opioids too quickly or trying to detoxify without rehabilitative support could easily lead to relapse. If an individual really wanted to recover, it seemed that they would need to work hard in treatment – both to understand themselves and their addiction and to foster the necessary life skills that would enable them to live without drugs.¹²⁸

The study emphasised the importance of programmes other than treatment in order for recovery to be sustained “such as help with money management, education, training and employment.” As well as the obvious motivation of helping them to rebuild their lives, another reason that such courses helped them was because by giving their day structure and keeping them busy it reduced cravings. This research supports the evidence we received from ex-addicts and practitioners in the field who were clear that the barrier was

¹²⁴ Home Office, *The drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* (2010), p 18

¹²⁵ RSA, *The everyday lives of recovering heroin users* (October, 2012), p 24

¹²⁶ Ev w254, Ev w325

¹²⁷ Prof. Nutt, *Drugs without the hot air*, (UIT Cambridge, 2012), p 167

¹²⁸ RSA, *The everyday lives of recovering heroin users* (October, 2012), p 48

rarely an addict refusing treatment that would put them on a path to recovery but rather that they were unable to access such services. Wendy Dawson told us:

Just yesterday...we had a referral from a chap who had asked to go to residential rehab, had continued to ask to go to residential rehab, had been continually scripted with methadone, had asked to have his methadone reduced and in fact it was increased. He then decided to self-detoxify because he did not want to take methadone any more. He did, he became drug and alcohol free, asked to go to rehab, and he was told he was no longer a priority because he was drug and alcohol free. They are the kind of barriers that we face, because we had done our assessment, we were waiting for him, and he rang up and said, "I have been told I'm not priority." It took him to relapse for his commissioning panel to allow him-and I use that word "allow"-to come into rehab. Surely it should be about choice. The Community Care Act 2000 talked about service user choice. The Health and Social Care Act 2008 talks about service user choice. Where was the choice in treatment, whether that is a community-based treatment or a residential rehab?¹²⁹

The successful implementation of the Government's recovery strategy requires the support of Local Authorities, the Department for Work and Pensions and the Department for Communities and Local Government. It will also require the support of the new Health and Wellbeing Boards which will have the responsibility of funding drugs treatment in the local area.

Health and Wellbeing Boards

104. One of the concerns raised with us about implementation of the Government's recovery agenda is that treatment funding will now be allocated by local Health and Wellbeing Boards. Because the funding of drugs and alcohol treatment is no longer ring-fenced, there are concerns that it could lose out to other local priorities.¹³⁰ Noting that the local public health budgets are twice the amount currently spent on drug and alcohol treatment services (around £1 billion a year), the ACMD supported the concerns expressed by others—including DrugScope; the Recovery Partnership; the UKDPC; the Royal College of Psychiatrists and provider agencies—about the risk of local disinvestment in drug treatment.¹³¹

In addition to the competing demands on funding, the removal of the drug treatment "ringfence" and the context of cuts in overall local authority funding, drug users (as highlighted by the UKDPC work on drug use and stigma), are a stigmatised population who can be perceived as "undeserving". The risk of disinvestment is underlined, for example, by the impact of the removal of the ring-fence for central government funding for the Supporting People programme—in the current financial year, some local authorities have reduced Supporting People funding by over 50%. Despite government funding for young people's drug and alcohol treatment being

129 Q128

130 Q181

131 Ev 184

maintained in cash terms, there is evidence of significant reductions in service provision in some areas.¹³²

They have also suggested that future trends in drug use, prevalence and incidence of drug-related morbidity levels and drug mortality data will need to be closely monitored to analyse the effects of differing types of treatment and the drug strategy as a whole.

105. The ACMD raised further concerns about the co-ordination between the Health and Wellbeing boards and drug treatment services located in prisons, saying that it was unclear how the NHS Commissioning Board (which will oversee prison based treatment) will work with community based services and the responsibilities of Health and Wellbeing Boards.¹³³

106. Drug treatment in prisons is a point of critical intervention—if a drug-dependent offender is treated effectively then it greatly improves their chance of rehabilitation on release. Given that drug and alcohol dependence treatment in prisons has been so heavily criticised for the lack of co-ordination with treatment in the community, we are concerned that new structural changes may reverse the gradual improvement we have seen in treatment for drug-dependent offenders. We recommend the Government closely monitor the transition of treatment funding responsibilities to the Health and Wellbeing Boards and the NHS Commissioning Boards respectively.

107. There are also concerns that those in the local area will have a harm reduction background and therefore be less likely to advocate programmes aimed at recovery. One witness told us that many commissioners lacked the “ability to translate what they believe the national policy to be in their locality.” He followed on by saying that “some comment on where commissioning fits is needed because that is where we translate the good practice and the high ideals into reality for an individual whose behaviour we are seeking to influence.”¹³⁴ This is of particular concern to those who advocate residential rehabilitation which, as a more expensive treatment in the short term, could be considered to be less viable by the board.¹³⁵

108. However, the Home Office have stated that the benefit of giving responsibility for funding to the Health and Wellbeing Boards is that they will be able to react to local needs in determining where budgets ought to be allocated. The “greater control of budgets locally to make decisions in response to local need, will enable increased flexibility. Service provision will be tailored at a local level, achieving efficiencies and delivering the best possible joint services in response to local need.”¹³⁶

109. The Government goal of recovery will require the co-ordination of several government departments: the Department of Health to ensure that effective treatment is being funded, the Department for Work and Pensions to support patients to re-enter the workforce and local authorities which must take responsibility for ensuring that

132 Ev 186

133 Ibid

134 Ev 205 [Huseyin Djemil]

135 Q124

136 Ev 174, para 40

they have appropriate accommodation. We believe that giving the Home Secretary and the Secretary of State for Health joint overall responsibility for coordinating drug policy (see paragraph 83) will help to improve the focus on the goal of recovery. We recommend that the Inter-Ministerial Group works with the Recovery Committee of the Advisory Council on the Misuse of Drugs to carry out an assessment of how the situation is working once the changes have been fully implemented, and to publish its findings by July 2013.

Payment by results

110. The Payment by results pilots are running in eight local areas: Bracknell Forest, Enfield, Lincolnshire, Oxfordshire, Stockport, Wakefield, West Kent and Wigan. The three stated key outcomes for recovery are:

- free from drug(s) of dependence;
- reduced offending; and,
- health and wellbeing.

111. Several concerns have been raised about implementing a payment by results model within drugs treatment. The UKDPC told us that

The evidence suggests that where it works is where you have a single, very clear outcome, and you are quite clear about the interventions that will get you there, so that everybody is clear about what needs to be done, and about the outcome you are going to pay for. Unfortunately, recovery does not really tick those boxes. Recovery is recognised as a very complex and individual process. People start from different points. They have different resources themselves, and they may also have a different opinion of what recovery will mean to them. It is very hard to pay for recovery or to measure the recovery when you get to it.

They also raised concerns about the interim payments included in payment by results, which recognise that it will be a long time before some people achieve the abstinence outcome, as they suggest that such payments could skew the objectives of the scheme. By giving a high weight to the interim outcomes, it makes the long-term outcome less attractive. If the long term outcome is weighted more heavily then providers could decide that certain individuals are not worth treating.¹³⁷

112. One of the concerns raised by witnesses was that organisations which have a payment by results structure may not wish to take on clients who are particularly complex or difficult. The Royal College of Psychologists told us that they were concerned that the payment by results systems “in their current form will fail to take account of the most vulnerable individuals, with the most severe and complex addictions, for whom the

137 Ev 203 [Nicola Singleton, UKDPC]

recovery journey will be most difficult.”¹³⁸ This was supported by DrugScope who told us that payment by results may not be supportive of smaller voluntary and community sector providers who find it difficult to manage the cash flow and financial risks associated with outcome-based payments, and there are risks of “gaming” the system, for example, cherry picking clients most likely to achieve the desired outcomes.¹³⁹

113. The fears regarding the marginalisation of smaller voluntary sector providers (which were voiced by several organisations) seem to have been borne out in the case of the pilot in West Kent. The Kenward Trust, a provider of drug and alcohol recovery services in Kent, told us

My understanding is that only two large national providers eventually put in a bid [for the model in West Kent], so the first point that I want to make is that in our experience, a payment by results model will exclude smaller voluntary sector providers that can provide innovative and quality services, and that will certainly have good local knowledge and good well-established relationships with all the variety of agencies that we know contribute to a successful outcome.¹⁴⁰

The Trust also raised concerns that the payment by results model could result in a substantial bureaucracy involved in collecting payments with a danger of becoming target-driven, rather than outcome-focused. There was especial unease about the potential for such a system to change by relationships “between the recovery worker and the individual who is sat in front of them when they have a tariff attached to their head.”¹⁴¹ The concerns the Kenward Trust raised regarding services becoming target driven were echoed the Substance Misuse Management in General Practice who told us that

Payment by results (PbR) in primary care based drug treatment—this outcome measure is being piloted in several areas and whilst measurable positive outcomes are important, it risks oversimplifying a complex issue. There are many people who are cared for over long periods in primary care, who are severely affected either by their substance misuse, or who have turned to drugs and alcohol as a result of complex problems. A system that financially rewards services that may “cherry pick” those individuals they perceive as having more “recovery capital”, compared to primary care that commit to seeing all for as long as necessary, is flawed.¹⁴²

114. Payment by results potentially produces a very cost-effective system in which the taxpayer pays only for successful outcomes. However, past experience in other areas such as employment has shown that it is easy for the market to become dominated by a small number of large providers, leading to the marginalisation of smaller, innovative voluntary sector organisations. Another risk is that the most difficult to treat patients may be denied access to services. We recommend that the Government establish ways to create provider diversity to ensure that smaller providers and civil society are not

138 Ev 144, para 2.19

139 Ev w196

140 Ev 202 [Angela Painter, Kenward Trust]

141 Ibid.

142 Ev w237

excluded and that a wide range of services are available. This could be achieved by ring-fencing a certain proportion of expenditure for such providers. The model will also need to ensure that providers are rewarded appropriately for taking on the most difficult patients, so that those who are harder to help will not be denied services.

Prescription drugs

115. The issue of addiction to prescription drugs has increased dramatically in the past few decades. In North America, this increase has led to a situation where non-medical use of prescription opiates is on a par with heroin use.¹⁴³ This trend is also evident in Australia and is thought to have occurred as a result of low levels of available heroin.¹⁴⁴ In January, the Centre for Disease Control called the increase in non-medical prescription drug use an epidemic, noting that it was the fastest growing drugs problem in the United States and that since 2003, more overdoses had involved opioid analgesics than heroin and cocaine combined.¹⁴⁵ In a North American context, the International Narcotics Control Board 2006 Annual Report observed that “the high and increasing level of abuse of prescription drugs by both adolescents and adults is a serious cause of concern”. Prescription drugs are now the second most abused class of drugs in the USA after cannabis and have led to a rising number of deaths.¹⁴⁶

116. Because of differences between the US and UK healthcare systems—such as the monitoring of GP prescribing—it may be less likely that such wide scale addiction to opioid analgesic could occur in the UK. However, the National Treatment Agency found that prescription of opioid analgesics in the community increased very rapidly from 228.3 million items in 1991 to 1,384.6 million items in 2009.¹⁴⁷

117. A cause of concern in the UK is dependence upon benzodiazepines, which during the 1970s were prescribed for between 10 and 20% of adults in the western world.¹⁴⁸ These are drugs which help alleviate anxiety and insomnia. Following a 1988 report on the potential side effects with a recommendation to exercise judgement when prescribing benzodiazepines, prescriptions began to decrease. The National Treatment Agency found that the prescriptions of hypnotic and anxiolytic medicines [a group of drugs, that have sedative, sleep-inducing, anti-anxiety, anticonvulsant, muscle relaxant and amnesic properties, of which benzodiazepines are one of several available on the NHS] decreased from 878.7 million items in 1991 to 550.4 million items in 2009.¹⁴⁹

118. Despite this decrease, in May 2011, a joint review of the literature was published by researchers at the National Addictions Centre of Kings College London and the School of Social and Community Medicine, University of Bristol which confirmed the perception

143 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 179

144 Ibid, p 33

145 <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>

146 International Narcotics Control Board, *Annual Report* (2006), p 6

147 National Treatment Agency, *Addictions to medicine* (2011), p 3

148 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 84

149 National Treatment Agency, *Addictions to medicine* (2011), p 3

that benzodiazepine misuse, either intentional or unintentional, is relatively common, but could not definitively establish its prevalence or trends in prevalence.¹⁵⁰

119. The Royal College of Psychiatrists told us that there is significant evidence of changing drug use both in the UK and internationally. Of particular concern is “the apparent rise in the use of club drugs, over-the-counter medications, abuse of prescription medications and internet sourcing.”¹⁵¹ However, Dr Gerada of the Royal College of GPs reassured us that

What we have had in this country over the last decade is a fantastic training initiative, run, I hesitate to say, through the RCGP, also the RC of Psych, to educate GPs about prescribing, about safe prescribing, about giving two week prescriptions and not whole month prescriptions. I will say that in terms of diverted drugs, patients getting addicted on drugs that started life with a prescription of mine is very unusual now. Ten years ago it was very usual.¹⁵²

120. It is not possible to assess the scale of dependence upon prescription medicine within the UK as the data on prescription drug dependence is not collected in the same way that data on heroin dependence is. Instead the majority of those in treatment who report prescription drug dependence will usually have used them in conjunction with other, illicit, drugs.¹⁵³ However this data may not be representative given the historic focus of drug treatment on heroin and/or crack and the fact that support and treatment for people who develop problems in relation to prescription only medicine or over the counter medicine would be provided by GPs, many of whom do not report to the National Drug Treatment Monitoring Service.¹⁵⁴

121. When we questioned the ACMD about the prevalence of dependence upon prescription medication, we were told that although the situation was much better than in America, they intended, “to do a review of prescription medicine diversion to recreational use. We will be doing that next year.”¹⁵⁵

122. Prescription drug dependence and the use of prescription drugs for non-medicinal purposes is widely and erroneously viewed as being less harmful and certainly more acceptable than drugs which are part of the classification system. Prescription drugs are becoming more widely available, through diversion of prescriptions and unregulated sales via the internet. This was not an issue which our predecessor committee looked at in 2002 but we are alarmed by the increase in availability of and addiction to prescription drugs. Having seen first-hand the scale and impact of prescription drug use in Florida, we recommend that the Government publish an action plan of how it intends to deal with this particular issue as part of the next version of the drug strategy to prevent the situation here in the UK deteriorating further.

¹⁵⁰ Reed et al *The changing use of prescribed benzodiazepines and z-drugs and of over-the-counter codeine-containing products in England: a structured review of published English and international evidence and available data to inform consideration of the extent of dependence and harm*, May 2011, p 89

¹⁵¹ Ev 146, para 5.7

¹⁵² Q200

¹⁵³ National Treatment Agency, *Addictions to medicine* (2011), p 3

¹⁵⁴ Ibid, p 4

¹⁵⁵ Q349

123. It is unacceptable that no government agency can give us information on the prevalence of dependence on prescription drugs. We welcome the proposed review of prescription medicine diversion by the ACMD. The issue is one which has been highlighted as a growing problem and as the overall trends of drug use change, the Government must ensure that it has access to suitable treatment for dependence on all drugs rather than just focussing on a narrow sub-set. It is ultimately the responsibility of the medical profession to ensure that their prescribing decisions do not lead patients into drug dependency. However, the police and public should be aware of this deeply concerning trend, so they too can be vigilant in seeking to prevent it.

5 The legislative framework and law enforcement relating to drugs

Misuse of Drugs Act 1971

125. In the evidence submissions to this inquiry, there was a repeated theme of criticism of the Misuse of Drugs Act 1971. The Act, which classifies drugs into three classes: A, B or C, sets out the penalties for the possession and dealing of any drugs classified under it.

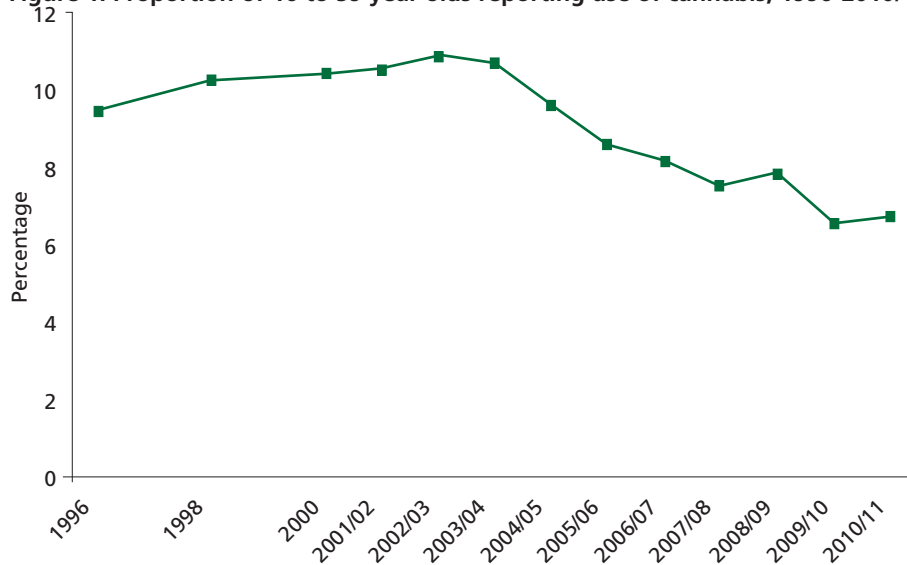
		Possession	Dealing
Class A	Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms, amphetamines (if prepared for injection).	Up to seven years in prison or an unlimited fine or both.	Up to life in prison or an unlimited fine or both
Class B	Amphetamines, Cannabis, Methylphenidate (Ritalin), Pholcodine.	Up to five years in prison or an unlimited fine or both	Up to 14 years in prison or an unlimited fine or both
Class C	Tranquilisers, some painkillers, Gamma hydroxybutyrate (GHB), Ketamine.	Up to two years in prison or an unlimited fine or both	Up to 14 years in prison or an unlimited fine or both

Home Office website

126. In 2004 cannabis was re-classified from Class B to a Class C drug. Following a decision taken in 2008, this re-classification was reversed in 2009. The re-classification of Cannabis to a Class C drug had no impact on its use according to the British Crime Survey.¹⁵⁶ However, as noted in paragraph 4 the number of people seeking treatment for problem cannabis use has increased significantly since 2005. As the table below shows, there was an overall trend of decrease in cannabis use whilst cannabis was a Class C drug. Use of cannabis, which peaked in 2002–03 at 10.9%¹⁵⁷, decreased steadily up until its re-classification as a Class B drug in 2009. This episode demonstrates that the classification of a drug may have little effect on the prevalence of its use. We remain, however, of the view expressed in our predecessor's report, namely that cannabis be reclassified from class B to C, and therefore regret the decision taken by the Government in 2008.

¹⁵⁶ Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 173

¹⁵⁷ Home Office, *Drug Misuse Declared: Findings from the 2011-12 Crime Survey for England and Wales*, 2nd edition (July 2012), p 9

Figure 1: Proportion of 16 to 59 year olds reporting use of cannabis, 1996-2010/11

Source: Home Office, *Drug Misuse Declared: Findings from the 2010-11 British Crime Survey* (July 2011), p 19

127. The majority of criticism voiced by those who gave evidence to this inquiry centred on the inconsistency of not all intoxicating substances (including cigarettes and alcohol) being classified under the Act. In their recent report, the UK Drugs Policy Commission said that a major criticism of current policy is that such substances are dealt with through a range of legislative frameworks. Solvents are regulated through the Intoxicating Substances Act; alcohol and tobacco are regulated through trading standards and licensing as well as through taxation policies while illicit drugs are classified under the Misuse of Drugs Act.¹⁵⁸ Such inconsistent control measures have the potential to send confusing messages about the potential harms of such substances, especially as information on the effects of illicit drugs becomes more available via the media and the internet.

128. This view was also supported by the Royal Society of the Arts¹⁵⁹ and DrugScope.¹⁶⁰ The Angelus Foundation called for a review of the Act, making the point that

The Misuse of Drugs Act 1971 has not shown it can be used to reduce prevalence of the new drugs—it should be fully reviewed. ... The Misuse of Drugs Act 1971 was drafted in a very different era for drug misuse. The pace of change cannot be sustained by the legislation. The Angelus Foundation advocates a review of the act similar to the one carried out by in New Zealand by their Law Commission.¹⁶¹

129. Whilst we accept the premise that all intoxicating substances ought to be judged against each other in terms of the levels of harm that they cause, we also note the view of the House of Commons Science and Technology Committee which looked at drug classification in 2006.

¹⁵⁸ UK Drug Policy Commission (Oct 2012), p 152

¹⁵⁹ Ev w9

¹⁶⁰ Ev w194

¹⁶¹ Ev 142

In our view, it would be unfeasible to expect a penalty-linked classification system to include tobacco and alcohol but there would be merit in including them in a more scientific scale, decoupled from penalties, to give the public a better sense of the relative harms involved.¹⁶²

130. We return to a recommendation made by our predecessor Committee as part of its inquiry in to the cocaine trade in 2009.

We therefore support calls for a full and independent value-for-money assessment of the Misuse of Drugs Act 1971 and related legislation and policy.¹⁶³

The Government refused to accept this recommendation, saying that

The Misuse of Drugs Act 1971, as amended, responds to the three UN Drug Conventions. It controls the drugs which the UK is required to control as a signatory to the Conventions. International agreement would be required for any change to the Convention controls and the UK will not alter its stance on them and has no intention of breaking our obligations in respect of them by acting unilaterally. Nor do we intend to undertake an assessment comparing the costs and benefits of different legislative options for domestic drug policy. However, we will work with other Government Departments to explore putting in place an evaluative framework which encompasses the broad range of individual strands with a view to establishing a more coherent evaluative overview of the strategy in its entirety. This should also provide more integrated information with which to make a more robust assessment of VFM.¹⁶⁴

131. Our predecessor Committee's recommendation for an independent assessment of the Misuse of Drugs Act 1971 was rejected on the basis that it gives effect to the UK's international obligations in this area. That is not, in our view, a compelling reason for refusing to review our own domestic legislative framework, particularly given the growing concern about the current international regime in many producer nations. The message from Colombia and other supplier and transit states is clear—what the international community is currently doing is not working. We are not suggesting that the UK should act unilaterally in these matters, but our Government's position must be informed by a thorough understanding of the global situation and possible alternative policies.

132. This inquiry has heard views from all sides of the argument and we believe that there is now, more than ever, a case for a fundamental review of all UK drugs policy in the international context, to establish a package of measures that will be effective in combating the harm caused by drugs, both at home and abroad. We recommend the establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs in an increasingly globalised world. In order to avoid an overly long,

162 Science and Technology Committee, Fifth Report of Session 2005–06, *Drug Classification: Making a hash of it?*, (HC 1031), para 106

163 Home Affairs Committee, Seventh Report of Session 2009–10, *The Cocaine Trade*, (HC 74), para 24

164 Home Office. *The Cocaine Trade. The Government reply to the 7th Report from the Home Affairs Committee, Session 2009-10, HCP 74*. July 2010. (Cm 7910), p 3

overly expensive review process, we recommend that such a commission be set up immediately and be required to report in 2015.

Drug-related policing

133. There are a number of police activities related to drug enforcement carried out by, amongst others, UK police forces, SOCA and the UK Border Force. These Agencies will work both separately and jointly to reduce the supply of illicit drugs at home and abroad. The UK agencies will also work with foreign partners when required. Drug-related policing activities include:

- Raids e.g. Cannabis factories, drug suppliers
- Crackdown related to drugs e.g. pubs, drugs, key hot spots
- Drug-related covert surveillance
- Test purchasing of drugs
- Joint operations relating to drugs e.g. borders/customs
- Asset forfeiture and Proceeds of Crime Act (POCA) investigations related to drugs
- Drug money laundering detection and prevention
- Controls on precursor chemicals
- Controls on prescribed drugs and work with primary care trusts (PCTs)
- Community policing including Police Community Support Officers (PCSOs)
- Drug-related work with community groups
- Drug Intervention Programmes including drug testing on arrest
- Drug education/schools
- Forensic testing relating to drugs
- Drug cautions and warnings
- Use of drug dogs

- Discretionary spend relating to drugs e.g. provision of match funding
- Crime mapping technology/intelligence.

UK assistance abroad

134. In evidence to the Committee, Trevor Pearce of SOCA highlighted the work that they were currently doing abroad “I think we have taken the lead, the UK, in how we operate in third-party countries and with them and help them develop their regional approaches.”¹⁶⁵ He went on to elaborate

The capacity building is about how we can bring the experience we have from working with other jurisdictions, but also in terms of our approach to those countries, recognising that their resource levels are woefully small in this. Being able to surge activity from the UK to support them, we have done that in Sierra Leone, following a 600 kg seizure of cocaine; we have done it in The Gambia where we were able to identify the facility where another 2.1 tonnes of cocaine were being stored. Through that, through taking our forensic experts and taking investigators, we were able to build the experience and importantly build experience in how they operate in the criminal justice system.¹⁶⁶

135. SOCA spends almost 10%¹⁶⁷ of its budgets on agents based overseas in some 40 countries worldwide. Most overseas posts maintain a wider remit than the country in which the officers are stationed, enabling an operational reach across more than 150 nations.¹⁶⁸ A 1987 study which examined the role of interdiction (seizure of drugs in source countries) found that it was much more cost effective than seizures in the domestic market because, as the product is trafficked to consumer countries, the list of law enforcement targets increases.¹⁶⁹

136. The majority of SOCA's seizures take place abroad as the table below shows

		UK		Abroad		Total
		2011-12	%	2011-12	%	2011-12
Heroin	kg	1, 216	25.41%	3,571	74.59%	4,788
Cocaine	kg	1,507	2.22%	66,311	97.78%	67,818
Opium	kg	10	0.12%	8,551	99.88%	8,561
Cannabis	kg	5,844	7.23%	75,020	92.77%	80,864

¹⁶⁵ Q516

¹⁶⁶ Q515

¹⁶⁷ Q520

¹⁶⁸ Serious Organised Crime Agency, *Annual report 2011-12*, (July 2012) p 10

¹⁶⁹ Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 141

Total	kg	8,578	5.29%	153,453	94.71	162,031
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Correspondence to Chair from Trevor Pearce (SOCA) dated 24 September 2012

This breakdown is perhaps unsurprising as local police forces and the UK Border Force are primarily responsible for seizing illicit drugs within the UK. The statistics for UK drug seizures mean that there is a possible comparison that can be made from drug seizures made by local police forces, the UK Border Agency and SOCA.

		Drug seizures made in 2011-12 in England and Wales by police (including the British Transport Police) and the UK Border Agency (including HM Revenue and Customs) ¹⁷⁰	SOCA drug interdiction in the UK 2011-12	SOCA drug interdiction abroad 2011-12
Heroin	Tonnes	1.8	1.2	4.8
Cocaine	Tonnes	3.5	1.5	66.3
Opium	Tonnes	Not available	0.01	8.6
Cannabis	Tonnes	41.5	5.8	75

Compiled by Committee staff

137. The interdiction and capacity building work was highly valued by Anti-Narcotic officers that we spoke to during our visit to Colombia and President Santos himself was quick to highlight the importance of the work of SOCA to the counter-narcotic effort. He explained however, that whilst demand from consumer countries was maintained, the drug traffickers would find a way to supply the drugs. It was this, he said, which led to his calls for an international debate on the future of drugs policy, not any sort of belief that drugs are harmless.

138. We endorse the praise from President Santos and others for the work of the Serious and Organised Crime Agency. In the countries we visited, it was clear that they did an excellent job and were well respected. We encourage the Government to find a way to retain the SOCA brand overseas, in the move to the National Crime Agency, perhaps as a Serious Overseas Crime Arm of the NCA. However, despite their best efforts and considerable success, we agree with President Santos and others that it is impossible for them to prevent drug trafficking completely.

Money laundering

139. The trade in illicit drugs is estimated to generate an annual \$300 billion profits worldwide¹⁷¹, the majority of which will be laundered through the legitimate financial system. Although more difficult to trace than the drugs themselves, seizure of financial assets is more worthwhile. Whilst drugs can be ‘cut’ with other chemicals to ‘bulk up’ the

170 Home Office, *Seizures of drugs in England and Wales 2011-12*, (November 2012)

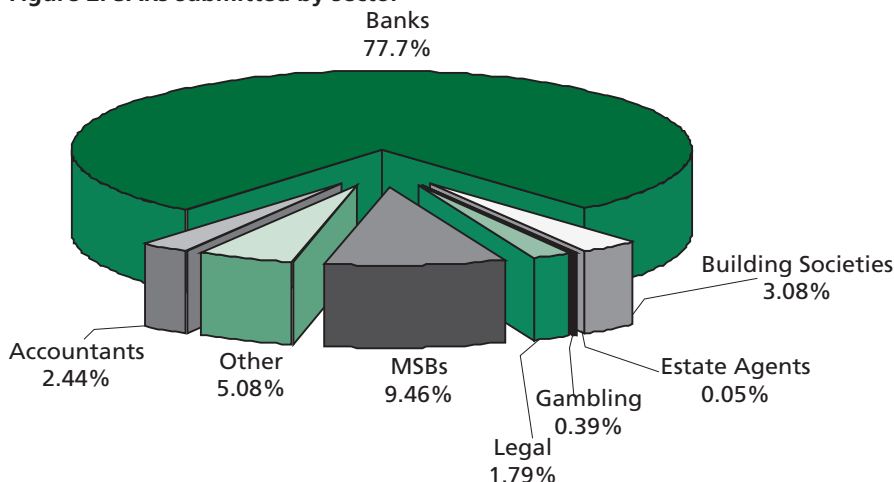
171 United Nations Office on Drugs and Crime, *World Drug Report* (2012), p 60

remaining product available, once the money is seized, it cannot be replaced and the cycle of the business is disrupted.¹⁷² SOCA, the agency responsible for seizing the profits of organised crime state that

Money is at the heart of all organised crime. The lifestyle and status it brings is the main motivation for most criminals. And just as legitimate businesses need funding to stay afloat, so does organised crime. Without cash flow, deals can't be made and people can't be paid. For both these reasons, many organised criminals fear attacks on their finances and lifestyle more than prison. ... Interrupting cash flow stalls business deals, leaves criminals owing each other, creates tensions, and paralyses plans, all of which reduces their capacity to stay in business.¹⁷³

140. One way that SOCA identifies possible money laundering is through the reporting of suspicious activity reports (SARs), a piece of information which alerts law enforcement that certain client or customer activity is in some way suspicious and might indicate money laundering or terrorist financing. A range of professions including accountants, lawyers, bankers and estate agents are responsible for reporting suspicious activity. There were 247,601 SARs reported between October 2010 and September 2011. The information contained in a SAR will provide “opportunities to identify and develop new intelligence on criminal movements of funds. This in turn can enhance existing intelligence from other sources to build a better picture of criminal networks and vulnerabilities.”¹⁷⁴

Figure 2: SARs submitted by sector



Source: *Serious Organised Crime Agency, SARs Annual Report (2011), p 14*

141. As the majority of SARs come from banks, it is vital to ensure that they are following the Money Laundering Regulations. This is currently the responsibility of the Financial Services Authority. The FSA undertake three main types of work in regards to anti-money laundering controls—checking the anti-money laundering systems of authorised firms subject to the Money Laundering Regulations, casework (where something appears to have gone wrong in a firm) and thematic reviews of the industry. They are responsible for

172 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain's Drug World* (2012), p 171

173 <http://www.soca.gov.uk/about-soca/how-we-work/asset-recovery>

174 Serious Organised Crime Agency, *SARs Annual Report* (2011), p 10

enforcing and prosecuting breaches of the regulations. Under the regulations, any firm which is based in the UK must ensure that they apply their UK Anti-Money Laundering standards throughout their non-EEA operations.

FSA review of money laundering compliance

142. In June 2011, the Financial Services Authority published a report entitled ‘Banks’ management of high money-laundering risk situations’. The report made some worrying criticisms about the banks that had been reviewed.

Some banks appeared unwilling to turn away, or exit, very profitable business relationships when there appeared to be an unacceptable risk of handling the proceeds of crime. Around a third of banks, including the private banking arms of some major banking groups, appeared willing to accept very high levels of money-laundering risk if the immediate reputational and regulatory risk was acceptable. ... At a few banks, the general Anti-Money Laundering culture was a concern, with senior management and/or compliance challenging us about the whole point of the Anti-Money Laundering regime or the need to identify Politically-Exposed Persons.¹⁷⁵

The main conclusions of the report included the finding that serious weaknesses were identified in banks’ systems and controls and that there were indications that some banks were willing to enter into very high-risk business relationships without adequate controls if there were potentially large profits to be made. This would make it likely that some banks are handling the proceeds of corruption or other financial crime.

143. The report highlighted that in “some banks, we found that the dominant culture appeared to undermine the effective implementation of Anti-Money Laundering policies. At nearly half the banks in our sample, a poor Anti-Money Laundering compliance culture and an apparent lack of leadership on Anti-Money Laundering issues from senior management were accompanied by a lack of senior management involvement in Politically-Exposed Persons and high risk customer sign-off processes.”¹⁷⁶ The inference throughout the report is that it is the smaller banks that have not fully adopted an attitude change towards Anti-Money Laundering compliance. The FSA were concerned that senior management at a quarter of banks visited, mainly in private banks or the private banking arms of major banks, seemed to view money laundering as a reputational risk issue rather than a moral or criminal issue. In these banks, senior management attached greater importance to the risk that a customer might be involved in a public scandal, than to the risk that the customer might be corrupt or otherwise engaged in financial crime, and using the bank to launder criminal proceeds.¹⁷⁷

144. Tracey McDermott, head of the enforcement and financial crime division at the FSA told us that they

175 Financial Services Authority, *Banks’ management of high money-laundering risk situations* (June 2011), p 4-5

176 Ibid, p 32

177 Financial Services Authority, *Banks’ management of high money-laundering risk situations* (June 2011), p 32

were disappointed by our findings in a number of areas; we found that the banks we had visited as part of that review had, in some areas, good controls but had many more weaknesses than we would have expected to see and than we would think were appropriate. We have taken a series of enforcement cases off the back of findings from that thematic review, and we have made it very clear that we expected to see improvement.¹⁷⁸

As well as intending to do a follow-up on the report in the future¹⁷⁹, the FSA are rolling out a 'Systematic Anti-Money Laundering Programme' which will focus on fourteen of the largest financial institutions.

145. The Systematic Anti-Money Laundering Programme will assess (on an ongoing basis) how robust the anti-money laundering and sanctions defences are in the banks that are responsible for the majority of the financial transactions in this country. The programme will consider each bank's anti-money laundering defences as an end-to-end process – due diligence when accounts are opened and reviewed, monitoring of customer transactions to identify unusual/suspicious activity and the quality of reports made to SOCA. The benefits of such a programme are increased understanding of how standards are evolving on the ground and helping to inform the assessment of risks. Ms McDermott explained the benefits of the programme

actually the banks and people on the front line often see new ways of moving money, so that is another source of information for us in assessing the risks and so on. Part of it is around deterrence, part of it is around spotting actual problems, and part of it is around making sure we are close to what is actually happening on the ground.¹⁸⁰

Allegations of lax money laundering controls

146. In 2010, in an interview with Executive Intelligence Review, then-UNODC Executive Director Antonio Maria Costa said that

The 2008 financial crisis, still unfolding, hit the entire trans-Atlantic banking sector. The illiquidity associated with the banking crisis, the reluctance of banks to lend money to one another, and so on and so forth, offered a golden opportunity to criminal institutions—which had developed huge financial power, money which was liquid because it could not be recycled through the banking system in earlier years. At this point in time, we're talking about the 2008-11 period, the need for cash by the banking sector and the liquidity of organized crime created an extraordinary opportunity for a marriage of convenience, namely, for organized crime to penetrate the banking sector.¹⁸¹

In the same interview he said that infiltration of the financial sector by criminal money has been so widespread that “it would probably be more correct to say that it was not the mafia

178 Q552

179 Q567

180 Q562

181 Executive Intelligence Review, *Former UNODC Head Talks about Drugs in the World Banking System*, (April 2012) Accessed November 2012: http://www.larouchepub.com/other/2012/3917costa_drugs_banks.html

trying to penetrate the banking system, but it was the banking sector which was actively looking for capital—including criminal money—not only as deposits, but also as share acquisitions and in some cases, as a presence on Boards of Directors.” However, when we put this suggestion to Lord Turner, head of the FSA, he told us that

I do not think it is a credible description of the survival of the global banking system at the end of 2008. I find it difficult to make sense of those comments in that it could only have been the thing that kept the banking system afloat if new money came into the banking system, and new money only comes into the banking system through two routes. One is when people take cash— physical paper currency—and put it into the banking system, and there is no sign that that occurred in late 2008; indeed, in most banking systems in the world, there was a slight flow the other way. The other thing that can go into the banking system is central bank money—provided by the Bank of England, the Federal Reserve, the Bank of Japan, the ECB—and that is essentially what kept the banking system afloat in autumn 2008.¹⁸²

147. Antonio Maria Costa has also highlighted the case of Wachovia as proof of the wide scale involvement of the financial services sector with organised crime. In 2010, following a 22-month investigation by agents from the US Drug Enforcement Administration, the Internal Revenue Service and others, it emerged that cocaine smugglers had laundered \$480 million over a period of three years through one of the biggest banks in the United States: Wachovia, now part of Wells Fargo. Wachovia paid federal authorities \$110m in forfeiture, for allowing transactions later proved to be connected to drug smuggling, and incurred a \$50m fine for failing to monitor cash used to ship 22 tons of cocaine.

148. One of the people involved in identifying the issues at Wachovia was a London-based member of staff, Martin Woods. Mr Woods, who had previously been a police officer tasked with investigating money laundering, started working for Wachovia as a money laundering compliance officer. Having identified transactions which made him suspicious, he reported them to his superiors who denied that anything was wrong. In 2008, he wrote to the Financial Services Authority which he copied to the Drug Enforcement Agency and the Office of the Comptroller of the Currency (the US banking regulatory authority). However because the suspicious transactions were taking place in banks in the US and Mexico, Wachovia questioned his right to probe matters which took place abroad. It was only after Mr Woods contacted US law enforcement that the case was investigated. Mr Woods later gave an interview in which he said

When I blew the whistle on Wachovia, I blew it on the UK’s Financial Services Authority and the Office of the Comptroller of the Currency. Both were involved in a catastrophic failure of banking regulations – they gave the bank clean bills of health for five years despite an ever-growing mountain of evidence against it. Putting banking secrecy over the public interest is unforgivable.

There is a way to tackle the drug economy, the question is, is there the will? As a whistle blower, having gone through what I’ve gone through I wonder whether the

whole thing is a charade. ... The banks and the drug industry have what appears to be a mutually beneficial system.¹⁸³

149. One of the contributing factors to the length of time it took for the concerns about Wachovia to be taken seriously may be the width of the role of the FSA. The Authority is responsible for both the financial stability of banks as well as the overall economy and the conduct and standards of financial institutions. From April 2013 however, the FSA will be split in to two separate bodies, the Prudential Regulation Authority (PRA) and the Financial Conduct Authority (FCA). Lord Turner explained that this would increase the focus on anti-money laundering compliance.

We will have, in the Financial Conduct Authority, people who are focusing on that, even if we were back in 2008 and 2009 and the world financial system was collapsing. ... Bluntly, I think in the past that the FSA was doing too much; putting all of those activities into one organisation made it very difficult for the top management to be focused on all those issues. If you were to honestly ask me how much attention did I pay to anti-money laundering in autumn 2008, the answer is not much because the financial system was collapsing and it felt that the single most important thing for myself and Hector Sants and the other most senior people to be focusing on was how we were going to rescue the banking system.¹⁸⁴

150. Despite this renewed focus on anti-money laundering compliance, drugs profits laundered through the financial system are estimated to represent 0.4-0.6% of global GDP.¹⁸⁵ As with the trafficking of drugs, whilst it may be possible to reduce its prevalence, displacement means that it is unlikely that drugs-related money laundering could be completely eradicated. In 2003, Lord Turner gave a speech to the WWF in which he stated that

if we want to help sustainable economic development in the drug states – such as Colombia and Afghanistan – we should almost certainly liberalise drugs use in our societies, combating abuse via education, not prohibition, rather than launching unwinnable “wars on drugs” which simply criminalise whole societies.¹⁸⁶

When we asked him if this was still his position, he replied that it was his personal view but that as long as drugs were controlled under UK legislation, laundering drugs-related proceeds is a criminal activity and banks must not allow the transmission of criminal money. He emphasised “a point of view as to whether or not the overall approach is a sensible one does not change in any sense the moral responsibility and the legal responsibility of banks to stick to the rules as they are at the moment.”¹⁸⁷

151. Like any business, the international drug trade thrives on profit. Identifying and seizing the profits of the drug trade, wherever they are in the world, must be a central

183 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain's Drug World* (2012), p 192-193

184 Q569

185 UNODC *Estimating illicit financial flows resulting from drug trafficking and other transnational organized crime*, (September 2012), p 7

186 WWF *Founders' Memorial Lecture* (5 November 2003)

187 Q568

part of the global fight against drugs. In that context, the UK's approach to money-laundering has been far too weak. Whilst we recognise that the financial crisis has occupied the attention of the FSA since 2008, there is little evidence that it treated the issue of money laundering sufficiently seriously prior to that time. We welcome the creation of the Financial Conduct Agency and we recommend that it produce annual reports which show the prevalence of money laundering within the UK financial sector.

152. Being fined by a regulatory body is an inadequate a sanction for complicity—however peripheral, and whether it is wilful or negligent—in an international criminal network which causes many thousands of deaths each year. We recommend that the Government bring forward new legislation to extend the personal, criminal liability of those who hold the most senior posts in the banks involved where they are found to have been involved in money laundering.

The impact of austerity on drug-related policing

153. The UK Drug Policy Commission recently carried out a survey looking at the impact of recent cuts in funding and the transfer of responsibilities to Policing and Crime commissioners on drug-related policing activities. The key findings were:

- Drug-related policing expenditure and activity is expected to decrease and there is a perception that it is faring worse than other police activities.
- Proactive work related to the detection of drug supply is expected to decrease. Activities such as covert surveillance, test purchasing and other intelligence gathering work were most often mentioned as likely to decrease. This may have an impact on the police's ability to monitor the drug problem in their area and to contribute to broader initiatives such as Street Level Up.
- Those drug-related activities that appear likely to increase are ones, such as asset forfeiture, that could contribute to income.
- Uncertainty about partner agencies is high and less partnership working and work with community groups is expected. This is of concern given the evidence of the importance of partnership working and community engagement for effective drug-related policing.¹⁸⁸

154. The survey was completed by officers based upon their own experiences meaning that it is anecdotal rather than statistical evidence. However, there appears to be real concern that if some activities are curtailed, it could significantly impact on the ability of police forces to restrict supply effectively. The survey highlighted several specific areas:

The drug-related activities that were most often mentioned as likely to decrease were mainly those that relate to intelligence and evidence-gathering around drug supply. For instance, around half of all survey respondents expected their level of drug test purchasing activities to decrease: 45% of forces and 49% of BCUs reported that this

188 UK Drug Policy Commission, *Drug enforcement in the age of austerity* (2011)

would either ‘decrease a little’ or experience a ‘major decrease’. Alongside this, 44% of force-level respondents expected their level of drug-related forensic testing to reduce, while over a third of all respondents (38% of forces and 37% of BCUs) said that they expected their drug-related covert surveillance to decrease. Over a quarter of force respondents (27%), and 25% of BCU respondents, expected the use of drug dogs to decrease.¹⁸⁹

155. All of these activities provide information to produce a wider picture of drug use and activity. The annual publication of drug seizures in November 2011 highlighted one case where this had already happened as the new system used to record drug seizures by Merseyside Police resulted in the force recording 1,797 seizures in 2010-11, an 86 %decrease on the number recorded during the previous year (12,946 seizures). The total number for England and Wales excluding Merseyside’s seizures was 207,033 in 2010-11 compared to 207,507 in 2009/10, a decrease of 0.2 per cent.¹⁹⁰

156. Financial constraints on the police are not a new phenomena – a recent publication based on interviews with officers working in drug policing gave several examples of the impact of budgetary concerns.

“We would be discouraged by our bosses from arresting someone towards the end of the day because of the overtime factor. And dealers are often aware of that” ... Officers who carry out a drug-dealing arrest must complete the process back at the station themselves rather than hand it over to a colleague working a later shift. “We spot a user buying a few bags of heroin from a dealer and we grab them both. That would take five officers – two taking out the dealer, two on the user and one doing the surveillance. We would need the user because he holds the vital evidence of the sale. If you arrest two people at 2 p.m. then most of you will be busy until 10 p.m. It’s a lot of overtime.”¹⁹¹

Another officers gave a similar example

“A straightforward job can take hours for all the officers involved and so arrests late in the day are avoided” says the officer “But, by the end of the financial year in March, it’s all about spending money: our bosses are desperate to get rid of any under spend. There is usually a feeding frenzy in March by officers in my force fighting for overtime.”¹⁹²

157. Drug-related policing is a vital component of reducing supply and the intelligence aspect, whether it be data on supply routes, the trend in available products or the location of markets, assists not just local police forces but other law enforcement agencies. Following the election of Police and Crime Commissioners, the use of police budgets will be decided with increased community input and local accountability. There is a risk that significant variations in the local approach to drugs could lead to

189 UK Drug Policy Commission, *Drug enforcement in the age of austerity* (2011)

190 Home Office, *Seizures of drugs in England and Wales 2010/11*, Home Office, (November 2011), p 9

191 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain’s Drug World* (William Heinemann 2012), p 158

192 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain’s Drug World* (William Heinemann 2012), p 159

geographical displacement of the drugs trade within the UK. Commissioners will therefore need to be fully briefed on the wider impact of decisions which they might take locally. We recommend that the National Crime Agency submit to every Police and Crime Commissioner and Chief Constable an annual, confidential briefing setting out the measures they could take to contribute to disrupting the drugs trade nationally and internationally.

158. Police time is always limited and needs to be carefully prioritised to have the most impact. As budgets get tighter going forward this situation will intensify. It is important that Police Commissioners carefully consider how best to target drugs crime in their local area. In particular, we encourage Police Commissioners to ensure they are fully informed about the relative effectiveness of different forms of drug-related policing, including cannabis warnings and other forms of diversion work, and to carefully consider the issue of how police time is best prioritised between different kinds of drug-related offences, whether simple possession, acquisitive crime, supply or trafficking.

Identifying drug-related crime

159. There are three types of drug-related crime: crime which results from the intoxication and disinhibition effects of the drugs on the user; crime committed to fund the purchase of drugs; and crime related to drug markets and distribution.¹⁹³ Identifying the levels of drug related crime is vital to ensure that those that commit offences as a result of drug dependence are treated for that dependence rather than simply incarcerated because without addressing the dependence, incarceration alone is unlikely to be an effective deterrent to an addict and the cycle of addiction and drug-related reoffending will not be broken. In 2003-04, the Home Office estimated that £13.9 billion is the annual cost of drug-related offending (mainly acquisitive crimes committed by problem drug users such as theft and burglary). Of the £13.9 billion, £9.9 billion are the costs to the victims of these crimes and £4.0 billion are the costs incurred by the criminal justice system.¹⁹⁴

Drug Intervention Programme

160. The Drug Interventions Programme (DIP) was introduced in April 2003 with the aim of developing and integrating measures for directing adult drug-misusing offenders into drug treatment and reducing offending behaviour. The Drug Interventions Programme identifies offenders using Class A drugs as they go through the criminal justice system and puts into action a range of interventions to deal with their behaviour, with the aim of getting them out of crime and into treatment and other support. This begins at an offender's first point of contact with the criminal justice system (at which point a drug test is undertaken). Following a positive test, the individual then continues through the journey that can include custody, court, sentence, treatment and beyond into resettlement.

193 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 78

194 Home Office, *Measuring different aspects of problem drug use: methodological developments*, (November 2006), p 43

161. In April 2005 Testing on Arrest was introduced as part of DIP. The police gained this power as part of the Drugs Act 2005. Previously the police could test individuals on charge only. This change increased the number of individuals that could be tested (many of those arrested are not charged) and gave the police a greater chance of identifying offenders who were using drugs. It has several constraints in terms of providing data about the extent of drug-related crime: drug testing only applies to those aged 18 years or over and those tested are only tested for cocaine and heroin use. Also, not all areas undertake testing on arrest and it was introduced in different areas at different times. Within geographical areas that operate the 'Intensive' Drug Interventions Programme, all offenders arrested for certain types of offences are routinely tested for opiates and cocaine metabolites. Those arrested for other offender types may also be tested, at the discretion of a senior police officer.

Dedicated drug courts

162. As part of the evaluation of dedicated drug courts, the offences tried in drug courts were recorded and the results are attached below. In 40% of the cases heard by the drug courts, the offence was theft. The next most common offence was possession of Class A drugs accounted for 8% of cases.

Distribution of offence types recorded by pilot site (column percentage) *							
Offence code	Barnsley	Bristol	Cardiff	Leeds	Salford	West London	Total
Theft	201(20%)	299(64%)	223(46%)	274(45%)	102(47%)	37(55%)	1136(40%)
Possession Class B drugs	139(14%)	7(2%)	30(6)	4(1%)	18(8%)	1(1%)	199(7%)
Possession Class C drugs	110(11%)	4(1%)	13(3%)	6(1%)	15(7%)	0(0%)	148(5%)
Possession Class A drugs	89(9%)	8(2%)	67(14%)	38(6%)	12(6%)	12(18%)	226(8%)
Cultivating Cannabis	93(9%)	0(0%)	2(0%)	5(1%)	8(4%)	0(0%)	108(4%)
Other	82(8%)	22(5%)	10(2%)	87(14%)	23(11%)	3(4%)	226(8%)
Possessions any class of drug with intent to supply	41(4%)	0(0%)	0(0%)	3(1%)	0(0%)	0(0%)	44(2%)
Driving Offences	39(4%)	13(3%)	27(6%)	6(1%)	6(3%)	1(1%)	92(3%)

Possession of controlled drug with intent to supply	39(4%)	0(0%)	9(2%)	3(1%)	0(0%)	0(0%)	51(2%)
Breach of Community Order	30(3%)	0(0%)	6(1%)	120(20%)	3(1%)	2(3%)	161(6%)
Fraud	29(3%)	5(1%)	1(0%)	5(1%)	7(3%)	1(1%)	47(2%)
Fail to Surrender	22(2%)	47(10%)	41(8%)	3(1%)	0(0%)	5(7%)	118(4%)
Burglary	17(2%)	9(2%)	13(3%)	21(3%)	3(1%)	2(3%)	65(2%)
Criminal Damage	14(1%)	3(1%)	6(1%)	4(1%)	7(3%)	0(0%)	34(1%)

*P45, The Dedicated Drug Courts Pilot Evaluation Process Study, Ministry of Justice, January 2011 * Concerns over the quality of data collected means that caution should be exercised with this set of findings.*

163. Identifying drug-related crime is vital in order to ensure that the right approaches to reduce re-offending are targeted and effective. Drug-dependent offenders are often prolific re-offenders—by identifying their prevalence, the Government and local authorities can make targeted interventions in the community.

New psychoactive substances

164. New psychoactive substances (often referred to as ‘Legal Highs’) are drugs which are not classified under the Misuse Of Drugs Act 1974, having been newly manufactured in order to bypass traditional controls. These drugs are available to purchase in outlets (known as ‘head shops’ or ‘smart shops’) and on the internet and, as they are labelled ‘not for human consumption’ there are no controls or regulations placed upon them. Probably the most well-known new psychoactive substance (NPS) is Mephedrone which was widely reported upon in the UK media in March 2010 following several deaths which were suspected to be associated with substance. Since then, many more substances have been marketed as ‘legal highs’—in Europe there were 41 new substances discovered in 2010. In 2011, UK police discovered a new substance almost once a week on average.¹⁹⁵

165. The prevalence of these NPSs led the Government to introduce a ‘Temporary Class Drug Order’ which allowed them to temporarily ban a drug for 12 months whilst the ACMD examine the drug to decide whether it should be controlled under the Misuse of Drugs Act 1971. Importation, exportation, production and supply of a drug placed under a Temporary Class Drug Order is illegal but possession is not. After the 12 month period expires, the drug must either be classified or the temporary order is revoked. The first Temporary Class Drug Order was introduced in March 2012, to control a substance

¹⁹⁵ The European Monitoring Centre for Drugs and Drug Addiction, *Report* (2012), p 89

known as ‘Mexxy’. On the 1 November 2012, the Home Office announced that ‘Mexxy’ was classified as a Class B drug. The scale of the problem however has led many to question whether Temporary Class Drug Orders are a suitable solution. The Angelus Foundation told us that

The Misuse of Drugs Act is not equipped to deal with such rapid change in the drugs landscape and research on Mephedrone prevalence shows simply illegalising a drug does not reduce prevalence and harms. Temporary Orders are simply a stop-gap for that out-dated process.¹⁹⁶

166. Mephedrone, which was banned in April 2010, was registered as the joint-third most-prevalent drug used by 16-24 year olds in the most recent Drug Misuse Declared survey.¹⁹⁷ The number of deaths recorded as being caused by Mephedrone actually rose after the ban, from 5 in 2009 to 29 in 2010¹⁹⁸ (the latest year for which we have data available). In fact, although there were reports of its use from 2009, it did not become widely used until the media reports started in 2010.¹⁹⁹ When ACPO submitted evidence to us, it described the situation surrounding NPSs.

The feedback from police forces is that legal highs are readily available across the country and there is considerable uncertainty, some would say confusion, as to the nature and status of such substances and the risks associated with their use. There is also strong anecdotal evidence of poly-drug use. It must be assumed that this ready availability will continue for the foreseeable future. ACPO Drugs Committee is of the opinion that these substances present the most significant challenge to existing legislation and the Government’s Drug Strategy.²⁰⁰

167. The traditional approach of the UK police to combating drug use is tackling the criminals involved in drug trafficking and drug dealing and taking a less harsh ‘deterrent/diversion’ approach to instances of personal possession. This approach does not work with new psychoactive substances for several reasons:

- The speed with which new substances are being produced and made available
- The use of the internet and retail outlets such as ‘head shops’ to supply these substances
- The use of social networking to spread news about such substances and to promote their use. Instances have been seen of party invitations circulating on smart-phones including an embedded internet link to a supplier of legal highs.²⁰¹

168. ACPO stated that “the problems caused by new psychoactive substances are different to the issues caused by conventional illegal drugs and so police officers have little comparable experience.” Instead of treating NPSs as a conventional illicit drug, ACPO

¹⁹⁶ Ev 142

¹⁹⁷ P17, 2011-12

¹⁹⁸ NSPAD, *Annual report* (2010), p 95

¹⁹⁹ Prof. David Nutt, *Drugs without the hot air*, UIT Cambridge, (2012) P115

²⁰⁰ Ev 179

²⁰¹ Ev 180

suggested that legislation aimed at those who sell the substances in ‘Head Shops’ might allow them to reduce supply.

The combination of budget pressure and substantial and ongoing changes to the provision of forensic services means that it is most unlikely that unidentified substances such as legal highs will be sent off for analysis. Consequently information with regards to these substances and potential intelligence will not be routinely available. The practical problems are predictable. Operational officers report that some Head Shops appear to exploit the letter of the law by deliberately mislabelling substances and misrepresenting their use and purpose. They are labelled variously as plant food, bath salts, pond cleaner, room odorises or ‘research’ chemicals. They continue this pretence by adding the warning – ‘Not for Human Consumption’, which is designed primarily to protect them from the Medicines Act and Food Labelling Regulations.²⁰²

ACPO accepted that some ‘Head Shop’ proprietors may not know exactly what the chemical ingredients of the substances they are selling are, but contend that “they do know exactly what they are intended for – e.g. to be consumed by users to mimic the stimulant effects of an illicit drug, e.g. cocaine, ecstasy or amphetamine. Why else would a user pay £20 per gram for plant food?”²⁰³ ACPO suggests that consideration should be given to the Head Shop owner being made accountable for all the products they sell and to be potentially liable for any subsequent harm or injury they may cause to a purchaser or user of the product. Although in general they are unlicensed, some forces have worked in partnership with Local Authorities (regarding by-laws) and Trading Standards departments (regarding consumer legislation) in an attempt to bring some form of control to this area of business. ACPO suggest that legislation could be passed to control these by drafting legislation similar to that which controls sex shops, betting offices and other licensed premises.²⁰⁴

169. Another alternative method of dealing with the situation was developed in New Zealand which also had high levels of NPSs from the mid-2000s. Rather than try to classify these substances within existing drug law, the Government asked the New Zealand Law Commission to review their drug laws. The Commission proposed that whilst the existing drug laws stand, the Government take a different approach to the regulation of new drugs. A new regulatory regime

would require manufacturers and importers of a new substance to obtain an approval for a substance before releasing it onto the market, based on trials that find it to pose a ‘low risk.’ A new independent regulatory authority would determine applications for approvals. If the regulator decided that a substance was so harmful that it should not be approved, the regulator would refer the substance on to be considered for inclusion in the prohibited drugs regime. Prohibition would also be

202 Ev 180

203 Ev 180

204 Ibid

considered if the regulatory regime proved to be ineffective in minimising the harm of a regulated drug.²⁰⁵

170. The market in new psychoactive substances is changing quickly, too quickly for the current system of temporary banning orders to keep up. Forty-nine new substances were found in Europe last year, a rate of development which makes additional measures critical. At the moment, businesses are legally able to sell these products until such time as they are banned with apparently no legal consequences when they lead to death or long-term illness. We recommend that the Government issue guidance to Local Authority trading standards departments, citizens advice bureaux and other interested parties on the action which might be taken under existing trading standards and consumer protection legislation to tackle the sale of these untested substances. A restaurant which gave its diners food poisoning, a garage which left cars in a dangerous state, or a shop which sold dangerously defective goods could all be prosecuted for their negligence. Retailers who sell untested psychoactive substances must be liable for any harm the products they have sold cause. It is unacceptable that retailers should be able to use false descriptions and disclaimers such as “plant food” and “not for human consumption” as a defence where it is clear to all concerned that the substance is being sold for its psychoactive properties and the law should be amended.

Use of the internet

171. The internet is not only facilitating access to new psychoactive substances, there is also evidence that illicit drugs are being purchased via the world wide web.²⁰⁶ In the past year or so there have been several press reports in the US and UK about websites selling illegal drugs. The American website Gawker reported in June 2011 on a website called ‘Silk Road’ which it described as “Amazon – if Amazon sold mind-altering chemicals.”²⁰⁷ It interviewed a software developer who had purchased 10 tabs of LSD using bitcoins—an electronic currency which is used legitimately by online gamers, but which can be used by criminals to mask their financial transactions. It is a peer-to-peer currency which is supposedly untraceable, not issued by banks or governments, but created and regulated by a network of other bitcoin holders’ computers. The author described a selection of the items available for purchase on Silk Road as including cannabis, ecstasy, LSD and heroin.²⁰⁸

172. More recently, BBC 5Live reported on a network known as ‘Dark Web’ an online black market which sells drugs, fake passports, guns and child pornography. It allows users to remain anonymous. Users often do not know the real identity of the fellow users they are dealing with, and it is difficult for authorities to track them. Dark Web also uses bitcoins as currency. The researchers at the BBC ordered DMT, a Class A drug via Dark Web which arrived three weeks later which contained a white powder concealed between

205 UK Drug Policy Commission, *A fresh approach to drugs* (2012), p 136

206 UK Drug Policy Commission, *A fresh approach to drugs* (2012), p 30

207 <http://gawker.com/5805928/the-underground-website-where-you-can-buy-any-drug-imaginable>

208 Ibid

two thin strips of cardboard. Analytical Services International, at St George's University of London examined the drugs and found that the powder was DMT.²⁰⁹

A 2012 publication which looked at the prevalence of drug dealing on the internet stated that

The internet is transforming the drug industry. ... Free from the threat of violence that pervades the street market, buyers and sellers feel safe cloaked by anonymous usernames, protected from the authorities by readily available encryption software. ... The online drug market accounts for only a fraction of drug sales worldwide. It is a trade in its infancy. But it has opened a door to a completely new way of buying and selling drugs that renders existing enforcement efforts, designed to combat the traditional drug smuggling and distribution system, irrelevant. ... The fluidity of the internet, and the privacy it provides, making policing the online drug trade even more of a 'needle in a haystack' exercise than searching freight.²¹⁰

The effect of having a drugs conviction

173. Whilst there are no professions which automatically bar someone with a drugs-related conviction or caution, the Independent Safeguarding Authority can assess people with convictions before allowing them to work with children or vulnerable adults. Anyone with a conviction for supplying drugs to children, for instance, would be barred from working in a profession whereby they came in to regular contact with children.²¹¹

174. In most other professions, under the terms of Rehabilitation of Offenders Act 1974, whether or not a conviction or caution is disclosed to a potential future employer depends whether it is 'spent' or 'unspent'. An unspent conviction or caution must be disclosed whereas a spent conviction or caution does not need to be. A spent conviction is a conviction which can be effectively ignored after a specified amount of time (between five and ten years, depending of the length of the sentence) and so does not need to be disclosed. A conviction which results in a sentence for longer than 30 months can never become spent. A simple caution becomes spent as soon as it is given and a conditional caution becomes spent three months from the date on which it was given.²¹²

175. There are however professions which are exempt the under Rehabilitation of Offenders (Exceptions) Order 1975 and so require disclosure of both spent and unspent convictions:

- Healthcare Professional – A person who is regulated by a body mentioned in subsection (3) of section 25 of the National Health Service Reform and Health Care Professions Act 2002.

209 <http://www.bbc.co.uk/news/business-16801382>

210 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain's Drug World* (William Heinemann 2012), p 129

211 Information supplied by the House of Commons Library

212 Information supplied by the House of Commons Library

- Barrister (in England and Wales), solicitor.
- Chartered accountant, certified accountant.
- Veterinary surgeon
- Actuary
- Registered foreign lawyer
- Legal executive
- Receiver appointed by the Court of Protection.²¹³

176. According to NACRO, from which we commissioned research into the effects of a drug-related conviction on employment,

an individual would not necessarily be restricted from employment in an exempt profession for having a conviction for possession of Class A or B drugs, even in professions which involve the individual having unrestricted access to prescription drugs.

In addition, our research confirmed that an individual would not necessarily be prevented from applying to other professions which require the applicant to have a higher level of personal integrity including working as an MP or local councillor, working in the security services or for the Serious Organised Crime Agency. The only role we could identify where an individual would automatically be barred for having a conviction for possession of Class A or B drugs is the newly created Police Crime and Commissioner role.²¹⁴

The security services will often require any drug use to have been prior to service however. The Ministry of Defence document 'Drugs in the Armed Forces' explains the MOD's approach to previous drugs convictions:

Because of the prevalence of drug misuse in society generally, a previous episode of drug misuse without aggravating circumstances (e.g. an unspent criminal conviction) would not necessarily prevent an individual from being recruited into the Armed Forces. However, all individuals are required to read and sign that they have understood the Services' policy on drugs in the recruiting office. They also receive a briefing on Service policy during initial training and become liable for Compulsory Drugs Testing (CDT) after the first 6 weeks of training.

213 <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/CRB/about-the-crb/eligible-positions-guide?view=Binary>

214 Ev w381

Evidence of drug misuse, on or off-duty, by serving personnel would normally result in Discharge *Services No Longer Required*, which is a dishonourable discharge and precludes returning to employment in the Armed Forces at a later date.²¹⁵

177. NACRO also highlighted concerns that many organisations routinely carry out enhanced CRB checks (which detail spent and unspent convictions, cautions, reprimands and final warnings) even though the position is not eligible for these checks under the under the Rehabilitation of Offenders (Exceptions) Order 1975. Their research shows that these unlawful checks often have an extremely negative impact upon an individual's ability to obtain employment and that many employers "routinely withdraw job offers once they receive a CRB certificate detailing a conviction, even when the applicant has already disclosed their criminal record during the recruitment process. In addition, many employers operate a clean CRB policy, will not accept applicants with any information on their record and will not take into account any other factors such as: the disposal issued; the length of time that has elapsed since the conviction; mitigating circumstances; or the person's employment record before and after the conviction."²¹⁶ Their research also shows that many employers will not knowingly consider employing an applicant with a conviction, and nearly 50% of employers would not employ an individual with a drug-related conviction.²¹⁷

178. We believe that former drug users should be encouraged to play an active part in society, and that making it harder for them to find employment is likely to hinder that process, and make it more likely they will be unemployed and supported by the state. We therefore recommend that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in CRB checks after they become spent, or after three years, whichever is shorter. The review should, in particular, take account of those areas of employment to which drugs convictions are directly relevant. We also recommend that cannabis warnings be treated as spent immediately.

Cross-Departmental strategy

179. The responsibility for drugs policy lies within the Home Office in the UK although that has not always been the case—between 1994 and 2002, drugs policy was under the purview of the Lord President of the Council (the senior Cabinet Office Minister). In 2007, the RSA recommended that responsibility for drug policy be moved to the Department for Communities and Local Government.²¹⁸ The Home Office lead on drugs policy is unique in Europe as the chart below shows.

Country	Ministry of	Home/Interior	Other Ministry
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215 Ministry of Defence, *Drugs in the Armed Forces* (accessed 09 October 2012), p 1
http://www.mod.uk/NR/rdonlyres/B4247457-89A9-4F34-8EF0-8462544DE7F5/0/drugs_armedforces.pdf

216 Ev w381

217 Ev w380

218 RSA Commission on Illegal Drugs, *Drugs – facing facts* (Communities and Public Policy 2007)

	Health	Ministry	
Austria	X		
Belgium			X - General Drugs Policy Cell (Operates at Inter-Ministerial level but coordinated by the national drug coordinator and supported by the Federal Public Service of Health, Food Chain Safety and Environment)
Bulgaria			X - National Drugs Council (Operates at the inter-ministerial level. Chaired by the Minister of Health, the Council includes three deputy chairpersons (the Secretary General of the Ministry of Interior, the deputy chairperson of the State Agency for National Security and a Deputy Minister of Justice), a secretary and 24 members.)
Cyprus			X - The Cyprus Anti-Drugs Council (Formerly presided by the Minister of Health, since 2010 the Council has been presided by the CAC President, who is effectively a national drugs coordinator appointed directly by the President of the Republic, and has the Chairperson of the Cyprus Youth Board as Vice-President. The other members are seven experts nominated by the Council of Ministers).
Czech Republic			X - The Government Council for Drug Policy Coordination. (Presided over by the Prime Minister, the Council includes all ministries involved in the delivery of the national drug policy and three representatives of civil society respective regions (Czech Medical Association — Association for Addictive Diseases, Association of NGOs dealing with drug prevention and treatment, and Association of the Regions).
Denmark	X		
Estonia			X - Minister of Social Affairs
Finland			X - National Drug Policy Coordination Group (composed of representatives from all involved Ministries and is reappointed every four years).
France			X - The Inter-ministerial Committee on Drugs (The committee is placed under the authority of the Prime Minister and is composed of ministers and state secretaries. The Inter-ministerial Mission for the Fight against Drugs and Drug Addiction (Mission interministérielle de lutte contre la

			drogue et la toxicomanie, MILDT) prepares, coordinates and partly implements the decisions of the committee.)
Germany	X		
Greece			X - National Committee for the Coordination and Planning of Drugs Responses (comprised of representatives from 10 Ministries. The work of the National Committee is coordinated by the Greek Organisation Against Drugs (OKANA).)
Hungary			X – Coordination Committee on Drug Affairs (CCDA).(Chaired by the Secretary of State for Social, Family and Youth Affairs).
Ireland	X		
Italy			X - The Department for Anti-drug Policies is tasked with the day-to-day operational coordination of Italian drug policy and is placed under the competency of the Minister for International Cooperation and Integration. Coordination at the regional level is undertaken through the regional office for drugs and drug addiction within either the Health or Social Policy Department.
Latvia			X - The Drug Control and Drug Addiction Restriction Coordination Council (Chaired by the Prime Minister and comprised of seven ministers and several national experts).
Lithuania			X - Drug, Tobacco and Alcohol Control Department
Luxembourg	X – in conjunction with the inter-Ministerial Committee on Drugs		
Malta			X - Ministry for Justice, Dialogue and the Family
Netherlands			X - The Minister of Health, Welfare and Sport is tasked with the coordination of drug policy, while the Ministry of Security and Justice is responsible for law enforcement and matters relating to local government and the police. The Ministry of Foreign Affairs is in charge of certain issues, including matters relating to HIV/AIDS and injecting drug use on behalf of the

			Government at the international level.
Norway	X		
Poland			X – Council for Counteracting Drug Addiction (Chaired by the Secretary or the Undersecretary of State in the office where a minister competent for health matters operates).
Portugal	X		
Romania			X – National Anti-drug Agency
Slovakia			X - Ministerial Council (Headed by the Prime Minister, the Council includes representatives from all Government Ministries.)
Slovenia			X - Government Commission for Drugs of the Republic of Slovenia. (The Commission includes representatives from the Ministry of Health, Ministry of Interior, Ministry of Education, Science, Culture and Sport, Ministry of Labour, Family and Social Affairs, Ministry of Justice, Ministry of Finance, Ministry of Defence, Ministry of Agriculture and Environment, as well as the Ministry of Foreign Affairs. The administrative work of the Commission is performed by the Ministry of Health.)
Spain			X - Inter-ministerial Group, chaired by the Minister for Health, Social Policy and Equality, and including the Ministers for Foreign Affairs and Cooperation, Justice, the Interior, Education, Work and Immigration and Territorial Policy and Public Administration, as well as several Secretaries of State.
Sweden	X		
United Kingdom		X – Supported by Inter-Ministerial Group which is chaired by the Home office and includes Ministers from the Department for Communities and Local Government, the Department for Education, the Department of Health, the Department for	

		Work and Pensions, the Ministry of Justice and the Cabinet Office	
Total	9	1	17

Collated from the EMCDDA website by Committee staff. Accessed September 2012.

180. In the US drug policy is co-ordinated by the White House Office of National Drug Control Policy (ONDCP). A component of the Executive Office of the President, ONDCP was created by the Anti-Drug Abuse Act of 1988. It advises the President on drug-control issues, coordinates drug-control activities and related funding across the Federal government, and produces the annual National Drug Control Strategy, which outlines Administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences.²¹⁹ In Australia, the Intergovernmental Committee on Drugs (IGCD) is a Commonwealth, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction and in New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations. The committee provides policy advice to relevant ministers on drug-related matters, and is responsible for implementing policies and programs under the National Drug Strategy framework.²²⁰

181. Whilst discussing where drug policy should lie within Government, the recent UKDPC report concluded that they could find little concrete evidence that different departmental leadership delivers different outcomes. Instead, they found that the quality of the leadership was probably more important than which Secretary of State had responsibility for coordination and leadership. The report highlighted the view that without the strong influence of the Home Office and their overriding interest in reducing crime, efforts to expand drug treatment and recovery services would never have happened as the Secretary of State for the Department of Health will “always have other and more pressing priorities.”²²¹

182. Throughout the report, we have demonstrated the importance of the various different government departments involved in the 2010 drug strategy not only playing their own roles effectively but also working well together. Cross-departmental working is not historically a strength of the British Government although we are assured that this is changing over time with Rt Hon Kenneth Clarke QC MP stating,

what has improved is the co-ordination between Departments. I was once given the thankless task of co-ordinating the Government's whole approach to drugs, and pulling together the work of the different Departments in the late 1980s. It was a complete waste of time. I did not have sufficient seniority in the Government to get anybody to take the faintest notice of me, and they merely thought it was a bid by my

²¹⁹ <http://www.whitehouse.gov/ondcp/about>

²²⁰ Australian Government. *National Drug Strategy 2010-2015*, p24

²²¹ UK Drug Policy Commission, *A fresh approach to drugs* (2012), p 138

Department to muscle in on the territory of either the Home Office or the Health Department or whatever. That has not vanished but it is very, very much less than it used to be.²²²

Some of this cross-departmental working will be implemented through the inter-ministerial group on drugs, chaired by Jeremy Browne MP. A former civil servant who now works with the Angelus Foundation recently published criticism of the inter-ministerial group, describing it as

a woefully inadequate decision-making body, which I attended as an official. Departments often do not send representatives which underlines the lack of a co-ordinated approach. It was not a business-like forum, the tone was more like, “so, tell us what have you’ve been up to lately?” There is an absence of transparency about the committee—there are no minutes available and it is not even mentioned in the drug strategy document.²²³

183. Tackling drug use touches on issues of criminal justice, social justice, education, health and local authorities, which is why the formation of an Inter-Ministerial Group to coordinate Government policy on the subject makes sense. However, as with any other cross-departmental challenge, driving through reform requires clear, senior leadership. Our recommendation for the Home Secretary and the Secretary of State for Health to take joint overall responsibility for drugs policy will help to strengthen inter-departmental co-operation, with a focus on prevention and public health.

222 Q416

223 <http://blogs.bmj.com/bmj/2012/03/20/jeremy-sare-on-the-french-drugs-model/>

6 Drugs in prisons

Drug use in prisons

184. Drug use is a major problem in the prison system:

- 70% of offenders report drug misuse prior to prison;
- 51% report drug dependency;
- 35% admit injecting behaviour;
- 36% report heavy drinking; and
- 16% are alcohol dependant.²²⁴

A survey by the Prison Reform Trust has found that 19% of prisoners who had ever used heroin reported first using it in prison.²²⁵

185. The Ministry of Justice's overall measure of success in tackling prison drug-use is the proportion of prisoners testing positive under the random mandatory drug testing programme. This figure has fallen significantly, from 24.4% in 1996–7 to 7.1% in 2010–11, representing a 71% decline in the proportion of prisoners testing positive.²²⁶ However, despite this overall reduction in measured drug use, it continues to be a serious problem in certain prisons. A recent Report on HMP Durham by Her Majesty's Inspector of Prisons found that as many as one in three prisoners tested positive in random tests, and 13% told inspectors that they had developed a drug problem while in prison.²²⁷

186. Boredom and a lack of structured activity are often cited as reasons for drug use among prisoners.²²⁸ HM Chief Inspector of Prisons has said that the main issue facing prisons is not “how many prisoners could be squeezed into the available cells”, but “whether there were the resources available to hold all detainees safely and securely and do anything useful with them when they were there”.²²⁹ In Durham, the inspectors found that education was operating at only two-thirds capacity, and prisoners spent between 16 and 20 hours locked in their cells each day.²³⁰

224 Ev 192

225 Prison Reform Trust, *Out for Good: taking responsibility for resettlement* (September 2012), p 47

226 Ev 194

227 <http://www.justice.gov.uk/downloads/publications/hmipris/prison-and-yoi-inspections/durham/durham-2011.pdf>

228 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain's Drug World* (William Heinemann 2012), p 42

229 Her Majesty's Inspectorate of Prisons, *Annual report 2011-12*, p 8

230 <http://www.justice.gov.uk/downloads/publications/hmipris/prison-and-yoi-inspections/durham/durham-2011.pdf>

Availability of drugs in prisons

187. In the annual report 2011-2012 of Her Majesty's Chief Inspector of Prisons, information taken from surveys carried out during the previous year found that 24% of prisoners reported that it was easy or very easy to get drugs in their prison.²³¹ Officials from the National Offender Managing Service told us that drugs enter prisons by a variety of means: they are brought in by corrupt staff, smuggled in by visitors, newly-arriving prisoners or in the post, or quite commonly thrown over the wall from outside.²³² Prison inspectors recently found that there had been 54 "throw-over" packages detected at HMP Birmingham over a three-month period. Prisons use a range of strategies to prevent drugs and other contraband getting in, including the physical searching of prisoners and visitors, drug detection dogs, intelligence sharing with the police and mandatory drug testing.²³³ There are also plans to increase intelligence sharing between prisons under "Project Mercury" a secure IT based intelligence system, which is intended to improve NOMS' ability to assess the threat to prison security locally, regionally and nationally, including drugs.²³⁴ This is due to be rolled out over the course of the next year.

188. We accept that prisons cannot be hermetically sealed and that it will never be possible to eradicate completely the availability of drugs within prisons. However, the fact that almost a quarter of prisoners surveyed found it easy to get drugs in prison is deeply disturbing. The methods of reducing supply are only effective if they are implemented as intended. We recommend that the National Offender Management Service ensure that measures such as the installation of netting to stop 'throw-over' packages, regular cell searches and regular drug tests based on suspicion are put into operation.

Drugs addiction treatment in prisons

189. Almost half of the prison population have an addiction to drugs. A majority of addicts in prison will be there because of crimes committed related to their addiction, whether it be acquisitive crime, violent crime, supplying or possessing drugs.²³⁵ Prison is an opportunity to help them recover and so break the cycle of drug use and re-offending. However, this outcome is not easy to achieve—partly because offenders do not always want to change their behaviour and partly because there is a lack of support for those who do wish to change. The Prison Reform Trust found that 47% of adults released from prison re-offended within a year. The figure was 57% for those serving sentences of less than 12 months.²³⁶ A 2008 study found that rates of using heroin, cocaine or crack were higher (44% to 35%) for prisoners sentenced to less than one year than for those serving longer terms,²³⁷ suggesting that drug dependent offenders might be more likely to re-offend.

231 Her Majesty's Inspectorate of Prisons, *Annual report 2011-12*, p 8

232 Q387

233 Ev 192 [Ministry of Justice]

234 Ev 192 [Ministry of Justice]

235 Prison Reform Trust, *The Bromley Briefings* (June 2012), p 59

236 Prison Reform Trust, *The Bromley Briefings* (June 2012), p 26

237 Ministry of Justice, *The problems and needs of newly sentenced prisoners: results from a national survey* (2008)

190. The Patel Report,²³⁸ published in September 2010, highlighted some of the recent improvements in the field of treatment for drug addiction within prisons. In particular, it identified an apparent link between spending on drug treatment in prison, reduction in drug use and reduction in reoffending rates:

- Funding for prison drug treatment was in 2010 over 15 times greater than in 1997 – with record numbers engaging in treatment.
- During the same period, drug use in prisons, as measured by random mandatory drug tests, decreased by 68%.
- This was accompanied by a significant decline in adult re-offending since 2000, with a fall of 13% between 2005 and 2006.
- Since the establishment of the Drug Interventions Programme (DIP) in 2002, to provide a route out of crime and into treatment, recorded acquisitive crime—of which drug-related crime constitutes a large proportion—has fallen by almost a third.²³⁹

This sense of improvement is repeated in a more recent report on prisoner rehabilitation by the Prison Reform Trust, which quotes one prisoner as saying:

Well, I have drug issues, and the substance misuse team here have been brilliant, they've been really good, really focused, really helpful and always there as and when you need them, now if that's a negative side of something I bring to prison, then they've been very positive and pro-active where they've been concerned.²⁴⁰

191. However Her Majesty's Inspectorate of Prisons has found significant variance in standards of drug treatment across the prison service.

First night treatment was inadequate at Belmarsh, Brixton and Wandsworth, yet at Chelmsford, a GP was available on the designated drug treatment unit until 9pm to provide first night prescribing, treatment was flexible and needs-led, and prisoners were offered an impressive range of activities and support services. At Wormwood Scrubs, we found a much improved service and prompt access to clinical support and, at Pentonville, it was evident that prisoners were fully involved in their treatment plan and a new substance misuse unit provided a much improved environment.²⁴¹

192. As well as clinical management of drug addiction (through detoxification or maintenance prescribing programmes), there are also psychosocial interventions within the prison service. CARAT (Counselling, Assessment, Referral, Advice, Throughcare) services have been available in all adult and young offender prisons in England and Wales

238 Report by Professor Lord Patel of Bradford OBE, Chair of the Prison Drug Treatment Strategy Group, *The Patel Report: Reducing Drug-Related Crime and Rehabilitating Offenders* (Department of Health, September 2010)

239 Prison Drug Treatment Strategy Review Group, *The Patel Report* (September 2010), p 23

240 Prison Reform Trust, *Out for Good: taking responsibility for resettlement* (September 2012), p 48

241 Her Majesty's Inspectorate of Prisons, *Annual report 2011-12*, p 35

since 1999. These services assess the nature and extent of a user's problematic drug use before providing, or referring to, a range of psychosocial interventions. It is designed to address the needs of low, moderate and severe drug users and to act as a gateway or link to other services within prisons and the community.²⁴² Some prisons also run accredited drug treatment programmes such as cognitive behaviour therapy, 12-step programmes and structured therapeutic communities which offenders can be referred to by the CARAT team.²⁴³

193. There are a number of issues with accessing the CARAT services for prisoners. Some prisoners report that security issues limit their access.

The Screws are so understaffed, when the CARAT team come on the wing and the Screws are like, 'No we're not unlocking anybody because we haven't got the staff to supervise you'. You can see the CARAT team arguing with them saying, 'We have to see these people to give them some support and help them for when they get out'. But the Screws are saying, 'We haven't got the staff to unlock them and supervise you doing this work'. I only saw them once and that was on my second day there, then I didn't see them after that in the whole six months I was there.²⁴⁴

There is a particular problem with prisoners who are serving shorter sentences, who are less likely to receive assistance with rehabilitation, partly due to waiting lists.²⁴⁵

Drug recovery wings and support on release

194. One of the newest innovations is the piloting of a number of drug recovery and drug-free wings in some prisons. We visited the drug recovery wing in Brixton Prison and were highly impressed by what we saw. We spoke with offenders based on the wing and received very positive accounts. The Drug recovery wing is gated and has 69 beds. It is an incentives-based therapeutic community aimed at prisoners with a minimum sentence of 3 months and a maximum sentence of 2 years. It has rooms available for therapeutic groups such as Alcoholics Anonymous and Narcotics Anonymous. These groups have 5 or 6 meetings a week in Brixton. We were concerned to find however, that there was an issue with the lack of funding for voluntary drug testing. The prison has had all funding for voluntary drug testing cut and although they have managed to use some of the PCT budget to sustain it, this will run out in March 2013. Both staff and prisoners are adamant that the voluntary drug testing regime is a key strand of the drug recovery wing and that the recovery of prisoners is less likely without it.

195. Both the Ministry of Justice and the Department of Health are currently undertaking evaluations in to the effectiveness of the drug recovery wings. If it is a success, the intention is to roll it out across the prison service as the Justice Secretary explained

The whole history of the struggle against drugs shows that an outbreak of enthusiasm occurs among politicians—everybody—for tackling it in a particular

242 Prison Drug Treatment Strategy Review Group, *The Patel Report* (September 2010), p 28-9

243 Ibid.

244 Ibid, p 20

245 Prison Reform Trust, *Out for Good: taking responsibility for resettlement* (September 2012), p 48

way, and it is pursued for a few years, and then you discover that it is producing rather disappointing results. So we will roll it out as resources permit, but that is not the main constraint, but we have to evaluate it carefully and get evidence to reinforce our optimism that we are going about it the right way.²⁴⁶

196. Despite these positive strides, two main gaps in provision for prisoners remain, as the Justice Secretary acknowledged: addressing the needs of those serving short sentences; and ensuring that continued support is available on release. In evidence to this inquiry, the Justice Secretary highlighted that he was aware of both of these matters.

One difficulty of course is the short term prisoners, the ones with 12 months or less, who don't stay in prison long enough to make a dramatic improvement, though we do concentrate on them. We find people who are trying to get off drugs and can be helped get on the way. We don't at the moment usually give any support to them when they leave the prison, so you have to put in place the programmes that will give them support.²⁴⁷

The need for support on release was emphasised to us by those we met on the drug recovery wing at Brixton Prison. In their experience, prison provided an opportunity for recovery which was then lost because on release there was so little support within the community. According to the prisoners, almost no one stays off drugs following release as they have so little structure in their lives.

197. The Prison Reform Trust has identified the provision of housing, employment, health and social care, and family support to be “pivotal to successful rehabilitation.”²⁴⁸ The point of release from prison is a particularly dangerous one for addicts. Not only is the risk of relapse high, even after they might have been drug-free for several months, but the risk of overdose is increased when an addict who has been abstinent for some period of time first relapses, taking a dose to which their body might no longer be habituated.

198. One of the ways which the Brixton drug recovery wing are addressing this problem was by organising housing and treatment within the community to start on the day of release and registering inmates on courses to provide structure to their day. This was done mainly by a peer support mentor working with a number of agencies including voluntary sector agencies including the St Giles Trust which supports prisoners on release.

199. Another prison that we visited—HMP Pentonville—has also addressed this issue, by having Islington Council fund a Prison Officer to work with the prisoners in their Integrated Offender Management²⁴⁹ cohort of prisoners who lived in Islington before they were incarcerated. Release planning starts immediately and as much as possible is completed prior to release. This could be the Housing Needs Assessments that local

246 Q404

247 Q405

248 Prison Reform Trust, *Out for Good: taking responsibility for resettlement* (September 2012), p 87

249 Local IOM arrangements involve a wide range of social agencies, including the voluntary sector, who have a role to play in tackling risk factors associated with crime and offending. IOM provides areas with the opportunity to target those offenders of most concern in a more structured and co-ordinated way. Building on an analysis of the crime and offending problems in an area, IOM will help to ensure coherent joint working across partnership agencies to make the best use of local resources, to ensure that targeted offenders do not fall through the gaps between existing programmes and approaches, and that identified problems are addressed.

authorities need or finding a specific support mechanism in the locality that would meet a particular need. Islington Council's monitoring of reducing re-offending rates and other targets, such as completions of licences, shows a reduction in crime. As this cohort tends to consist of prisoners convicted of acquisitive crime and those with a history of substance misuse, this has had a huge impact on the local community. Neighbouring Haringey Council has also recently joined the partnership.²⁵⁰

200. The scope for expanding this programme nationally is limited as it depends on working with a cohort of prisoners who come from the local area. For example, HMP Brixton has offenders from 33 London boroughs. A further complication is that every borough has a different Integrated Offender Management system which makes it impossible to have a standard process for the release of prisoners. HMP Brixton made the suggestion that each prison should serve a limited number of boroughs in order to make release easier to manage.

201. **We commend the work taking place on the drug recovery wings and the drug free wings in certain prisons. The examples that we saw of both were inspiring. If the evaluation of the pilots shows them to be successful, we recommend that they be rolled out nationwide as a matter of priority. We also recommend that the Government ensure that they remain fully funded. The matter of the lack of funding for voluntary drug testing in HMP Brixton's drug recovery wing is worrying and we ask that the Justice Secretary reassure us that such a vital strand of the recovery programme remains funded.**

202. **There is some very impressive work happening in some prisons at present with innovative approaches being formulated in regards to treatment and managing the transition of release but this is not the standard and there is considerable scope to spread best practice**

Abstinence or maintenance?

203. The Government's 2010 drug strategy announced that

This Government will work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and will offer a route out of dependence by putting the goal of recovery at the heart of all that we do.²⁵¹

In July 2012, the National Treatment Agency published a report which highlighted the importance of not allowing those addicted to heroin to remain on opioid substitution prescriptions without monitoring their progress.

It is not acceptable to leave people on [opioid substitution] without actively supporting their recovery and regularly reviewing the benefits of their treatment (as well as checking, responding to, and stimulating their readiness for change). Nor is it acceptable to impose time limits on their treatment that take no account of

250 Information supplied by HMP Pentonville (not printed)

251 Government's 2010 Drug Strategy, p 4

individual history, needs and circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational, realistic and protective.²⁵²

204. We were therefore concerned that representatives from the National Offender Management Service seemed to dismiss the possibility of abstinence-based programmes being introduced in prisons. Asked whether NOMS had adjusted drugs treatment strategies in prisons away from maintenance towards abstinence-based programmes, Richard Bradshaw, Director of Offender Health, replied:

Well, the simple answer is no because we have NICE-approved guidelines around the treatment with methadone, which has been established since 2006. So the integrated drug treatment system, which combines clinical with psychosocial, is the same as we have been applying since 2006. It is evidence-based in terms of being able to treat the addictions, and also in reducing reoffending. We have not moved away from that, but, with the advent of the idea of drug recovery wings, we have really placed that on a journey towards recovery.²⁵³

However the Justice Secretary later clarified that the policy was to “move towards a drug treatment system based on recovery, which does not maintain heroin users in prisons indefinitely on prescription alternatives, such as methadone, unless absolutely necessary.”²⁵⁴

205. Treatment in prisons, just like treatment outside prisons, should be tailored to the individual. Some people will be able to enter abstinence programs, and should be encouraged to do so. For others, such as those who are already being maintained on methadone, prescription alternatives may be the best option, and should be made available.

Breaking the cycle

206. In 2010, the Ministry of Justice published a consultation paper entitled ‘Breaking the Cycle. It stated that

The criminal justice system cannot remain an expensive way of giving the public a break from offenders, before they return to commit more crimes.²⁵⁵

Nowhere is that more true than in the area of drugs policy. A 2003 estimate placed the cost of drug-related offending at £13.9 billion a year, with £4 billion of that incurred by the criminal justice system.²⁵⁶ There are also the social costs of the low level crime associated with drug dependence, for the victims of crime and their communities. Drug-related re-

252 Recovery Orientated Drug Treatment Expert Group, *Medications in recovery: re-orientating drug dependence treatment* (July 2012), p 5

253 Q390

254 Q408

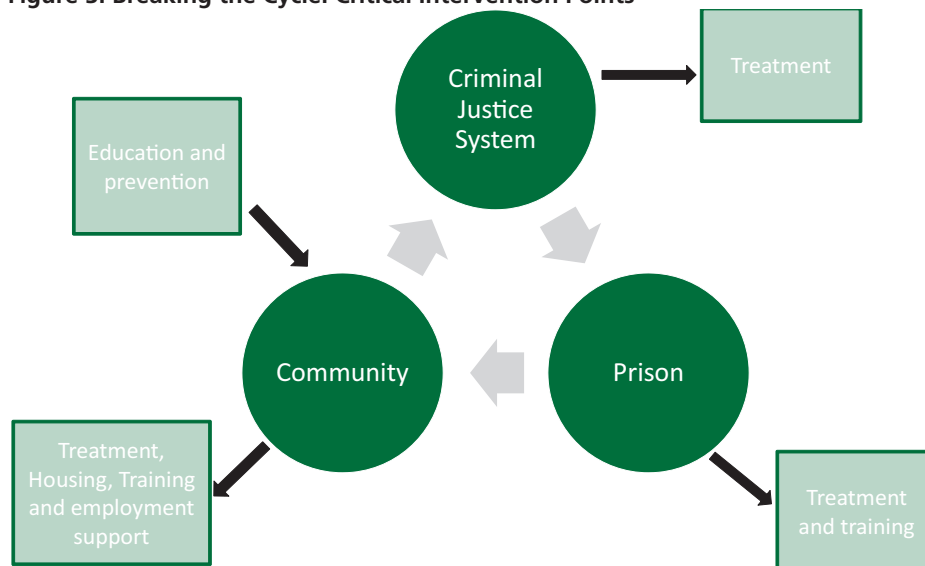
255 <http://www.justice.gov.uk/downloads/consultations/breaking-the-cycle.pdf>

256 Home Office, *Measuring different aspects of problem drug use: methodological developments*, (November 2006), p 43

offending is a cycle which must be broken, and we believe that it can be broken. There are several points where a drug-dependent offender can be helped.

- Education and prevention: drug-dependent offenders are not created in a vacuum, there are circumstances which contribute to their offending behaviour. We believe that one of the critical intervention points is before that offending starts. By using preventative methods to reduce drug use, we can reduce the prevalence of drug-related offending.
- Non-custodial treatment referrals: The Government response to the white paper stated that it “will explore options for intensive drug and alcohol treatment based accommodation.”²⁵⁷ Many drug-dependent offenders are likely to be on short sentences which reduces their treatment options within prisons. If the criminal justice system can divert such offenders in to treatment successfully, the reduction in future offending and prison costs could be substantial.
- Treatment and training in prison: we discussed the impact of treatment and training within prisons earlier in this chapter. Prison is a prime opportunity to get offenders off drugs.
- Treatment, housing, training and employment support: The 2010 Drug Strategy highlighted goal of developing a holistic, joined-up recovery system that goes beyond drug treatment and addresses the wider needs of those with dependence on drugs. Drug-dependent offenders will need support within the community if they are to avoid the circumstances which may lead to them re-offending.

Figure 3: Breaking the Cycle: Critical Intervention Points



Lack of reliable data

207. On arrival at a prison, offenders will undergo a health check, including an interview about previous and current drug use. This information is recorded in order to ascertain

257 <http://www.justice.gov.uk/downloads/consultations/breaking-the-cycle-government-response.pdf>

whether they have a problem which requires clinical management. Throughout their sentences, offenders are subject to random, mandatory drug testing. However, there are several criticisms of the mandatory testing regime. The Prison Reform Trust point towards a Home Office study which found that “mandatory drug testing results generally underestimate the level of drug misuse as reported by prisoners”. In addition HM Inspectorate of Prisons reported frequently seeing MDT programme staff diverted to other duties, resulting in a lack of timely target testing and abandoned tests.²⁵⁸

208. A 2010 Policy Exchange report also highlighted flaws in the system, arguing that the fact that prisons are required to meet a target for the number of positive tests – and the fact that the overall performance of the prison is partly judged according to how low this figure is – “disincentivises staff from building up a true picture of the scale of drug misuse”.²⁵⁹

209. Offenders are also subject to what is known as a “suspicion test”, whereby if a member of staff suspects drug use, they can recommend a test be carried out. However, in the reports on HMP Durham and HMP Birmingham, Her Majesty’s Inspectorate of Prisons criticised the lack of suspicion tests which were recommended but not carried out.^{260 261}

210. We were also surprised that drug tests were not carried out on offenders being released or follow-up on those who had been treated for drug addiction in prison once they were released. When we asked the Justice Secretary about why there was not a standard drug test on exit, he replied that

I think because it would be just vastly expensive. We get the figures, and we have people telling us what their history of drug abuse is. Obviously, some testing goes on, but the idea you introduce a regime of mandatory drug testing all the time [...] would be pointless because we know we have a problem, so we just don’t need to keep testing what it is. Obviously, once you get into a drug rehabilitation wing, and so on, I am sure they look out for any indication that someone is reverting. But testing does go on now. It is used as a control technique, and we usually produce figures prison by prison, so the Inspectorate discovers what the rates are.²⁶²

Given that the data produced by the test would not only aid the department in building a picture of drug use prevalence across the prison system but could assist in identifying those who might benefit from information about treatment in the community, we do not agree that a test on release would be superfluous.

211. Producing an evidence base of effective interventions is one of the most vital building blocks of drugs policy. We recommend that the Ministry of Justice introduce mandatory drug-testing for all prisoners arriving at and leaving prison whether on conviction, transfer or release. Tests should be carried out for both illegal and prescription drugs. This should be in addition to the existing random testing regime,

258 Prison Reform Trust, *The Bromley Briefings* (June 2012), p 60

259 Policy Exchange, *Coming Clean: Combating Drug Use in Prison*, (January 2010), p 6

260 <http://www.justice.gov.uk/downloads/publications/hmipris/prison-and-yoi-inspections/durham/durham-2011.pdf>

261 Her Majesty’s Prison Birmingham, <http://www.justice.gov.uk/downloads/publications/hmipris/prison-and-yoi-inspections/birmingham/birmingham-2012.pdf>, p 25

262 Q403

the principal purpose of which is deterrence. The information obtained from such a test would be very valuable in evaluating the effectiveness of the current systems in place and identifying those prisons which have a serious problem. Prisons are a key point in the cycle of drug addiction and if addicted offenders can be got off drugs, the monetary and societal benefits would be huge.

212. Release from prison is a critical intervention point in the cycle of addiction and re-offending. We welcome the Justice Secretary's recent announcement that prisoners will be "met at the prison gate" by mentors who can help them to settle back into the community. Successful rehabilitation is a challenging outcome to achieve, but it is worth investing the resources necessary to ensure that those leaving prison have the care and support they need in the community, including suitable and stable housing, to provide them with the best possible chance of a long-term recovery. Under the our recommended regime of universal drug testing on release, those who test positive—however long they have served—should be automatically referred to the appropriate community drug rehabilitation service. Given the importance of this point of critical intervention, we intend to return to this issue in the near future to assess whether there has been an improvement following the implementation of the Justice Secretary's policy.

7 Alternatives to Prohibition?

213. In the terms of reference to our inquiry, we asked “Whether detailed consideration ought to be given to alternative ways of tackling the drugs dilemma, as recommended by the Select Committee in 2002 (*The Government's Drugs Policy: Is It Working?*, HC 318, 2001–02).” This was partly in response to the calls for the liberalisation of drug policy by a number of current and former South American Presidents as discussed in Chapter 1.

Comparison with alcohol

214. The Government’s 2010 drug strategy also covers alcohol addiction as the Government “recognises that severe alcohol dependence raises similar issues and that treatment providers are often one and the same.” It is emphasised that alcohol plays “an important part in the cultural life of this country, with large numbers employed in production, retail and the hospitality industry. Pubs, bars and clubs contribute to community and family life and also generate valuable revenue to the economy.” However, it notes that alcohol is a regulated product and that “some individuals misuse it, contributing to crime and anti-social behaviour, preventable illness and early death.”²⁶³

215. The comparison between drugs controlled under the Misuse of Drugs Act 1974 and alcohol is one that has been raised throughout this inquiry. Some witnesses have argued that prohibition didn’t work in the United States in the early part of the 20th Century and that criminalisation of drug use is simply repeating a failed experiment.

The war on drugs was never winnable, on the basis that the numbers of people who use have risen year on year on year to such extraordinarily high levels; it was never going to be a war that was going to be winnable; in the same way that the war on alcohol, in terms of prohibition in the 1920s and 1930s, was never going to be winnable, unless the numbers could be kept down to a level low enough to keep organised crime and criminality out of the supply side.²⁶⁴

However others have argued that this is a poor comparator:

If you have all day we can go into the problem of alcohol, which I think in this country should be much more severely restricted. I think we should return to the 1915 licensing laws, at the very least. But to prohibit a drug that had been in common use for hundreds or indeed thousands of years—or in the case of the United States had never been illegal—and to try and introduce laws prohibiting it; laws, I might add, that had exactly the same failure as our anti-drug laws, in that they prosecuted supply and transport but not possession. So to appeal to that, and say that failed and, therefore, any attempt to not so much prohibit as to interdict and discourage the use of drugs, to say that, because of that one particular, individual, specific failure, in a culture very different to our own, we can never attempt, ever again in the rest of the history of the human race, to try and prevent the spread of unpleasant, damaging

263 Home Office, *The Government's Drug Strategy* (December 2010), p 7

264 Q341

and dangerous drugs, just seems to me to be, again, illogical and not evidence-based.²⁶⁵

216. Others have used alcohol as a warning rather than a comparison when asked about whether drugs laws ought to be liberalised, highlighting the fact that the harm caused by prohibition may well be outweighed by the benefits of reduced use as a result of that same prohibition.²⁶⁶ Professor Strang told us that

If you look over the fence at the alcohol and the tobacco fields, where we have much better evidence, we know this is a price-elastic commodity, that if you make it easier for people to access these products and make it more price accessible, the levels of use will increase and the levels of harm that result from that will increase. On that basis, I would not be in favour of relaxing it.²⁶⁷

217. There are also contradictory arguments regarding the relative harm of alcohol and illicit drugs. In November 2010, Professor Nutt, Dr King and Lawrence Phillips (on behalf of the International Scientific Committee on Drugs) published an article ‘Drug harms in the UK: a multi-criteria decision analysis’.²⁶⁸ Using a multi-criteria decision analysis, the ISCD identified sixteen harms. Nine relate to the harms that a drug produces in the individual and seven to the harms to others both in the UK and overseas. These harms are clustered into five subgroups representing physical, psychological, and social harms.

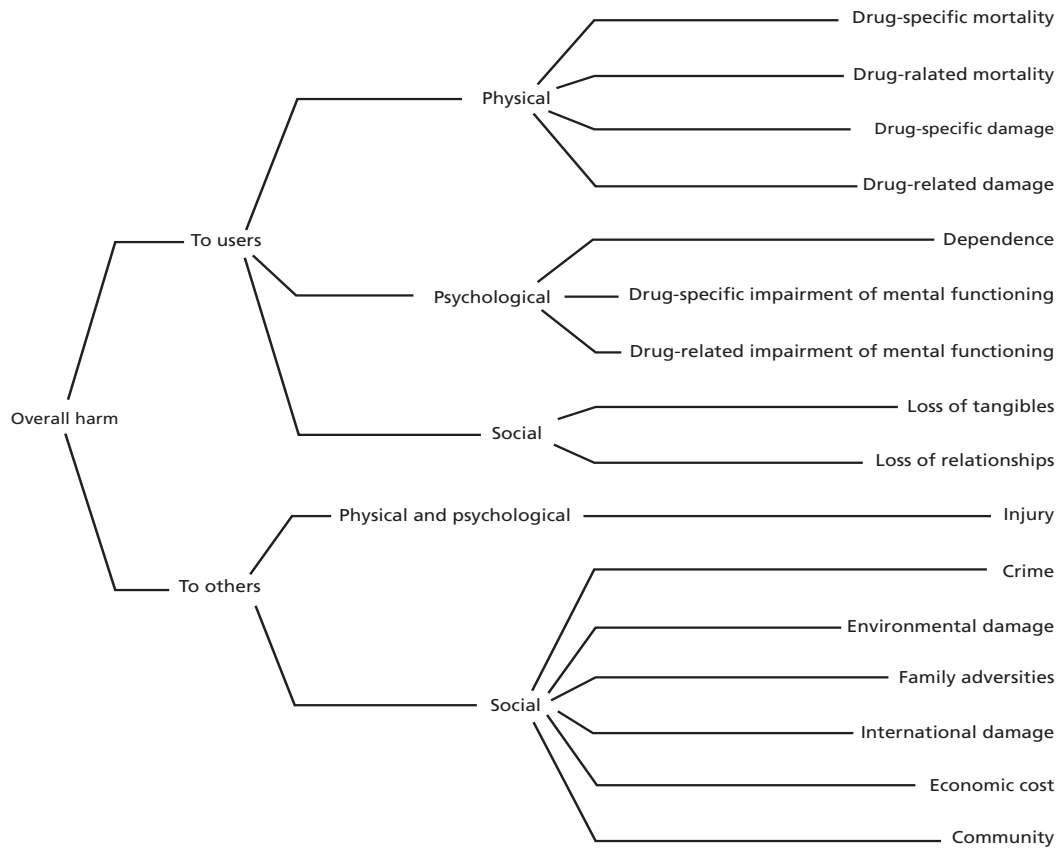
Figure 4: Evaluation criteria organised by harms to users and harms to others, and clustered under physical, psychological and social effects.

265 Q289

266 Babor et al, *Drug Policy and the Public Good* (Oxford University Press, 2010), p 79

267 Q144

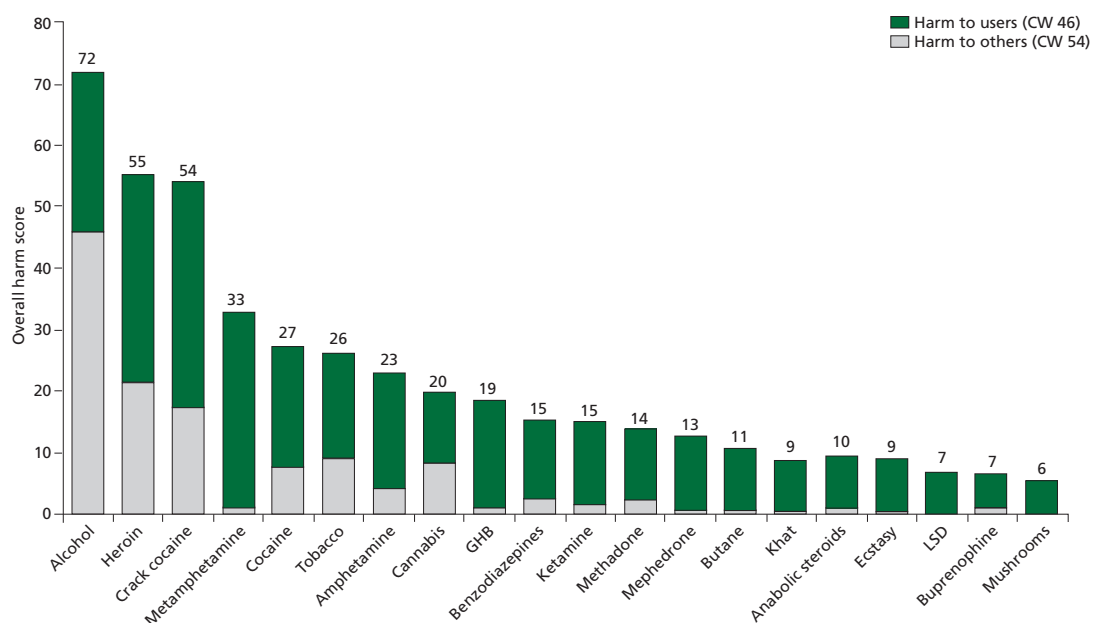
268 David J Nutt, Leslie A King, Lawrence D Phillips, ‘Drug harms in the UK: a multicriteria decision analysis’, *The Lancet*, Vol 376, Issue 9752 (6 November 2010), pp 1558-1565



Source: David J Nutt, Leslie A King, Lawrence D Phillips, 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, Vol 376, Issue 9752 (6 November 2010), pp 1558–1565

Using these criteria, the Committee ranked 20 drugs according to the harms to users and the harms to others. Finally they combined the scores to rank the drugs by their harmfulness. By virtue of its harms to others, alcohol was ranked as the most harmful drug.

Figure 5: Drugs ordered by their harm scores



Source: David J Nutt, Leslie A King, Lawrence D Phillips, 'Drug harms in the UK: a multicriteria decision analysis', *The Lancet*, Vol 376, Issue 9752 (6 November 2010), pp 1558–1565

218. We asked Professor David Nutt whether he thought drugs ought to be decriminalised:

Absolutely, yes, no question about that. I think the Dutch model, the Portuguese model, the current Spanish model are all very rational approaches. They would reduce harm in society because what we see now is a rising, rising, rising tide of damage from alcohol. There is no doubt a lot of people drink because it is legal and if there was an opportunity to use cannabis in a coffee shop-like model, they would not drink.²⁶⁹

He was also asked to explain why he considered tobacco to be less harmful than alcohol

alcohol harms a lot of other people in society through traffic accidents, through violence, domestic violence. Tobacco, by and large, just kills the people who smoke. Now we have legislation to stop people smoking in private places. Most tobacco smokers just harm themselves.

This answer is surprising because it is generally accepted that whilst alcohol may influence the behaviour of those who imbibe it, it bears no responsibility in itself. Rather those that are responsible are they that choose to drive whilst drunk or commit acts of violence. When we put this suggestion to Professor Nutt, he seemed not to accept it.

Most domestic violence is alcohol-fuelled. Okay, you can debate whether it is causal or not but the fact is less alcohol in the home equates to less violence. [...] Alcohol is a major factor in violence across society, in the home, on the streets, at social events. It is not causal but it is an unfortunate aggravating factor so if you reduce the amount of intoxication you will reduce violence, we know that. There is a great example in my book about Euro 2000 when two separate countries had two different ways of dealing with the drinking British football supporter. The country that gave them less strong alcohol, the Netherlands, had much less violence than the country that gave them strong alcohol, Belgium. We know therefore that less alcohol means less violence; that is a fact.²⁷⁰

219. We would emphasise that alcohol, like all other drugs has no sentience. It may impair the judgement of those who consume it but the responsibility must nonetheless lie with the individual. If you accept the argument that alcohol is itself responsible for violence then it also stands that heroin is responsible for acquisitive crime or that cocaine may be responsible for football hooliganism. Use of all psychoactive substances can lead to the impairment of judgement with various associated harms. The difference is that alcohol is widely available and more socially acceptable. In the UK, there are around 10 million adults in the UK who smoke cigarettes. Each year, smoking causes around 115,000 deaths, while alcohol causes 35,000 whereas illicit drug use causes about 2,000 deaths.²⁷¹ However, it does not necessarily follow that because some dangerous substances are readily available, others should be. Dr Clare Gerada, giving evidence as Chair of RCGPs and an ex-member of the ACMD, also raised the issue of the health risks posed by cannabis smoking when stating her opposition to decriminalisation of cannabis:

269 Q302

270 Q342

271 UK Drug Policy Commission, *A fresh approach to drugs: the final report of the UK Drugs Policy Commission*, p80

Cannabis is not a particularly good drug to be on. It causes lung cancer. It causes oesophageal cancer. It causes failure at school. It is an addiction in its own right, so in terms of its health issues, I would not advocate a young person, or any person, using cannabis....we are here, I think, to protect people from entering a life of substance misuse that could cause them harm. I would say cannabis is not a good drug to be using at any age. We have just spent the last 60 years sorting out tobacco, let us not drop in the same problem now with cannabis and make it much more available and pretend that it is a safe drug. It is not a safe drug.²⁷²

We are concerned that while significant public education efforts are ongoing about the public health risks of smoking, similar efforts are not apparent on the health risks of cannabis. This is despite the fact there is substantial medical evidence about the serious health risks posed by cannabis use, not just as a possible gateway drug, but in its own right.

Decriminalisation and Legalisation

220. We took evidence from organisations which supported the decriminalisation or legalisation of drug use as well as asking the rest of our witnesses whether they believe that such systems are viable. Decriminalisation is defined as

meaning that drugs are still illegal, but either the police decide not to enforce the laws (a de facto model) or that possession and use are dealt with through the civil system (a de jure model).²⁷³

An alternative model is Legalisation (or legal regulation) which would regulate it meaning regulation of drug production, supply and use. There are a number of examples of frameworks which could be used for regulating production, supply and use of currently-controlled drugs. The spectrum of regulation referenced by one of our witnesses, Transform²⁷⁴ is described in detail below.

Regulation	Description	example	market controller
Prohibition/Criminalisation	Prohibiting/criminalising non-medical production, supply, possession and use, with punitive sanctions. Intensity of enforcement and severity of penalties can vary. Decriminalisation of personal possession and use can operate within a prohibitionist framework.	heroin, cocaine, cannabis, ecstasy, etc.	criminal entrepreneurs, corrupt police and officials.
Regulated markets	A range of regulatory controls are deployed covering drug production	prescription drugs, over the counter drugs,	moderate to intense regulation by government

272 Qq177-184

273 Ev 135 [Release]

274 Ev 152

	and trade, product, gatekeepers of supply, and user. Some drugs, preparations, and activities remain prohibited.	alcohol, tobacco.	agencies.
Free market legalisation, or 'supermarket model'	Drugs are legal and available for essentially unrestricted sale in the 'free market', like other consumer goods.	caffeinated drinks.	corporate/private enterprise, with minimal regulation by government agencies, voluntary codes for retailers.

Source: Transform 'After the war on drugs: Blueprint for regulation' (2009) p 16

221. There are several different policy measures which fall under the term 'decriminalisation'.

- **Threshold quantities:** Many, but not all, decriminalisation policies use maximum quantity thresholds to distinguish between trafficking or sale offences (criminal prosecution) and personal possession offences (administrative penalties or non-prosecution). However, whilst some countries claim to have adopted a decriminalisation model, the threshold levels are so low that in practice the policy has no effect. Using the example of cocaine, Mexico allows possession of up to 0.5 grams of cocaine without prosecution while Spain allows up to 7.5 grams—a difference of 1,400 per cent.
- **Types of administrative penalties:** Different jurisdictions have different sanctions in place which an individual can receive for an administrative or civil drug use or possession offence. These include: fines, community service orders, warnings, education classes, driver's or professional license suspensions, travel bans, property confiscation, bans on associating with specified individuals, mandatory reporting, termination of public benefits, administrative arrest, or no penalty at all.
- **Roles of the judiciary and police:** Some jurisdictions, such as the Australian states with civil penalty schemes and the Czech Republic, allow the police to issue fines for small drug offences in the field, similar to issuing a traffic violation. Other jurisdictions, such as Brazil and Uruguay, require individuals arrested for drug offences to appear in court before a judge to determine the charge and receive an appropriate sentence, if any.
- **Implementation:** Despite the existence of a statutory, judicial, or regulatory decriminalisation policy, a jurisdiction's inability or unwillingness to implement that policy in practice can make assessment of a policy's merits challenging. In Peru, for example, researchers report police regularly detain individuals arrested for decriminalised drug offences for long periods without charge. In practice, for those in detention, such a system does not resemble decriminalisation despite Peruvian law instructing no penalty for certain minor possession offences.²⁷⁵

275 Release, *A Quiet Revolution: drug decriminalisation policies in practice across the globe* (July 2012), p 12-13

222. There are a number of countries which have some form of decriminalisation: Argentina; Armenia; Australia (South Australia, Western Australia, Australian Capital Territory and Northern Territory); Belgium; Brazil; Chile; Colombia; Czech Republic; Estonia; Germany; Italy; Mexico; The Netherlands; Paraguay; Peru; Poland; Portugal; The Russian Federation; Spain; Uruguay, and the United States of America (State of California).²⁷⁶

Case study: Portugal

223. Several witnesses drew our attention to Portugal's drug policy, a key component of which is the 'decriminalisation' or 'depenalisation' of possession of small quantities of drugs for personal use. In fact, although the term 'decriminalisation' is commonly used to describe the regime in Portugal and some other countries, 'depenalisation' is more accurate as while criminal penalties are not applied, the possession of small quantities of certain drugs is still technically an offence. We decided to travel to Portugal to examine the policy in more detail, and to establish a more rounded picture of the treatment of drug-users, and those involved in the production, import, export, and supply of illegal drugs in Portugal. Three Members of the Committee visited Lisbon from 18 to 20 July 2012, for a programme of meetings and visits which was organised by the British Embassy in Lisbon. We are grateful to HM Ambassador Jill Gallard and her colleagues at the Embassy for organising an interesting and informative visit.

224. We were warmly received by our Portuguese hosts and we are grateful to all those who gave up their time and expertise to assist us in understanding the Portuguese experience of dealing with illegal drugs. HE João de Valleria, the Portuguese Ambassador in London, hosted us to lunch before our visit, which gave us an opportunity to discuss the Portuguese policy before we visited the country.

The road to depenalisation

225. Portugal's international isolation under Salazar's *Estado Novo* regime provided it with a degree of insulation against the growing acceptance of recreational drug use in Western Europe and North America during the 1960s. Significant cannabis use came to Portugal after the Carnation Revolution of 1974, as the end of the colonial wars in Angola and Mozambique saw the return of many Portuguese nationals from the colonies, where cannabis use had been widespread. The sudden growth in cannabis consumption was followed by heroin along the same supply chain, via East Africa.

226. By the 1990s, problems associated with drug use had become a major concern. Several people suggested that the tipping point was a Eurobarometer survey in 1997 which identified drug use as the biggest social problem facing Portugal, in the eyes of the general public. The following year, the government appointed a committee of experts to develop a new drugs strategy. The committee recommended the depenalisation of possession of small amounts of drugs for personal use, as part of a wider range of measures which included education, harm reduction and treatment for addicts.²⁷⁷ Dr João Goulão, the

²⁷⁶ Ibid

²⁷⁷ An English version of the Committee's Report is available on the website of the IDT: www.idt.pt/EN/RelacoesInternacionais/Documents/2009/estrategia_eng.pdf

National Drugs Co-ordinator and a member of the 1998 Committee, was keen to stress that depenalisation was not a “magic bullet” but, he suggested, it removed some of the obstacles to addicts seeking treatment. The central principle behind the committee’s recommendations was that drug addiction was a disease; that drug addicts were sick; and that treating them as criminals did nobody any good.

227. A new law was passed in November 2000 to establish “Dissuasion Commissions” to deal with those caught in possession of small amounts of drugs for personal use. This legislation was not uncontroversial at the time, and its opponents feared that it would remove disincentives to drug use and turn Portugal into a haven for drugs tourism. However, during our visit we were struck by the broad consensus in support of the policy. Even MPs, including many on the right, who had originally opposed the legislation in Parliament told us that their fears had not been realised, and the limited criticism we did hear tended to focus on matters of detail—such as the quantities of drugs which were defined as being for personal use—rather than the principles behind the policy. Indeed, despite asking everyone we met about their views on the policy, we did not encounter a single person who opposed it.

The Dissuasion Commission

228. We visited the offices of the Lisbon Commission for the Dissuasion of Drug Addiction, one of 18 in mainland Portugal. The President of the Commission is a clinical psychologist and the two vice-presidents are a sociologist and a jurist. Doctors, social workers and other people with an appropriate qualification in the field of drug addiction can also be nominated to commissions. The Commission is supported by a Technical Team of three social workers and a clinical psychologist. The Commission typically sees around eight people a day.

229. The Commission deals with drug users who have been caught by the police in possession of small quantities of drugs for personal use, where there is no other evidence to suggest that they are involved in supplying drugs. For each drug, the precise amount that constitutes possession for personal use is defined in law, at a quantity that is supposed to equate to around ten days’ supply. Those amounts are set out in the table below.

Plant/Substance	Threshold quantity
Heroin	1g
Methadone	1g
Morphine	2g
Opium	10g
Cocaine (hydrochloride)	2g
Cocaine (methyl ester of benzoylecgonine)	0.3g
Cannabis (herbal)	25g
Cannabis (resin)	5g

Cannabis (oil)	2.5g
Phencyclidine (PCP)	0.1g
LSD	0.0005g
MDMA	1g
Amphetamine	1g
Tetrahydrocannabinol (THC)	0.5g

Provided by the Dissuasion Commission visited in Portugal

230. Users are issued with a notice by the police requiring them to attend the Commission within 72 hours. They are first assessed by a member of the Technical Team, who then discusses the user's circumstances with the Commission. This is followed by a hearing, which is in practice quite informal and takes place in an ordinary conference room. The main objective of the hearing is to decide whether the user is addicted or not, and to establish a picture of his or her drug use.

For a first offence, if the user is not an addict, proceedings are suspended at this stage. If the user is an addict, then proceedings are suspended if he or she agrees to undergo treatment. The Commission may suspend proceedings if the user has a previous record of possession, but will in practice usually apply a sanction for second and subsequent offences. Suspension lasts for up to two years, after which proceedings are discontinued. During this time, proceedings can be resumed if the user re-offends, or ceases to participate in any treatment on which the suspension was dependent. The treatment provider is required to notify the Commission of the user's participation every three months. The Commission may also decide to dispose of proceedings with a verbal warning, if it considers that this will be an effective deterrent against further use.

231. The Commission has a number of penalties at its disposal. They include

- Banning from the exercise of a profession or occupation, namely those subject to licensing requirements, when such exercise jeopardises the well being of the consumer or third parties;
- Banning from certain places;
- Prohibiting the consumer from accompanying, housing or receiving certain persons;
- Forbidding the consumer to travel abroad without permission;
- Requiring the consumer to be present himself periodically at a place to be indicated by the commission;
- Disenfranchisement, removing the right to be granted or to renew a fire arms license for defence, hunting, precision shooting or recreation;
- Seizure of objects belonging to the consumer which represent a risk to him or her or to the community or which encourage the committing of a crime or other offence;

- Privation from the right to manage the subsidy or benefit attributed on a personal basis by public bodies or services, which shall be managed by the organization managing the proceedings or monitoring the treatment process, when agreed to by the consumer.²⁷⁸
- Impose a fine, though these may only be applied to non-addicts, the principle being that fining a drug addict is likely to push them towards further acquisitive crime.

232. Once a penalty has been decided, its imposition on an addict may be suspended in favour of an order requiring the addict to present him or herself for treatment, with a frequency deemed necessary by the treatment provider. The imposition of a penalty on a non-addict may be suspended if the Commission believes this to be the most effective way of preventing future consumption.

233. We were told that it was possible for someone attending the Commission to deny that they had been in possession of drugs—in effect, to plead not guilty—but that it was very unusual for this to happen, as users did not see the Commission as a hostile intervention. Users did not leave the Commission with a criminal record and the fact that they had attended was confidential (except for minors, whose parents were involved). It was also unusual for people to fail to attend. The emphasis was on treatment, and sanctions were used only as a last resort. It was suggested that a periodic attendance order might only be issued about once a year, for example. Ultimately, we were told that somebody who simply refused to comply with the Commission would be guilty of the offence of ‘disobedience’ but this was virtually unheard of.

234. The proceedings and the outcome of the Commission meetings are then placed on a central register which allows other Dissuasion Commissions to access the information and ensure that repeat offenders are treated as such. The central register is also a vital tool in assessing the prevalence of drug use, creating a profile of drug users and also establishing the availability of each type of drug in each of the provinces. Not only does it assist in evaluating the success of the policy, it also aids law enforcement in creating a picture of supply.

Treatment of drug addiction

235. It was pointed out to us on more than one occasion that depenalisation and the introduction of the dissuasion commissions was only part of the story. Much of Portugal’s success in tackling drug-related harm was down to the provision of effective drug treatment services. We were told that most of the patients at the Centro das Taipas, the country’s oldest specialist drug-treatment centre, were self-referrals.

236. We were told, as we have been in the UK, that alcohol is the biggest problem drug. Of the illegal drugs, heroin and cocaine are generally regarded as the biggest source of problem drug use and significant resources are directed at treating those with opioid addiction, who account for more than 60% of all patients undergoing drug treatment (compared with around 15% undergoing treatment for cannabis use and slightly less for cocaine). The proportion of new patients presenting with heroin addiction is, however,

²⁷⁸ Law 30/2000, http://www.idt.pt/EN/Legislacao/Legislacao%20Internacional%20Ficheiros/Decree-law/130_00.pdf

falling, with ongoing treatment focused on the “old” cohort of heroin users, many of whom are aged over 35.

237. Healthcare for drug users is organised through the public health service, and co-ordinated by the Institute on Drugs and Drug Addiction (IDT) and the Ministry of Health. This was described to us as, in effect, a parallel healthcare system for drug users, with complete vertical integration from the IDT downwards. The Government plans to transfer this network of drug treatment centres into the five regional health authorities, in order to provide better integration with other aspects of healthcare, as well as reducing costs which has caused some political controversy.

Prevention

238. Preventing consumption of drugs is a high priority for the new Portuguese Government. Cannabis is seen as a particular problem as its use is very widespread. The Secretary of State for Health (who is also a physician) told us that he thought the social and medical harm associated with cannabis needed to be emphasised to young people since many regard it as harmless. We were told that mass-media campaigns had proved to be ineffective and more targeted ways of getting the message across were being tried. Medical professionals were involved in the training of school teachers, so that they could communicate accurate messages about the harms caused by drug use to their students.

239. It was suggested that the fall in heroin use was likely to be a result of people becoming more aware of the harmful effects but we heard conflicting views on the prevalence of cannabis use. Some suggested that it had increased since depenalisation but others did not believe it had.

Law enforcement

240. Portugal continues to make strenuous efforts to disrupt the supply of drugs, from street-level dealers to international traffickers. We spoke to officers from the Public Security Police (*Polícia de Segurança Pública* (PSP)), the national police force which operates in Lisbon and other urban areas; the Coastal Control Unit of the Republican National Guard; the *Autoridade Tributária e Aduaneira* (AT), the customs force which intercepts drugs at ports and airports; and the Judicial Police (*Polícia Judiciária*), the national force which deals with serious and organised crime. We received the strong impression that the Portuguese authorities continued to pursue drug traffickers and dealers with the same rigour that one would find in the UK, the USA and other countries where possession of small amounts of drugs is still an imprisonable crime. There is no suggestion that depenalisation of drug users has resulted in any more relaxed attitude to drug traffickers. It is also important to emphasise that the new policy in Portugal does not appear to be associated with a social toleration of drug use. Depenalisation need not imply 'coffee shops' on the Dutch model.

241. Officers from the PSP told us that the new law had reduced the suspicion of the police among drug users, making it easier for them to gather intelligence and to target dealers. Users were not always co-operative, since they feared repercussions if their assistance to the police became known to dealers, but this could be dealt with by the police taking care to protect their sources. It also liberated police resources to concentrate on more serious

crimes, since the process of issuing a summons to attend a dissuasion commission was less time-consuming than the process of making an arrest. One senior officer told us that, having originally opposed the law, he now supported it, having seen it in operation.

242. It is important to note that in the experience of Portugal, depenalisation has by no means been the “cheap” option. One argument often heard in favour of decriminalisation is the potential savings available if the criminal justice system no longer have to spend time and money targeting recreational users. However, in his speech to the Committee’s International Conference on Drugs, the Portuguese Secretary of State for Health was clear that depenalisation was not necessarily less expensive.

If you agree and accept that you are decriminalising the use of certain harmful substances and give opportunities for treatment, you must have in place good structures to attend to everybody who needs treatment. It is not necessarily going to be cheaper than putting people in jail, but apart from the humane principles that rule medicine and politics in general, one has also to consider that from the technical point of view we prefer to spend money that way.²⁷⁹

243. **We were impressed by what we saw of the Portuguese depenalised system. It had clearly reduced public concern about drug use in that country, and was supported by all political parties and the police. The current political debate in Portugal is about how treatment is funded and its governance structures, not about depenalisation itself. Although it is not certain that the Portuguese experience could be replicated in the UK, given societal differences, we believe this is a model that merits significantly closer consideration.**

The legalisation of cannabis in Washington State and Colorado

244. In the US, eighteen states and the District of Columbia have laws which allow the use of ‘medical marijuana’, cannabis which is available on prescription.²⁸⁰ On Tuesday 6 November, Washington State and Colorado legalised the recreational use of cannabis. Both had previously legalised the use of medical marijuana. The text of the ballot proposition 64 in Colorado read

Shall there be an amendment to the Colorado constitution concerning marijuana, and, in connection therewith, providing for the regulation of marijuana; permitting a person twenty-one years of age or older to consume or possess limited amounts of marijuana; providing for the licensing of cultivation facilities, product manufacturing facilities, testing facilities, and retail stores; permitting local governments to regulate or prohibit such facilities; requiring the general assembly to enact an excise tax to be levied upon wholesale sales of marijuana; requiring that the first \$40 million in revenue raised annually by such tax be credited to the public school capital construction assistance fund; and requiring the general assembly to enact legislation governing the cultivation, processing, and sale of industrial hemp?²⁸¹

279 Ev 216

280 <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881>

281 [http://ballotpedia.org/wiki/index.php/Colorado_Marijuana_Legalization_Initiative,_Amendment_64_\(2012\)](http://ballotpedia.org/wiki/index.php/Colorado_Marijuana_Legalization_Initiative,_Amendment_64_(2012))

Colorado's measure allows possession and purchase of as much as one ounce by those aged 21 and older, along with permission to grow as many as six plants in private, secure areas. The law requires Colorado's revenue department to adopt regulations by July 1, 2013, on procedures for issuing a marijuana business license, labelling requirements for marijuana products, restrictions on advertising and civil penalties for not complying with the rules.²⁸²

245. The amendment passed in Washington State (Initiative 502) will allow those aged 21 years and older to buy as much as one ounce of marijuana from a licensed retailer. The measure directs the state liquor control board to regulate marijuana and tax its sales at a rate of 25 percent. The board must set rules on marijuana advertising, licensing producers, processors and retailers, and limiting the number of retail outlets allowed in each county by Dec. 1, 2013. Additionally, the amendment makes it illegal for a motorist to have more than 5 nanograms of THC (an active ingredient of marijuana) per millilitre of blood in their system. Initiative 502 dedicates a percentage of the tax revenue for substance-abuse prevention, research, education, and healthcare, including \$200,000 for cost-benefit evaluations by the Washington State Institute for Public Policy.²⁸³

246. Marijuana remains illegal under federal law however and so anyone possessing under an ounce of marijuana in Colorado or Washington is still subject to federal enforcement. The Drug Enforcement Agency (the federal agency responsible for enforcing the controlled substances laws, under which marijuana remains a classified substance) would have to increase its presence in both Washington and Colorado—at present, with the exception of federal land and national parks, almost all possession arrests are carried out by police at local or state level.²⁸⁴ The budgetary implications of this would be significant, especially at this time of austerity. However, there are a number of measures which the federal government could use to enforce the law.

- Both legalisation measures passed make mention of taxation upon marijuana. The Colorado state ballot information booklet estimates that “state revenue from sales taxes and licensing fees is expected to increase between approximately \$5.0 million and \$22.0 million per year.”²⁸⁵ Potentially, the federal government could confiscate any money raised through the taxation of marijuana on the basis that it was the proceeds of an illegal transaction.
- Both states require a licensing system for marijuana producers, processors and retailers. Such a system would identify those supplying marijuana and so the US Department of Justice could use this information to seize the marijuana and enforce criminal sanctions.
- The Inland Revenue Service could invoke a section of the IRS code which disallows tax deductions if businesses traffic in schedule I drugs (such as marijuana). The removal of tax deductions would have significant financial implications for those businesses.

282 <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlob&blobwhere=1251822971738&ssbinary=true>

283 <http://www.leg.wa.gov/Senate/Committees/documents/Initiatives/2012/502Summary.pdf>

284 Caulkins et al, *Marijuana Legalisation: What everyone needs to know* (Oxford University Press, 2012), p 185

285 <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlob&blobwhere=1251822971738&ssbinary=true>

- Rather than enforcing sanctions against the businesses, the federal government could threaten to enforce sanctions against the property owners where marijuana is being produced or sold (under federal law, any property leased to an illegal organisation can be seized and confiscated). The federal government could also threaten to investigate any bank which held accounts for marijuana-related businesses for money laundering of drug profits.²⁸⁶

There is no guarantee that any or all of the above will happen. Firstly, federal government is made up of a wide range of agencies and officials and some may not wish to enforce laws in a state which has democratically chosen to accede from them. US attorneys (the chief federal prosecutor in each judicial district) have a considerable amount of discretion as to whether to prosecute a case. Each will have varying opinions as to the importance of the enforcement of federal drug laws relating to marijuana and some will have political ambitions which may help govern their decisions as to the value of such prosecutions.²⁸⁷

247. Although both Colorado and Washington have differing systems of cannabis legalisation, both are based on private business. In contrast, Uruguay announced in June that it was intending to legalise cannabis with a state monopoly on production and sale. Under the Government's proposal, Uruguayans older than 18 would be able to register for a monthly pot ration of up to 30 grams (1.06 ounces), though sales to foreigners would remain prohibited. Sales would be taxed, with proceeds funding treatment for addicts of harder drugs.²⁸⁸ The bill to legalise marijuana and bring it under state control will be tabled in Parliament in the near future and given the Government's majority in the legislature, it is likely to pass within the next year.

248. The introduction of differing systems of marijuana legalisation will allow us to see what legalisation looks like in practice. All three systems are different as are any future marijuana legalisation systems likely to be – there have been seventeen proposed amendments to legalise marijuana in the US and all of the proposed systems have been different.²⁸⁹ **Following the legalisation of marijuana in the states of Washington and Colorado and the proposed state monopoly of cannabis production and sale in Uruguay, we recommend that the Government fund a detailed research project to monitor the effects of each legalisation system to measure the effectiveness of each and the overall costs and benefits of cannabis legalisation.**

Implications of discussing drugs policy – politics and the media.

249. The UK Drugs Policy Commission is a body that was set up in order to look at the evidence base for drugs policy. It is a charity whose core funding is provided by the Esmée Fairbairn Foundation, and which receives some funding from the Home Office and the National Treatment Agency. Earlier this year they published their final report, based on collected data and interviews with those previously or currently involved in the formation of drugs policy. Their report emphasised that although many communities, families,

286 Caulkins et al, *Marijuana Legalisation: What everyone needs to know* (Oxford University Press, 2012), p 188-190

287 Caulkins et al, *Marijuana Legalisation: What everyone needs to know* (Oxford University Press, 2012), p 188

288 <http://www.businessweek.com/articles/2012-09-12/uruguays-government-eyes-legalized-marijuana>

289 Informal meeting with Professor Caulkins

treatment providers and increasingly the police do not agree that drug policy is working, there remains a surface political consensus about drug policy across the UK.

Probably most politicians are of the view that while drug policy may be imperfect, the alternatives are too risky or uncertain and, as one ex-Home Secretary said to us, the case for change has not been made adequately made.

[...]

It is seen as particularly controversial to suggest that drug laws should be amended, which is perhaps why ministers and senior professionals generally only speak their mind about drug policy once they have left office, or in the early stages of their careers.²⁹⁰

250. Former British ministers who have called for a reform in drugs policy after leaving include Bob Ainsworth, Clare Short, Tony Banks, Mo Mowlam, Roy Jenkins, Peter Lilley, Alan Duncan, Michael Portillo, Lord Baker and Lord Lawson.²⁹¹ In a poll carried out between May and June 2012, UKDPC found that 75% of MPs felt that it can be difficult to have an objective debate about the best solution because drug policy is such a controversial issue. 77% of the MPs surveyed disagreed with the statement that current policies are effective in tackling the problems caused by illegal drugs. However, only 31% of the MPs supported consideration of changes to the drug laws so that possession of small quantities of currently illegal drugs for personal use only is not treated as a criminal offence,²⁹² as is the case with the Portuguese system. In contrast, a YouGov poll of the general public for The Sun newspaper carried out less than a month later found that 60% of respondents supported the Portuguese system of depenalisation.²⁹³

251. The importance of evidence-based policy was also cited by the UK Drugs Policy Commission in their final report but noted that whilst research was improving in regards to work done by a cross-departmental drug research coordination group and the intention to boost international collaboration on drug research, “the reality is, at a time of austerity across all government departments, research has been afforded a lower budget priority. Government spending on research to support the drug strategy has declined over the past few years.”²⁹⁴ Government-commissioned research and data collection is vital as it can often fill a gap in knowledge which is not a priority of other commissioning bodies.

252. As with many different subject matters, use of anecdotal evidence and media reporting of research and data collection can sometimes lead to a distortion of facts. In November 2009, a data analyst published a blog called deadly drugs. Using information on drug related deaths from the office of national statistics, he analysed newspaper coverage to see what percentage of deaths had been reported upon. He found that whilst 2% of alcohol-

290 UK Drug Policy Commission, *A fresh approach to drugs: the final report of the UK Drugs Policy Commission*, p 139

291 Max Daly & Steve Sampson, *Narcomania: A Journey Through Britain's Drug World* (William Heinemann 2012), p 251

292 <http://www.ukdpc.org.uk/wp-content/uploads/politicians-views-on-drug-policy1.pdf>

293 <http://www.thesun.co.uk/sol/homepage/news/politics/article4416608.ece>

294 UK Drug Policy Commission, *A fresh approach to drugs: the final report of the UK Drugs Policy Commission*, p 138

related deaths and 7% of paracetamol-related deaths had received coverage, 100% of ecstasy-related deaths had been reported.²⁹⁵

253. In October 2009, Professor David Nutt was dismissed from his role as the Chair of the ACMD by the then-Home Secretary, Alan Johnson MP. A pamphlet, based on a lecture given by Professor Nutt in July 2009, was published on the internet. The lecture covered a range of topics but the pamphlet was picked up by the media primarily on the basis that Professor Nutt had repeated his assertion (as published in a 2007 *Lancet* article) that cannabis was less harmful than alcohol. Cannabis had been re-graded as a Class B drug (against the recommendations of the ACMD) in January 2009, a decision which the then Home Secretary Jacqui Smith has recently conceded “caused confusion and dissent”.²⁹⁶

254. Following the media coverage, the then Home Secretary, Alan Johnson MP, asked Professor Nutt to resign as Chair of the ACMD. When Professor Nutt refused, he fired him. He later explained his reasons for doing so in a letter to *The Guardian*

He was asked to go because he cannot be both a government adviser and a campaigner against government policy. [...] As for his comments about horse riding being more dangerous than ecstasy, which you quote with such reverence, it is of course a political rather than a scientific point.²⁹⁷

Responding in *The Times*, Professor Nutt said:

I gave a lecture on the assessment of drug harms and how these relate to the legislation controlling drugs. According to Alan Johnson, the Home Secretary, some contents of this lecture meant I had crossed the line from science to policy and so he sacked me. I do not know which comments were beyond the line or, indeed, where the line was.²⁹⁸

Between October 2009 and April 2010, a further seven members of the ACMD resigned—five citing concerns about the termination of Prof. Nutt’s contract and two citing concerns about what they felt was a politically-motivated ban on Mephedrone.²⁹⁹ It is perhaps unsurprising that in the aforementioned poll of MPs carried out by the UKDPC that 76% agreed with the statement that “the process of making policy about illegal drugs should make more use of evidence and research than it currently does.”³⁰⁰

255. The Government’s 2010 drug strategy states that “The UK is of course not unique in having to confront drug misuse. So, as we build upon this strategy, we are committed to continuing to review new evidence on what works in other countries and what we can

295 <http://www.informationisbeautiful.net/2009/visualising-the-guardian-datablog/>

296 Radio Times interview. Referenced in <http://www.telegraph.co.uk/news/politics/9688040/Jacqui-Smith-admits-cannabis-reclassification-was-wrong.html>

297 Alan Johnson ‘Why Professor David Nutt was shown the door’, *The Guardian*, 2 November 2009 <http://www.guardian.co.uk/politics/2009/nov/02/drug-policy-alan-johnson-nutt>

298 David Nutt, ‘Penalties for drug use must reflect harm’, *The Times*, 2 November 2009 http://www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article6898671.ece.

299 Ev w244

300 <http://www.ukdpc.org.uk/wp-content/uploads/politicians-views-on-drug-policy1.pdf>

learn from it.”³⁰¹ When discussing the Portuguese system of depenalisation, the Home Secretary remarked that

I think it is rather—if I can put it like this—perhaps less clear than it is sometimes claimed to be. I know that it is constantly being adduced as an example of where decriminalisation and a different approach can have an impact on drugs—I was just looking for some figures that I know were in my briefing. However, I am not convinced that that has actually had the impact that everybody feels it has had.³⁰²

The Home Secretary was asked if she had discussed the Portuguese system with her counterparts there as, following a recent visit as part of this inquiry, we had been surprised by the high levels of cross-party support for the system. She replied

I personally have not had conversations with individuals in Portugal. ... Of course, we have looked at what has happened in Portugal and elsewhere, but the facts, as I say, give a slightly different picture than the one that is sometimes portrayed. ... I suspect we may come from a fundamentally different point of view in relation to drugs. I have some very clear views that we should be doing everything we can to deal with drugs, having seen some of the impacts of drugs on individuals and on families.³⁰³

256. In written evidence to the inquiry, the Prime Minister highlighted the importance of using an evidence base to form drugs policy. He said that

the Government acknowledges the value of keeping the debate open and I am grateful to the Committee for its work in this complex area. We attach great importance to keeping abreast of the evidence both here and abroad to inform our drugs policies.³⁰⁴

257. Drugs policy ought to be evidence-based as much as possible but we acknowledge that there is an absence of reliable data in some areas. We therefore recommend the Government allocated ring fenced funding to drugs policy research going forward. Such a funding stream would most appropriately sit with the Medical Health and Research Council so that the evidence base for prevention and recovery aims of the Drugs Strategy can be strengthened, although cross disciplinary applications in this area will be vital.

258. We recommend that the responsible minister from the Department of Health and the responsible minister from the Home Office together visit Portugal in order to examine its system of depenalisation and emphasis on treatment.

259. As our predecessor Committee supported in their 2002 report, we recommend that the Government initiate a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma.

301 Home Office, *The Government's Drug Strategy* (December 2010), p 4

302 Q67

303 Qq 68-69

304 Ev w380

260. We welcome the Government's efforts to make clear its commitment to reducing drug misuse and tackling the consequences of drug misuse. We also recommend that the Government instigate a public debate on all of the alternatives to the current drugs policy, as part of the Royal Commission (see paragraph 132).

261. We have made a number of recommendations regarding the need for further evidence gathering. We believe that this would be most effective if it were co-ordinated through one body. The appropriate body to do this would, in our view, be the Advisory Council on the Misuse of Drugs, which is already tasked with advising the Home Secretary on classification decisions. It is logical that the body which is responsible for formulating scientific advice to ministers should also have a role to play in coordinating the gathering of scientific evidence on the subject.

Appendix 1:

Recommendations from the 2002 Home Affairs Committee report on drug policy: Paper by the House of Commons Library

We believe it is self-evident that by focussing on the relatively small group of problematic drug users, the Government could have a significant impact on the harm caused by drug use. (Para 24)

We believe that drugs policy should primarily be addressed to dealing with the 250,000 problematic drug users rather than towards the large numbers whose drug use poses no serious threat either to their own well-being or to that of others. (Para 38)

The Government accepted these in its 2002 response to the Report, adding that “there are strong arguments for focusing on problematic drug users”. These recommendations would be “central to the Government’s updated Drugs Strategy”. The Updated Drug Strategy 2002 included “a stronger focus on education, prevention, enforcement and treatment to prevent and tackle problematic drug use”.

The current Government’s 2010 Drugs Strategy does not appear to focus specifically on problematic drug users.

We believe it is unwise, not to say self-defeating, to set targets which have no earthly chance of success. We recommend (1) that the Government distinguishes explicitly between aspirational and measurable targets; (2) that it focuses on outcomes rather than processes as indicators of success and that where a process is intended to lead to a particular outcome, the basis for expecting this be explained, with evidence; and (3) that baselines are established as soon as possible for all targets. (Para 42)

The Government’s 2002 response to the Report did not address this recommendation fully. The current Government’s 2010 Drugs Strategy states that “Drug use in the UK remains too high” but does not set targets for reduction.

While acknowledging that there may come a day when the balance may tip in favour of legalising and regulating some types of presently illegal drugs, we decline to recommend this drastic step. (Para 66)

We accept that to decriminalise the possession of drugs for personal use would send the wrong message to the majority of young people who do not take drugs and that it would inevitably lead to an increase in drug abuse. We, therefore, reject decriminalisation. (Para 74)

The Government’s 2002 response to the Report made clear that the Government did not plan to legalise any currently illegal drugs (with limited exceptions for medical purposes)

The current Government's 2010 Drugs Strategy states that "this Government does not believe that liberalisation and legalisation are the answer".

No controlled drugs have been decriminalised since 2002, although one manufactured preparation of cannabis extract, Sativex oral spray, was licensed under medicines legislation in June 2010 as a treatment for muscle spasm associated with Multiple Sclerosis (MS).

We are not persuaded that an intent to supply should be presumed on the basis of amounts of drugs found; we therefore recommend that the offences of simple possession and possession with intent to supply should be retained without alteration. (Para 77)

The then Government's accepted the recommendation in para 77 in its response to the Report. Its response to the recommendations in paragraphs 82 and 83 was:

The Government's view is that, with the exception of the new offence discussed below, the existing laws allow the courts to take account of all the circumstances in cases of supply of drugs. Cases of commercial supply should lead to a higher penalty than supply within a social circle. The maximum penalties for supply are set at a sufficiently high level to allow for the full range of circumstances of any case to be taken into account.

Young people need to be protected from the influence of drug dealers, and it is important to send a message that targeting young people will not be tolerated.

The Government therefore proposes to introduce a separate criminal offence of supplying drugs to young people. The new offence will attract higher maximum sentences than are currently available to the courts for supply cases. It is proposed that this new offence would cover the supply of drugs to young people of 16 years of age or under.

Despite accepting the Committee's recommendation that intent to supply should not be presumed on the basis of the quantity of drugs found, in 2005 the Government legislated to introduce just such a provision. This was set out in section 2 of the Drugs Act 2005 (see also the related Explanatory Notes and pages 27 to 28 of Library Research Paper 05/07 The Drugs Bill for background information). However, section 2 was repealed without ever being brought into force: see section 12 and Schedule 7, Part 13, paragraph 122 of the Policing and Crime Act 2009.

The offences of simple possession and possession with intent to supply in section 5 of the Misuse of Drugs Act 1971 as currently in force do not therefore include any statutory presumption of an intent to supply based on the quantity of drugs found.

However, quantity is one of the factors (among others) that the Crown Prosecution Service (CPS) will consider when deciding whether to charge someone with possession or the more serious offence of possession with intent to supply. If an offender is convicted of a supply offence, the quantity of drug involved will play a key role when the court is determining his sentence. This is because sentencing guidelines use the quantity and class of drug involved as the main indicator for determining the level of harm caused by the offence in question: see the Sentencing Council's Drug Offences: Definitive Guideline, 2012, pp10-15.

We do not agree with the Police Foundation. Those guilty of "social supply" should not escape prosecution for this offence on the basis that their act of supply was to their friends for their personal consumption. We believe that this act of "social supply", while on a different scale from commercial supply, is nonetheless a crime which must be punished. (Para 82)

In relation to the recommendation in paragraph 82, CPS guidance makes it clear that in cases involving the sharing of small quantities of class B or C drugs between friends it may not always be in the public interest to prosecute.³⁰⁵

We believe that while there are two different crimes of supply, the law only formally recognises one. We recommend that a new offence is created of "supply for gain", which would be used to prosecute large scale commercial suppliers. So-called "social suppliers" who share drugs between their friends on a not-for-profit basis should continue to be prosecuted for supply. (Para 83)

In relation to the recommendation in paragraph 83, no new offence of "supply for commercial gain" has been created since the Committee's report was published. A person convicted of supply on a commercial scale would be convicted of the same basic offence – i.e. supply of a controlled drug contrary to section 4(3) of the 1971 Act – as a person convicted of supply on a lesser scale. However, an offender who was involved in supply on a commercial scale will obviously be subject to a harsher sentence than an offender involved in social supply between friends: again, see the Sentencing Council's Drug Offences: Definitive Guideline, 2012, pp10-15.

In the Government's response to the recommendation in paragraph 83, it set out its plans to introduce a new criminal offence of supplying drugs to young people. It did this by way of section 1 of the Drugs Act 2005, which introduced a section 4A into the 1971 Act setting out an aggravated form of the supply offence in section 4 of the 1971 Act. Section 4A, which came into force on 1 January 2006, applies where an offender aged 18 or over commits the supply offence in section 4 of the 1971 Act and either of the following conditions is met:

- the offence was committed in the vicinity of school premises in use by under 18s during school hours or one either before or after school hours; or
- the offender used a courier aged under 18 in connection with the commission of the offence.

If either of these conditions is met, section 4A requires the court to treat this as an aggravating factor when sentencing the offender.

Please see the related Explanatory Notes and pages 26 to 27 of Library Research Paper 05/07 The Drugs Bill for background information.

³⁰⁵ CPS website, Legal Guidance – Drug Offences, incorporating the Charging Standard: Public Interest Considerations: Supply/Possession with intent to supply/Offering to supply (accessed 23 August 2012)

We recommend that techniques to test drivers for drug-related impairment are improved, and that all police officers responsible for testing receive the necessary training. (Para 99)

The Government's response to the Report accepted this recommendation. For a detailed overview of developments in this area, including research into testing techniques and proposals for a new drug driving offence, please see Library Standard Note 2884 Driving: drugs, which was last updated on 8 June 2012.

In the event of the successful completion of clinical trials and a positive evaluation by the Medicines Control Agency, we recommend that the law is changed to permit the use of cannabis-based medicines. (Para 109)

The Government's response to the Report accepted this recommendation.

One manufactured preparation of cannabis extract, Sativex oral spray, was licensed under medicines legislation in June 2010 as a treatment for muscle spasm associated with Multiple Sclerosis (MS). This has not altered its classification as a form of cannabis under the Misuse of Drugs Act 1971. However, it can be legally prescribed, dispensed, possessed and used under provisions of a specific licence issued for Sativex by the Home Office in December 2005. The Government is currently considering legislative amendments to remove the need for this license following advice from the ACMD that this would be an appropriate step.

Any registered medical practitioner can legally prescribe Sativex but its Summary of Product Characteristics (a statutory document registered as part of the medicines approval process) states "Treatment must be initiated and supervised by a physician with specialist expertise in treating this patient population."

Doctors prescribing Sativex for problems other than muscle spasm in MS would be doing so outside its current UK license. While such "off-label" prescribing is relatively common in many areas of medicine, it places clear responsibility on the doctors for assuring themselves that the drug is safe and appropriate for the intended use. The General Medical Council (GMC) provides guidance to doctors in this area.

We accept that cannabis can be harmful and that its use should be discouraged. We accept that in some cases the taking of cannabis can be a gateway to the taking of more damaging drugs. However, whether or not cannabis is a gateway drug, we do not believe there is anything to be gained by exaggerating its harmfulness. On the contrary, exaggeration undermines the credibility of messages that we wish to send regarding more harmful drugs. (Para 120)

We support, therefore, the Home Secretary's proposal to reclassify cannabis from Class B to Class C. (Para 121)

The Government's response to the Report took this recommendation into consideration and noted its intention to reclassify cannabis from Class B to Class C, on the advice of the ACMD. Cannabis was reclassified from Class B to Class C in January 2004.

Cannabis was reclassified from Class C to Class B in January 2009. However, this contravened the advice of the ACMD, which had stated in a 2008 review that:

after a most careful scrutiny of the totality of the available evidence, the majority of the Council's members consider – based on its harmfulness to individuals and society – that cannabis should remain a Class C substance. It is judged that the harmfulness of cannabis more closely equates with other Class C substances than with those currently classified as Class B.³⁰⁶

We believe that nothing should be done to imply that the taking of ecstasy is harmless, legal or socially desirable. Ecstasy is a dangerous drug. We recognise, however, that some young people will take ecstasy, and we want to reduce the numbers of deaths which result. We recommend that advice on the dangers of ecstasy and the ways to reduce the risks of death should be made available in nightclubs, and we welcome the recent publication by the Home Office of the guidance under the title Safer Clubbing. Police, club owners and licensing authorities should continue to aim for drug-free clubs and should work together to achieve this. (Para 129)

The Government's response to the Report accepted this recommendation. Ecstasy remains a Class A drug. However, the current Government's 2010 Drugs Strategy does not mention drugs information in nightclubs

We agree with the Police Foundation and therefore recommend that ecstasy is reclassified as a Class B drug. (Para 135)

See above (response to paragraphs 120 and 121)

We recommend that the number of treatment places for cocaine users is substantially increased. We recommend that resources are channelled into researching and piloting innovative treatment interventions for cocaine users. (Para 140)

As with cocaine, we recommend that more treatment places are created for crack users and that resources are channelled into researching and piloting more effective treatments. We further recommend that in the meantime efforts are redoubled to extinguish supply of crack cocaine. (Para 147)

We recommend that the Government substantially increases the funding for treatment for heroin addicts and ensure that methadone treatments and complementary therapies are universally available to those who need them. We recommend that the guidance on the correct dosage of methadone to be used is strengthened. (Para 161)

We recommend that the broadest possible range of treatments is made available to opiate users, and that all treatments and therapies should have abstinence as their goal. (Para 164)

Details of policy up on drug treatment up to 2009 can be found in the POST Note Treatments for heroin and cocaine dependency published in 2009.

The Department responsible for drug treatment is the Department of Health. Currently funding and treatment for drug addiction is split between local and central Government. Figures for the level of funding and successful treatments for 2009-10 can be found in

306 Advisory Council on Misuse of Drugs, *Cannabis: classification and public health* (2008)

written answer from 27 June 2011 c529W when 63.8% of the total £597.6 million budget for 2010/11 coming from central sources.

The Government is moving towards a system, to be implemented in April 2013, where full responsibility for drug treatment commissioning is passed onto local bodies:

In April 2013 upper tier and unitary local authorities will take on responsibility for commissioning the full range of drug and alcohol prevention, treatment and recovery services. Also, from 22 November 2012, newly elected Police and Crime Commissioners will be responsible for cutting crime and improving community safety. This note highlights the new opportunities for joint working to improve outcomes and use resources more efficiently. It outlines the support that will be available to help you meet the needs of your community.

The 2010 Drug Strategy highlighted the importance of tackling dependence on drugs and alcohol which are key causes of crime, family breakdown and poverty¹. Promoting recovery is central to addressing drug use. A key element of government reforms is to give local areas the freedoms and powers necessary to develop a holistic, joined-up recovery system that goes beyond drug treatment and addresses the wider needs of those with dependence on drugs and/or alcohol.³⁰⁷

As part of its approach the Government is piloting treatment contracts that are based on Payment by Results:

Government is working with eight areas over two years to pilot Payment by Results as an approach to contracting. These pilots are being formally evaluated. In addition, a number of other drug partnerships are incorporating a PbR element into their contracts with providers, and there is increasing use of PbR for other public services. The skill of local authorities and their partner agencies in developing new forms of contracts and in managing the interface between PbR schemes for different services will be crucial to the success of this approach.³⁰⁸

Further details on the progress of the pilots can be found on the Department of Health website.

From a medical aspect NICE has published two sets of guidelines on treatment of drug misuse – ‘Drug misuse: psychosocial interventions’ (NICE clinical guideline 51) and ‘Drug misuse: opioid detoxification’ (NICE clinical guideline 52). They cover: the support and treatment people can expect to be offered if they have a problem with or are dependent on opioids, stimulants or cannabis; and how families and carers may be able to support a person with a drug problem and get help for themselves.

We consider that the risks posed by cocaine to the user and to other people merit it remaining a Class A drug. (Para 141)

The Government agreed and cocaine remains a Class A drug in the UK.

307 Letter from the Department of Health to Local Authorities Chief Executives (April 2012)

308 Ibid

Where crack is concerned we see no prospect for compromise. We note that few of our witnesses argued outright for legalisation. We leave it to those who do argue for general legalisation to explain how this could be justified given that, unlike other illegal drugs, crack can trigger violent and unpredictable behaviour. (Para 148)

The Government “wholeheartedly” accepted this recommendation in its response to the Report.

We recommend that appropriate treatment forms a mandatory part of custodial sentences and that offenders have access to consistent treatment approaches within the prison estate as well as outside it. This should include strictly supervised methadone treatment in the first instance, as the most effective treatment available. (Para 169)

In the interests of consistency, we recommend that the National Treatment Agency should have responsibility for auditing drug treatment services in prisons, as it does for services outside prisons. (Para 171)

The then Government’s official response to the recommendation in paragraph 169 was:

The Government will give careful further consideration to this recommendation. Issues to be considered include the principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a patient and the possibility that coerced participants may disrupt programmes and reduce their overall effectiveness for others. Above all the Government would wish to ensure that treatment capacity is available before introducing mandatory treatment in Prisons.

Drug assessment and treatment services have been introduced in every prison in England and Wales to meet the needs of prisoners with low, moderate and severe drug misuse problems. All prisoners identified as having drug-related problems are referred to Counselling, Assessment, Referral, Advice and Throughcare Services.

The Government recognises the importance of continuity of treatment and aftercare provision for ex-offenders. There are two reasons for this: to ensure their successful reintegration into the community, and to prevent treatment services from becoming over-burdened by ex-offenders relapsing into drug use.

A new Prison Service Standard for Health Services to Prisoners (January 2000) requires all establishments to have in place a written and observed statement of their substance misuse service.

The Government’s current objective is to focus on increasing the uptake, standard and quality of the drug detoxification services offered to prisoners. There is currently provision for methadone maintenance treatment in appropriate cases.³⁰⁹

And its response to the recommendation in paragraph 171 was:

³⁰⁹ The Government Reply to the Third Report from the Home Affairs Committee Session 2001-2002, HC 318, Cm 5573 (July 2002), p18

The NTA has a wide-ranging agenda to improve the capacity, quality and staffing arrangements of treatment services. This has a positive impact where prisons make use of treatment options provided by community services.

How best to audit treatment services in prison will be kept under review. Our goal is to ensure we set the highest standards possible. The Prison Service will work closely with the NTA to make sure that high quality treatment and support is available to prisoners.³¹⁰

In 2006, the Department of Health and HM Prison Service introduced an “Integrated Drug Treatment System” for prisons. Guidance from the Department of Health acknowledged the potential role of methadone treatment:

In its review of drug policy and treatment, the Home Affairs Select Committee (2002) recommended that methadone maintenance should be available across the prison estate. It is acknowledged that there has been considerable unease around this practice within the Prison Service, but through careful evaluation and study, it has become apparent that this intervention within a prison setting can lead to important harm reduction benefits (Dolan 2003).³¹¹

Section 5 of the guidance provides a detailed overview of when prisons should “stabilise” new opiate-dependent prisoners by subscribing methadone during the very early days of their time in custody. Section 7 deals with opiate agonist maintenance, and section 8 with the continuation of methadone treatment for patients arriving in prison who are currently receiving a community methadone prescription. See also the Department of Health, Updated guidance for prison based opioid maintenance prescribing, March 2010.

The consultation paper *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* set out (amongst many other things) how the Government intended to help prisoners get off drugs for good:

We must ensure that more drug misusing offenders fully recover from their addiction and that they do not take drugs while they are in prison. To achieve this we are proposing to:

- reduce the availability of illicit drugs in prison and increase the number of drug free environments;
- introduce pilots for drug recovery wings in prisons;
- work with the Department of Health and other government departments to support the design and running of pilots to pay providers by the results they deliver in getting offenders to recover from their drug dependency;
- test options for intensive community based treatment; and

310 Ibid

311 *Department of Health, Clinical Management of Drug Dependence in the Adult Prison Setting* (2006), para 1.4

- learning the lessons from the approach to managing women offenders and apply them more broadly.³¹²

Use of new technologies would be one part of that and prisons would work in closer partnership with other agencies:

91. While the proportion of samples testing positive under the prisons random mandatory drug testing programme has declined, nearly one in thirteen drug tests are still positive. Prisons and their law enforcement partners must work together closely to share intelligence and tackle staff corruption. We will investigate new technologies to tackle drugs and mobile phones in prisons. We are committed to creating drug free environments in prison and we will therefore increase the number of drug free wings, where increased security measures prevent access to drugs.

92. Doing more to tackle the supply of drugs is one half of the equation. The other is to reshape drug treatment in prisons so that there is an increased emphasis on recovery and becoming drug free. This means working in partnership with health services which are now responsible for funding and commissioning drug treatment in prisons. In doing so we will look at the evidence collected by the Prison Drug Treatment Strategy Review Group, chaired by Professor Lord Patel of Bradford, on how to raise the ambition for drug treatment and interventions in prisons.³¹³

Within six months, though, it was reported that plans had been modified and the approach based on abstinence had been replaced with one based on recovery:

The plans for "drug-free wings" in prisons have been renamed as "drug-recovery wings", although they would need to be "abstinence-focused". The justice secretary, Kenneth Clarke, underlined that point last week when he told Tory critics demanding a "drug-free" approach in prisons that simply making problem drug users go "cold turkey" was clinically dangerous. Mr Clarke said he didn't oppose the use of methadone as long as the objective was to get the user off drugs completely.

James Brokenshire, the Home Office minister responsible for drugs policy, said the new strategy was a major policy shift, putting more responsibility on individuals to seek help and overcome their dependency.

The document marks a step away from the language of "harm reduction" that has dominated the past 10 years, but it stops far short of the abstinence-based policy demanded by some rightwing Tory thinktanks.

(...)

Six pilot schemes will explore how a payments-by-results system could work. The precise benchmark as to what constitutes recovery – either reducing drug use or total

312 Cm 7972, December 2010: page 27

313 Cm 7972, December 2010: page 28

abstinence – has yet to be spelled out. Former addicts would also be promoted as "drug recovery champions", to act as mentors to problem drug users.³¹⁴

Drug recovery wings in five prisons — Bristol, Brixton, High Down, Holme House and Manchester — were launched in June 2011. According to the Ministry of Justice, these would “place a strong emphasis on connecting offenders with a wide range of community services to help them to live drug-free lives on release - such as finding a home, a job and rebuilding relationships with their families.”³¹⁵

For guidance on the different roles and responsibilities of the various bodies involved in drug treatment in prisons, please see Integrated Drug Treatment System (IDTS): Guidance On Roles & Responsibilities and Governance Arrangements, Dept of Health/Ministry of Justice, 2009 (in particular section 11.3, which deals with the role of the National Treatment Agency).

We conclude that the licencing system of providing a limited number of heroin addicts with diamorphine on prescription is badly monitored and evaluated, provides practitioners with inadequate training and guidance, and patients with a variable standard of care. (Para 177)

We do not think that it is enough for the Government simply to expand the number of doctors licensed to prescribe diamorphine to heroin addicts. (Para 183)

A response to a Freedom of Information request to the Home Office date March 2012 sets out the current level of monitoring of diamorphine licences:

1. The Home Office holds records of 250 - 300 licences issued to individual doctors for the treatment of addiction; a significant proportion of these would enable the prescription of diamorphine. a doctor holding a licence should be in a position to provide, upon request of a legitimate and reasoned request, a copy of his or her licence.
2. Since April 2011, the Home Office has issued 11 licences under The Misuse of Drugs (Supply to Addicts) Regulations 1997 to doctors to prescribe diamorphine.

These licences are open-ended and we do not have a record of any being withdrawn during this time. A licence remains active until an individual moves premises or seeks to amend their licence at which time we would revoke the previously issued licence. It is possible that we, or the Department of Health (or equivalent body) may be notified of a change to an individual's registration status with the General Medical Council (GMC). Should relevant information be received we may review a previously issued licence in consultation with relevant parties to determine whether a person should continue to hold a licence.

3. The Home Office does not collect or store any data regarding prescriptions. The Department for Health has responsibility for health matters, including prescriptions.

314 Alan Travis , “Coalition shelves plans for 'abstinence-based' drug strategy” *Guardian* , 8 December 2010

315 Ministry of Justice Government launches drug recovery wings to help cut reoffending 22 June 2011

4. As outlined above, licences remain active until such time as they are withdrawn. Licences are open-ended and not issued with an expiry date.

We recommend that a proper evaluation is conducted of diamorphine prescribing for heroin addiction in the UK, with a view to discovering its effectiveness on a range of health and social indicators, and its cost effectiveness as compared with methadone prescribing regimes. (Para 178)

We recommend that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that if, as we expect, this is successful, the programme is extended across the country. (Para 186)

We conclude that the Dutch and Swiss evidence provides a strong basis on which to conduct a pilot here in Britain of highly structured heroin prescribing to addicts. We recommend that a pilot along the lines of the Swiss or Dutch model is conducted in the UK. Should such a pilot generate the positive results which one would expect from the Dutch and Swiss experience, we recommend that such a system should supersede the little-used "British system" of licensing. (Para 190)

We recommend that a pilot offering prescribed diamorphine to heroin addicts is targeted, in the first instance, at chronic addicts who are prolific offenders. (Para 191)

We recommend that the Government commissions a further trial to look at the prescription of diamorphine to addicts who have not yet, or are not currently accessing any treatment, despite having a long history of heroin addiction. (Para 194)

We recommend that the Government reviews Section 9A of the Misuse of Drugs Act 1971, with a view to repealing it, to allow for the provision of drugs paraphernalia which reduces the harm caused by drugs. (Para 252)

We recommend that Section 8 of the Misuse of Drugs Act 1971 is amended to ensure that drugs agencies can conduct harm reduction work and provide safe injecting areas for users without fear of being prosecuted. (Para 257)

Supervised Injectable Opioid Treatment is now a recognised approach to dealing with diamorphine addiction in hard to treat cases. The Department of Health website provides the following information:

Supervised Injectable Opioid Treatment (IOT) is the prescription of injectable diamorphine (pharmaceutical heroin) in a supervised setting for the treatment of opiate misusers who have not responded to other types of treatment.

Funded by the Department of Health (DH) and supported by the National Treatment Agency (NTA), the Randomised Injectable Opioid Treatment Trial (RIOTT) in England established a small number of new supervised injecting clinics, following the recommendations of the 2002 UK Drug Strategy. Results published in the Lancet (Strang et al, 2010) showed that treatment with supervised injectable diamorphine leads to significantly lower use of street heroin than does supervised injectable methadone or optimised oral methadone.

As a result of the studies in the UK and overseas, IOT is now evidenced as a clinically effective second line treatment for a small group of people who have repeatedly failed to respond either to standard methadone treatment or to residential rehabilitation. The distinctive feature of this treatment is the complete supervision of all injectable doses, usually twice daily, every day of the year.

It is also currently in the process of setting up various pilots to determine how best to deliver this form of treatment.

We believe that all drugs education material should be based on the premise that any drug use can be harmful and should be discouraged. (Para 201)

We acknowledge the need to provide realistic drugs education, but we believe that examples such as the Lifeline leaflet cross the line between providing accurate information and encouraging young people to experiment with illegal drugs. We believe that publicly funded organisations involved in educating impressionable young people about drugs should take care not to stray across this line. (Para 207)

The Government accepted these two recommendations in its response to the Report.

The FRANK website, launched in 2003, offers factual information about drugs including the “highs and lows” of drug use. However, it has been criticised for example in 2003, the UKCIA complained about FRANK’s advice on cannabis and the Transform Drug Policy Foundation stated that “though vastly superior to US counterparts, FRANK leaves much to be desired in terms of drugs included, harm reduction advice offered and level of detail”.

The FRANK service is a key lever to deliver the 2010 drug strategy. The current Government relaunched the FRANK service in 2011 as a resource for young people seeking advice and information about drugs: it states that all drugs are potentially dangerous.

We do not share the view that confronting young people with shocking images of the harm caused by some drug use is counter productive. (Para 208)

The Government accepted this recommendation in its response to the Report

We acknowledge the importance of educating all young people about the harmful effects of all drugs, legal and illegal. Nonetheless, we recommend that the Government conducts rigorous analysis of its drugs education and prevention work and only spends money on what works, focussing in particular on long term and problem drug use and the consequent harm. (Para 211)

The Government accepted this recommendation in its response to the Report and added that it would “be considering how its guidance to schools can be revised”. It stated that the Government would invest £7.5 million over the next five years “to determine the most effective approach to delivering drug education in English schools”.

The 2010 Drug Strategy states:

Schools have a clear role to play in preventing drug and alcohol misuse as part of their pastoral responsibilities to pupils. We will make sure school staff have the information, advice and the power to:

- Provide accurate information on drugs and alcohol through drug education and targeted information via the FRANK service;
- Tackle problem behaviour in schools, with wider powers of search and confiscation. We will make it easier for head teachers to take action against pupils who are found to be dealing drugs in school; and
- Work with local voluntary organisations, the police and others to prevent drug or alcohol misuse.

We will strengthen the quality of alternative provision, including drawing on the expertise of the voluntary and community groups and enabling schools to develop and fund their own local approaches to best meet the needs of excluded pupils. We will also share teaching materials and lesson plans from successful schools and organisations online and promote effective practice.

This will all be supported by revised, simplified guidance for schools on preventing drug and alcohol misuse.

Currently the Department for Education is the Government lead for young people and substance misuse.

We recommend that drugs prevention and education programmes are targeted towards particularly vulnerable groups of young people, such as truants, those excluded from school and children in care. (Para 213)

The Government accepted this recommendation in its response to the Report.

The 2010 Drug Strategy recognises that:

Some young people face increased risks of developing problems with drugs or alcohol. Vulnerable groups - such as those who are truanting or excluded from school, looked after children, young offenders and those at risk of involvement in crime and anti-social behaviour, those with mental ill health, or those whose parents misuse drugs or alcohol - need targeted support to prevent drug or alcohol misuse or early intervention when problems first arise.

The Government's approach is described in the drug strategy:

Developing responses to these needs is best done at the local level, supported by consistent national evidence and advice on effective approaches. We will simplify funding to local authorities, including the creation of a single Early Intervention Grant, worth around £2 billion by 2014–15. This will draw together a range of funding streams for prevention and early intervention services, allowing local government the flexibility to plan an approach to reach vulnerable groups most effectively. Sitting alongside the Public Health Grant, this will allow local areas to

take a strategic approach to tackling drug and alcohol misuse as part of wider support to vulnerable young people and families.

Some family-focused interventions have the best evidence of preventing substance misuse amongst young people. Local areas are already using a range of family-based approaches. These have led to significant reductions in risks associated with substance misuse, mental ill health and child protection and have led to reductions in anti-social behaviour, crime, truanting and domestic violence.

Leaders in a number of local areas are redesigning their services so that they are better equipped to respond to the demands that families with multiple problems make on services, and to use evidence based family support to prevent further problems from developing. Intensive family interventions are highly cost effective with every £1 million invested achieving £2.5 million in savings to local authorities and the state.

Young people's substance misuse and offending are often related and share some of the same causes, with 41% of the young people seeking support for drug or alcohol misuse also being within the youth justice system. New funding arrangements for youth justice services will incentivise local government to find innovative ways to reduce the number of young people who commit crime, including tackling drug or alcohol misuse where this is part of the reason for their offending.

Directors of Public Health and Directors of Children's Services will be empowered to take an integrated and co-ordinated approach to determine how best to use their resources to prevent and tackle drug and alcohol misuse. They will be supported by evidence, advice and by sharing the most effective approaches from those areas that are already succeeding. They will also have access to simplified, flexible budgets both through the Early Intervention Grant and Public Health Grant.

We recommend that the guidance and training provided to practitioners prescribing diamorphine to heroin addicts is strengthened, with a view to spreading best practice. (Para 179)

We conclude that General Practitioners are, for the most part, inadequately trained to deal with drug misuse. We recommend that training in substance misuse is embedded in the undergraduate medical curriculum and postgraduate General Practice curriculum, as a problem which will arise with increasing frequency over the careers of all prospective doctors training today. We recommend that the Department of Health funds more training courses in substance misuse for existing General Practitioners. (Para 218)

We would also expect the British Medical Association and the Royal College of General Practice to take a rather greater interest in this area than is evident so far. In particular we would expect these organisations to use their considerable influence to ensure that treatment of drug misuse is included in the medical curricula. We would also expect the professional bodies to encourage more of their members to take an interest in treating drug abusers so that a handful of dedicated General Practitioners are not left to shoulder the burden alone. (Para 219)

We recommend that training for healthcare professionals in addiction is improved, and we believe that it ought to be possible to provide treatment for those urgently in need within a week. (Para 235)

The Government accepted that training for GPs and other medical staff was “of central importance in its response to the Report and that it would work with the BMA and RCGP. It added that:

The Government has funded the Royal Colleges of General Practitioners to develop a Certificate in Drug Misuse for Primary Care Practitioners and a Diploma in Primary Care Substance Misuse.

The Royal Colleges of General Practitioners (RCGP) provides training courses on substance misuse for existing GPs (e.g. Certificate in the Management of Drug Misuse in Primary Care in Scotland and the RCGP Certificate in the Management of Drug Misuse in England).

In 2007 the International Centre for Drug Policy published guidance on Substance Misuse in the Undergraduate Medical Curriculum. It was funded by the Department of Health and welcomed by the then Chief Medical Officer, Sir Liam Donaldson. The guidance states:

Substance misuse as a topic in the medical curriculum does not have a high profile, and it is timely that this project seeks to address this. If our health service is to succeed in combating the problem of growing substance misuse, our new doctors must have a better understanding of the nature of the problem and the interventions which are available. In addition to focusing on the needs of patients, the curriculum must not omit the task of educating students about the risks to their own health and professional practice through their misuse of drugs and alcohol. If attitudes are to change a sustained, consistent and high-impact message is required.

It cannot be said too strongly that, given the damage to the community that the chaotic drug user can cause, investment in effective treatment is in the wider public interest. (Para 229)

We welcome the setting up of the National Treatment Agency, with its aim to provide "more treatment, better treatment and more inclusive treatment". (Para 234)

The Government concurred with this and welcomed these conclusions in its response to the Report

We also believe that the quality of the service needs to be improved. Drug Action Teams need to make more effort to involve the families and carers of drug abusers and listen to what they have to say rather than simply tell them what is good for them. (Para 236)

The Government agreed that the families and carers of drug abusers have an important part to play in designing services. In its response to the Report the Government stated that “the NTA is working to establish national and regional user and carer forums and to encourage commissioners and providers to include users and carers in contributing to a range of aspects of drug treatment.”

The NTA website (accessed August 2012) states that “having drug users and their families and friends involved in the treatment system is crucial for effective treatment”. It outlines how a user or carer can be involved in the treatment system, including contacting their nearest drug action team (DAT) or one of the NTA’s regional teams.

We recommend that a target is added to the National Strategy explicitly aimed at harm reduction and public health, in addition to the Treatment objective. This target should be measured through two indicators: to reduce the number of overdoses (measureable through Accident and Emergency records) and to reduce the number of new infections through injecting of HIV and Hepatitis (measureable through medical records of drug users). (Para 245)

The Government’s response to the Report stated that:

The Government accepts the need for a target aimed at minimising drug-related harm and protecting public health. The development of harm minimisation programmes, including work to reduce drug related deaths by 20% by 31 March 2004 from a baseline set in March 2002, will address the Committee’s underlying concerns to protect individual and public health.

The 2010 drug strategy “has recovery at its heart” although neither of those two targets is explicitly stated:

- puts more responsibility on individuals to seek help and overcome dependency
- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
- aims to reduce demand
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause.

The first Annual Review of the strategy published in May 2012 provides further details on progress.

We recommend that the Government reviews existing guidelines on the treatment of injecting drug users for Hepatitis C and amends the guidelines if necessary to ensure that users are not excluded from treatment. (Para 248)

Current NICE guidelines on the treatment of Hepatitis C do not exclude drug users.

We recommend that the Home Office and the Department of Health urgently review the current legal framework on the dispensation of controlled drugs by community pharmacists in consultation with the Royal Pharmaceutical Society. (Para 260)

The Government accepted this recommendation in its response to the Report.

We consider it highly undesirable that it should be easier for a drug addict to access treatment through the criminal justice system than in the community. This is a further reason, if any were needed, for the Government to provide more treatment in the community. (Para 262)

As mentioned previously the Government is intending to devolve all commissioning of drug treatment to local bodies by April 2013.

We recommend that Drug Abstinence Orders are amended to carry the requirement of access to treatment. (Para 264)

The then Government's official response to this recommendation was:

The Government does not accept this recommendation. Effective and more quickly available treatment that fills gaps in provision is central to delivering overall. That is why we are employing a number of initiatives within the criminal justice system that are designed to deliver treatment to those who need it. A Drug Abstinence Order (DAO) is a stand-alone order targeted at low level offenders who are not assessed as requiring drug treatment but where there is sufficient concern about their risk of drug misuse to justify ongoing monitoring. DAOs are being piloted in nine areas across England and Wales and may be amended following a comprehensive evaluation of their impact. DAOs, and Drug Abstinence Requirements, a voluntary treatment option, complement Drug Treatment and Testing Orders by providing the courts with new community sentence options, providing a range of sentencing options which the courts can use as they deem appropriate to 'fit' the offender.

Drug abstinence orders were introduced in July 2001 by the Criminal Justice and Court Services Act 2000, which inserted a new section 58A into the Powers of Criminal Courts (Sentencing) Act 2000. However, they were abolished with effect from April 2005, when section 58A was repealed by the Criminal Justice Act 2003. The recommendation is paragraph 264 is therefore obsolete.

The 2003 Act replaced the various community-based orders that previously existed – including drug abstinence orders and various other orders, such as community rehabilitation orders and community punishment orders – with a generic community order. When sentencing an offender to a community order, the court must impose at least one of the requirements listed in section 177 of the Criminal Justice Act 2003. One of the requirements that can be imposed is a “drug rehabilitation requirement”: see sections 209 to 211 of the 2003 Act.

Details of what a drug rehabilitation requirement involves are summarised in Dr David Thomas QC's Sentencing Referencer:

A drug rehabilitation requirement may be made only if the court is satisfied that the offender is dependent on or has a propensity to misuse drugs; and that his dependency or propensity is such as requires and may be susceptible to treatment. The treatment and testing period must be at least six months.

A drug rehabilitation requirement requires the offender to submit, during the treatment and testing period, to treatment by a specified person with a view to the

reduction or elimination of the offender's dependency on or propensity to misuse drugs. The treatment may be treatment as a resident in a specified institution or place, or treatment as a non-resident in a specified institution or place. The nature of the treatment is not specified in the order.

The requirement must also require the offender to provide samples during the treatment and testing period at times and in circumstances determined by a responsible officer or person providing treatment, for the purpose of ascertaining whether he has any drug in his body during the treatment and testing period.

A court must not make a drug rehabilitation requirement unless it is satisfied that arrangements have been or can be made for the treatment intended to be specified in the order, and the requirement has been recommended by an officer of a local probation board.

A requirement may not be included in an order unless the offender expresses his willingness to comply with the requirement.

A drug rehabilitation requirement may (and must if the treatment and testing period is more than 12 months) provide for the order to be reviewed periodically at intervals of not less than one month at a hearing held for the purpose by the court responsible for the order. The offender may be required to attend each review hearing (and must if the period is more than 12 months).

At a review hearing the court, after considering the responsible officer's report, may amend any requirement or provision of the order. The court may not amend the treatment or testing requirement unless the offender expresses his willingness to comply with the amended requirement, and must not reduce the treatment and testing period below the minimum of six months. If the offender fails to express his willingness to comply with the amended order, the court may revoke the order, and deal with him, for the offence in respect of which the order was made, in any manner in which it could deal with him if he had just been convicted by the court of the offence.

If at a review hearing the court is of the opinion that the offender's progress under the order is satisfactory, the court may so amend the order as to provide for each subsequent review to be made by the court without a hearing, but this may be reversed.³¹⁶

Section 74 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 will remove the current requirement for the treatment and testing period of a drug rehabilitation requirement to last at least six months. This means that there will be no minimum treatment and testing period. Section 74 has not yet been commenced so is not yet in force.

Drug rehabilitation requirements under the 2003 Act are more akin to the old drug treatment and testing orders that existed under section 52 of the Powers of Criminal

316 Dr David Thomas QC, *Sentencing Referencer* (2012), p 47-48

Courts (Sentencing) Act 2000 (also repealed by the 2003 Act), rather than drug abstinence orders.

The current community sentencing regime under the 2003 Act does not currently include any requirement that is directly equivalent to the old drug abstinence orders (although the Government has recently legislated to introduce a new alcohol abstinence and monitoring requirement: see section 76 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 and the related Explanatory Notes).

We recommend that the Government initiates a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma. (Para 267).

The Government did not accept this recommendation.

Annex 1: Some of the drugs available in the UK³¹⁷

Legal

2-MK	2-MK is a drug which is being marketed as the new and legal version of Methoxetamine (MXE). Almost nothing is known about its harms. Its chemical name may be 2-(2-methoxyphenyl)-2-(methylamino)cyclohexanone). MXE was itself originally manufactured as a legal alternative to ketamine but was banned under a temporary order in April 2012. 2-MK is also a “research chemical”.
5-IT (AKA: He-Man)	5-IT is a fairly new legal drug whose harms and effects are still mostly unknown. Sometimes it has been referred in the media as He-Man. It is a stimulant but also has some tryptamine qualities which mean it can give powerful hallucinations.
5-MeO-DALT	5-MeO-DALT is an extremely powerful illegal hallucinogen (tryptamine) with strong psychedelic effects.
Annihilation (AKA: x, Tai High Hawaiian Haze, Mary Joy, ecess, devil's weed, Bombay Blue Extreme, Annihilation, Amsterdam gold)	Annihilation is brand of a legal, herbal smoking mixture that contains a synthetic form of cannabis. It is much stronger than normal cannabis (including skunk). It can give a short intense hallucinatory trip.
Benzo Fury (AKA: White Pearl, Bliss, 6-APDB, 6-APB, 5-APDB, 5-APB)	Benzo Fury is a brand of new legal stimulant which may contain almost anything, including the chemical 6-(2-aminopropyl) benzofuran. Some batches may also contain other substances, some legal some illegal. Its effects are fairly close to ecstasy including increased energy, mood enhancement with some hallucinations.
Ethylphenidate (AKA: Legal crack)	Ethylphenidate is a white-powdered stimulant and is generally an amphetamine like substance. It is mainly snorted, sometimes swallowed and acts on the central nervous system. It causes rapid heartbeat but also gives some euphoria which has been described as a mild form of cocaine.
Glues, gases and aerosols . (AKA: Whippets, Volatile Substances, Tooting, Solvents, Petrol, Nitrous oxide, Laughing gas, inhalants, Huffing, Glues, glue sniffing, Gases, Gas, dusting, chroming, Aerosols)	Volatile substances cover a wide range of products, such as gases, glues and aerosols. The products that are abused all have a legitimate day to day use, which means they can be easily obtained. When inhaled, volatile substances have a similar effect to alcohol. They make people feel uninhibited, euphoric and dizzy.
Khat (AKA: Quat, qat, qaadka, chat)	Khat (Catha edulis) is a leafy green plant containing 2 main stimulants. Their main effects

³¹⁷ Collated from the Angelus Foundation, FRANK and DrugScope websites

	are similar to, but less powerful than, amphetamine (Speed).
Kronic (AKA: K2)	Kronic is a brand of herbal smoking mixture which contains a synthetic form of cannabis. It is not something you can just smoke casually – it is a lot stronger than normal cannabis (including skunk). One or two tokes will have a very powerful effect, and often too much for the inexperienced smoker. Kronic is smoked in a spliff or a pipe and gives a very intense high, or even a short hallucinatory trip.
MDAI (AKA: Sparkle)	MDAI is a legal stimulant and club drug. Chemically it is 5,6-Methylenedioxy-2-aminoindane. Its effects are reported to be fairly close to ecstasy including mood enhancement with some hallucinations. However it is usually a much more pure drug than ecstasy. Its effects are generally milder.
Methiopropamine (AKA: MPA)	Methiopropamine (MPA) is a legal powerful stimulant which is similar chemically and in action to methamphetamine but milder. It is synthetic and made from a collection of chemicals. Not much is known about its harms and dangers. It can be snorted or swallowed but is often smoked, giving a strong sense of confidence and energy.
Poppers (AKA: TNT, Thrust, Rock hard, Ram, Liquid Gold, Kix, Amyls, Rush, Buzz, Tibal juice)	Poppers are the common term for the volatile liquid amyl nitrite. There are other varieties (butyl and isobutyl nitrites) and collectively they are called alkyl nitrites. It gives a rapid rush, making the heart race.
Salvia (AKA: Mexican Magic Mint, holy sage, Eclipse)	Salvia divinorum is a Mexican plant, with leaves that contain psychoactive chemicals that produce hallucinations when chewed or when dried and smoked. Depending on dosage, experiences can vary from the fairly mild to full blown with psychedelic hallucinations. At higher doses users can experience dramatic time distortion, vivid imagery and scary hallucinations.
Tramadol. (AKA: Ultram, Tramal)	Tramadol is an opiate painkiller used to treat moderate to severe pain which is sometimes used recreationally. Like other opiates, it stimulates brain opioid receptors but it also increases brain serotonin levels. It is only available with a prescription from your doctor.

Illegal (Classified under the Misuse of Drugs Act 1971)

2CB (AKA: 2CT-7, Tripstacy, T-7, Seventh-heaven, 7-Up)	2CB is a powerful hallucinogenic drug. It is also a stimulant and is a Class A drug.
2-DPMP (AKA: Vanilla Sky, Purple Wave, Ivory Wave, Diphenylmethylpyrrolidine, Desoxypipradrol, D2PM)	2-DPMP is a powerful stimulant that has been found in the product 'Ivory Wave'. It was taken as a 'legal high' and has amphetamine-like stimulant effects similar to speed. It is a Class B

	drug.
Anabolic Steroids (AKA: Juice, Roids, Stanazol, Anadrol)	Steroids are drugs designed to help restore or build muscle tissue if combined with appropriate exercise and diet. They mimic the effects of the naturally produced testosterone in the body. They are a class C drug but it is not an offence to possess them in a medicinal form, only supplying and selling them.
Amphetamine (AKA: Whizz, Sulph, Phet, Paste, Dexies, Billy, Base, Speed)	Amphetamines—including amphetamine sulphate, Dexedrine, and dexamphetamine—are stimulants that people take to keep them awake and alert. They are Class B drugs (although Methamphetamine and amphetamines in injectable form are both Class A).
Barbiturates (AKA: Barbs, barbies, blue bullets, blue devils, gorillas, nembies, pink ladies, red devils, sleepers, Amytal, Sodium Amytal, Soneryl, Seconal, Tuinal)	Barbiturates are drugs which used to be regularly prescribed for anxiety, depression and insomnia. However, they are only prescribed for very serious insomnia. They are a Class B drug.
Cannabis. (AKA: weed, skunk, sinsemilla, sensi, resin, Puff, Pot, Marijuana, herb, hashish, hash, grass, ganja, draw, Dope, Bud, bhang)	Cannabis is a Class B drug derived from the cannabis plant, a bushy plant found wild in most parts of the world and easily cultivated in Britain.
Cathinones. (AKA: pyrovalerone, Methylone, MDPV, M1, butylone)	Cathinones are the family of related chemicals, including cathinone and many synthetically produced chemicals, like Mephedrone, methylone (M1) and MDPV. Cathinones are 'cousins' of the amphetamine family of drugs, which includes amphetamine itself (speed) and MDMA (ecstasy), and which have similar effects. Cathinones were sold as so called 'legal highs' until they became Class B drugs in April 2010.
Cocaine (AKA: White, Wash, Toot, Stones, Snow, Sniff, Rocks, Percy, Pebbles, Freebase, Crack, Coke, Ching, Charlie, Chang, C)	Powder cocaine (also called coke), freebase and crack are all forms of cocaine which is a Class A drug. They're all powerful stimulants, with short-lived effects – which that means that they temporarily speed up the way your mind and body work, but the effects are short-lived.
Dimethyltryptamine . (AKA: DMT, Dimitri)	Dimethyltryptamine (DMT) is a hallucinogenic drug, whose effects are similar to LSD and magic mushrooms. It is a Class A drug.
Ecstasy. (AKA: XTC, X, Rolex's, Pills, Mitsubishi's, MDMA, Mandy, E, Dolphins, Crystal, Cowies, Brownies)	Ecstasy is a Class A drug that usually comes in tablet or capsule form. The chemical name of pure ecstasy is 3,4 methylenedioxymethamphetamine or MDMA for short and it makes users feel alert and energised.
GHB. (AKA: Liquid Ecstasy, GBL, GBH, 4-BD, 1)	GHB (gamma-hydroxybutyrate) and GBL (gamma-butyrolactone), are closely related, dangerous drugs with similar sedative and anaesthetic effects. GBL is converted to GHB shortly after entering the body. Both produce a feeling of euphoria and can reduce inhibitions and cause sleepiness. GHB is a Class C drug.

Ketamine (AKA: Green, K, Special K, Super K, Ket, Vitamin K, Donkey Dust)	Ketamine is a Class C drug. It is a powerful general anaesthetic that's used for operations on humans and animals. Ketamine can cause a loss of feelings in the body and paralysis of the muscles. It can also lead to users experiencing a distortion of reality.
LSD. (AKA: Window, Trips, Tripper, Tab, Stars, Smilies, Rainbows, Paper Mushrooms, Micro Dot, Lucy, Liquid Acid, Lightning Flash, L, Hawk, Flash, Drop, Dots, Cheer, Blotter, Acid)	Lysergic acid diethylamide (LSD) is an hallucinogenic drug that is derived originally from ergot, a fungus found growing wild on rye and other grasses. It's a Class A drug.
Magic Mushrooms. (AKA: Shrooms, Philosopher's Stone, Mushies, Magics, Liberty Cap, Liberties, Amani, Agaric)	These are hallucinogenic mushrooms that grow wild in many parts of the world and the UK in autumn. The main type used is the liberty cap (<i>Psilocybe semilanceata</i>) but fly agaric (<i>Amanita muscaria</i>) is also sometimes used. Magic Mushrooms are a Class A drug.
Mephedrone (AKA: White Magic, Miaow, Meph, Meow Meow, MC, M-Cat, Drone, Charge, Bubble, Bounce, 4-MMC)	Mephedrone (often called 'meow meow') is a powerful stimulant and is part of the cathinone family, a group of drugs that are closely related to the amphetamines – including amphetamine itself (often called 'speed'), methamphetamine and ecstasy. Mephedrone is a Class B drug.
Mescaline. (AKA: peyote buttons, peyote)	Mescaline is a Class A drug. It is a psychedelic or hallucinogenic drug whose use leads to altered perceptions. It comes from button-shaped 'seeds' found in the Peyote cactus and also from some other members of the Cactaceae plant family and from Fabaceae bean family.
Methadone. (AKA: Physeptone, Mixture, Linctus)	Methadone is a synthetic opiate manufactured for use as a painkiller and as substitute for heroin in the treatment of heroin addiction. It has similar effects to heroin but doesn't deliver the same degree of buzz or high as heroin. Without a valid prescription, it is a Class A drug.
Methamphetamine (AKA: Yaba, Tina and Christine, Meth, Ice, Glass, Crystal Meth, Crank)	Methamphetamine stimulates the brain and nervous system in a similar way to cocaine and 'speed'. Methamphetamine has stronger effects that last longer than the classical speed, amphetamine sulphate and is a Class A drug, while amphetamine sulphate is a Class B drug. The crystal form of methamphetamine, sometimes called Crystal Meth or Ice, is extremely powerful and addictive.
Methoxetamine . (AKA: Roflcopt, Rhino Ket, MXE, Moxxy, MKET, Mexy, mexxy)	Methoxetamine (also known as mexxy or MXE) is a newly reported 'legal high'. Although there is very little evidence about its short and long term effects, we do know that it is chemically related to 'dissociative anaesthetics' like ketamine and PCP, and has similar effects. It was made a Class B drug in 2012.
Naphyrone. (AKA: Rave, NRG1, NRG-1, Energy1, Energy-1)	Naphyrone is a Class B drug. It is a stimulant with effects similar to recently controlled drugs like Mephedrone. This drug is chemically related to pyrovalerone which used to be prescribed to

	treat lethargy and fatigue, but was discontinued because of concerns over potential for misuse. (Pyrovalerone is a Class C drug).
Piperazines. (AKA: The Good Stuff, Smiley's, Silver Bullet, Rapture, Pep Twisted, Pep Stoned, Pep Love, pep, Party Pills, Nemesis, Legal X, Legal E, Happy Pills, Frenzy, Fast Lane, Exodus, Euphoria, ESP, Cosmic Kelly, BZP, Bolts Extra Strength, Blast, A2)	Piperazines are a broad class of chemical compounds which mimic the effects of ecstasy. They were produced as a legal alternative to ecstasy (though have since been classified as Class C drugs).
PMA (AKA: red mitsubishi, PMMA, Pink McDonalds, Pink Ecstasy, mitsubishi turbo, killer, Dr Death, double stacked, Chicken Yellow, Chicken Fever)	PMA is a Class A drug similar to MDMA (ecstasy). It can make users feel alert, alive and full of energy. Its similarity means that PMA is actually sometimes sold as ecstasy. It is also known as paramethoxymethamphetamine, or paramethoxymethamphetamine.
Tranquillisers. (AKA: Vallies, Rugby balls, Roofies, Rohypnol, Norries, Moggies, Mazzies, Jellies, Eggs, Downers, Blues, Benzos, Bonzai)	Tranquillisers can induce periods of calmness, relaxation and sleep and are used to treat anxiety and insomnia. They are prescription only medicines that can normally only be prescribed following a consultation with a doctor. Without a prescription, they are a Class C drug. There are many different types of minor tranquillisers, but the most common are the group of drugs called benzodiazepines. These include Rohypnol, Valium (also called diazepam), temazepam and phenazepam (although this latter drug is sometimes found in street drugs, it is not prescribed by doctors in the UK).

Conclusions and recommendations

Recommendations from the last Home Affairs Committee report on drugs policy

1. The Department for Transport has set up a panel of experts to advise on those drugs which should be covered by the new offence driving with concentrations of drugs in excess of specified levels and, for each drug, the appropriate maximum permissible level of concentration in a person's blood or urine. We believe that this maximum should be set to have the equivalent effect on safety as the legal alcohol limit, currently 0.08 mg/ml. (Paragraph 2)
2. We recommend that the Government continue to monitor the decisions of the Health and Wellbeing Boards as to allocation of treatment places, recording each request, monitoring waiting times to enter treatment and assessing the success rate of those dependent on different drugs. The Government should publish this information in an easily accessible and understandable format and consider developing a league table of Health & Wellbeing Boards' performance on local drugs provision while taking care in selecting assessment criteria not to introduce perverse incentives into the decision making process. This will allow Boards to benchmark their provision against each other, having due regard to local need. (Paragraph 7)
3. New evidence which has emerged in the decade since our predecessor Committee's Report on drugs suggests that diamorphine is, for a small number of heroin addicts, more effective than methadone in reducing the use of street heroin. It is disappointing therefore that more progress has not been made in establishing national guidelines for the prescription of diamorphine as a heroin substitute. We recommend that the Government publish, by the end of July 2013, clear guidance on when and how diamorphine should be used in substitution therapy. (Paragraph 10)

The aims of drugs policy

4. Drug use can lead to harm in a variety of ways: to the individual who is consuming the drug; to other people who are close to the user; through acquisitive and organised crime, and wider harm to society at large. The drugs trade is the most lucrative form of crime, affecting most countries, if not every country in the world. The principal aim of Government drugs policy should be first and foremost to minimise the damage caused to the victims of drug-related crime, drug users and others. (Paragraph 14)

Current international drugs policy

5. The Committee saw for itself during its visit to Colombia the effect of the drugs trade on producer and transit countries—the lives lost, the destruction of the environment and the significant damage caused to governance structures by corruption and conflicts. We recognise and sympathise with the immense suffering and slaying of innocent people which tragically has taken place over the years in Colombia and

other Latin American countries, as a result of the murderous rivalry between drug gangs. (Paragraph 25)

6. We believe it is important that countries remain inside the Single Convention on Narcotic Drugs of 1961, rather than entirely outside it. We therefore believe that Bolivia should be allowed to re-accede to the Convention, with the reservation they require for traditional practices. We recommend that the UK Government support this position and encourage other countries to do likewise. (Paragraph 27)

The impact of globalisation on the drugs trade

7. We were concerned to discover that the Maritime Analysis and Operations Centre (Narcotics) has seen a sharp fall in its rate of drug interdiction and now faces an uncertain future over its funding, 95% of which is currently provided by the European Commission. Gathering reliable intelligence about the maritime trafficking of illegal drugs is a crucial part of the international fight against the drugs trade. While recognising that this is not a matter for the UK Government alone, we urge the Government to work with both EU countries and other key international partners to ensure more effective drug interdiction in the future. (Paragraph 35)

The balloon effect

8. Targeting supply at an early stage is the most effective way of reducing supply, as larger amounts can be intercepted higher up the supply chain. Even so, we do not believe that it will be possible to reduce the overall volume of the international drugs trade dramatically only by tackling supply — it is too easy for narco-criminals to respond by diversifying their supply routes. (Paragraph 41)
9. The global nature of the drugs trade, and the potential for displacement of drug cultivation and supply routes in response to law enforcement measures, means that the international drug trade can only ever be tackled effectively by co-operative, co-ordinated international efforts. We must recognise that no one nation can do this on its own. (Paragraph 42)
10. The potential for “substance displacement”, where users switch from one drug to another in response to changes in supply, has clear implications for public policy. In particular, the Government must be mindful of the fact that tougher measures against one drug can lead to increased consumption of another. Where the drug that is being targeted is less harmful than its substitutes—and all recreational drugs are harmful to a greater or lesser extent—there is the clear potential for measures which are intended to tackle the supply and consumption of drugs to result in an overall increase in the harm they cause. We recommend that, where decisions about the classification of drugs are concerned, the opinion of the Advisory Council on the Misuse of Drugs should be sought on the potential for substance displacement, and the comparative risk associated with the likely substitutes. (Paragraph 44)

Links between drugs, organised crime and terrorism

11. We are concerned that despite significant international efforts to disrupt supply of illegal drugs and bear down on demand, the illegal drugs trade remains a hugely profitable enterprise for organised criminals and narco-terrorists. In part this is due to the highly inflated prices of the drugs in question, inevitable in a high demand underground market, and in part due to very low production costs, arising from cheap labour costs where many workers are exploited and the fact that most illicit drugs are very simple and inexpensive to make. This ultimately causes massive harm and deaths around the world. We urge the Government to continue to factor this unintended consequence into considerations on drugs policy. (Paragraph 55)

Human rights abuses

12. The Government should not turn a blind eye to capital punishment and other human rights abuses affecting those involved in the drugs trade. In particular, we recommend that the Government ensure that no British or European funding is used to support practices that could lead to capital punishment, torture, or other violations. (Paragraph 61)

Drug education in schools

13. The evidence suggests that early intervention should be an integral part of any policy which is to be effective in breaking the cycle of drug dependency. We recommend that the next version of the Drugs Strategy contain a clear commitment to an effective drugs education and prevention programme, including behaviour-based interventions. (Paragraph 75)
14. We recommend that Public Health England commit centralised funding for preventative interventions when pilots are proven to be effective. (Paragraph 76)

The Inter-Ministerial Group on Drugs

15. We believe that the current, inter-departmental approach to drugs policy could be strengthened by identifying a Home Office Minister and a Department of Health Minister, supported by a single, named official, with overall responsibility for co-ordinating drug policy across Government. We recommend that the Home Secretary and the Secretary of State for Health should be given joint overall responsibility for co-ordinating drug policy. By giving joint lead responsibility to the Home Office and Department for Health, the Government would acknowledge that the misuse of drugs is a public health problem at least as much as a criminal justice issue. (Paragraph 83)
16. We recommend that the agenda, a list of attendees and minutes of each meeting of the inter-ministerial group on drugs be published on a government website. We would also welcome work addressing the harmful effects of drug consumption. (Paragraph 84)

Current treatment options

17. Different treatment regimes will work for different patients. It is clear that, for some people, residential rehabilitation is the most effective treatment, backed by proper aftercare in the community. Although it is expensive when compared to treatment entirely in the community, it is cost-effective when compared to the cost of ongoing drug addiction. While we welcome the Government's focus on recovery in the Drugs Strategy 2010, we have consistently been told that there is a shortage of provision, and in particular provision for specific groups such as teenagers. We recommend that the Government expand the provision of residential rehabilitation places. In addition, we recommend the Government review the guidance for referrals to residential rehabilitation so that inappropriate referrals are minimised and amend the National Drug Treatment Monitoring System form so that where incidents of inappropriate referral do occur they can be captured and an accurate picture of the effectiveness of residential rehabilitation as a treatment option can still be obtained. (Paragraph 94)
18. Outcomes which range from 60% of patients overcoming their dependence to just 20% suggest that the quality of provision is very variable. We recommend that, in line with the publication of certain outcome statistics for National Health Service providers, publicly-funded residential rehabilitation providers should be required to publish detailed outcome statistics so that patients and clinicians can make better-informed choices of provider. (Paragraph 96)
19. We make no comment on the relative merits of methadone and buprenorphine. It is for the individual prescriber to decide which drug is clinically indicated for each patient. However, we note that recent pharmacological advances in opioid substitution therapy mean that there are other options to patients being "parked" on methadone are notably treatment using buprenorphine which was less widespread when our predecessor committee published its report in 2002 and that it is possible that OST could in the future become a more effective route to abstinence than it has been in the past. **Policy makers should understand the potential for more effective OST treatments and, rather than ignoring reports of the negative side effects of current OST drugs because they are available, familiar and cost-effective, should continue to keep sight of a greater emphasis on buprenorphine relative to methadone prescription to lead to better patient and societal outcomes.** (Paragraph 100)

Implementation of the Government's goal of recovery

20. Drug treatment in prisons is a point of critical intervention—if a drug-dependent offender is treated effectively then it greatly improves their chance of rehabilitation on release. Given that drug and alcohol dependence treatment in prisons has been so heavily criticised for the lack of co-ordination with treatment in the community, we are concerned that new structural changes may reverse the gradual improvement we have seen in treatment for drug-dependent offenders. We recommend the Government closely monitor the transition of treatment funding responsibilities to the Health and Wellbeing Boards and the NHS Commissioning Boards respectively. (Paragraph 106)

21. The Government goal of recovery will require the co-ordination of several government departments: the Department of Health to ensure that effective treatment is being funded, the Department for Work and Pensions to support patients to re-enter the workforce and local authorities which must take responsibility for ensuring that they have appropriate accommodation. We believe that giving the Home Secretary and the Secretary of State for Health joint overall responsibility for coordinating drug policy (see paragraph 83) will help to improve the focus on the goal of recovery. We recommend that the Inter-Ministerial Group works with the Recovery Committee of the Advisory Council on the Misuse of Drugs to carry out an assessment of how the situation is working once the changes have been fully implemented, and to publish its findings by July 2013. (Paragraph 109)
22. Payment by results potentially produces a very cost-effective system in which the taxpayer pays only for successful outcomes. However, past experience in other areas such as employment has shown that it is easy for the market to become dominated by a small number of large providers, leading to the marginalisation of smaller, innovative voluntary sector organisations. Another risk is that the most difficult to treat patients may be denied access to services. We recommend that the Government establish ways to create provider diversity to ensure that smaller providers and civil society are not excluded and that a wide range of services are available. This could be achieved by ring-fencing a certain proportion of expenditure for such providers. The model will also need to ensure that providers are rewarded appropriately for taking on the most difficult patients, so that those who are harder to help will not be denied services. (Paragraph 114)
23. Prescription drug dependence and the use of prescription drugs for non-medicinal purposes is widely and erroneously viewed as being less harmful and certainly more acceptable than drugs which are part of the classification system. Prescription drugs are becoming more widely available, through diversion of prescriptions and unregulated sales via the internet. This was not an issue which our predecessor committee looked at in 2002 but we are alarmed by the increase in availability of and addiction to prescription drugs. Having seen first-hand the scale and impact of prescription drug use in Florida, we recommend that the Government publish an action plan of how it intends to deal with this particular issue as part of the next version of the drug strategy to prevent the situation here in the UK deteriorating further. (Paragraph 122)
24. It is unacceptable that no government agency can give us information on the prevalence of dependence on prescription drugs. We welcome the proposed review of prescription medicine diversion by the ACMD. The issue is one which has been highlighted as a growing problem and as the overall trends of drug use change, the Government must ensure that it has access to suitable treatment for dependence on all drugs rather than just focussing on a narrow sub-set. It is ultimately the responsibility of the medical profession to ensure that their prescribing decisions do not lead patients into drug dependency. However, the police and public should be aware of this deeply concerning trend, so they too can be vigilant in seeking to prevent it. (Paragraph 123)

Misuse of Drugs Act 1971

25. Our predecessor Committee's recommendation for an independent assessment of the Misuse of Drugs Act 1971 was rejected on the basis that it gives effect to the UK's international obligations in this area. That is not, in our view, a compelling reason for refusing to review our own domestic legislative framework, particularly given the growing concern about the current international regime in many producer nations. The message from Colombia and other supplier and transit states is clear—what the international community is currently doing is not working. We are not suggesting that the UK should act unilaterally in these matters, but our Government's position must be informed by a thorough understanding of the global situation and possible alternative policies. (Paragraph 131)
26. This inquiry has heard views from all sides of the argument and we believe that there is now, more than ever, a case for a fundamental review of all UK drugs policy in the international context, to establish a package of measures that will be effective in combating the harm caused by drugs, both at home and abroad. We recommend the establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs in an increasingly globalised world. In order to avoid an overly long, overly expensive review process, we recommend that such a commission be set up immediately and be required to report in 2015. (Paragraph 132)
27. We endorse the praise from President Santos and others for the work of the Serious and Organised Crime Agency. In the countries we visited, it was clear that they did an excellent job and were well respected. We encourage the Government to find a way to retain the SOCA brand overseas, in the move to the National Crime Agency, perhaps as a Serious Overseas Crime Arm of the NCA. However, despite their best efforts and considerable success, we agree with President Santos and others that it is impossible for them to prevent drug trafficking completely. (Paragraph 138)
28. Like any business, the international drug trade thrives on profit. Identifying and seizing the profits of the drug trade, wherever they are in the world, must be a central part of the global fight against drugs. In that context, the UK's approach to money-laundering has been far too weak. Whilst we recognise that the financial crisis has occupied the attention of the FSA since 2008, there is little evidence that it treated the issue of money laundering sufficiently seriously prior to that time. We welcome the creation of the Financial Conduct Agency and we recommend that it produce annual reports which show the prevalence of money laundering within the UK financial sector. (Paragraph 151)
29. Being fined by a regulatory body is an inadequate a sanction for complicity—however peripheral, and whether it is wilful or negligent—in an international criminal network which causes many thousands of deaths each year. We recommend that the Government bring forward new legislation to extend the personal, criminal liability of those who hold the most senior posts in the banks involved where they are found to have been involved in money laundering. (Paragraph 152)

The impact of austerity on drug-related policing

30. Drug-related policing is a vital component of reducing supply and the intelligence aspect, whether it be data on supply routes, the trend in available products or the location of markets, assists not just local police forces but other law enforcement agencies. Following the election of Police and Crime Commissioners, the use of police budgets will be decided with increased community input and local accountability. There is a risk that significant variations in the local approach to drugs could lead to geographical displacement of the drugs trade within the UK. Commissioners will therefore need to be fully briefed on the wider impact of decisions which they might take locally. We recommend that the National Crime Agency submit to every Police and Crime Commissioner and Chief Constable an annual, confidential briefing setting out the measures they could take to contribute to disrupting the drugs trade nationally and internationally. (Paragraph 157)
31. Police time is always limited and needs to be carefully prioritised to have the most impact. As budgets get tighter going forward this situation will intensify. It is important that Police Commissioners carefully consider how best to target drugs crime in their local area. In particular, we encourage Police Commissioners to ensure they are fully informed about the relative effectiveness of different forms of drug-related policing, including cannabis warnings and other forms of diversion work, and to carefully consider the issue of how police time is best prioritised between different kinds of drug-related offences, whether simple possession, acquisitive crime, supply or trafficking. (Paragraph 158)
32. Identifying drug-related crime is vital in order to ensure that the right approaches to reduce re-offending are targeted and effective. Drug-dependent offenders are often prolific re-offenders—by identifying their prevalence, the Government and local authorities can make targeted interventions in the community. (Paragraph 163)

New psychoactive substances

33. The market in new psychoactive substances is changing quickly, too quickly for the current system of temporary banning orders to keep up. Forty-nine new substances were found in Europe last year, a rate of development which makes additional measures critical. At the moment, businesses are legally able to sell these products until such time as they are banned with apparently no legal consequences when they lead to death or long-term illness. We recommend that the Government issue guidance to Local Authority trading standards departments, citizens advice bureaux and other interested parties on the action which might be taken under existing trading standards and consumer protection legislation to tackle the sale of these untested substances. A restaurant which gave its diners food poisoning, a garage which left cars in a dangerous state, or a shop which sold dangerously defective goods could all be prosecuted for their negligence. Retailers who sell untested psychoactive substances must be liable for any harm the products they have sold cause. It is unacceptable that retailers should be able to use false descriptions and disclaimers such as “plant food” and “not for human consumption” as a defence where it is clear to all concerned that the substance is being sold for its psychoactive properties and the law should be amended. (Paragraph 170)

The effect of having a drugs conviction

34. We believe that former drug users should be encouraged to play an active part in society, and that making it harder for them to find employment is likely to hinder that process, and make it more likely they will be unemployed and supported by the state. We therefore recommend that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in CRB checks after they become spent, or after three years, whichever is shorter. The review should, in particular, take account of those areas of employment to which drugs convictions are directly relevant. We also recommend that cannabis warnings be treated as spent immediately. (Paragraph 178)

Cross-Departmental strategy

35. Tackling drug use touches on issues of criminal justice, social justice, education, health and local authorities, which is why the formation of an Inter-Ministerial Group to coordinate Government policy on the subject makes sense. However, as with any other cross-departmental challenge, driving through reform requires clear, senior leadership. Our recommendation for the Home Secretary and the Secretary of State for Health to take joint overall responsibility for drugs policy will help to strengthen inter-departmental co-operation, with a focus on prevention and public health. (Paragraph 183)

Availability of drugs in Prisons

36. We accept that prisons cannot be hermetically sealed and that it will never be possible to eradicate completely the availability of drugs within prisons. However, the fact that almost a quarter of prisoners surveyed found it easy to get drugs in prison is deeply disturbing. The methods of reducing supply are only effective if they are implemented as intended. We recommend that the National Offender Management Service ensure that measures such as the installation of netting to stop 'throw-over' packages, regular cell searches and regular drug tests based on suspicion are put into operation. (Paragraph 188)
37. We commend the work taking place on the drug recovery wings and the drug free wings in certain prisons. The examples that we saw of both were inspiring. If the evaluation of the pilots shows them to be successful, we recommend that they be rolled out nationwide as a matter of priority. We also recommend that the Government ensure that they remain fully funded. The matter of the lack of funding for voluntary drug testing in HMP Brixton's drug recovery wing is worrying and we ask that the Justice Secretary reassure us that such a vital strand of the recovery programme remains funded. (Paragraph 201)
38. There is some very impressive work happening in some prisons at present with innovative approaches being formulated in regards to treatment and managing the transition of release but this is not the standard and there is considerable scope to spread best practice (Paragraph 202)

39. Treatment in prisons, just like treatment outside prisons, should be tailored to the individual. Some people will be able to enter abstinence programs, and should be encouraged to do so. For others, such as those who are already being maintained on methadone, prescription alternatives may be the best option, and should be made available. (Paragraph 205)

Lack of reliable data

40. Producing an evidence base of effective interventions is one of the most vital building blocks of drugs policy. We recommend that the Ministry of Justice introduce mandatory drug-testing for all prisoners arriving at and leaving prison whether on conviction, transfer or release. Tests should be carried out for both illegal and prescription drugs. This should be in addition to the existing random testing regime, the principal purpose of which is deterrence. The information obtained from such a test would be very valuable in evaluating the effectiveness of the current systems in place and identifying those prisons which have a serious problem. Prisons are a key point in the cycle of drug addiction and if addicted offenders can be got off drugs, the monetary and societal benefits would be huge. (Paragraph 211)
41. Release from prison is a critical intervention point in the cycle of addiction and re-offending. We welcome the Justice Secretary's recent announcement that prisoners will be "met at the prison gate" by mentors who can help them to settle back into the community. Successful rehabilitation is a challenging outcome to achieve, but it is worth investing the resources necessary to ensure that those leaving prison have the care and support they need in the community, including suitable and stable housing, to provide them with the best possible chance of a long-term recovery. Under the our recommended regime of universal drug testing on release, those who test positive—however long they have served—should be automatically referred to the appropriate community drug rehabilitation service. Given the importance of this point of critical intervention, we intend to return to this issue in the near future to assess whether there has been an improvement following the implementation of the Justice Secretary's policy. (Paragraph 212)

Decriminalisation and Legalisation

42. We were impressed by what we saw of the Portuguese depenalised system. It had clearly reduced public concern about drug use in that country, and was supported by all political parties and the police. The current political debate in Portugal is about how treatment is funded and its governance structures, not about depenalisation itself. Although it is not certain that the Portuguese experience could be replicated in the UK, given societal differences, we believe this is a model that merits significantly closer consideration. (Paragraph 243)
43. Following the legalisation of marijuana in the states of Washington and Colorado and the proposed state monopoly of cannabis production and sale in Uruguay, we recommend that the Government fund a detailed research project to monitor the effects of each legalisation system to measure the effectiveness of each and the overall costs and benefits of cannabis legalisation. (Paragraph 248)

Implications of discussing drugs policy – politics and the media

44. Drugs policy ought to be evidence-based as much as possible but we acknowledge that there is an absence of reliable data in some areas. We therefore recommend the Government allocated ring fenced funding to drugs policy research going forward. Such a funding stream would most appropriately sit with the Medical Health and Research Council so that the evidence base for prevention and recovery aims of the Drugs Strategy can be strengthened, although cross disciplinary applications in this area will be vital. (Paragraph 257)
45. We recommend that the responsible minister from the Department of Health and the responsible minister from the Home Office together visit Portugal in order to examine its system of depenalisation and emphasis on treatment. (Paragraph 258)
46. As our predecessor Committee supported in their 2002 report, we recommend that the Government initiate a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma. (Paragraph 259)
47. We welcome the Government's efforts to make clear its commitment to reducing drug misuse and tackling the consequences of drug misuse. We also recommend that the Government instigate a public debate on all of the alternatives to the current drugs policy, as part of the Royal Commission (see paragraph 132). (Paragraph 260)
48. We have made a number of recommendations regarding the need for further evidence gathering. We believe that this would be most effective if it were co-ordinated through one body. The appropriate body to do this would, in our view, be the Advisory Council on the Misuse of Drugs, which is already tasked with advising the Home Secretary on classification decisions. It is logical that the body which is responsible for formulating scientific advice to ministers should also have a role to play in coordinating the gathering of scientific evidence on the subject. (Paragraph 261)

Formal Minutes

Monday 3 December 2012

Members present:

Keith Vaz, in the Chair

Nicola Blackwood	Bridget Phillipson
James Clappison	Mark Reckless
Michael Ellis	Mr David Winnick
Julian Huppert	

Draft Report (*Drugs: Breaking the Cycle*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 125 read and agreed to.

Paragraph 126 read.

Amendment proposed, in line 9, at the end to add “We remain, however, of the view expressed in our predecessors’ Report, namely that cannabis be reclassified from class B to C, and therefore regret the decision taken by the Government in 2008”.—(*Mr David Winnick*.)

Question put, That the amendment be made.

The Committee divided.

Ayes, 3	Noes, 3
Julian Huppert	Nicola Blackwood
Mark Reckless	Mr James Clappison
Mr David Winnick	Michael Ellis

Whereupon the Chair declared himself with the Ayes.

Amendment accordingly agreed to.

Paragraph, as amended, agreed to.

Paragraphs 127 to 129 read and agreed to.

On the proposal of the Chair, and with the leave of the Committee, a single Question was put on paragraphs 130 to 132.

Paragraphs 130 to 132 read.

Question put, That the paragraphs stand part of the Report.

The Committee divided.

Ayes, 4	Noes, 3
Julian Huppert	Nicola Blackwood
Bridget Phillipson	Mr James Clappison

Mark Reckless

Michael Ellis

Mr David Winnick

Paragraphs accordingly agreed to.

Paragraphs 133 to 261 agreed to.

Annex and Summary agreed to.

A Paper was appended to the Report as Appendix 1.

Motion made and Question put, That the Report, as amended, be the Ninth Report of the Committee to the House.

The Committee divided.

Ayes, 4

Noes, 1

Julian Huppert

Michael Ellis

Bridget Phillipson

Mark Reckless

Mr David Winnick

Question accordingly agreed to.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Ordered, That the following written evidence relating to Drugs be reported to the House for publication on the internet: Transcript taken at conference on 10 September 2012.

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 13 and 22 March, and 24 April 2012, in the previous session of Parliament, and 15 May, 19 June, 18 September, 16 October, and 13 and 27 November).

[Adjourned till Tuesday 4 December at 2.30 pm]

Witnesses

Tuesday 24 January 2012

Page

Sir Richard Branson, Global Commission on Drugs Policy, and **Dame Ruth Dreifuss**, Global Commission on Drugs Policy Ev 1

Dame Ruth Runciman, Chair, and **Roger Howard**, Chief Executive, UK Drug Policy Commission Ev 8

Tuesday 21 February 2012

Paul Tuohy, Mentor, and **Maryon Stewart**, the Angelus Foundation Ev 14

Wendy Dawson, Chief Executive, The Ley Community, **Dominic Ruffy**, RehabGrads and **Adam Langer** Ev 19

Professor John Strang, Director of the National Addictions Centre Ev 24

Thursday 22 March 2012

Professor Averil Mansfield, Chair of the Board of Science, British Medical Association, **Dr Owen Bowden-Jones**, Chair, Faculty of Addictions, Royal College of Psychiatrists, and **Dr Clare Gerada**, Chair, Royal College Of General Practitioners Ev 28

Paul Hayes, Chief Executive, National Treatment Agency Ev 34

Tuesday 24 April 2012

Russell Brand, former drug-user, and **Chip Somers**, Chief Executive, Focus 12 Ev 39

Mary Brett, former Vice-President of Eurad, Member of Prisons and Addictions Forum at the Centre for Policy Studies, Trustee of CanSS, **Kathy Gyngell**, Chair, Prisons and Addictions Forum and Research Fellow at the Centre for Policy Studies and **Peter Hitchens**, journalist and author Ev 44

Tuesday 19 June 2012

Professor David Nutt, Independent Scientific Committee on Drugs and former Chairman of the Advisory Council on the Misuse of Drugs and **Dr Les King**, former ISCD and former ACMD member Ev 52

Professor Les Iversen, **Professor Ray Hill**, and **Annette Dale-Perera**, Advisory Council on the Misuse of Drugs Ev 60

Tuesday 3 July 2012

Richard Bradshaw, Director of Offender Health, National Offender Management Service and **Digby Griffith**, Director of National Operational Services, National Offender Management Service Ev 65

Rt Hon Kenneth Clarke QC MP, Lord Chancellor and Secretary of State for Justice Ev 68

Tuesday 11 July 2012

Danny Kushlick, Transform Drug Policy Foundation and **Niamh Eastwood**,
Release Ev 76

Chief Constable Tim Hollis CBE, QPM, Association of Chief Police Officers, and
Tom Lloyd, former Chief Constable of Cambridgeshire Ev 82

Trevor Pearce, Director General, Serious Organised Crime Agency Ev 89

Tuesday 30 October 2012

Lord Turner, Chairman, Financial Services Authority and **Tracey McDermott**,
Financial Services Authority Ev 93

List of printed written evidence

1	Dr Leslie King	Ev 99, Ev 103
2	Mary Brett	Ev 104, Ev 107
3	UK Drug Policy Commission	Ev 109
4	Mentor	Ev 117
5	National Treatment Agency for Substance Misuse	Ev 121, Ev 124
6	Serious Organised Crime Agency	Ev 125, Ev 128, Ev 129
7	Tom Lloyd	Ev 129
8	Release	Ev 133
9	Independent Scientific Committee on Drugs	Ev 138
10	Angelus Foundation	Ev 139
11	Royal College of Psychiatrists	Ev 143
12	Kathy Gyngell	Ev 147, Ev 151
13	Transform Drug Policy Foundation	Ev 152, Ev 157
14	Adam Langer	Ev 161
15	RehabGrads	Ev 165
16	Peter Hitchens	Ev 168
17	Home Office	Ev 170, Ev 176
18	Association of Chief Police Officers	Ev 177
19	Advisory Council on the Misuse of Drugs	Ev 181, Ev 188
20	Russell Brand	Ev 189
21	Ministry of Justice	Ev 191
22	Royal College of General Practitioners	Ev 194
23	Professor John Strang	Ev 195
24	Transcript of conference held in Portcullis House on 10 September 2012	Ev 196

List of additional written evidence

(published in Volume III on the Committee's website
www.parliament.uk/homeaffcom@parliament.uk)

1	Centre for Policy Studies	Ev w1
2	Addiction Recovery Training Services	Ev w4
3	Professor David Hannay	Ev w7
4	Daniel Haynes	Ev w10
5	Dhiresb Tailor	Ev w10
6	Andy McKay	Ev w11
7	Joe Milburn	Ev w12
8	Jamie Barnard	Ev w12
9	Lucy Ingham	Ev w13
10	Against Violence and Abuse	Ev w14
11	Derek Williams	Ev w17, Ev w20
12	Anonymous	Ev w21
13	Miguel da Silva	Ev w22
14	Chris Stevens	Ev w25
15	Dara Fitzpatrick	Ev w29
16	Neil	Ev w31
17	Allan R Davie	Ev w31
18	James Gordon	Ev w32
19	Richard Spooner	Ev w33
20	David John Robertson	Ev w35
21	Philippa Matthews	Ev w36
22	Martin Hand	Ev w39
23	Candice Amson	Ev w40
24	Matthew Heenan	Ev w41
25	Anthony Cullen	Ev w43
26	Mohammed Daud	Ev w56
27	Frank Windsor	Ev w56
28	Stephen Simpson	Ev w56
29	Andrew Warwick	Ev w58
30	Roger Titcombe	Ev w61
31	Andy Dove	Ev w62
32	Jason Reed	Ev w63
33	John Cavendish	Ev w67
34	Darren-Jack Broad	Ev w67
35	Ben Swift	Ev w68
36	Anonymous	Ev w69
37	David Marjot	Ev w69
38	Andrew Preston	Ev w73
39	Brian Plester	Ev w73
40	Joan Margalith	Ev w77

41	Oliver Dolloway	Ev w77
42	Michael Drury	Ev w78
43	Parents Against Lethal Addictive Drugs	Ev w80
44	Stuart Harper	Ev w83
45	Sue Pryce	Ev w86, Ev w88
46	Neil McKeganey	Ev w90
47	Darren Eardley	Ev w92
48	Applewoods Hydroponica Ltd	Ev w94
49	Criminal Justice Alliance	Ev w101
50	Amy Ratter	Ev w102
51	Ewan Hoyle	Ev w102
52	International Centre on Human Rights and Drug Policy	Ev w106
53	Laurel Bush	Ev w113
54	Jasper Knight	Ev w113
55	Linda Lee	Ev w116
56	Tom Longland	Ev w117
57	Anthony James	Ev w119
58	Abby Hughes	Ev w120
59	J M Moore, University of the West of England	Ev w121
60	International Drug Policy Consortium	Ev w127
61	Reckitt Benckiser	Ev w129
62	Tjalling Erkelens	Ev w130
63	Adfam	Ev w133
64	University of Kent	Ev w136
65	Mark Eltringham	Ev w144
66	Antidote	Ev w144
67	National Users' Network	Ev w147
68	Robert Young	Ev w150
69	The Alliance	Ev w152
70	Adam Corlett	Ev w153
71	Alistair Crawford	Ev w157
72	Grant Finlay	Ev w158
73	Anonymous	Ev w158
74	Indigo Hawk	Ev w161
75	Duncan Reid	Ev w161
76	Carl Nolan	Ev w162
77	Pheon Management Services	Ev w163
78	Fraser Ross	Ev w168
79	Paul Sax	Ev w169
80	Harm Reduction International	Ev w171
81	Crime Reduction Initiatives	Ev w177
82	Chris Bovey	Ev w180
83	Dr Mark Monaghan, School of Sociology and Social Policy, University of Leeds	Ev w182
84	Royal College of Veterinary Surgeons	Ev w184
85	British Veterinary Association	Ev w185

86	Association of Directors of Public Health	Ev w185
87	Students for Sensible Drug Policy UK	Ev w189
88	DrugScope	Ev w194
89	Dave Harris	Ev w197
90	Kate Francis	Ev w200
91	Peter Reynolds	Ev w 202, Ev w206
92	Colin Fisher	Ev w208
93	Joseph Burnham	Ev w209
94	Sir Keith Morris	Ev w209
95	Chris W Hurd	Ev w211
96	Elizabeth Wallace	Ev w213
97	Daniel Stamp	Ev w215
98	Gavin Ferguson	Ev w217
99	Jonathan Ford	Ev w218
100	Europe Against Drugs	Ev w220, Ev w221
101	Berkshire Cannabis Community	Ev w222
102	Michael Williams	Ev w228
103	Vision Drug Policy Network	Ev w229
104	James McGuigan	Ev w233
105	Substance Misuse Management in General Practice	Ev w237
106	Dan O'Donnell	Ev w238
107	Anonymous	Ev w238
108	Drug Equality Alliance	Ev w239, Ev w247
109	All-Party Parliamentary Group for Drug Policy Reform	Ev w249
110	National Drug Prevention Alliance	Ev w253
111	Law Enforcement Against Prohibition	Ev w257
112	London Drug and Alcohol Policy Forum	Ev w261
113	Professor Jake Chapman, Demos Associate	Ev w264
114	The Addiction Recovery Foundation & Concordat of Rehab Recovery Providers	Ev w267
115	Anonymous	Ev w270
116	Sheila M Bird, Medical Research Council, Biostatistics Unit, Cambridge	Ev w272
117	Health Poverty Action	Ev w276
118	The Beckley Foundation	Ev w280
119	John Blackburn	Ev w284
120	Richard	Ev w286
121	Kevin A Sabet, DPhil (Oxon)	Ev w286
122	Joel Dalais	Ev w289
123	Medical Research Council	Ev w290
124	Malcolm Kyle	Ev w295
125	Jack Brown	Ev w295
126	Andy Lyonette	Ev w296
127	Jeffrey Ditchfield	Ev w299
128	Charlie Lloyd and Neil Hunt	Ev w300
129	The World Federation Against Drugs	Ev w302
130	Anonymous	Ev w307

131	Mick Humphreys	Ev w307
132	Simon Eldridge Lent	Ev w310
133	Jeremy Collingwood	Ev w312
134	James Taylor	Ev w313
135	The Maranatha Community	Ev w315
136	Sarah Graham Solutions	Ev w323
137	Deborah Judge	Ev w329
138	Hope Humphreys	Ev w331
139	User Voice	Ev w333
140	Caroline Lucas MP for Brighton Pavilion	Ev w335
141	Mat Southwell	Ev w338
142	Julian Pursell and Cannabis for Autism UK	Ev w340
143	Cam Lawson	Ev w342
144	UK Cannabis Social Club	Ev w343
145	Stuart Warwick	Ev w351
146	R P Jones	Ev w354
147	Nick Morris	Ev w356
148	Alliance Boots	Ev w356
149	Michael Mac	Ev w360
150	Anonymous	Ev w361
151	Anonymous	Ev w363
152	Eric Mann	Ev w364
153	Max Cruickshank	Ev w364
154	Stephen Halliday	Ev w368
155	Joanne Luker	Ev w368
156	Simon Chorley	Ev w369, Ev w372
157	Anthony Coombs and Alexander Coombs	Ev w373
158	Joe South	Ev w374
159	Department for Education	Ev w375
160	Stephen Dowle	Ev w376
161	Mr B Samson	Ev w377
162	Victor Hamilton	Ev w378
163	Bryan and Judith Spence	Ev w379
164	The Prime Minister	Ev w379
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Fourth Report	Private Investigators	HC 100
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Twentieth Report	Extradition	HC 644
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