RESEARCH PAPER 00/37
27 MARCH 2000

The *Criminal Justice and Court Services Bill* – Drug Testing

Bill 91 of 1999-2000

Part III of the Criminal Justice and Court Services Bill includes provisions designed to tackle the links between illegal drug use and crime: to identify and monitor problem drug users in contact with the criminal justice system who may need treatment.

The Bill provides for compulsory drug testing of offenders and alleged offenders in contact with the criminal justice system. Positive tests will be used to inform bail decisions. It also introduces a new community sentence, a Drug Abstinence Order.

These measures extend to England and Wales only.

Alex Sleator

SCIENCE AND ENVIRONMENT SECTION

HOUSE OF COMMONS LIBRARY

Recent Library Research Papers include:

00/22	The *Health Service Commissioners (Amendment) Bill* [Bill 15 of 1999-2000]	01.03.00
00/23	The Criminal Justice (Mode of Trial) (No. 2) Bill [Bill 73 of 1999-2000]	03.03.00
00/24	The National Lottery	08.03.00
00/25	The *Regulation of Investigatory Powers Bill* [Bill 64 of 1999-2000]	03.03.00
00/26	The *Warm Homes and Energy Conservation Bill* (Revised edition) [Bill 16 of 1999-2000]	07.03.00
00/27	The *Race Relations Amendment Bill* [HL] Bill 60 of 1999-2000	08.03.00
00/28	Unemployment by Constituency, February 2000	15.03.00
00/29	Unemployment by Constituency, Revised rates	15.03.00
00/30	The *Countryside and Rights of Way Bill* – Wildlife and Conservation Bill 78 of 1999-2000	16.03.00
00/31	The *Countryside and Rights of Way Bill* – Access and Rights of Way Bill 78 of 1999-2000	16.03.00
00/32	Human Rights in the EU: the Charter of Fundamental Rights	20.03.00
00/33	Russia: The Presidential Election and Future Prospects	23.03.00
00/34	The Euro Zone: Year One	27.03.00
00/35	The *Criminal Justice and Court Services Bill*: Children and Family Court Advisory and Support Service, Disqualification from Working with Children, and Truancy [Bill 91 of 1999-2000]	24.03.00
00/36	The *Criminal Justice and Court Services Bill*: Probation, Community Sentences and Exclusion Orders [Bill 91 of 1999-2000]	27.03.00

Research Papers are available as PDF files:

- *to members of the general public on the Parliamentary web site, URL:* ***http://www.parliament.uk***
- *within Parliament to users of the Parliamentary Intranet, URL:* ***http://hcl1.hclibrary.parliament.uk***

ISSN 1368-8456

Summary of main points

- Decreasing the threat to communities because of drugs related crime is one of the aims of the Government's drug strategy. Measures are being introduced to address the link between drugs and crime: to identify and monitor problem drug users in contact with the criminal justice system who may need treatment.

- Although the links between drugs and crime are complex a large proportion of those arrested are involved in illegal drug use and many of these use addictive and expensive drugs.

- Treatment is effective in reducing rates of criminal behaviour in problem drug users.

- The Criminal Justice and Court Services Bill introduces powers for compulsory drug testing of offenders and alleged offenders for specified Class A drugs at various points in their contact with the criminal justice system.

- There is a provision to extend drug testing beyond those charged or convicted to include people at a police station who have been arrested but not charged.

- Test results will be used to inform bail decisions.

- The Bill introduces a new community sentence, the Drug Abstinence Order.

- This paper discusses the background to the drug testing provisions in the Bill, the proposals put forward in the Bill, and areas of concern raised by interested groups.

- This paper deals only with the drug testing provisions which are in Part III of the Bill. Research paper 00/36 covers the probation, community sentences and Exclusion Order aspects of the Bill; research paper 00/35 covers the court services, truancy and child protection aspects of the Bill.

CONTENTS

I Introduction

Part III of the *Criminal Justice and Court Services Bill*, Dealing with Offenders, includes proposals for compulsory drug testing of offenders and alleged offenders for drugs at various points in their contact with the criminal justice system: in police detention, pre-sentencing, and as a condition of release from prison on licence.

Testing will take place largely in relation to acquisitive and drugs related crime, and will be restricted to specified Class A drugs. The Government's explanatory notes indicate that testing may focus on heroin and cocaine/crack as the drugs particularly associated with acquisitive crime.[1]

The Bill proposes a requirement for courts to have regard to any evidence of drug misuse in the setting of bail. It introduces a new community sentence, a Drug Abstinence Order, and drug abstinence requirements in other community sentences in certain circumstances. It also creates a new offence for failing without good cause to give a sample for testing purposes and provides for detention for up to six hours following charge, for the purposes of drug testing.

All these apply after the alleged offender has been charged. An important further provision is included: drug testing in police detention may be extended (by Order) to people who have been arrested but not charged.

The Government states that these measures are designed to address the link between drugs and crime: to identify and monitor problem drug users in contact with the criminal justice system who may need treatment, and to inform bail decisions. Decreasing the threat to communities because of drugs related crime is one of the aims of the Government's drug strategy.

The provisions for drug testing have raised a number of issues which are discussed in section IV of this paper. Responses to the Bill include a recurring theme: testing should be linked to treatment if the measures are to be successful in reducing crime.

A. UK drug strategy

The Government issued its UK drug strategy in the form of a White Paper in April 1998, *Tackling drugs together to build a better Britain*.[2] The ten year plan applies a cross-departmental approach, and was drawn up following recommendations by the UK Anti-drugs Co-ordinator (UKADC), Keith Hellawell. Although a strategy for the UK, it focuses mainly on England. Scotland and Northern Ireland have issued broadly comparable strategies, and another is under development in Wales.

---

1 *Criminal Justice and Court Services Bill*, Explanatory notes, Bill 91-EN, p 6

2 *Tackling drugs together to build a better Britain*, Cm 3945, April 1998

The UK strategy sets out four main aims:

1. Young people: to help young people resist drug misuse in order to achieve their full potential in society.
2. Communities: to protect our communities from drug related anti-social and criminal behaviour.
3. Treatment: to enable people with drug problems to overcome them and live healthy and crime-free lives.
4. Availability: to stifle the availability of illegal drugs on our streets.[3]

Key objectives are:

- to reduce the proportion of people under 25 using illegal drugs
- to reduce the level of re-offending among drug misusing offenders
- to increase the participation of problem drug misusers, including prisoners, in drug treatment programmes
- to reduce the access to drugs among 5-16 year olds

Performance targets set in the UKADC's First Annual Report and National Plan are exacting:

- reducing the proportion of people under 25 reporting use of heroin and cocaine in the last month and the previous year by 25% by 2005 and by 50% by 2008
- reducing the level of repeat offending among drug misusing offenders by 25% by 2005 and 50% by 2008
- increasing the participation of problem drug misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime by 66% by 2005 and 100% by 2008
- reducing access to the drugs which cause most harm, particularly heroin and cocaine among young people (under 25) by 25% by 2005 and by 50% by 2008[4]

B. Controlled drugs

The *Misuse of Drugs Act 1971* and its associated Regulations, the *Misuse of Drugs Regulations 1985*, lay down the circumstances in which it is lawful to import, produce, supply, possess with intent to supply, and possess drugs of misuse – "controlled" drugs.

The Advisory Council on the Misuse of Drugs is the body appointed by the Home Secretary under the Act which keeps under review drugs which are, or are likely to be misused. It advises the Government, whether it is consulted on the matter or not, on

---

[3] ibid

[4] United Kingdom Anti-Drug Co-ordinator's, *First Annual Report 1998/99 and National Plan 1999/2000,* May 1999

measures which ought to be taken for preventing the misuse of drugs. Amendments and additions to the Schedules to the *Misuse of Drugs Act 1971* and Regulations may take place on its recommendations.[5]

1. Classes and penalties

The maximum penalties applicable to offences involving the different drugs are graded broadly according to the harmfulness attributable to a drug when it is misused and for this purpose the drugs are defined in three classes, A, B and C.

Offences involving those in **Class A,** the drugs that do the most harm, attract the highest penalties: a maximum of seven years and/or unlimited fine for possession; life and/or fine for production or trafficking. This class includes the more potent of the opioid painkillers (heroin, morphine, methadone,[6] dipipanone, pethidine), hallucinogens (eg LSD, esctasy) and the stimulant cocaine.

Class B has lower penalties: a maximum of five years and/or fine for possession; 14 years and/or fine for production or trafficking. It includes cannabis, cannabis resin, less potent opioids (codeine, pentazocine), strong synthetic stimulants (eg oral amphetamines), and sedatives(eg barbiturates). Any Class B drug prepared for injection counts as Class A.

Class C has the lowest penalties: a maximum of two years and/or fine for possession; five years and/or fine for trafficking. It includes tranquillisers, some less potent stimulants, anabolic steroids and mild opioid analgesics (eg buprenorphine which is used in the treatment of opioid dependency).

Most offences involving drugs are triable either way, that is, triable either summarily by magistrates or on indictment with a jury at the Crown Court. Less serious offences are usually dealt with by magistrates' courts, where sentences cannot exceed six months and/or £5,000 fine, or three months and/or fine for less serious offences. Eighty five per cent of all drug offenders are convicted of unlawful possession. Although maximum penalties are severe, just over 20 per cent of offenders receive a custodial sentence (even fewer actually go to prison), and nearly 3/4 of fines are £50 or less.[7] Where a person is convicted for the third time of an offence involving trafficking in Class A drugs a mandatory sentence of 7 years imprisonment must be imposed.

2. Drug schedules

The *Misuse of Drugs Regulations 1985*, made under the Act, divide the controlled drugs up in a different way to take account of the needs of medical practice. They define the classes of persons who are authorised to supply and possess controlled drugs while acting

---

5 *Bucknell & Ghodse on Misuse of Drugs*, 3rd Edition, 1996, para 1-022

6 Methadone is used in the treatment of opioid dependency but is also misused

7 Institute for the Study of Drug Dependence, http://www.isdd.co.uk/drugsearch/index.html

in their professional capacities and lay down the conditions under which these activities may be carried out. In the Regulations drugs are divided into 5 schedules each governing such activities as import, export, production, supply, possession, prescribing, and record keeping which apply to them.

Schedule 1, the most restricted drugs, for example LSD and cannabis, are not available for normal medical uses and cannot be prescribed by doctors who do not have a licence. They can only be supplied or possessed for research or other special purposes by people licensed by the Home Office.

All the other drugs are available for medicinal use. Most are Prescription Only, so they can only be obtained if prescribed by a doctor and supplied by a pharmacy (eg, strong analgesics like morphine, stimulants like amphetamines or cocaine, tranquillisers and most sedatives). Some very dilute, non-injectable preparations of controlled drugs - because they are so unlikely to be misused - can be bought over the counter without a prescription, but only from a pharmacy (eg, some cough medicines and anti-diarrhoea mixtures containing opiates). Medicines available in this way can also legally be possessed by anyone. The same also applies to benzodiazepine tranquillisers and hypnotics (except temazepam and flunitrazepam) even though these drugs can only be legally obtained on prescription. Details of the schedules are as follows:[8]

Schedule 2 includes such drugs as diamorphine (heroin) , morphine, pethidine, cocaine. These are subject to the full controlled drug requirements relating to prescriptions, safe custody, the need to keep records, etc.

Schedule 3 includes the barbiturates (except secobarbital, now in schedule 2), buprenorphine, pentazocine, the tranquillisers nitrazepam and flunitrazepam. These are subject to the special prescription requirements, but not, for the most part, to the safe custody requirements, nor to the need to keep registers.

Schedule 4 includes benzodiazepines (other than flunitrazepam and tamazepam which are now in schedule 3) and anabolic steroids. Controlled drug prescription requirements do not apply and Schedule 4 Controlled Drugs are not subject to the safe custody requirements.
Schedule 5 includes those preparations which because of their strength, are exempt from virtually all Controlled Drug requirements other than retention of invoices for 2 years.
Additional regulations (the *Misuse of Drugs (Supply to Addicts) Regulations 1997)* effectively restrict the ability to prescribe heroin, dipipanone and cocaine for the treatment of addiction to a few specially licensed doctors.

Solvents are not controlled under the Misuse of Drugs Act. However, under the *Intoxicating Substance (Supply) Act 1985* it is an offence to sell solvents to someone

---

8 *British National Formulary,* September 1999

under 18. Because of the high number of volatile substance abuse deaths in which butane lighter refills have been implicated, and the difficulty in enforcing the legislation, under which it must be proved that the retailer believed the lighter fuel was intended for intoxication before prosecution can take place, measures were taken to prohibit sales of butane lighter fuel to young people.

The *Cigarette Lighter Refill (Safety) Regulations 1999*, make it an offence to sell gas lighter refills containing butane to persons under 18 years of age. Retailers found guilty of not taking reasonable steps to avoid selling gas lighter refills to under 18s are liable to a maximum of 6 months imprisonment or a fine not exceeding £5000. The provision came into effect on 1 October 1999.[9]

3. Testing for drugs

Drug tests fall into a number of categories, and the usefulness of the results is constrained by the sophistication or otherwise of the technology used. Urine tests have traditionally been preferred because the concentration of a drug in the urine is usually very much higher than in blood or saliva.[10] Technologies are developing rapidly, and it is estimated that sensitive saliva tests should be available in two or three years time.[11]

Initial screening tests, such as 'dipstick' tests employed at police stations, aim to identify a group of similar chemicals eg the opiate group of drugs, or amphetamines, or cocaine. A screening test will not necessarily differentiate within a group as it will usually be detecting a break-down product of metabolism common to several drugs. An example is the detection of morphine in a urine test – this may indicate the presence of any of the opiate group, including codeine (a class B drug, used in over the counter painkillers and cough suppressants). False positives and false negatives can occur in screening tests.

Screening tests are not definitive: confirmatory analysis is always necessary. These have much greater specificity. They identify the specific drug accurately and determine the level of the drug in the sample.

A positive result does not tell the observer whether it was taken legitimately (for example methadone may be used in treating heroin addiction), or was misused. Interpretation of the test will therefore depend on the sensitivity and specificity of the test used, and must then be viewed in the context of any drug taken for legitimate medical reasons.

The results of screening tests can be available very rapidly: confirmatory laboratory tests may take two to four days.[12]

---

9 http://www.isdd.co.uk/

10 *Bucknell & Ghodes on Misuse of Drugs*, 3rd edition, 1996, para 2-011

11 Personal communication, Forensic Science Service, 24 March 2000

The testing carried out as an integral part of a Drugs Treatment and Testing Order (see section II below) takes the following form:

> Routine testing during the course of the order may only need to be a quick 'dipstick' test to monitor abstinence from the index drug(s).
>
> A positive test showing the presence of an index drug or drugs will require confirmatory testing unless the offender admits to using the drug. Where admissions are made, confirmatory testing may still be important … Failed tests should be confirmed using Gas Chromatography/Mass Spectrometry. Where such tests are undertaken off-site, results should be returned to the treatment provider within 5 days of being dispatched.[13]

There are large variations in drug metabolism and excretion between individuals: the period of detection of an individual drug cannot be given exactly, and opinions differ. It is agreed that cannabis lasts significantly longer than opiates; cannabis may remain traceable for perhaps a week in an occasional user and a month in a heavy user; traces of opiates can be detected possibly up to seven days.[14] Estimates supplied by the Forensic Science Service[15] follow:

Periods of detection of commonly misused drugs[16]

Substance	**Class**	**period of detection**
Opioids		
Heroin	A	1-2 days
Morphine	A	1-2 days
Codeine	B	1-2 days
Methadone	A	1 day –1 week
Stimulants and hallucinogens		
LSD	A	8 hours
Ecstasy(MDMA)	A	1-2 days
Amphetamine	B	1-2 days
Cocaine	A	1-4 days

12 ibid

13 Home Office and The Standing Conference on Drug Abuse (SCODA), *Commissioning drug treatment and testing orders*, Draft, September 1999

14 Home Affairs Committee, *Drugs and Prisons*, Fifth Report, 9 November 1999, HC 363-II 1998-9, Memorandum by HM Prison Service, para 5.15

15 Personal communication, 21 March 2000

16 Derived from National Institute on Drug Abuse (US) web page, http://www.nida.nih.gov/DrugsofAbuse.html

II Links between drugs and crime and effectiveness of interventions

A. Links between drugs and crime

(The statistical content of this section has been provided by Graham Vidler from the Social and General Statistics Section.)

The interaction between drugs and crime is complex. Crime may result from:

- the illegality of the drug itself
- the influence of the drug on the individual
- the need for money to buy drugs

A review of the literature regarding drug abuse and the criminal justice system (Hough 1996) concluded that, despite the widespread use of illegal drugs, most drug users are not drawn into other forms of crime.[17] A small minority of drug users develop serious dependency problems, need substantial sums of money and finance at least part of their drug misuse through crime. The variety of sources includes income, benefits, gifts, loans, selling property, theft, prostitution and drug dealing. This review also found that a significant minority of crime is drug-related (where the proceeds of the offence happen to be spent on drugs) but a smaller proportion is drug-driven (where the offence is committed solely to pay for illegal drugs).

While hard and fast definitions are impossible, the term 'problem drug users' is generally employed by drug workers to include those whose drug taking involves dependency, regular excessive use, or use which creates serious health risks.[18] There are between 85,000 and 215,000 problem drug users in England and Wales who could benefit from different forms of treatment.[19] A Home Office report on referring offenders to drug services adds:

> Those users whom we regard as problematic typically use large amounts of heroin, crack or amphetamine; usually as part of a pattern of polydrug use; they generally show signs of dependency; their drug use poses risks to themselves and others; and they are often extensively involved in crime to support their drug use.

---

[17] Michael Hough, *Drug misuse and the criminal justice system: a review of the literature*, Drugs Prevention Initiative Paper 15, 1996

[18] M Edmonds et al, *Doing Justice to treatment: referring offenders to drug services* Drugs Prevention Advisory Service Paper 2, September 1999

[19] M Edmonds et al, *Arrest referral: emerging lessons from research*, Drugs Prevention Initiative Paper 23, 1998

> Problem drug users are those who could benefit from the services of drug agencies offering medical or other forms of treatment.[20]

However, the Association of Chief Officers of Probation advises caution in drawing too precise a conclusion about crime and drug use:

> It is simplistic to assume drug misuse causes otherwise honest individuals to commit crime. What appears to happen is that problematic drug use often co-exists with other deviant behaviour including offending. As drug use becomes increasingly problematic, the individual's propensity to offend increases. Increasingly problematic drug use is therefore associated with the frequency and scale of offending but is much less often associated with initiating a criminal career.[21]

The effectiveness of treating problem drug users is being studied in the National Treatment Outcome Research Study (NTORS), commissioned by the Department of Health. This is a large prospective study monitoring the progress of clients recruited into the most widely used types of treatment services in the UK: residential (specialist inpatient treatment, and rehabilitation) programmes; and community treatment (methadone maintenance and methadone reduction programmes). Follow up at one year found that, apart from the health benefits to be gained through treatment programmes:

- The economic costs imposed upon society by the NTORS cohort were largely due to their criminality. High rates of criminal behaviour were found prior to treatment, and crime costs prior to treatment greatly outweighed all of the treatment costs. The most commonly reported crime was shoplifting.
- At one year [of treatment] there was a marked reduction in criminal activity. The savings to society in terms of reduced criminal behaviour and reduced demands upon the criminal justice system were estimated to be worth £5.2 million per year.
- For every extra £1 spent on drug misuse treatment, there is a return of more than £3 in terms of cost savings associated with victim costs of crime, and reduced demands upon the criminal justice system. The increased expenditure of £1.6 million for treatment interventions yielded an immediate cost saving of £4.2 million in terms of the reduced victim costs of crime, as well as cost savings within the criminal justice system of about £1 million. The true cost savings to society may be even greater than this. [22]

Importantly, Hough's literature review noted that legally coerced treatment is no less effective than treatment entered into voluntarily:

---

[20] M Edmonds et al, *Doing Justice to treatment: referring offenders to drug services*, Drugs Prevention Advisory Service Paper, 2 September 1999

[21] Home Affairs Committee, *Drugs and Prisons*, Fifth Report, 9 November 1999, HC 363-1 1998-99, para 12

[22] Michael Gossop, John Marsden and Duncan Stewart, *NTORS - At One Year: The National Treatment Outcome Research Study: Changes in Substance Use, Health and Criminal Behaviour One Year after Intake,* 1998

Research also has some pointers about the provision of treatment within *the criminal justice system:*

- Coerced treatment appears to be no less effective than voluntary treatment.
- The criminal justice system can effectively coerce people into treatment.
- It can also help keep them there.
- Drug testing provides a technology to make this coercion meaningful. [23]

Patterns of drug misuse are complicated: polydrug use and excessive alcohol consumption are common.[24] Patterns of drug taking among those involved with the criminal justice system have been studied. A Home Office research study involving testing the urine of arrestees found that around one in ten tested positive for cocaine/crack and around one in five tested positive for heroin.[25] Suspected property offenders, and particularly suspected shoplifters, were most likely to test positive. Almost half of those arrested for shoplifting tested positive for heroin or other opiates. Table 2 shows the results for selected Class A drugs and selected offence types.

Table 2
Suspected offenders testing positive for class A drugs
% of suspected offenders

Offence/Offence Group	Opiates	Methadone	Cocaine
Crimes against the person	17%	4%	5%
Property crimes	23%	11%	14%
Burglary	16%	3%	3%
Robbery	5%	0%	5%
Vehicle theft (from or of)	18%	8%	13%
Shoplifting	47%	29%	30%
Alcohol/drug offences	11%	0%	7%
Disorder	8%	4%	2%
All offences	18%	8%	10%

Source: Home Office Research Study 183 *Drugs and Crime* (tables 3.1, 3.3, 3.4)

Table 2 reveals a far greater prevalence of drug use among the sample of arrestees than among the general population. The 1998 British Crime Survey found that around 3% of

[23] Michael Hough, *Drug misuse and the criminal justice system: a review of the literature*, Drugs prevention paper 15, 1996

[24] Michael Gossop, John Marsden and Duncan Stewart, *NTORS At One Year: The National Treatment Outcome Research Study: Changes in Substance Use, Health and Criminal Behaviour One Year after Intake*, 1998

[25] T Bennet, *Drugs and Crime: the results of research on drug testing and interviewing arrestees*, Home Office study No 183, 1998

the adult population reported taking cocaine in the previous year, while less than 0.5% reported taking either the more potent crack cocaine, methadone or heroin.[26] In itself this does not prove a causal relationship between drug use and crime. The research used interviews with arrestees to examine such a link.

Around half of arrestees believed their drug use and crime were connected; around 30% of those arrested said they were currently dependent on one or more drugs (11% heroin). Only one in five had received some kind of treatment for drug dependence in the past with the same proportion wishing to receive treatment at the current time.[27]

There was a statistically significant link between the amount of illegal income reported and the number of drugs to which arrestees proved positive. The average illegal income of those with no positive tests was £3,000 compared to over £12,000 for those with three positive tests. Arrestees testing positive for opiates, methadone or cocaine reported levels of illegal income 2-3 times higher than those who tested negative for those drugs.

Using self-reported illegal income over the past 12 months as a measure of criminal involvement, a statistical analysis was performed to see which of a set of independent variables[28] gave the best explanation of variation in illegal income. The best predictors of illegal income were heroin use and crack cocaine use. The greatest illegal income (over £20,000 a year on average) was associated with the use of both together. (The report points out this does not prove any *causal* link.) The researchers took this one stage further and performed a hypothetical 'what-if' calculation. This and their other findings led them to conclude:

> … The research has shown that that a large proportion of arrestees are involved in drug use and that many of these use addictive and expensive drugs. It has shown that a number of measures of drug use and crime are strongly correlated. A substantial proportion of arrestees (approximately half) believe that their drug use and crime are related. Finally, the research has shown that (on the basis of the findings from these five areas) use of heroin and crack cocaine may be responsible for inflating criminal involvement by as much as one-third.[29]

B. Effectiveness of existing interventions

Interventions designed to identify problem drug users and to refer them to treatment can take place at a number of points in the criminal justice process: on arrest, pre-sentence, on probation, during a prison sentence, and on release from custody. The long-term aim of criminal justice interventions is to reduce levels of repeat offending among drug-misusing

---

[26] M Ramsay and S Partridge, *Drug Misuse Declared in 1998: results from the British Crime Survey*, Home Office Research Study 197, Home Office, 1999

[27] Cabinet Office, *United Kingdom Anti-Drug Co-ordinator's First Annual Report 1998/99 and National Plan 1999/2000*, May 1999, p 6

[28] Sex, age, race, marital status, tenure, legal income, employment status, methadone use (alone), cocaine use (alone), heroin use (alone), crack use (alone) all over the last three days

[29] T Bennet, *Drugs and Crime: the results of research on drug testing and interviewing arrestees*, Home Office study No 183, 1998, p 47

offenders by half by 2008. By 2002, the aim is to reduce the number of arrestees testing positive for Class A drugs from 18% to 15%.[30]

Compulsory drug testing already takes place in two situations: in prison, and as an integral part of a Drug Treatment and Testing Order (DTTO). This community sentence was brought in because arrangements to impose drug (or alcohol dependency) treatment as part of a probation order (a provision which is still available to the courts), were not widely used. Coerced treatment was considered of limited use. Research now indicates that it is no less effective than voluntary treatment.[31] Arrest referral schemes, by contrast, are voluntary.

1. Arrest Referral

Arrest referral schemes vary. In theory they depend on identification and assessment by arrest referral workers and drug specialists. Contact is initiated by a drug worker, information and advice offered, and referral to a specialist treatment service for assessment arranged where appropriate, and where the client agrees. At other times, police and others in the police station make telephone referrals. Although implementation is only partial at present, face to face schemes should be available in all custody suites by 2002.

Assessment of pilot arrest referral schemes has been positive:

> …arrest referral schemes have a positive impact on drug use and offending: 74% of the sample of arrestees referred took up treatment; their drug use and spending on drugs reduced significantly, with a corresponding impact on criminal activity. In follow-up gains were still apparent 12 months later.[32]

The Home Office comments further:

> Evaluation of the DPI (Drugs Prevention Initiative) work showed that people do take up and participate in interventions at the arrest stage, and it seems likely that this would be the case at all stages of the criminal justice process. The evaluation included a follow up of 60 people referred through the 'Get it while you can' project in Brighton and a further 68 who were referred through the East Midlands and South London projects and demonstrated clearly that:

---

30 Drugs Prevention Advisory Service, *Our developing agenda*, February 2000

31 Michael Hough, *Drug misuse and the criminal justice system: a review of the literature*, Drugs prevention paper 15, 1996

32 United Kingdom Anti-Drug Co-ordinator's, *First Annual Report 1998/99 and National Plan 1999/2000*, May 1999, p 6

- Interventions work: they reach an important target group – offenders with serious drug problems – most of those referred were polydrug users, injectors, with lengthy drug using careers which started when they were very young. More than half were using both opiates and stimulants

- They addressed an unmet need: offenders have on average 21 previous convictions but previous arrests have not deterred them from a life of drugs and crime; only a quarter of them are currently in touch with drug services, and a third have never been in touch at all; the average age of those referred was 27 to 31 years, involved mainly in property offences, with lengthy drug using and related offending careers.

- They have a real impact and lead to significant reductions in reported levels of drugs misuse and related offending: those who were referred to treatment or given some other forms of help reported large falls in their drug use and in drug related crime; nearly half of those injecting before contact said they no longer injected; median weekly spend on drugs before and after contact reflected reductions in the Brighton project, from £450 per week to £50; in the East Midlands from £400 to £35; and in South London from £325 to £133.[33]

However, a report prepared for the Home Office on referring offenders to drug services emphasises the necessity for adequate provision for referral and treatment: if drug services are already stretched and lack the capacity to absorb extra clients, setting up criminal justice referral schemes will simply reallocate available treatment among problem users:

> Arguably this may yield community safety gains - if resources are transferred from a client group which is less criminally involved to one which is heavily into crime - but in the process raises difficult ethical issues. Equally it may have no benefits at all - if those who are displaced from the treatment queue have as serious health and legal problems as those who displace them.
>
> …Referral systems will be worthwhile only if they are properly resourced and there are appropriate drug services to which to refer. There are choices to be made about the sequencing of investment in referral and treatment services. Referral systems themselves need to be properly resourced. Approaches which require drug workers to take on extra will run a high risk of failure.[34]

---

[33] Drugs Prevention Advisory Service, *Drugs Interventions in the Criminal Justice System: Guidance Manual*, 1999, para 2.4, http://www.homeoffice.gov.uk/dpas/cjsint.pdf

[34] M Edmonds et al, *Doing Justice to treatment: referring offenders to drug services*, Drugs Prevention Advisory Service Paper 2, September 1999, pp 44-45

Expansion and funding of arrest referral schemes was the subject of a PQ in October 1999:

> **Mr. Lidington:** To ask the Secretary of State for the Home Department if he will state in respect of each police force in England and Wales the number of offenders entering drug treatment programmes as a result of arrest referral schemes (a) during 1998-99 and (b) during 1999-2000 to date; and if he will make a statement.
>
> **Mr. Charles Clarke**: The information requested is not currently available. Information from Drug Action Teams' plans for 1999-2000, submitted in December 1998, suggested that coverage of custody suites by arrest referral schemes was partial across police forces.
>
> We have set targets to double the number of schemes this year, with coverage of all custody suites to be achieved by 2002.
>
> Tackling drug related crime is one of the Home Secretary's Policing Priorities for 1999-2000, and it is accompanied by a supporting key performance indicator concerned with the numbers entering treatment as a result of arrest referral. Police forces will report to my right hon. Friend the Home Secretary on their performance at the end of this financial year.
>
> To assist the national roll out of arrest referral, my right hon. Friend the Home Secretary announced in July that up to £20 million will be available to police forces to accelerate the introduction of arrest referral schemes and to help ensure that treatment is available for those with drug problems identified by these schemes. [35]

The performance target for 1999/2000 is to double the number of face to face arrest referral schemes and the number of arrestees referred to and entering treatment programmes.[36]

2. Drug treatment and testing orders (DTTOs)

These community sentences were introduced through the *Crime and Disorder Act 1998*.[37] Initial pilot schemes have been set up in Liverpool, Croydon and Gloucester, and another is due to start in Glasgow.

Courts in those areas are able to sentence offenders aged 16 or over who are considered to be susceptible to treatment and who express willingness to do so to receive non-custodial

---

35 HC Deb 26 Oct 1999 cc 826-7W

36 United Kingdom Anti-drugs Co-ordinator, *National Plan for 1999/2000*, May 1999

37 *Crime and Disorder Act 1998*, s .61-64

community based treatment for drug addiction and to undergo regular random and compulsory drug testing. The order must:

- State whether the treatment will be residential or non- residential;
- identify the treatment provider;
- specify the frequency of drug testing;
- specify the petty sessions area where the offender will reside.

The court will review the offender's progress under treatment on a monthly basis. If the offender fails to respond to treatment the court has the power to recall the offender and re-sentence for the original offence. This could mean a prison term. There is no provision in the *Crime and Disorder Act* to specify that a single positive test or a single failure to attend an appointment will result in breach of the Order: the offender's commitment to the programme can be viewed as a whole.[38] Pilot schemes started on 30th December 1998.

The level of uptake and degree of success of DTTOs have been questioned. A PQ in November 1999 addressed this:[39]

> **Mr. Simon Hughes**: To ask the Secretary of State for the Home Department how many cases have been referred for assessment for a drug treatment and testing order in each of the three pilot areas since October 1998; how many orders were made in each area over the period; how many orders have been (a) completed and (b) revoked; and if he will make a statement.
>
> **Mr. Boateng**: The information is given in the table:

Area	Referrals	Orders made	Orders completed (1)	Orders revoked
Croydon (South East London)	96	35	-	9
Gloucestershire	203	80	-	35
Liverpool (Merseyside)	132	53	-	12
Total	431	168	-	56

> (1) None - the first completion of orders is not anticipated until the beginning of the new year at the earliest

Funding for those who have been through the courts and are subject to Drug Treatment and Testing Orders is the responsibility of the probation service. Costs were given in answer to a PQ:

---

38 Home Office and The Standing Conference on Drug Abuse (SCODA), *Commissioning drug treatment and testing orders*, Draft, September 1999

39 HC Deb 26 November 1999 c 242W

> **Mr Clappison:** To ask the Secretary of State for the Home Department how many drug treatment and testing orders he has forecast to be made in his financial plans for the first full year of their operation.
>
> **Mr. George Howarth:** Our current best estimate of the unit cost of a Drug Treatment and Testing Order (DTTO) is £6,400. On that basis, the funds allocated should allow probation services to fund treatment and testing of approximately 6,000 offenders sentenced to DTTOs in 2001-02. The pilot evaluation report will provide accurate information on the unit cost and, therefore, the number of DTTOs that can be made each year.[40]

The pilots and their evaluation are not yet complete, but the Government has commented on an interim report:

> ..the interim evaluation report provides valuable evidence of their success, even at this early stage. Sentencers in the pilot areas were positive about the new order. It must be recognised that short-term gains are valuable. There is no magic bullet: there will always be those who drop out of treatment during the order and others that relapse after the order has been completed. The evidence from the pilots is that even if a typical offender in a DTTO stays away from drugs and crime for only six months, he or she will have spent well over £9,000 less and committed over 500 fewer offences.[41]

Addaction, a voluntary service provider, has commented:

> Addaction is concerned that DTTOs should achieve greater success than the Probation Orders with a condition of treatment (Section 1a6) introduced in the Criminal Justice Act 1991. Where these conditions have been used, they have been extremely successful.[42] However, nationally, there are only a limited number of areas where the probation services have utilised this method at their disposal. Strong guidance from the Home Office is required to ensure that DTTOs are adopted by all probation services. Field probation officers will need training in their use and a keen awareness of treatment availability and local agencies.[43]

The Government intends to expand Probation and court referral schemes, "in line with emerging evidence from the DTTO pilots and other studies".[44] It is hoped that reluctance

---

40 HC Deb 9 June 1999 c 332W

41 Home Affairs Committee, *Government reply to the fifth report from the Home Affairs Committee Session 1998-99: Drugs and Prisons*, Second Special Report, 22 February 2000, HC 271 1999-98, para 5

42 M Hugh et al, *Doing Justice to Treatment*, Drugs Prevention Advisory Service, 1999

43 Peter Martin, Chief Executive, Addaction, *An integrated drug treatment system & criminal justice system*, Representation to the Home Office, 2 November 1999

44 Cabinet Office, *United Kingdom Anti-Drug Co-ordinator's First Annual Report 1998/99 and National Plan 1999/2000*, May 1999, p17

to impose treatment requirements as a condition of probation may be overcome as evidence of the success of imposed, rather than voluntary, treatment emerges.

3. Drug testing in prison

Mandatory drug testing (MDT) had been introduced in all prisons in England and Wales by March 1996. This involved all prisons testing ten per cent of inmates every month but is now being reduced.[45] About 5000 tests per month are carried out on a randomly selected basis; these tests are standard urine tests for cannabis, opiates including methadone, barbiturates, benzodiazepines, amphetamines and others.[46]

The Home Affairs Committee discusses the MDT results:

> 79. The random MDT results provide a baseline for assessment of the current levels of drug use and for trends in their use. Positive test results have been as follows:
>
> | | *Total* | *Cannabis* | *Opiates/heroin* | *Cocaine* |
> |---|---|---|---|---|
> | 1996/97: | 24.4% | 19.9% | 5.4% | 0.2% |
> | 1997/98: | 20.8% | 16.5% | 4.2% | 0.2% |
> | 1998/99: | 18.3% | 14.0% | 4.4% | 0.3% |
>
> The highest rates of positive tests have been in open prisons and in local male prisons (though rates are also relatively high in male category C training prisons), with the lowest rates in the higher security male dispersal and category B training prisons. The Prison Service is currently subject to a target of achieving a further reduction in the positive random test rate to 16% by 2002. The target for the current year (1999/2000) is that the positive random test rate should be under 18.5%.
>
> 80. *Assessment of random MDT results* These results *can* be interpreted as suggesting that overall rates of use are not as high (particularly for harder drugs) as has been feared, and that the trend in consumption (particularly for cannabis) is downward. However, given the statistical margin of error, the figures do not necessarily support such conclusions, and in respect of opiate use may only indicate that there has been no significant increase in use; particular doubts surround the reliability of the figures as a measure of the numbers using drugs *at some time* while in prison.[47]

---

45 Home Affairs Committee, *Drugs and Prisons*, Fifth Report, 9 November 1999, HC 363-II 1998-9, para 78

46 National Addiction Centre, *An analysis of the Mandatory Drug Testing Programme, Key Findings*, April 1998

47 Home Affairs Committee, *Drugs and Prisons*, Fifth Report, 9 November 1999, HC 363-II 1998-9, para 79, 80

The Home Affairs Committee is concerned that the scheme fails to detect sufficiently the drugs that do most harm: cannabis use is deterred because it shows up in urine tests for as long as 5 weeks (in heavy users). Most opiates are only detected for 1-2 days. The Government agreed with the conclusions of the Committee that:

> The random MDT results provide evidence consistent with a downward trend in the use of cannabis within prison; we are not sure that we can go much beyond this to be confident that there is a clear downward trend in drug use overall. We see no indication that there is any downward trend for the use of opiates.[48]

The Government rejects the view that the MDT programme has caused a shift towards opiates in prison:

> There is no evidence of a shift from cannabis towards more harmful drug use in prison. While the MDT results show a fall in cannabis use, they do not show a rise in the use of other drugs.[49]

In 1998 the all-party Parliamentary Drug Misuse Group published a report critical of the treatment available at that time for drug misusers in prison.[50] At about the same time revised prison service drugs strategy, *Tackling Drugs in Prison,* was launched.[51] This set out an extensive programme to tackle drug s in prisons.

Provision of drug treatment services under the new strategy involves the establishment of the Counselling, Referral, Advice and Throughcare Service (CARATS) in all prisons, voluntary testing units in all prisons ("drug-free wings"), enhanced detoxification facilities, rehabilitation programmes and therapeutic communities. It is envisaged that this pattern will provide programmes of different intensity according to whether a prisoner has a low, moderate of severe drug problem. Additionally, the support provided to a prisoner will include continued contact with the prisoner in the community for up to 8 weeks after his or her release. Targets have been set for the CARATS caseload to reach 20,000, for 30 new rehabilitation programmes to be in place, and for 5000 prisoners a year to be going through treatment programmes, by 2002.[52]

---

48 Home Affairs Committee, *Government reply to the fifth report from the Home Affairs Committee Session 1998-99: Drugs and Prisons*, Second Special Report, 22 February 2000, HC 271 1998-99, para 33

49 Home Affairs Committee, *Government reply to the fifth report from the Home Affairs Committee Session 1998-99: Drugs and Prisons*, Second Special Report, 22 February 2000, HC 271 1998-99, para 38

50 All Party Parliamentary, Drug Misuse Group *Prison and drug misuse,* July 1998

51 Home Office; HM Prison Service, *Tackling Drugs in Prison*, Dep 98/420, 1998

52 Cabinet Office, *UKADC First Annual Report and National Plan*, May 1999

4. Care after release

The CARATS scheme provides for continued contact with the ex-prisoner for eight weeks after release, and for liaison with services in the community. These are critically important. Accidental overdose in the few weeks after discharge is common as tolerance to hard drugs will be diminished. Low level interventions are needed which would provide support and prevent relapse. Home Office research has found that inmates who had been involved in prison-based referral schemes were optimistic about their intentions to stop using drugs on release, but in spite of this half of those previously imprisoned had used drugs on the day of release.[53]

In view of the rising prison population, the Home Affairs Committee stresses the importance of alternatives to custodial sentences, and has suggested that "The likely advantages of new sentences for drug-related offenders which would combine treatment both in custodial and non-custodial settings should be fully assessed."[54] In its response to the Committee's report on drugs and prisons, the Government said it was considering a new Drug Testing Order for those offenders at risk of misusing drugs while serving community sentences.[55]

The Home Office suggests that gaps in provision are at the point of arrest, and on release from short prison sentences. Those who shoplift to support their habit are more likely to be fined than to get probation or custodial sentences; the court is unlikely to request a pre-sentence report. Arrest referral would channel these people towards drug services. Some drug-dependent burglars and shoplifters get prison sentences, but ones of six months or less (all given custodial sentences by magistrates will fall in this category). This group is unlikely to receive help either while in prison or on release.[56]

C. Compulsory drug testing in Europe

While most European countries aim to put drug users in contact with helping services (arrest referral), Sweden has a mandatory system. Legislation in 1993 enabled police to take blood or urine samples from arrestees who they suspect of being under the influence of drugs. In 1997 sixty police stations across Sweden had urine testing facilities and 30,00 people had been screened. Of those who tested positive, 95% were fined and

---

53 M Edmonds et al, *Doing Justice to treatment: referring offenders to drug services*, Drugs Prevention Advisory Service Paper 2, September 1999, p 54

54 Home Affairs Committee, *Drugs and Prison*, fifth report, 9 November 1999, HC 363 1998-99, para 22

55 Home Affairs Committee, *Government reply to the fifth report from the Home Affairs Committee Session 1998-99: Drugs and Prisons*, Second Special Report, 22 February 2000, HC 271 1998-99, para 6

56 M Edmonds et al, *Doing Justice to treatment: referring offenders to drug services*, Drugs Prevention Advisory Service Paper 2, September 1999, p 54

referred to helping services, the vast majority on a voluntary basis. Police credit this intervention with an average decrease in dishonesty offences of 24%.[57]

In Greece compulsory testing is carried out on: individuals arrested for traffic accidents; some alcohol-intoxicated drivers; all individuals arrested for drug-law offences; and on individuals arrested for other law offences whenever it is considered necessary.[58]

In Spain a compulsory drug test can be performed in the case of road traffic accidents.[59]

D. Drug treatment capacity

Care for drug misusers has tended over recent years to be centred on specialist treatment services. The Government is encouraging appropriately trained general practitioners to become more involved in shared care, and to underpin this has issued guidelines on the clinical management of drug misuse and dependency.[60]

The inclusion of substance misuse within the community care framework[61] gave local authorities the responsibility for commissioning specialist services for those who misuse alcohol and drugs.

At March 1998, there were around 24,000 people in England presenting for treatment for the first time or after a break of 6 months, and 30,000 in the UK. The number of drug misusers with serious problems has been estimated at between 100,000 and 200,000, many of whom do not seek or cannot get access to effective services.[62]

In response to increasing demand the Government plans to recruit and train 300 extra specialists in the treatment of drugs misuse. A press release states

> The plans for a recruitment campaign have been drawn up after a government-funded study showed that providers would face additional pressures over the next few years.[63]

---

57 Annual Report of the State of the Drugs Problem in the European Union, *Demand Reduction*, 1997 Chapter 2, p 64

58 Personal communication, Greek Reitox focal point (Reitox is the European information network on drugs and drug addiction), 24 March 2000

59 Personal communication, office of the Minister of the Interior, Spain, 17 March 2000

60 Department of Health, *Drug misuse and dependence: guidelines in clinical management*, 1999

61 *NHS and Community Care Act 1990*

62 United Kingdom Anti-Drugs Co-ordinator, *First Annual Report 1998/99 and National Plan for 1999/2000*, May 1999, p 8

63 Cabinet Office Press release CAB 39/00, *Dr Mowlam announces extra funding for workers in the treatment of drugs misuse*, 3 February 2000

Recruitment plans were informed by a study of drug service capacity commissioned by the Department of Health and carried out by the National Economic Research Association. This is not yet in the public domain.[64]

1. Access to treatment

Research from the Standing Conference on Drug Abuse suggested that the average waiting time for access to drug services was 14 weeks in 1998. This included the NHS and voluntary sector (community-based and residential services). *Tackling Drugs Together to Build a Better Britain* said that the Government would reduce the number of drug misusers being denied immediate access to treatment.[65] Furthermore,

> The United Kingdom Anti-Drugs Co-ordinator's Annual Report and National Plan details that by 2002 all Drug Action Teams will be required to have established a locally agreed maximum waiting time for admission into a drug treatment service and be monitoring agencies' performance. The Department currently has no plans to set a maximum centrally for waiting times for drug treatment services.
>
> One of the conditions for local authorities to receive Drug and Alcohol Specific Grant monies in 1999-2000 (about a quarter of them will) is to achieve three targets: 10 per cent increase in the number of problem substance misusers participating in effective treatment and care programmes purchased or provided by local authorities; reduction in the time spent by problem misusers in waiting for an assessment of their needs, after engaging with a service, to 48 hours; A 10 per cent increase in the proportion of decisions to approve funding made within two weeks of a misuser having been formally assessed as needing funding for a service.[66]

The Standing Conference on Drug Abuse (SCODA) has undertaken a national survey of the funding of specialist drug treatment providers during autumn 1997.[67] This independent organisation is the umbrella group for service providers, and receives funding from the Department of Health.

The Chief Executive of SCODA, introducing the report (1998) states:

> This report reveals a specialist drug treatment system in England under mounting strain, whose modestly increased resources have failed to keep pace with increased demand. The ripples reach far wider than the agencies concerned; services such as probation, prison and primary health care rely on specialist drug

---

64 Department of Health personal communication, 17 March 2000
65 HC Deb 18 June 1998 c 306W
66 HC Deb 21 July 1999 c 551W
67 SCODA, *Feel the Wait: A national survey of the funding of specialist drug treatment providers*, 1998

> services being available to accept their referrals and to support them in their work. As police officers point out, schemes to curb crime by diverting drug-motivated offenders into treatment rely on treatment being available, and quickly. For these schemes, and for GPs seeking treatment for their patients or probation officers looking to place vulnerable clients in a safe, drug-free environment, the waiting times reported here are a daily frustration.[68]

The report states that half the services which responded to the survey reported waiting lists for assessment for drug treatment. The average wait was 14 weeks. The lag between assessment and treatment varied from an average 4 weeks for residential rehabilitation to nearly 4 months for NHS in-patient detoxification. Some services admitted to indefinite waiting lists, others said that in some areas certain types of clinical treatment were simply unavailable.

> If the clients are typical of the range sampled by an ongoing national research study, which also drew clients from a range of services, then in the six months many will wait for treatment each will commit on average 120 crimes. They will also risk their own and others' health through unsafe injection practices and face the threat of death through the lottery of street drug use.[69]

The survey revealed a mixed picture, growth and expansion in some sectors, constriction and pressure in others, with considerable funding insecurity.

The recent Home Affairs Select Committee report on *Drugs and Prisons* comments on the demands made on drug treatment agencies and providers:

> 48. Just as the Prison Service drugs policy cannot be viewed in isolation from what is going on in the rest of the Prison Service, nor can it be assessed in isolation from what is going on in the field of drugs policy generally. As we have already noted, the national anti-drugs policy overseen by the UKADC is a part of the background against which the prisons strategy has been formulated. However, concerns were raised with us that the available pool of drug workers in the community was insufficient to provide the numbers that would be required across the different elements of the overall strategy. It must be remembered that the demand arises not just from the planned treatment services to be provided within prison, but at other stages of the process also: for supporting arrest referral schemes, for supporting Drug Treatment and Testing Orders, and for providing support for prisoners after their release from prison.
>
> ... SCODA spoke of "a wide gap between those intentions [to divert problem drug users into treatment] and the availability of effective treatment services both inside prison and outside." Mr Howard, their spokesman, told us that "The simple

---

[68] SCODA, *Feel the Wait: A national survey of the funding of specialist drug treatment providers*, 1998

[69] ibid

fact of the matter is there are not the skilled people out there at the moment... Already many of the treatment organisations both in the NHS and outside the NHS are reporting major problems with recruitment"; he spoke of a need for "a fairly heavy crash programme of training and development to put these people in place". The Association of Chief Officers of Probation pointed to "a shortage of appropriately qualified and experienced community drug agency staff" adding that there was also a shortage of probation staff to support the aspects of the strategy which required an input from them.

50. Mr Narey, for the Prison Service, speaking in early May (before bids for providing contract services had been received), said that he was "satisfied" that outside agencies would be able to cope with the demands being placed upon them for provision of treatment services for prisons, claiming that they "have been cautious in planning the spending and investment of [the CSR funding] over the next three years to make sure that we could take agencies along with us". Speaking at the end of July, Mr Howarth, the then Home Office Minister, reported that "there is no evidence we are not getting the bids for all the programmes" and indicated that to some extent the demand would be catered for by an expansion of capacity by the criminal justice system as a whole. Mr Griffith, the head of the Prison Service Drugs Strategy Unit, noted a possible danger that because the Prison Service had been able to make plans somewhat in advance of other areas of the criminal justice system it could "syphon off" workers before other agencies had developed specific assessments of their needs; he explained that "the UK Anti-Drugs Coordination Unit, with us and the Department of Health and with other agencies is doing some modelling to try to find out what the pattern of need looks like for the provision of drugs workers over the next few years" and the Minister added that discussions on this were "ongoing".

51. We note that the UK Anti-Drugs Coordinator has pointed to the possibility that, so far, far from seeing an expansion in available places "There is evidence ... that over recent years we have actually been losing residential treatment places". The Prison Service later told us that the need for suppliers who had been awarded contracts for elements of the planned expansion of drug services to recruit new staff had led to minor delays in making the contracts fully operational. It is clear that there is a danger of a shortage of qualified drug workers in the community; any such shortage would de-rail the Prison Service anti-drug strategy or adversely impact on the national anti-drugs strategy. Appropriate steps must be taken by all relevant government agencies—which must include the Department of Health as well as the Home Office—to address this problem. The UKADC must have an overall responsibility to ensure that overall needs are assessed and that the necessary steps are taken to ensure sufficient training takes place.[70]

---

[70] Home Affairs Select Committee, *Drugs and Prisons*, Fifth Report, 23 November 1999, Vol 1

2. Performance targets for treatment

The UKADC's First Annual Report set performance targets for treatment:

> To increase the participation of problem drug misusers, including prisoners, in drug treatment programmes which have a positive impact on health and crime by 100% by 2008; and by 66% by 2005
>
> By 2002:
>
> - Require all DATS[71] to have established a maximum waiting time for admission into a drug treatment service and to be monitoring agencies performance;
> - Ensure the CARATS[72] annual caseload reaches 20,000; and that there are 30 new prison-based rehabilitation programmes; and that 5000 prisoners a year go through treatment programmes;
> - Have in place National Occupational Standards for specialist drug and alcohol workers;
> - Reduce the numbers of those in treatment who report injecting and the numbers of those injecting who report sharing;
> - Have in hand a plan of action to reduce drug-related deaths, from a base-line established in 2000/01;
> - Ensure that all treatment programmes accord with a nationally accepted quality standard.[73]

Also, by 1999/2000 (among others):

> - require each DAT to produce an action plan to meet the local demand for detoxification and substitute prescribing services and for the community-based structures therapeutic programmes
> - have established CARATS; the basic treatment framework to improve the assessment, advice, throughcare and support of prisoners; and put in place more and better quality treatment programmes[74]

As stated above, the Government has made provision for recruitment and training of 300 extra drug workers.

---

[71] Drug Action Teams: these co-ordinate anti-drugs activity in the community, including drug treatment agencies

[72] Prison Service Drug Strategy Counselling Assessment Referral in Advice Throughcare Services (CARATS)

[73] United Kingdom Anti-Drugs Co-ordinator, *First Annual Report 1998/99 and National Plan for 1999/2000*, May 1999

[74] ibid

E. Funding the UK drug strategy

The 1998 Comprehensive Spending Review announced a 25 % increase in spending for prevention and treatment services. An extra £217 million will be available in total up to 2001/2. This is in addition to the estimated £340 million spent on pro-active anti-drugs activity in 1997/98.

Allocation of funding was set out by the Cabinet Office:

- Drugs education and prevention programmes. An extra £3 million will be allocated to support cross-departmental development of more effective drugs education and prevention programmes across the country. This will include a new Drugs Prevention Advisory Service, replacing the Drugs Prevention Initiative, with £21 million to support education in schools.

- Support for Drug Action Teams and national research into the effectiveness of anti-drug activity. An extra £10.5 million will be allocated.

- New treatment and testing services for drug-using offenders to help break the cycle of drugs and crime. An extra £133 million will provide for the implementation of the comprehensive strategy to tackle drugs in prison and the new Treatment and Testing Orders.

- Extra services for drug misusers. Health and local authorities will be allocated £70.5 million extra funding to provide new treatment services - including a significant proportion for young people at risk - and to improve community care services for drug misusers.[75]

An additional £3 million would be made available in 1999/2000 by channelling the assets seized by convicted drug dealers back into action against drugs. This hypothecated "Confiscated Assets Fund" goes to the UK Anti-Drugs Co-ordination Unit, not the Treasury. This money should rise to £5 million in 2000/01 and £7million in 2001/02.

> Over the next three years a large proportion of the £217 million ring-fenced for drugs will be aimed at education and treatment.[76] This will now be supplemented with money seized from drug dealers who profit from other people's misery. We also aim to spend £6 million on a major new research programme to find out more accurately what drugs problems and which initiatives are most effective in reducing drug misuse among young people. It is essential that we focus in the long term on outcomes but first we need to develop the necessary information gathering mechanisms and baselines to allow us to do that.[77]

---

[75] Cabinet Office CAB 182/98, *Government's largest ever push to tackle drugs menace,* 1 September 1998

[76] Health authorities will receive £ 50million of this, one priority of which will be to develop support for treating drug misusers in primary care. (DoH press release 1999/0731 3 December 1999)

[77] Cabinet Office CAB 182/98, *Government's largest ever push to tackle drugs menace,* 1 September 1998

The distribution of funding across areas of the anti-drugs strategy was discussed on 15 December 1999 in Parliamentary Questions:[78]

> **Mr Simon Hughes**: to ask the Minister for the Cabinet Office how much money has been spent to date on each area of the Government's anti-drugs strategy following the comprehensive spending review.
> **Mr Ian McCartney**: It is not possible at this stage of the financial year to provide the information in the format requested. The Comprehensive Expenditure Review 1997-98 estimated drug-related spending across the UK to be in the region of £1.4 billion.
>
> The 1998 Comprehensive Spending Review settlement provided an additional £217 million over three years directed to health, local authorities and criminal justice agencies for targeted anti-drugs activities. The table details allocations. In addition, the Home Secretary announced the availability of a further £20 million for the development of Arrest Referral Schemes to get drug misusers into treatment.

Breakdown of additional anti-drugs money

£million

	1999-2000	2000-01	2001-02	total
PSS (purchase of community care services) Local Authority	3	5	12.5	20.5
NHS-Health Authorities drug misuse special allocation	12	18	20	50
Comprehensive provision for treatment of problem drug users in prison and effective links between prison and community	20	20	20	60
Voluntary drug testing in every prison	2	5	5	12
Piloting of Drug Treatment and Testing Orders followed by comprehensive Implementation subject to evaluation	1	20	40	61
Development funding for Drug Action Teams	1.5	1.5	1.5	1.5
Department of Health prevention work	1	1	1	3
Research	2	2	2	6
Total				217

[78] HC Deb 15 December 1999 cc 229-30W

III The Bill and drug testing: clauses 40, 41, 42, 48, 49, 51, 52 and 53

Part III of the Bill, 'Dealing with offenders', introduces a number of new powers which involve compulsory drug testing of offenders and alleged offenders over the age of 18 for Class A controlled drugs. These provisions apply to England and Wales. Where the provisions are included in the Powers of Criminal Courts (Sentencing) Act 2000, which is currently going through Parliament, these are included on the understanding that it makes appropriate progress.

The Bill:

- introduces a new community sentence, a Drug Abstinence Order, (clause 40)
- requires courts to include drug abstinence requirements in community sentences in certain circumstances (clause 42)
- provides for compulsory pre-sentence drug testing where the court is considering passing a community sentence (clause 41)
- requires courts to have regard to any evidence of drug misuse in the setting of bail or any conditions of bail (clause 49)
- allows for drug testing of persons in police detention: this can be extended (by Order) to include testing of those arrested but not charged (clause 48)
- creates a new offence for failing without good cause to give a sample for testing in police detention (clause 48)
- provides for the detention for up to six hours following charge, for the purposes of drug testing (clause 48)
- provides powers to impose drug testing as a condition of release from prison on licence in certain circumstances (clauses 51, 52)

These provisions give powers to test for certain Class A drugs, as "specified" by Order (clause 53), and (although not exclusively) in consideration of a list of "trigger" offences.[79] The drugs to be specified are not included on the face of the Bill, but the Government's explanatory notes indicate that testing may focus on heroin and cocaine/crack as the drugs particularly associated with acquisitive crime.[80]

Trigger offences are listed under schedule 5, and comprise acquisitive crimes (under the *Theft Act 1968*) and offences under the *Misuse of Drugs Act 1971* relating to production, possession and supply of specified class A controlled drugs. This list can be amended by Order (clause 53).

---

79 Trigger offences are listed in Table 1, section IV of this paper

80 *Criminal Justice and Court Services Bill*, Explanatory notes, Bill 91-EN, p 6

Drug testing powers are not only provided in respect of trigger offences. There are discretionary powers to test where the court, or a senior officer (in the case of police detention) considers that a non-trigger offence caused or contributed to the offence. This covers the circumstances where, for example, the offender has been convicted of a violent crime, and the court considers that misuse of heroin or cocaine contributed to this.

The powers to extend testing to those arrested but not charged, and to amend the list of trigger offences, are by affirmative resolution – a draft statutory instrument must be approved by both Houses of Parliament. Powers to amend the list of "specified" class A drugs can be made by negative resolution.

A. Community sentences: clauses 40 and 42

The Bill proposes a Drug Abstinence Order should be available to the courts (clause 40. This is a new 'stand alone' community sentence.[81]

The Order would require an offender to abstain from misusing specified Class A drugs and to undertake a drugs test on instruction. It would be applicable where, in the opinion of the court, the offender is dependent on, or 'has a propensity to misuse' specified class A drugs and the offence is a trigger offence, or misuse of a specified class A drug contributed to a (non-trigger) offence.

Drug Abstinence Orders would last from 6 months to three years; the Secretary of State is given the power to amend maximum and minimum periods by statutory instrument. The clause sets out the arrangements for supervision of the Order; allows for review of an Order; and requires that provisions for implementation should be in place in the area before any Order is made.

Where there is unacceptable failure to comply with the conditions of a Drug Abstinence Order a statutory warning would be given that a second unacceptable failure to comply within 12 months would result in a return to court. There is an option to return an offender to court after a first unacceptable failure.[82] On the face of the Bill, failure to comply encompasses both providing a sample and testing positive. The Home Office has indicated that the intention is to target those who fail to attend an appointment for testing; however, there will be individuals who consistently test positive. It is probable that guidance will be issued on this matter.[83]

There is no presumption of imprisonment for failure to abstain from using drugs. The warning and punishment provisions for community sentences in the Bill do not apply to failure to abstain from misusing specified drugs (Clause 46 subsection 6). It is recognised

---

[81] To be included after section 58 of the *Powers of Criminal Courts (Sentencing) Bill*

[82] HC Deb 22 March 2000 c 560W

[83] Personal communication, Home Office official, 23 March 2000

that the chaotic life style of some problem drug users may give rise to failures and the intention of the legislation is that his/her commitment to comply will be viewed as a whole.[84]

Drug abstinence requirements are also placed on other community sentences (clause 42), again where the offender is dependent on, or has a propensity to misuse, class A drugs, and has committed a trigger offence. Where a non-trigger offence has been committed to which his misuse of class A drugs contributed, the court has the discretion to impose drug abstinence requirements on a community sentence. This provides an alternative to inclusion of a *treatment* provision within a community sentence, which is already available to the courts.

Neither Drug Abstinence Orders nor drug abstinence requirements impose a requirement for treatment; they may therefore be applicable to the user who does not agree to treatment or for whom treatment is not appropriate. Consent is required for treatment which can be included as a condition of probation orders[85] or as part of a Drug Treatment and Testing Order.

The Home Office has indicated that the purpose of including drug abstinence requirements for community sentences in addition to the provision for Drug Abstinence Orders is to allow for flexibility. It is envisaged that the drug abstinence requirements could be employed where a trigger offence has been committed: taking and driving away a car, for example, might give rise to a community sentence to which a drug abstinence requirement would be imposed if the conditions are met.[86]

The new Drug Abstinence Orders/ Requirements will be piloted in the first instance. It is estimated that initial piloting in three areas would result in 3,500 offenders being subject to the drug abstinence requirement.[87]

B. Pre-sentence drug testing and setting of bail: clauses 41 & 49

The Bill provides courts with a new power where, after conviction with a relevant offence, if it is considering imposing a community sentence, it can require the offender to undertake a drug test (clause 41). It also gives courts a duty to have regard, so far as it is relevant, to any misuse of controlled drugs in consideration of setting bail or any conditions imposed (clause 49, amending section 4 of the *Bail Act 1976*).

---

84 Personal communication, Home Office official, 21 March 2000
85 Under Schedule 1A(6) of the *Powers of Criminal Courts Act 1973*
86 Personal communication, Home Office official, 21 March 2000
87 HC Deb 22 March 2000 c 561W

C. Drug testing after release: clauses 51 and 52

Powers are provided to impose drug testing conditions (for specified Class A drugs) on those who are convicted of a trigger offence, and are subsequently released subject to conditions (such as on licence) (clause 52). This provision is also applicable to young offenders over the age of 18 (clause 51).

The Government has stated that the use of the new licensing condition will not change any prisoner's eligibility for release. The use of the new drug testing provisions will be piloted before wider implementation. Evaluation will include an assessment of the impact on parole board discretionary release decisions. The Government estimates that:

> …the new powers will have no impact at all on release decisions, but will act solely as a reinforcing measure in cases where release would have been authorised or required in any case.[88]

D. Testing in police stations & failure to give a sample: clause 48

Provisions for drug testing in police detention are made through amendment to the *Police and Criminal Evidence Act 1984* (PACE).

Provisions are made to allow that samples *may* be taken for testing for specified Class A drugs from persons over 18 where:

- the person has been charged with a trigger offence or
- a person has been charged with a non-trigger offence if a police officer of the rank of inspector or above 'has reasonable grounds for suspecting that the misuse of specified class A drugs caused or contributed to the offence'

Importantly, provision is included under subsection 5 for the Secretary of State to extend compulsory drug testing to persons who have been arrested but not charged. This would require the agreement of both Houses of Parliament.

The clause provides that samples of urine or non-intimate samples can be taken for testing. There is no provision for blood testing. Non-intimate samples include mouth swabs, saliva and hair (other than pubic hair).[89] This range of samples can be taken by police officers: doctors are not required.

The Secretary of State may issue regulations authorising people other than police officers to take samples (by statutory instrument, subject to affirmative resolution). Delegation of

---

[88] HC Deb 22 March 2000 c 559W

[89] *Police and Criminal Evidence Act* (s.60)(1)(a) and s.66) Codes of Practice Revised edition, D, 1995, p 97

this duty could be made to an outside agency. This would reduce the burden on police officers.[90]

Regulations governing the taking of samples will be made by affirmative resolution, and will be included in the PACE Code. Details have not yet been finalised. Urine sampling is currently routinely employed for drug testing. Saliva for testing would be much easier to collect, but provides less satisfactory results: illegal drugs show up more readily in urine. However, technologies are improving, and the Forensic Science Service is exploring the possibilities.[91]

Failure to comply

The clause provides a new offence of failure without good cause to give a sample, which carries a penalty of up to three months imprisonment, and/or a fine of up to level 4 on the standard scale (currently £2,500). It includes provisions for detention of an individual for up to six hours after charge for the purposes of testing.

This meets concerns about consent expressed by doctors organisations:

> Doctors will certainly not be involved in any kind of examination or sampling without the consent of the patient.
>
> If testing is to be performed by police officers, then a non-invasive sample such as sweat or urine must be the preferred option. A legal sanction for refusing to provide a specimen, as contained within the current road traffic legislation, would avoid the need of any form of testing or sampling by police officers without the consent of the detained person.[92]

Use of the results

There has been some speculation that a positive test could lead to a construction of unlawful possession. The Government has stated that a positive test will not, in itself, result in prosecution for unlawful possession.[93] Nor will the Bill make drug use an aggravating factor in relation to an offence.[94]

There is a requirement that records should be made (both of the authorisation of testing and of the grounds for suspicion). The Home Office has indicated that the intention is

---

90 Personal communication, Home Office official, 22 March 2000

91 Personal communication, Home Office official, 21 March 2000

92 Dr Michael Wilks, Chairman, Ethics Committee BMA, Chairman, Metropolitan & City Group, Association of Police Surgeons, and Dr Michael Knight, Chairman, Forensic Medicine Committee BMA, Honorary Secretary, Association of Police Surgeons, *Guidelines for Drug Testing*, Letter to the British Medical Journal, 8 February 2000

93 HC Deb 22 March 2000 c 560W

94 ibid

that if no charge is brought the record would be destroyed whether the result was positive or negative. This would form part of the PACE Codes of Practice.[95]

E. Financial effects of drug testing measures

The Home Office provides an estimate of cost in the explanatory notes issued with the Bill:

> 133. Although the proposals will be piloted, the estimated annual cost for national implementation are approximately £45.5 million, of which £20 million will be police costs. This breaks down as follows:
> Drug testing on arrest after charge: net cost of £22.6 million;
> Drug testing under community sentence: net cost of £7.8 million;
> Drug testing on license from prison: net cost of £15.1 million.
>
> 134. Estimated costs for a pilot in three areas break down as follows:
> Drug testing on arrest after charge: net cost of £0.5 million;
> Drug testing under community sentence: net cost of £0.7 million;
> Drug testing on license from prison: net cost of £1.8 million.[96]

The Home Office estimates that the average cost of a Drug Abstinence Order/Requirement under community supervision is £1,500. It is estimated that initial piloting in three areas would result in 3,500 offenders being made subject to the drug abstinence requirement.[97]

The Home Office states that a full regulatory impact assessment has not been carried out: the Regulatory Impact Assessment Unit has been consulted and is content that the proposals will not impose a significant burden on business or on voluntary groups.[98]

---

95 Personal communication, Home Office official, 22 March 2000

96 *Criminal Justice and Court Services Bill*, Explanatory Notes, Bill 91-EN, 15 March 2000

97 HC Deb 22 March 2000 c 260W

98 ibid

IV Issues arising and responses to the Bill

Reception of the drug testing proposals in the Bill have been mixed. The measures have been welcomed in principle by some commentators as additional opportunities to tackle the links between drugs and crime.

- The Conservative Party is generally in favour of the proposals, but has flagged up a number of issues. These include the disposal of test results if the individual is not charged; discretionary powers for police in drug testing; the restriction of trigger offences to acquisitive crime, and action to be taken if an individual testing positive is not charged.[99]

- The Liberal Democrats support the aims of the drug testing measures in the Bill, but voice some reservations:

> Our primary concern with the Bill is one of interpretation of the provisions, which deal with drug testing of those who have committed certain categories of offences. We are concerned that clause 48 is so broad that it could be construed as criminalising for the first time the use of drugs. This would create a new offence and move beyond the present position where only the possession, manufacture and trafficking of illicit substances is criminalised. In principle we support the proposals to create an Abstinence Order. However these must be backed by provision for rehabilitation and drug treatment programmes. Otherwise this will simply be a method of forcing drug users back into custody.
>
> The view of the Liberal Democrats is that if someone is found in possession of drugs or if there is reasonable suspicion that someone is under the influence of drugs at the time of the alleged offence, then it ought to be lawful to test for use of drugs.
>
> We believe that the critical point at which testing should take place is after conviction for an offence and before sentencing. Once guilt has been established, drug testing can help identify the most appropriate sentence not only as punishment and deterrence but to address the causes of crime and to cut re-offending.
>
> The law should draw a distinction between those who use drugs and those who abuse drugs. Use of drugs in itself should not be criminalised because it in itself this does not harm others. There is already plenty of legislation to prevent the use of illegal drugs .There are however not enough resources for the treatment of drug users and not enough is being done to deal with the crimes that result from the use of alcohol.[100]

---

[99] Personal communication, Conservative Party 21 March 2000

[100] Liberal Democrat position on drug testing provisions in the Criminal Justice and Court Services Bill, personal communication, 24 March 2000

The Police Superintendents' Association welcomed the Bill. Concerns about overburdensome duties on police regarding the taking of urine samples have been met.[101] Clause 48 makes provision for regulations to delegate this duty.

Addaction, a provider of community based drugs services, views the drug testing provisions favourably. Peter Martin, Chief Executive of Addaction, has commented that testing of all those arrested provides "an opportunity for those tested positive to be diverted to treatment". He sees benefits in detecting drug misusing offenders at an early stage in contact with the criminal justice system, with a view to early treatment.[102] Flexibility and integration of the various criminal justice interventions is seen as the key to success in reducing drugs related crime. Addaction is concerned about provisions for those released from prison, and welcomes compulsory drug testing in appropriate circumstances for individuals released on licence.[103]

The Association of Chief Officers of Probation has welcomed the proposals as an extra opportunity to channel heroin and cocaine misusing individuals into treatment:

> The new provisions will provide the police with independent verifiable information about drug use enabling drug related offenders to be identified and scarce treatment resources to be better targeted.[104]

It warns, however, that the measures will generate additional demand for drug treatment services, and "significant investment will have to be increased further to build treatment capacity to meet the additional demand".[105]

The Police Federation supports the drug testing proposals, including the Drug Testing Order, in principle. It considers that "Offenders who commit numerous offences of Burglary and Theft, to feed a drug addiction, should in the vast majority of cases receive a custodial sentence". If the proposals lead to a reduction in bail, the Federation would support this, but it emphasises the need for adequate treatment provision within prisons.[106]

Others commentators raise a number of concerns.

Targeting: It is argued that a positive test does not identify whether a person has a drug *problem* or not, or whether there is a direct link between the alleged offence and the drug consumption.

---

[101] Personal communication, Police Superintendents' Association, 20 March 2000

[102] Peter Martin, Chief Executive, Addaction, *An integrated drug treatment & criminal justice system*, November 1999

[103] Personal communication, Peter Martin, Chief Executive, Addaction, 23 March 2000

[104] Paul Hayes, Association of Chief Officers of Probation, 17 March 2000

[105] ibid

[106] Copy of "Correspondence with Home Secretary", Police Federation of England and Wales, 1999

The Home Office does not collect figures on persons arrested for or charged with particular offences. Some idea of the potential pool of people who could be tested for committing a trigger offence can, however, be gleaned from data on the numbers proceeded against or cautioned. In 1997, around 290,000 adults in England & Wales were proceeded against or cautioned for one of the trigger offences.

Table 1[107]
Adults Proceeded Against or Cautioned for Trigger Offences
England & Wales, 1997

Offence	Cautions/ Proceedings
Theft	162,200
Robbery	10,900
Burglary	50,100
Aggravated burglary	1,400
Taking motor vehicle or other conveyance without authority	11,900
Aggravated vehicle-taking	6,600
Obtaining property by deception	24,300
Going equipped for stealing	4,500
Production of a controlled drug, possession with intent to supply (Class A)	5,900
Possession of a controlled drug (Class A)	10,900
Total	288,600

Source: Home Office *Criminal Statistics England and Wales Supplementary Tables*

Refusal of bail and impact on prisons: There are concerns that in the absence of immediate treatment provisions to refer those testing positive, bail will be refused. The National Association for the Care and Resettlement of Offenders (NACRO) is among those voicing concerns that if courts know of positive tests but lack immediate access to these services, they will remand more defendants to prison.[108]

There is a potential for putting further strain on prison capacity through an increase in remand prisoners, and for exposing casual or experimental drug users who test positive to the prison drugs culture. The Standing Conference on Drug Abuse (SCODA)[109] comments:

> We foresee significant increases in the prison population (remand and sentenced) as a result of these new measures:
> a) as a result of the change made to the Bail Act;
> b) as a result of breaches of the new abstinence order and abstinence requirements;
> c) as a result of the new legislation for breach of all community orders; and

[107] Statistics provided by Graham Vidler, Social and General Statistics Section
[108] National Association for the Care and Resettlement of Offenders News Release, *Nacro comments on the new crime bill*, 16 March 2000
[109] An independent umbrella group for treatment service providers

> d) as a result of some individuals refusing to provide a sample at the police station.
>
> We have no desire to see the prison population rise in this way. The more overcrowded our prisons, the less able the prison service will be to provide the structure and regimes needed to address the drug misuse and offending behaviour of those being held in them.[110]

The link with treatment: A number of criminal justice interventions designed to get drug taking individuals involved in the criminal justice system into treatment are being implemented, but are still in their infancy (see section II of this paper). Arguments have been put forward questioning the necessity of the new drug testing measures: Liberty (the National Council for Civil Liberties) sees them as "premature and unnecessary".[111] Many commentators have reservations about whether the new measures will be effective in tackling the links between drugs and crime because there is no direct link between the testing provisions and treatment. Commentators have stressed that treatment is the critical factor.

SCODA highlights the need for treatment and support:

> These proposals seek to identify the same drug-misusing offenders as those eligible for DTTO ('dependent on, or have a propensity to misuse'), but fail to ensure, or even to mention, treatment. This could only be described as setting drug misusing offenders up to fail. The Drug Abstinence Order amounts to a Drug Treatment and Testing Order, but without treatment. Having identified people in need of help, should it not be provided?
>
> Similarly, while testing for prisoners once released on license may provide some benefits, without adequate support for the re-integration of drug misusers, it is likely that many will relapse and potentially reoffend.[112]

Similarly, the National Association of Probation Officers (NAPO) is not convinced that a case has been made for a Drug Abstinence Order:

> It is already possible to attach a condition of treatment to an existing probation order and the government is currently piloting drug treatment and testing orders. The Drug Abstinence Order appears to be free standing and not to be backed up by treatment. Its approach is mechanistic. It is highly unlikely that a Class A drug user will cease to partake in illegal substances merely because a court passes a drug abstinence order. Without the backup of immediate treatment, it appears to have little purpose. NAPO believes, therefore, that there will be a high failure rate.[113]

---

[110] *The Criminal Justice and Court Services Bill*, submission for the second reading in the House of Commons, The Standing Conference on Drug Abuse, 23 March 2000

[111] *Criminal Justice and Court Services Bill*, Briefing for 2nd reading, Liberty, 23 March 2000

[112] *The Criminal Justice and Court Services Bill*, submission for the second reading in the House of Commons, The Standing Conference on Drug Abuse, 23 March 2000

[113] Harry Fletcher, Assistant General Secretary, National Association of Probation Officers, 20 March 2000

NAPO also comments that as we already know that about 20% of arrestees are using illegal drugs, and police usually have knowledge of the suspects and offenders, it is difficult to see why testing of persons in police custody is actually required:

> If this clause was implemented, it could lead to thousands of additional persons being remanded into police and prison custody. There is a logistical problem of space. In addition, NAPO understands that the tests can take several days to turn around. In the meantime, many suspects will have been released and may be difficult to trace. It is essential that users are persuaded to take treatment rather than be remanded in custody as that is the best way of reducing drug-related crime.[114]

Use of resources: There is concern that, in the context of scarce resources, those referred as a consequence of compulsory testing will displace drug misusers not involved in the criminal justice system. The Government has announced increased funding to expand arrest referral provision. Even so, concerns have been voiced that funding will not meet the needs of service provision. In addition the testing program itself will be costly.

NACRO is among commentators who argue that the compulsory drug testing measures are an unwise use of scarce resources, and that these would be "better spent on more assessment and treatment services to which addicted defendants can be bailed".[115]

SCODA considers that "at least some of the £45.5m in a full year allocated to pay for the proposed raft of drug testing would be better spent on investment in drug treatment capacity."[116]

Legal challenges to tests: It has been suggested that, although drug testing technology is developing, there remain differences in reliability of types and methods of tests, and the degree to which their evidence is acceptable in court. Consistency in standards of testing will be important. There will be individuals who have taken prescribed or over-the-counter medicines who will test positive. SCODA comments that while such genuine mistakes are possible, any positive test may be disputed on such grounds: "We foresee the courts' time being taken up with legal challenges to the validity of drug tests – an unwarranted waste of public resources".

Potential for damage: Arrest referral schemes, currently under development, depend on identification and assessment by arrest referral officers and drug specialists. Liberty and the anti-prohibition campaigning group Transform are among those concerned that the proposals for compulsory drug testing may be counterproductive, possibly damaging

---

[114] ibid

[115] National Association for the Care and Resettlement of Offenders News Release, *NACRO comments on the new crime bill*, 6 March 2000

[116] *The Criminal Justice and Court Services Bill*, submission for the second reading in the House of Commons, The Standing Conference on Drug Abuse, 23 March 2000

relationships created between arrest referral workers and those they see in the custody suite.[117] [118]

SCODA also sees a potential problem in the use of discretionary police powers:

> There are well understood correlations between drug misuse and social exclusion - drug problems are found to disproportionately affect economically deprived, marginalised and vulnerable individuals and communities. We wonder whether the drug testing proposals for police, and the use of discretionary powers, will help improve community relations in view of what has been said in recent times. The introduction of new discretionary police powers at this time is a worrying and potentially misguided step.[119]

European Convention on Human Rights: The Government considers the provisions of the Criminal Justice and Court Services Bill are compatible with the Convention of Human Rights.[120]

Commentators have questioned this with particular reference to Article 8 of the Convention, which says:

1. Everyone has the right to respect for his private and family life, his home and correspondence
2. There shall be no interference by a public authority except such as is in accordance with law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Commentators question whether the interference to privacy, such as the compulsory testing for drugs, can be justified in this context. Testing before charge, which under the proposals could be introduced by Order, is particularly contentious: SCODA commented in its initial response to the drug testing proposals:

> The evident conflicts with our obligations under International Law, would, we assume, prevent any system under which drug testing would take place before the decision to bring charges was made.[121]

---

[117] *Criminal Justice and Court Services Bill*, Briefing for 2nd reading, Liberty, 23 March 2000

[118] Letter to the Home Office, Danny Kushlick,Director, Transform, 26 November 1999

[119] *The Criminal Justice and Court Services Bill*, submission for the second reading in the House of Commons, The Standing Conference on Drug Abuse, 23 March 2000

[120] *Criminal Justice Court Services Bill*, Bill 91

[121] New drug testing proposals: an initial response from the Standing conference on Drug Abuse (SCODA) 1999

Liberty suggests that the drug testing powers in the Bill are too widely drawn and are likely to be ineffective and disproportionate:

> Liberty has a particular problem with Clause 48. It may be acceptable in some circumstances to require offenders, after they have been convicted, to undergo drug testing to ascertain whether dependency on drugs was relevant to the commission of the offence. Not only may this be relevant to sentencing, but also under Article 8, to the prevention of disorder or crime.
>
> The situation is significantly different prior to conviction. At this stage a person is still presumed to be innocent. When it has not been proven that an individual has committed an offence, indeed it is presumed that he is innocent, it is difficult to see how an infringement of his right to liberty can be justified on the basis of 'prevention of commission of crime'.
>
> This becomes even harder to justify, and would be a *disproportionate interference* with his rights, as if an individual refuses to comply with a drug test they will commit a criminal offence for which they could be imprisoned. Thus someone who has committed no offence, and has never taken drugs, could be sent to prison for refusing to consent to a drug test.
>
> The fact that the police decide whether to require a test, as opposed to a judicial authority, makes this proposal even more problematic. We question whether infringement of Article 8 rights to privacy could ever be justified and proportionate prior to conviction.[122]

[122] *Criminal Justice and Court Services Bill*, Briefing for 2nd reading, Liberty, 23 March 2000