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The *Drugs Bill*

Bill 17 of 2004-05

The *Drugs Bill* [Bill 17 of 2004-05] was introduced in the House of Commons on 16 December 2004. Explanatory Notes to the Bill have been issued [Bill 17-EN]. The Bill is scheduled to have a Second Reading on 18 January 2005.

The Bill seeks to introduce new measures to deal with the problems caused by the misuse of controlled drugs. It concentrates on measures designed to break the link between drug use and crime. It seeks to introduce harsher sentences for dealers who target children or who attempt to evade arrest by swallowing the evidence

The Bill would introduce further powers for police to test those suspected of misusing drugs on arrest, and require those who test positive to attend an assessment. There are also provisions to supplement anti-social behaviour orders in cases where behaviour is affected by drug misuse.

The Bill extends mainly to England and Wales but has some provisions for Northern Ireland.

A Research Paper, *Addiction and Drugs Misuse*, is to be published shortly and will provide further information on drug misuse.

Kate Haire

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Summary of main points

The misuse of drugs causes immense problems for both individuals and society. The damage inflicted is extensive, causing not only harm to the drug user's physical and psychological health but having wider detrimental effects on the community. In 1998 the Government published its ten year drug strategy, Tackling Drugs to Build a Better Britain. The strategy focuses on education, prevention, enforcement and treatment to prevent and tackle problematic drug use, especially of class A drugs. It emphasises the importance of drug treatment services to reduce the harm caused to individuals and the effects of crime on the community.

At present around four million people in England and Wales, aged over 16, use at least one illicit drug a year. A minority of these individuals, around 250,000, will develop a serious drug problem, which most usually involves heroin, or crack cocaine. This relatively small group of problematic drug users tends to be responsible for most of the problems arising from drug misuse.

The correlation between drug misuse and crime is high. Breaking the link between drugs and crime is one of the key features of government policy. There is increasing evidence for the efficacy of drug treatment services in reducing drug use and the related crime. The Drug Intervention Programme, (previously known as the Criminal Justice Intervention Programme), is an initiative designed to engage and retain problem drug users in drug treatment at all stages of the criminal justice system. The programmes have been established in 66 areas, and currently see around 4,600 offenders. Acquisitive crime, which is often associated with drug use, is falling faster in the areas with the Drug Interventions Programme than elsewhere.

However, there are still problems in delivering effective treatment. Many treatment services have high dropout rates. Criticism has also come from a number of sources, including a recent Audit Commission report, *Drug Misuse 2004*, that not enough is being done to provide a wider range of support services that problem drug users require to overcome their drug misuse.

Central to the *Drugs Bill* are measures which the Government believes will build on the existing work of the Drugs Intervention Programme and further increase the number of drug misusing offenders entering treatment. In addition, the Government believes the Bill will help protect communities from the disruption caused by drug users and dealers by introducing an intervention order to supplement anti-social behaviour orders and providing for more severe penalties for dealers.

CONTENTS

I Drugs policy

The Government's Drug Strategy, *Tackling Drugs to Build a Better Britain*, was published in 1998. The strategy sets out a range of policies and targets intended to reduce the harm caused by illegal drugs by 2008. The interventions focus on the more dangerous class A drugs[1] and the individuals with the most problematic drug misuse. The strategy has four elements:

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

In 2002, the strategy was reviewed and updated. The Strategy Update placed a greater emphasis on the prevention, treatment and enforcement of the more problematic drug users, specifically for class A drugs. In addition, more resources were committed to implementing the strategy.[3] Approximately £450 million of central and local government funding was spent directly on drug treatment services in England in 2003/04, excluding prison based treatment.[4]

In November 2004 the Drug Strategy Progress Report, *Keeping Communities safe from Drugs*, was published. The report highlights achievements on tackling drugs since the Government's Drug Strategy was published in 1998, and sets out the major targets for the next four years. The Government's targets for its Drug Strategy are set out within the framework of Public Service Agreements, and include:

- To reduce the harm caused by illegal drugs

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1 The *Misuse of Drugs Act 1971* divides controlled substances into 3 classes (A, B, C). Class A drugs are the most dangerous and include heroin, ecstasy, cocaine and crack cocaine.

2 The Government's Ten-Year Strategy, for Tackling Drugs Misuse, *Tackling Drugs to Build a Better Britain*, Cm3945, April 1998 at:
http://www.archive.official-documents.co.uk/document/cm39/3945/3945.htm

3 Updated Drugs Strategy 2002, February 2002 at:
http://www.drugs.gov.uk/ReportsandPublications/NationalStrategy/1038840683/Updated_Drug_Strategy_2002.pdf

4 The National Treatment Agency, funding of drug treatment services at; http://www.nta.nhs.uk/

- To increase the participation of problem drug users in treatment programmes by 100% by 2008

- To reduce the use of class A drugs among all young people

- To have a sustained impact on the supply of class A drugs to the UK

In a Home Office press release, the then Home Secretary, David Blunkett stated:

> "The misery caused by drug misuse must never be underestimated. It damages the health of individuals, ruins the communities they live in, and turns law-abiding citizens into thieves, including from their own families. The costs to society are enormous."
> (…)
> Crime and fear of crime have both fallen. The Government's Drug Interventions Programme is providing a route out of crime and into treatment for thousands of drug using offenders every month. Crime in these 66 areas is going down faster than in the rest of the country, for example in Bradford crime has fallen 33 per cent, and in City and Holbeck in Leeds crime has fallen 32 per cent.
>
> "But there is much more to be done if we are to reduce even further the harm caused by drugs. By 2008 we want to see safer communities with less crime. We want fewer lives to be destroyed by drug misuse and more young people achieving their full potential free from drugs. Effective treatment will be available promptly to all who need it. The new measures and legislation that we are announcing today will help us to achieve this."[5]

A. Extent of drugs problem

About 4 million people use at least one illegal drug each year and around 1 million people use a class A drug such as heroin, cocaine or ecstasy.[6] The majority of these individuals take drugs only once, or relatively infrequently. However, there are around 250,000 individuals who have serious drug misuse problem, characterised by a number of features such as dependence, injection of drugs and polydrug use, which produces a significant level of harm both to themselves and to others.

Key findings from the 2002-03 British Crime Survey show:

- Of all 16-59 year olds, around 12% people had taken an illicit drug and 3% (1 million) a class A drug in the last year.

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5 "*Tackling Drugs – More Action* ", Home Office Press Release, Reference: 370/2004, 25 Nov 2004

6 Updated Drug Strategy 2002: http://www.drugs.gov.uk/ReportsandPublications/NationalStrategy/1038840683/Updated_Drug_Strategy_2002.pdf

- The use of class A drugs in young people has been relatively stable since 1996, and is estimated at around 9%. Although the overall figure has remained approximately constant there has been a rise in the number of people using cocaine and crack, whilst there have been falls in the numbers using LSD. Ecstasy use has also fallen slightly over the past year.

- Levels of drug use among 16-59 year olds have remained stable since 2001-2.

- Cannabis is the most frequently used drug; around 3 million people had used it the past year.

- The majority of people using drugs in the last year had only used one type of drug.[7]

The economic and social cost of class A drug use in England and Wales were studied in a Home Office Research Study, published in 2002.[8] This looked at the data relating to the economic and social costs of class A drug misuse and identified the cost of a number of consequences of this drug misuse. It highlighted the huge difference between the costs associated with recreational drug use and the far higher economic and social costs resulting from problem drug users.[9] The key findings included:

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- For young recreational drug users, the total social costs were estimated at £28.8 million per year.

- For older recreational users the total social costs were about £6 million per year.

- For problem drug users, the estimated social costs of drug misuse ranged from £5,252 million to £17,441 million per year, depending on which estimate was used for the total number of problem drug users.

- Total economic and social costs for this group increase the range of figures to between £10.1billion and £17.4billion per year, which is £35,455 per user per annum.

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7 "Prevalence of drug use: Key findings from the 2002/2003 British Crime Survey", HORS 244, RDS Directorate, Home Office, September 2003, at: http://www.homeoffice.gov.uk/rds/pdfs/hors224.pdf

8 "The economic and social cost of class A drug use in England and Wales, 2000", Home Office Research Study 249, RDS Directorate, Home Office, July 2002, at; http://www.homeoffice.gov.uk/rds/pdfs2/hors249.pdf

9 A problem drug user is one who is dependent on drugs and tends to use a number of different drugs. They have associated health and social problems. This study produced estimates ranging from 281,125 – 506,025 problem users.

- Problem drug users account for 99% of the social and economic costs, with drug related crime accounting for around 88% of the total costs.[10]

The Audit Commission identified a number of factors that contributed to the high social and economic costs of problem drug misuse. These included homelessness, mental health problems, the lack of social or family support, and difficulties in accessing the benefit system and other support services.[11]

The Audit Commission found there was a 34% drop out rate from treatment within the first twelve weeks. For drug users to be successfully retained in treatment and to complete the course the Commission suggested that the following improvements were necessary:

- Better support and follow on services to sustain recovery.

- An integrated package of support service to address housing and other social problems.

- More flexible and accessible services designed to meet the varied treatment needs of drug users.

B. Drug related crime

There are strong links between problematic drug misuse and crime, although the nature of the link is not entirely clear. Significant amounts of acquisitive crime are driven by the need to support Class A drug habits.[12] Figures show that:

- Around three-quarters of heroin and/or cocaine users commit crime in order to be able to obtain drugs.

- Persistent drug misusing offenders commit almost ten times as many crimes as people arrested who do not use drugs.[13]

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10 "The economic and social cost of class A drug use in England and Wales, 2000", Home Office Research Study 249, Home Office Research, July 2002

11 *Drug Misuse 2004*, Audit Commission report, November 2004: http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=english^573&ProdID=BCD29C60-2C98-11d9-A85E-0010B5E78136

12 Acquisitive crime includes crimes such as shop lifting, burglary, vehicle crime and theft

13 Updated Drug Strategy 2002: http://www.drugs.gov.uk/ReportsandPublications/NationalStrategy/1038840683/Updated_Drug_Strategy_2002.pdf

The New English and Welsh Arrestee Drug Abuse Monitoring Project (NEW-ADAM) provides a detailed analysis of the association between drug use and crime. The results of the first two years of the NEW ADAM programme were published in 2004.[14] The programme involves interviewing and voluntary drug testing (on urine samples) of those arrested by the police in 16 custody suites in England and Wales. Arrestees are questioned about both their drug use and their offending behaviour in relation to acquisitive crime. Interviews were obtained with 3,091 arrestees, from the total of around 11,000 arrestees held in the 16 custody suites. About 95% of these individuals also provided a voluntary urine sample. The key findings, related to class A drugs included:

- 57% of arrestees reported having used a class A drug in the last 12 months.
- 48% or arrestees reported using heroin, crack or cocaine in the last 12 months.
- 31 % of the urine samples obtained tested positive for heroin, 22% for cocaine and 38% were positive for one or both drugs.
- 75% of those who had used crack in the past year reported committing one or more acquisitive crime in the same time period.
- The prevalence and incidence of offending were higher amongst arrestees who reported drug use than among arrestees who said they had not.
- 60% of arrestees who reported using an illicit drug believed there was a connection between their drug use and offending behaviour.
- The number of offences amongst those using crack were six times higher than offenders who had not used illicit drugs.[15]

A particular problem identified by the NEW-ADAM programme was the high proportion of offences committed by a relatively small group of drug misusing repeat offenders (DMROs).[16] The results show that:

- Overall 18% of the group were DMROs, although the proportion varied across the custody suites.

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[14] "The Results of the first two years of the NEW-ADAM programme", Home Office Online Report 19/04 at: http://www.homeoffice.gov.uk/rds/pdfs04/rdsolr1904.pdf

[15] "The Results of the first two years of the NEW-ADAM programme", Home Office Online Report 19/04 at: http://www.homeoffice.gov.uk/rds/pdfs04/rdsolr1904.pdf

[16] Drug misusing repeat offenders (DMROs) are defined in the study as those arrestees who reported using heroin and/or cocaine and/or crack on average at least once a week in the last 30 days, **and** who had reported committing on average two or more income-generating offences in the last 12 months.

- The majority of DMROs, 80 %, were not receiving treatment for drug misuse.

- 90% of DMROs reported a connection between their drug use and the criminal offences that they committed.[17]

The report concluded from these figures that a large proportion of the drug misusing repeat offenders had unmet needs for treatment, which had important implications for future drugs treatment strategy.

The NEW-ADAM programme may not reflect the national situation, as the information is based on only sixteen custody suites. For this reason the Home Office launched the Arrestee Survey Programme. This involves interviewing arrestees in custody about their drug use and offending. The first results of this new survey will be published early in 2005 and should improve the understanding of the extent of drug-related crime.

There is increasing evidence that effective treatment for drug misusing offenders reduces their criminal activity. The updated drugs strategy states that 'treatment breaks the cycle of drug misuse and crime'. This has led to an expansion in initiatives based in the criminal justice system. Between April 2003 and September 2004 some 8,000 drug misusing offenders entered treatment through the criminal justice system.[18]

The Home Office press release issued on the publication of the Drugs Bill stated:

> At the heart of new legislation are measures aimed at building on existing work to break the link between drug addiction and crime by getting more drug users into treatment at an early stage and taking tougher action against dealers.[19]

C. Drug Treatment

The National Treatment Agency for Substance Misuse (NTA) is a special health authority, created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England. The overall purpose of the NTA is to:

- Double the number of people in effective well managed treatment from 100,000 in 1998 to 200,000 in 2008.

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[17] "The Results of the first two years of the NEW-ADAM programme", Home Office Online Report 19/04, p.39, at: http://www.homeoffice.gov.uk/rds/pdfs04/rdsolr1904.pdf

[18] "Tackling Drugs, Changing Lives: Keeping Communities Safe from Drugs", Drug Strategy Progress Report 2004, p.4

[19] "Drugs and Crime: Home Office publishes Drugs Bill", Home Office Press Release, Reference: 393/2004 - Date: 17 Dec 2004

- Increase the proportion of people who successfully complete or, if appropriate, continue treatment.

In December 2002 the NTA published *Models of care for treatment of adult drug misusers*, a national framework for the commissioning of substance misuse treatment in England, to meet the objectives of the drugs strategy.[20]

1. Numbers in treatment

The National Drug Treatment Monitoring System (NDTMS) was introduced in April 2001 and is responsible for collecting the data on the numbers of drug misusers presenting for treatment and those in treatment. Previously, the data had been collected through regional Drug Misuse Databases. The most recent figures from the NDTMS were published in 2004. They do not include figures from prison based services. These showed that in 2003-04:

- An estimated 154,000 people were in contact with treatment services, which is a 9% increase on the figures from 2002-3.

- Of this number, 125,900 were receiving specialized treatment such as residential rehabilitation, prescribing services and structured counselling.

- 72% of people in specialized treatment either successfully completed, or were retained in treatment.

2. Effectiveness of drug treatment

In 1996, the Task Force to Review Services for Drug Misusers studied the evidence relating to treatment for drug misuse. This concluded that there was clear evidence that drug treatment was effective in reducing harm both to individual drug misusers and to society.[21]

The National Treatment Outcome Research Study (NTORS) estimated that for every £1 spent on drug treatment, £3 was saved in costs to the criminal justice system and victims of crime. A follow-up study to NTORS of 1,100 drug misusers in treatment found that a large number of the drug treatment interventions used in England were effective at reducing drug misuse, criminal activity and health risks. The study also confirmed the findings of research in the United States which showed that for treatment to be effective

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[20] Available online at: http://www.nta.nhs.uk/publications/MOCPART2/mocpart2_feb03.pdf

[21] Task Force to Review Services for Drug Misusers (1996), Report of an independent review of drug treatment services in England, London: Department of Health

clients had to be retained in treatment for a minimum of twelve weeks.[22] In addition, a significant proportion of those in the study maintained improvements four or five years after treatment with 47% of those attending residential rehabilitation and 35% of those in community based services reporting no illicit opiate use.[23]

The NTA recently published a study looking at treatment effectiveness, based on data collected by the National Drug Evidence Centre at the University of Manchester. The report used, as the measure of a successful treatment outcome, either retention in or completion of treatment.[24] The study found that clients were most likely to drop out of treatment in the first two weeks and this was especially frequent in individuals referred from the criminal justice system. Other key findings relating to predictors of outcome were:

Factors NOT associated with successful retention or completion:

- the ethnicity of the client
- the type of drug misused (heroin, crack cocaine, or both)
- whether the client administered their drugs by injection
- whether the client had been using methadone at the time of presentation for treatment

Factors which were associated with retention or completion:

- younger clients were more likely to drop out within 6 months than older clients
- males were 1.5 times more likely to drop out than females
- those with no previous experience of treatment were 1.7 times more likely to drop out than those who had been in treatment before
- those referred from the criminal justice system were 2.7 times more likely to drop out than those referred by other routes

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22 "Treatment effectiveness", National Drug Evidence Centre, NTA December 2004, available online at: http://www.nta.nhs.uk/publications/docs/Treatment_effectiveness.pdf

23 Gossop M et al, "*NTORS after 5 years: change in substance use, health and criminal behaviour during the 5 years after intake*", London Department of Health

24 NTA definition of retention: Evidence suggests that if a client is retained in treatment for at least 12 weeks, treatment is more likely to be effective. In 2003/04, the NTA started to measure the percentage of clients who, at the time they were discharged, had remained in structured treatment for at least 12 weeks. This figure is known as the retention rate. In 2003/04, 42,222 clients were discharged from treatment. Of these, 52% (21,900) had been retained or remained in treatment for at least 12 weeks.

- clients attending the worst performing services were 7.1 times more likely to drop out early than those attending the best services.[25] (The data was adjusted to take into account the effect of other factors such as client characteristics)[26]

The strongest predictor of a successful treatment outcome was related to the clinic at which the client received treatment, rather than any characteristic of the client. The NTA concluded that the type of treatment services offered could make a huge difference to the effectiveness of treatment and further work should be done to determine the factors relating to the treatment provider that would help predict a successful outcome.

There is recent evidence that individuals who had to wait a shorter time for treatment services were more likely to enter treatment, although there was little effect on the problem of the substantial early drop out rate.[27]

The Audit Commission report, *Drug misuse 2004*, estimated that 34% of drug users leave treatment within the first twelve weeks.[28]

3. Drug treatment and the criminal justice system

The Home Office states:

> *Monitoring the Links between Drug Misuse and Offending: An Overview of Progress:* The reduction of drug-related crime is one of the aims of the government's Drug Strategy. The Home Office has developed an end-to-end policy designed to reduce drug-related crime through enabling a greater number of drug-misusing offenders to have access to treatment through all the stages of the Criminal Justice System (CJS) (e.g. through drug testing at charge, Arrest Referral, and Drug Testing & Treatment Orders). These measures are intended to work in parallel with appropriate treatment interventions to establish an integrated care pathway. In implementing this policy, a better understanding of the relationship between drug use and offending and trends in drug-related crime is essential for the development and monitoring of these programmes.[29]

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25 THE NTA described clinics with the highest retention rates as 'successful', and those with the lowest retention rates as the 'worst performing'.

26 "Treatment effectiveness", National Drug Evidence Centre, NTA December 2004, p.4, available online at: http://www.nta.nhs.uk/publications/docs/Treatment_effectiveness.pdf

27 Research summary from the National Treatment Agency, "*Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate users awaiting out-patient treatment*", Strang et al, 2004 at: http://www.nta.nhs.uk/publications/rs3.html

28 *Drug Misuse 2004*, Audit Commission report, November 2004: http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=english^573&ProdID=BCD29C60-2C98-11d9-A85E-0010B5E78136

29 "*Monitoring the Links between Drug Misuse and Offending: An Overview of Progress*", Drugs Statistics, Research and Development in the Home Office at: http://www.homeoffice.gov.uk/rds/drugs1.html

a. Drug Interventions Programme

One of the measures contained in the Updated Drug Strategy was to improve access to treatment for drug-misusing offenders from within the criminal justice system and to improve the integration of the services offered in different parts of the system. In response to this the Criminal Justice Intervention Programme (CJIP) was set up in April 2003, initially focusing on the areas of the country with the highest acquisitive crime rates. The CJIP changed its name to the Drugs Intervention Programme (DIP) on 28 September 2004 and has implemented DIPs in 66 high crime areas. There are plans to expand to another 30 areas from April 2005.[30]

The system is designed to allow a single team to manage an individual's entire treatment from the point at which the drug misuse problem is identified through to the aftercare. This follows the ideal pathway of integrated care identified by the National Treatment Agency's report, *Models of Care.* This scheme is able to identify and assess drug misusers at any point within the criminal justice system and refer them into appropriate treatment. This allows drug misuse problems to be identified in offenders, many of whom would not otherwise have sought treatment. Drug intervention teams are currently managing 4,600 clients in treatment, with over 1,400 offenders entering treatment in September 2004.[31] Research has also shown that waiting times for treatment have fallen more sharply in DIP areas than elsewhere and are ahead of national targets.[32]

In order to improve services for this population the NTA recommends that:

- Drug-misusing offenders should have quick access and entry into drug treatment.
- They should be retained in continuous treatment for at least three months.
- They should have the option of methadone maintenance and not only be offered detoxification
- They have multiple needs, and a comprehensive care plan will need to encompass social and health problems
- There should be close co-ordination between service providers.[33]

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30 Drug Strategy Progress Report 2004, p.18 at: http://www.homeoffice.gov.uk/docs3/tacklingdrugs_changinglives.pdf

31 NTA Update Issue No. 6, September 2004, at: http://www.nta.nhs.uk/

32 "*Criminal Justice vs health care: dilemma or myth*", NTA update, September 2004, at http://www.nta.nhs.uk/

33 "Criminal Justice", NTA Models of care, p.181, at: http://www.nta.nhs.uk/publications/MOCPART2/mocpart2_feb03.pdf

The Drug Interventions Programme includes a range of interventions to improve access for drug using offenders into treatment. The Drug Strategy update published in November 2004 provides details of the following initiatives designed to improve treatment of drug misusing offenders:

Conditional cautioning: A caution can be issued to first time offenders with an attached condition, such as referral into drug treatment.

Throughcare: This ensures that continuous care is provided from the point of arrest through the criminal justice system:

Drug testing: Offenders charged with a trigger offence such as burglary may be required to produce an oral fluid sample to be tested for heroin or crack cocaine.

Restrictions on bail: Access to court bail may be withdrawn if defendants refuse to undergo a drugs assessment as part of a condition attached to their bail. In the first five months of the pilot 289 offenders have been bailed with restrictions.

Community sentencing: The current sentence, of a Drug Treatment and Testing Order[34], is to be replaced by a community order which will be designed to more closely match the needs of individual offenders. It would require the individual to undergo treatment for a specified time, with the court monitoring progress.

Prison drug treatment: The treatment services in prisons will be improved and the links with case management teams in the community strengthened.

Aftercare: This will comprise a package of support to meet the needs of a drug misusing offender as they complete treatment.

Targeted interventions for young people: There are plans to develop a range of targeted interventions for young people who are in contact with the criminal justice system.[35]

A Home office press release on the Drug Strategy Progress Report 2004 stated:

> The Government's successful Drug Interventions Programme, which already sees nearly 1,500 offenders entering treatment each month, will be expanded to 32 new areas from April 2005, so that by 2008 around 1,000 offenders will be entering treatment each week through this route.

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[34] Drug Treatment and Testing Orders (DTTOs) were introduced as a new community sentence under the Crime and Disorder Act 1998. The DTTO obliges the offender to undergo treatment at a specified place and for a set period of time ranging from 6 months to 3 years. The Standard Note: SN/SC/1437, Drug Treatment and Testing Orders, provides further details.

[35] "*Tackling Drugs, Changing Lives*: Keeping Communities Safe from Drugs", Drug Strategy Progress Report 2004, p19

> Routes into treatment for vulnerable young people will be expanded by requiring young offenders to attend drug treatment as part of a community sentence. This will be piloted in five areas from the beginning of December.[36]

b. Benefit of interventions

There is strong evidence of the efficacy of drug treatment services for drug-using offenders entering the criminal justice system in both reducing their drug use and decreasing the number of offences committed.

Some of the benefits of providing treatment to drug misusing offenders at the earliest possible stage are thought to include:

- The ability to focus on a group which is known to be difficult to involve in treatment services.
- Treatment is likely to be more effective at an early stage before the offender has developed a serious drug dependency.
- Early treatment reduces the incidence of associated medical problems such as HIV infection.
- Offenders who have entered treatment programmes commit less crime. [37]

Treatment has also been shown to produce wider benefits to the community. Acquisitive crime is falling faster in areas where Drug Intervention Programmes are running, compared with the rest of the country.[38]

c. Arrest Referral Schemes

A number of schemes exist that put offenders, voluntarily, in contact with treatment services. These interventions are designed to identify drug misusing offenders and provide them with the opportunity to access treatment services.

Arrest referral schemes operate in all police forces in England and Wales. These schemes involve specialist drug workers seeing drug misusing offenders in police custody suites to provide information and, if requested, referral onto drug treatment and advice services. They have no statutory basis and do not affect charging or sentencing. However, the aim

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[36] "*Tackling Drugs – More Action* ", Home Office Press Release, Reference: 370/2004, 25 Nov 2004

[37] NTA – Criminal Justice System at: http://www.nta.nhs.uk/

[38] Drug Strategy Update, November 2004, at: http://www.homeoffice.gov.uk/docs3/tacklingdrugs_changinglives.pdf

is to encourage an offender to take the opportunity to obtain assessment and treatment for their drug misuse problem whilst the criminal justice process continues.

Between October 2000 and September 2001, arrest referral workers screened about 49,000 individuals in England and Wales. More than half of them were voluntarily referred to a specialist drug treatment service and a quarter of those referred, about 5,500, actually entered treatment.[39] Several studies have shown the benefits of arrest referral schemes in reducing both drug use and drug related crime.[40] One study found that two-thirds of individuals using either heroin crack cocaine or both were arrested less often in the six months after seeing an arrest referral worker than in the six months before.[41]

In 2001, the Home Affairs Select Committee published the report, Government Reply to the Report of the Independent Inquiry into the Misuse of Drugs Act 1971. One of the issues raised was how to draw a clear distinction between questions designed to establish guilt and questions designed to establish an offender's willingness to undergo treatment. In response the Government said:

> Last year the Government announced that a total of £20million would be provided over the three years from 1999 to 2002 to ensure that by the end of that period all police forces in England and Wales operate a face to face Arrest Referral Scheme to identify problem drug misusers and encourage them to take up appropriate treatment. Rollout began in July 1999 and already 40 of the 43 police forces in England and Wales have joined the scheme: 22 forces are fully operational.
>
> Detailed guidance on setting up effective Arrest Referral Schemes was sent to all police forces, in a manual produced by the Drug Prevention Advisory Service; *Drugs Interventions in the Criminal Justice System.* A copy of this guidance can be obtained free of charge from the Drugs Prevention Advisory Service. This guidance covers the requirements of the Police and Criminal Evidence Act 1984 (PACE) and the Codes of Practice made there under. The guidance suggests, to ensure a proper distinction between the task of bringing the possibility of arrest referral to the attention of the suspect and the questioning of that person regarding his or her involvement in an offence under investigation, that it should be the Custody Officer who brings arrest referral to the attention of the suspect, as part of the booking in procedures. It is early days in the rollout of the Arrest Referral Scheme which includes monitoring arrangements to evaluate effectiveness. If experience shows that the requirements of PACE and the Codes of Practice are

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[39] "Criminal Justice", NTA Models of Care for treatment of adult drug misusers, December 2002 , p.184

[40] Drugs and the Law, "Report of the Independent Inquiry into the Misuse of Drugs Act", The Police Foundation, published in 2000, p.118

[41] "Criminal Justice", NTA Models of Care for treatment of adult drug misusers, December 2002, p.184

> adversely impinging on delivery of arrest referral, the Government will of course look at the need to amend this legislation. [42]

d. Treatment as part of sentencing

Some criminal justice interventions involve providing treatment for a drug misusing offender within a criminal justice context. Sentences imposed by the court will require the offender to undergo treatment for drug or alcohol problems. These types of sentence range from drug testing and treatment orders to less intensive schemes such as referral orders, action plan orders and supervision orders.

The *Crime and Disorder Act 1998* made provision for the Drug Treatment and Testing Order, a new community penalty which was targeted at drug misusing offenders. Drug Treatment and Testing Orders were introduced on 1 October 2000 giving the courts powers to impose a new community sentence aimed at breaking the link between addiction and offending. Orders, which are imposed only with the consent of the offender, require the offender to undergo treatment according to specified conditions. A key new aspect of this approach is the role of the court in reviewing the offender's progress on the order. Those undertaking an order will also be subject to frequent and mandatory drug testing.

Pilot schemes for the Drug Testing and Treatment Order were carried out in three areas. Results showed:

- Reductions in drug use and offending at the start of the order.
- A decrease in the average weekly spend on drugs.
- Reductions in levels of polydrug use.
- Six monthly interviews with offenders demonstrated these reductions were maintained over time.[43]

In 1997, of the 5,149 people sentenced to probation or supervision for drugs offences 1,970 were required to undergo drug treatment as part of the Order.[44] However, in

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[42] The Home Affairs Select Committee, Second Special Report, *Government Reply to the Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, HC 226, 7 February 2001, http://www.publications.parliament.uk/pa/cm200001/cmselect/cmhaff/226/22602.htm

[43] Criminal Justice", NTA Models of Care for treatment of adult drug misusers, December 2002 , p.186

[44] Drugs and the Law, "Report of the Independent Inquiry into the Misuse of Drugs Act", The Police Foundation, published in 2000, p.123

contrast almost 26,000 DTTOs have been issued from October 2000 to September 2004, which represents a large increase in the use of drug treatment as part of sentencing.[45]

In 2003, the Home Office Research Development and Statistics Directorate published a study which looked at the impact of DTTOs on offending in the pilot areas. The report summarised the impact of DTTOs on the rate of reconviction in the two years following the introduction of the order and looked at a total of 210 offenders. The key points from the report were:

- Completion rates for the DTTOs were low with only 30% of offenders successfully completing their orders, whilst 67% had their orders revoked.

- Overall two year reconviction rates were 80%.

- Those who completed their orders had a reconviction rate of 53%, whilst those had their orders revoked had a reconviction rate of 91%.

The report states that the greatest challenge facing DTTOs is to improve the retention rate, in order to increase the number of offenders completing their order. The report suggests that there is a need to provide more flexible and more appropriate treatment focusing on the particular needs of the offender if the proportion of offenders retained in treatment was to increase.[46]

The Drug Treatment and Testing Order programme has been expanded across England and Wales and national standards have been introduced. The Home Office has also introduced annual national targets for DTTO commencements. In 2003-04 the national target for DTTO commencements was 9,000, with a further increase to 12,000 for 2004-05.[47] In addition, the National Probation Directorate and the NTA have been studying the impact of national standards for DTTOs, and whether these are effective at improving the completion rate of DTTOs.

Other research has also been conducted on the effectiveness of DTTOs in reducing both drug use and crime. Most conclude that DTTOs are effective at reducing drug use and criminal activity of offenders whilst they are retained on the programme, but are less certain about the long term benefits of the programme. A large review of the published

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45 Drug Strategy Progress Report 2004, http://www.homeoffice.gov.uk/docs3/tacklingdrugs_changinglives.pdf

46 HORS 184: The Impact of Drug Treatment and Testing Orders on offending: two-year reconviction results, 2003.

47 "Commissioning Drug Treatment and Testing Orders", NTA, at: http://www.nta.nhs.uk/programme/national/Commissioning_DTTOs_guidance.htm

literature on quasi compulsory treatment (QCT)[48] from the University of Kent identifies some specific issues relating to effectiveness.[49] These include:

Differences in attitudes towards QCT: A number of studies have identified differences in values and attitudes between criminal justice and treatment staff, and difficulties with inter-agency working. In addition, it was noted that divergent views were particularly common in relation to the need to respect the treatment choices of clients referred from the criminal justice system, and the staff's views on whether the client would successfully complete treatment.
Elements of QCT which are associated with success or failure: Relatively little research has been done to determine the long term effectiveness of QCT in reducing drug use and crime. Factors thought to improve the chances of a successful outcome are retention for at least 3 months, high programme integrity and the provision of aftercare. The review emphasised the need for further research in this area.[50]

e. Problems with drug treatment services

Although the Drug Strategy has succeeded in increasing the number of drug misusing offenders entering treatment, concern has been expressed about the effectiveness of treatment and longer term outcomes for this group.

In March 2000, the Police Foundation published the Report of the Independent Inquiry into the Misuse of Drugs Act 1971, chaired by Dame Ruth Runciman and entitled Drugs and the Law. The Home Affairs Select Committee invited the Home Office to produce a full response to the report in the same way that they would reply to a select committee report. The Committee's Second Special Report, *Government Reply to the Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, was published in 2001.[51] One of the inquiry's recommendations was that further research was required on the effectiveness of treatment for drug misusing offenders.

> *Recommendation 72*: More far reaching research is needed to provide a better understanding of the precise dynamics and causal links in the drugs crime relationship and better evidence about the factors that influence treatment effects. There is a particular need to evaluate the cost effectiveness of different

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48 Quasi compulsory treatment is defined as treatment of drug dependent offenders that is motivated, ordered or supervised by the criminal justice system and takes place outside prison.

49 "Summary Literature Review: The international literature on drugs, crime and treatment", QCT Europe, Alex Stevens, European Institutes of Social Services, University of Kent, January 2003

50 "QCT Europe – Review of the Literature in English", Alex Stevens, European Institutes of Social Services, University of Kent, January 2003

51 Home Affairs Select Committee, Second Special Report, *Government Reply to the Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, HC 226, 7 February 2001, http://www.publications.parliament.uk/pa/cm200001/cmselect/cmhaff/226/22602.htm

> interventions, in order to inform future decisions on distribution of overall drugs expenditure.
>
> 56. As already mentioned the Government recognises the importance of a sound research base and has made significant money available for research in support of the National Drugs Strategy. But the Inquiry is right to identify the importance of these specific areas, which are being addressed through the following pieces of research:
> The drugs-crime relationship is being assessed through the NEW-ADAM programme. The latest report, Home Office Research Study 205, which was published in August 2000, included authoritative measurement over time of changes in drug use and offending, in two locations (Nottingham and Sunderland).
> Evidence about treatment effects is being gathered through the NTORS research programme, which the Department of Health is continuing to support, and also through a study published by the Home Office in August, concerned with methadone maintenance (Home Office Research Findings No.120).
> The cost effectiveness of different interventions is receiving heightened attention. For instance, the on-going evaluation of the effectiveness of arrest referral includes an economic component. Also, the study of methadone maintenance, just mentioned, included a cost effectiveness component.

In the 2001-02 session, the Home Affairs Select Committee conducted an inquiry into the Government's drugs policy, querying whether the existing drugs policy worked. The report, *The Government's Drugs Policy: Is It Working,* was published on 22 May 2002.[52] The Committee expressed concerns that there were still problems associated with the effective provision of drug treatment services.

> 220. The Committee believes that much could be gained in reducing the harm associated with drugs if the treatment element of the Strategy was further strengthened. The Government's commitment to treatment is clear:
> "in order to hit the targets, we need to grow treatment at about 7 per cent per year. We have managed to grow it at about 8 per cent per year, so we are really ahead of target at the moment".
>
> 221. Nonetheless, we believe more could and should be done if the levels of need are to be adequately met. A recent report from the Audit Commission on community drug treatment services for adults found that drug users were faced with a number of problems in accessing treatment, including lack of appropriate services, long waiting lists and inflexible services. These problems are compounded by the inadequate training of many drugs workers, poor care

[52] Home Affairs Select Committee Third Report The Government's Drugs Policy: Is It Working? 22 May 2002, HC 318-I, http://www.publications.parliament.uk/pa/cm200102/cmselect/cmhaff/318/31802.htm

> management and co-ordination, patchy joint working between agencies and poor links with primary care.

In relation to drug treatment and the criminal justice system, evidence was given suggesting that the focus on treatment through the criminal justice system could fail to meet all the health needs of drug users.

> 222. Many, if not most, of the witnesses to the Committee have been keen to impress upon us that the drugs issue is, at root a health rather than a criminal justice issue, and that it is both more appropriate and more effective to address it as such. With this in mind, concern has been expressed that responsibility for drugs policy has moved to the Home Office from the Cabinet Office. The drugs charity, Release, told us in evidence that "It is obvious that neither the use nor the misuse of drugs should be dealt with by the police and the criminal justice system". A survey conducted by Drugscope of its 900 members (of which almost one third responded) found that "The main way in which the drug strategy is thought not to be working was in the over-emphasis on the criminal justice elements of drug misuse and that this focus has had adverse effects on the health agenda". The Substance Misuse Faculty of the Royal College of Psychiatrists told us that "We believe that criminal justice initiatives are in conflict with health priorities". In a recent policy review, the Association of Chief Police Officers said: Police Officers said:
> "The diversion of misusers of Class A drugs into treatment must be the primary aim to achieve greater impact in reducing demand...[the Association] looks forward to when detainees appearing in court following the misuse of Class A drugs are able to have the opportunity to immediately access treatment...diversion direct to treatment should be a real option rather than a caution or in some cases a conviction".
>
> 223. The Association of Chief Police Officers said in evidence that the division of funds "may represent a disproportionate distribution of resources". Mr Keith Hellawell told us:
> "When I first looked at the amount of money we spent on anti-drug activities in this country in 1998, we spent 63 per cent of all our money on the criminal justice system. I said in my first report to the Treasury that two thirds of our money spent on dealing with the consequences was a bad policy".
>
> 225. Nonetheless, we would still question the effectiveness of money spent on criminal justice interventions of questionable effectiveness which could more usefully be put into treatment. Treatment of drug users is imperative on ethical grounds. As Mr Nelles of the Methadone Alliance told us, drug users deserve palliative and, where possible, curative treatment:

A recent NTA study on the effectiveness of treatment found that clients referred to treatment from criminal justice agencies were 2.7 times more likely to drop out of treatment than clients referred from other sources. The data also showed that this group of clients was more likely to lose contact within two weeks of initial contact. Overall only 34% of clients referred from the criminal justice system were in contact with the

same treatment centre six months after referral, compared with 56% of clients referred from other sources.[53]

The Audit Commission report, *Drug misuse 2004*, highlighted the lack of overall support services provided to drug misusers. The report stated that, whilst clinically effective treatment services are available, these tend to focus on the addiction problem and fail to address the many complex health and social needs of those with the most problematic drug misuse. The Commission believes that the failure to address the complex social and psychological problems of these individuals is responsible the poor success rate of many treatment services. They believe the result is that there is a considerable wastage of taxpayers' money in providing treatment services that are unlikely to succeed in a high proportion of cases, due to the failure to provide additional services. The Commission believes that to improve the success rate of completing treatment and sustaining recovery the interrelated problems such as mental health disorders, homelessness and lack of social services must also be dealt with.[54]

D. Future targets

The Home Office Annual Report published in 2004 reviews the progress made towards the targets of the National Drug Strategy and sets out future action for 2004-5.

During 2003-04 action included:

- Reducing average waiting times to just 3.2 weeks in December 2003 – down by almost two-thirds since December 2001;
- Increasing the number of drug treatment workers to 9,181 by December, up 36% from 6,738 in March 2002, exceeding the target of 9,000 by 2008;
- Having drug treatment included in the star ratings for Primary Care Trust performance; new guidance on inject-able heroin and methadone treatment published by the National Treatment Agency (NTA); and a wider range of treatment interventions for crack cocaine becoming available, supported by NTA best practice guidance;
- Drug related deaths fell by 7% between 2001 and 2002 (the latest data available) and are now at their lowest level since 1998.
- Direct annual expenditure across government on treatment in 2003-04 totalled £503m.

Future Delivery

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53 "Treatment effectiveness", National Drug Evidence Centre, NTA December 2004, p.4, available online at http://www.nta.nhs.uk/publications/docs/Treatment_effectiveness.pdf

54 "Drug misuse 2004", Audit Commission, December 2004, online at: http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=english^573&ProdID=BCD29C60-2C98-11d9-A85E-0010B5E78136

> Our focus will remain on reducing the use of the most harmful Class A drugs and to reduce drug-related crime by getting more problematic drug users into treatment; better education to reduce demand; and disruption of supply.
> Key actions for 2004-05 will include:
> - All local areas providing drug-related assessment, referral, treatment and other support to vulnerable young people;
> - Delivering the Criminal Justice Interventions Programme, including: the piloting of Criminal Justice Act drug provisions; and making at least 12,000 Drug Treatment and Testing Orders;
> - Sharply reducing attrition rates from drug testing offenders at charge through to completion of treatment;
> - Working with the Department of Health and the National Treatment Agency deliver better treatment outcomes, including reduced drug treatment waiting times down to a maximum of 2 to 3 weeks.[55]

II The Bill

The Drugs Bill is divided into four parts and two schedules.

A. Part 1: Supply of controlled drugs

Part 1 addresses the supply of controlled drugs. It provides for a new offence of aggravated supply of a controlled drug and amends the proof of intention to supply a controlled drug.

1. Aggravated supply of controlled drug:

a. Current position and background

The *Misuse of Drugs Act 1971* is the main law regulating drug control in UK and restricts the production and supply of controlled drugs. Drugs subject to the Act are known as controlled drugs. This Act also allows the UK to fulfil its obligations under the *UN Single Convention of Narcotic Drugs*. *The Misuse of Drugs Act 1971* and its associated regulations, mainly the *Misuse of Drugs Regulations 1985*, make extensive provision for the control of dangerous drugs, their import, export, production, supply, prescription, possession and possession with intent to supply. The Advisory Council on the Misuse of Drugs keeps the misuse of drugs in the UK under review and advises Ministers on measures to deal with the social problems caused by such misuse.

The *Misuse of Drugs Act 1971* divides controlled substances into 3 classes (A, B, C) with A being the most dangerous. These classes provide a basis for attributing varying penalties for offences depending on the class of drug involved. Unlawful possession of drugs is the most commonly committed offence and attracts lesser maximum penalties

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[55] Home Office Departmental Report 2003-04, Cm 6208, April 2004 online at: http://www.homeoffice.gov.uk/docs3/annrep2004sec3c.html

than supply or trafficking. Unlawful possession involving substances in Class A, such as heroin attract the highest penalties, and may result in a maximum prison sentence of up to seven years. The same offences for Class B drugs (such as amphetamines) and Class C drugs (such as cannabis) attract maximum penalties of 5 years and 2 years respectively. Supplying drugs or intention to supply always carries a more severe sentence than possession. Supplying and/or dealing in class A drugs, or possession with intent to supply, attract a maximum penalty of life imprisonment.

b. The Bill

Clause 1 would insert a new section, 4A, into the *Misuse of Drugs Act 1971*. This would make dealing near a school or using children as couriers an aggravating factor for sentencing purposes. Drug dealers found guilty of this would face a tougher penalty than that for supplying the same drug but in an area remote from a school. Any offence relating to the vicinity of a school would only be applicable during, or within one hour, of the school hours.

The only exceptions would be if the offender could not be expected to reasonably know that the school was being used by children or young people.

2. Proof of intention to supply a controlled drug

a. Current position and background

Section 5 of the *Misuse of Drugs Act 1971* relates to restrictions on the possession of controlled drugs. It includes provisions that make it an offence for a person to have a controlled drug in their possession, whether lawfully or not, with the intent to supply that drug. Section 5 makes a distinction between possession of a controlled drug (s. 5.2) and possession of controlled drugs with intent to supply to another (s. 5.3). Maximum penalties vary not only according to the class of substance but also whether the conviction is a summary one made at a Magistrates court or one made on indictment following trial at a Crown Court.

Supplying drugs or intention to supply attracts more severe penalties than unlawful possession. At present if an offender could convince the respective authorities that dealing was only undertaken to finance their own drug habit or that of a friend, then the sentence would usually be less than that of a professional dealer. This would not be applicable if the amount of drug involved was large.

In the case *R v. Spinks*,[56] the appellant admitted that he and a friend had agreed to buy £10 worth of heroin which they both duly consumed. He pleaded guilty on the basis that this

[56] *R v. Spinks* [1987] Crim. L. R. 786

amounted to supplying his friend. He had no previous convictions but was sentenced to 12 months' imprisonment. The Court held that this was an act of supply, although on a very limited scale, and the sentence should have been slightly more than would have been appropriate for simple possession, in this case about 3 months' imprisonment. Many cases have considered the extent to which a supply of drugs to a small circle of friends of other drug misusers, termed 'social supplying', is a mitigating factor. In similar case, *R v. Bennett*,[57] the Court implicitly regarded such a feature as amounting to some mitigation.

b. The Bill

Clause 2 would introduce a new presumption that those caught in possession of more drugs than is reasonable for personal use would be guilty of intent to supply drugs, rather than the lesser offence of possession. The specific amount of a drug that would allow the court to assume the defendant intended to supply the drug would be prescribed by the Secretary of State in regulations. There may be different amounts specified for each different controlled drug. These regulations would only be made following consultation with the Advisory Council on the Misuse of Drugs.

B. Part 2: Police powers relating to drugs

Part 2 contains provisions that would change police powers in relation to drug offence searches and testing for the presence of class A drugs.

1. Drug offence searches

a. Current position and background

The *Police and Criminal Evidence Act 1984* (PACE) sets out the police powers to stop, search and arrest, conditions of detention in police stations and codes of practice governing treatment of detained individuals.

Section 5 of the Act contains provisions relating to intimate body searches. Intimate searches of body orifices, without the need for the subject's consent, can be authorized in writing by a police superintendent who suspects that a Class A drug (such as cocaine or heroin) has been concealed with criminal intent. An officer may not authorise an intimate search of a suspect unless he or she has reasonable grounds for believing that the object of the search cannot be found without the suspect being intimately searched. An intimate search which is performed on the basis of a drugs offence must be conducted by a doctor or nurse in a hospital or clinic. In 2002-03, 172 intimate searches, mostly for drugs, were

[57] *R v. Bennett* (1981) 3 Cr. App. R. (S.) 68

carried out, 70 more than in 2001-02.[58] Searches made for drugs (91 per cent of all searches made) showed a five per cent rise on 2001-02. In 2002-03, Class A drugs (mainly heroin, other opiate drugs, LSD and cocaine) were found during one in three of the searches made for drugs.

The search provisions contained in the *Police and Criminal Evidence Act 1984*, relating to intimate searches without consent, have raised some disquiet in the past. The British Medical Association hand book of ethics and law, *Medical Ethics Today*, states:

> Intimate body searches: Intimate body searches without consent are lawful, provided that appropriate authorization has been received. Nevertheless, the ethical obligation to seek consent applies. The BMA and the Association of Police Surgeons have a joint guidance note setting out the policy that doctors should not carry out intimate body searches without consent. (The principles have also been supported by the General Medical Council's Standards Committee.)[59]

b. The Bill

Clause 3 would amend section 55 of the *Police and Criminal Evidence Act 1984*. This would require the police to obtain written consent from the detained individual in order to perform a drug offence search. In addition, the authorisation for the search, the grounds for the authorisation and the consent of the detainee must be recorded in the custody record.

However if the individual refuses consent for a drugs offence search, and they are later charged with a drugs offence the court would be informed of this refusal and would be able to make assumptions on the reason for such a refusal. This would make an unreasonable refusal to consent to an intimate body search count against the suspect.

Clause 4 would make equivalent provisions for Northern Ireland.

2. X-rays and Ultra Sound Scan (USS)

a. Current position and background

At present the *Police and Criminal Evidence Act 1984* only makes provisions for general and intimate body searches in relation to drug offences. Some drug dealers attempt to

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[58] Arrests for Notifiable Offences and the Operation of Certain Police Powers under PACE England and Wales, 2002/03, National Statisitcs,17/03, published 12 December 2003, at: http://www.homeoffice.gov.uk/rds/pdfs2/hosb1703.pdf

[59] "Doctors working in custodial setting", The British Medical Association hand book of ethics and law, *Medical Ethics Today,* 2004, p.640

evade arrest by swallowing suitably packaged drugs to hide the evidence from the police. The only way to detect the presence of these drugs would be by X-ray or USS or waiting for the packages to pass through the body.

b. The Bill

The Bill would strengthen police powers in relation to dealers who swallow their drugs or hide them in body cavities. A new clause inserts a new section 55A into the *Police and Criminal Evidence Act 1984*. Clause 5 would allow the police to order an X ray or ultrasound scan of the detained individual in order to detect the presence of concealed drug packages.

The person would be required to give their consent in writing for the X-ray or USS to be performed. The test would need to be performed by a qualified person such as a doctor or radiographer at a hospital or a general practitioner's surgery. If the person refused to give consent for an X-ray or USS the courts would be made aware of the fact and could draw their own conclusions as to the reason.

Clause 6 makes equivalent provision for Northern Ireland.

3. Extended detention of suspected drug offenders

At present, under the *Police and Criminal Evidence Act 1984* the police can detain individuals for up to 96 hours. This may be insufficient time to allow swallowed drugs to pass through the body, and to be recovered by the police.

In contrast, a magistrates' court is able to order a person suspected of swallowing evidence into the custody of customs officers for a maximum period of 192 hours. This maximises the chances of the customs officers being able to recover concealed evidence from individuals suspected of drug trafficking or to deal with the relatively widespread use of human couriers who have swallowed packages of a drug.

Clause 8 would allow for extended detention of suspected drug offenders for 192 hours (8 days).

4. Testing for presence of class A drugs

a. Current position and background

Section 63B of the *Police and Criminal and Evidence Act 1984*, allows offenders in police custody to be tested for the presence of class A drugs once they have been charged with an offence that is likely to be drugs related. Trigger offences are those which are known to be linked with drug misuse, and include most forms of acquisitive crime such as shop lifting and burglary. Persons charged with a non-trigger offence may also be tested for class A drugs if a police officer of the rank of inspector or above has reasonable

grounds for suspecting that the misuse of class A drugs caused or contributed 'to the offence'.

The only class A drugs currently tested for are cocaine and heroin. Failure to provide a test sample is a criminal offence that carries a three month prison sentence and/or a fine. The test result is made available to the court to assist with bail and sentencing decisions.

The *Criminal Justice and Court Services Act 2000* gives the courts the power to order a pre-sentence drug test if they are considering passing a community sentence.[60] The Act also gives the courts the power to attach a Drug Abstinence Order to a community rehabilitation or punishment order.[61]

On 1 August 2004 drug testing on charge was extended to include young people from the ages of 14-17 inclusive, in 10 pilot areas. There are no figures available yet from the pilot schemes.

b. The Bill

Clause 7 makes a number of amendments to the *Police and Criminal Act 1984*. The existing provisions for drug testing on charge would remain[62], but this clause would give the police additional powers to test offenders for class A drugs on arrest. The Government believes that this would improve the detection of drug misuse problems in offenders, who would then be directed into treatment at an earlier stage. The Home Office has said that allowing the police to test those individuals who have been arrested, but not yet charged, is likely to double the numbers tested in police stations from around 120,000 to 240,000 a year.[63]

The new provisions include:

- *Age condition*: The new provision would apply only to people over 18. However, the Secretary of State may, at a later date, (by statutory instrument), change the age at which drug testing, on arrest or charge, may be performed.

- *Charge condition*: The offender must have been arrested or charged with a trigger offence, or a police officer above the rank of inspector must believe there are reasonable grounds that the misuse of class A drugs has contributed to the offence. The arrested person must be brought before the custody officer before a sample for testing may be taken.

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60 *Criminal Justice and Court Services Act 2000*, section 58

61 *Criminal Justice and Court Services Act 2000*, section 49

62 Section 63B of the *Police and Criminal Evidence Act 1984*, as amended by section 5 of the *Criminal Justice Act 2003*

63 "Blunkett gets tougher on drugs", *The Guardian*, 22 November 2004

- *Notification condition*: The Secretary of State must give notification that arrangements have been made for the appropriate taking of samples in an area in which testing upon arrest will operate. The notification could be withdrawn at any time.

- *Other provisions:* If a sample is taken from a person at arrest, no further sample may be taken during the period of detention.

C. Part 3: Assessment of misuse of drugs

Part 3 contains provisions relating to the assessment of the individual's misuse of drugs, from the initial assessment through to follow-up, including requirements to provide samples for testing during this time.

1. Assessment following testing for the presence of class A drugs

a. Background

The National Treatment Agency recommends that a joint risk assessment and management policy should be developed and agreed by all the relevant health, social care and criminal justice agencies.[64] A professional should assess a drug misuser only if they have the required level of competence to do so. The necessary basic competencies are outlined in the new Drug and Alcohol Occupational Standards (DANOS), and are available on the National Treatment Agency website.[65] A full assessment should include:

- the presence and level of dependence on one or more substances, including alcohol

- the identification of other medical, social and mental health problems

- medical complications from drug misuse

- risk assessment[66]

An assessment is the first stage in formulating a specific care plan for the treatment of that individual's drug problem which could range from residential rehabilitation to a variety of community programmes. Drug testing following arrest has an important role in maximising the number of offenders accessing treatment services at an early stage.

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64 NTA, Models of Care for treatment of adult drug misusers, December 2002, p.37

65 www.nta.nhs.uk

66 "*Integrated care pathway*", NTA, Models of Care for treatment of adult drug misusers, December 2002, p.87

Currently, if a person tests positive for the presence of class A drugs there is no requirement for them to undergo an assessment of their drug misuse problem. Any decision to seek assessment and treatment of a drug problem will be a voluntary one, except for the minority of cases where this is imposed by the courts as part of a pre-sentence assessment or for a specific sentence. Arrest referral schemes operate in all police forces in England and Wales to allow offenders with a positive test for class A drugs to be voluntarily referred to drug treatment and advice services.

Whilst some offenders may choose to seek assessment of the drug problem, this will not be true of a significant proportion of offenders, especially those who have a more serious drug habit. However, it is thought that providing an early assessment of a drug misuse problem will encourage offenders to access treatment services, which is especially important for those who are known to be difficult to involve in treatment services. The NTA states that for many drug misusing offenders getting arrested is the trigger point for seeking help.

b. The Bill

The Bill introduces a new discretionary power for the police to require persons with a positive test for the presence of class A drugs to be required to undergo an assessment by a drug worker.

Initial assessment: Clause 9 would provide the police with the powers to require an individual who has tested positive for the presence of class A drugs to attend an initial assessment of their drug misuse problem. This would only apply to offenders who are 18 years or above. The Secretary of State would be given the power to change the age, (by statutory instrument), at a later date. The Secretary of State must give notification that arrangements have been made for the appropriate conducting of initial assessments in the police station, for individuals who have tested positive for class A drugs.

The initial assessment would be conducted by a qualified drugs worker with the necessary basic competencies. The assessment would need to determine if the offender is dependent on drugs and whether they could benefit from either further assessment of their drug problem or additional treatment interventions. The offender should have possible treatment options explained to them, and be given the opportunity to access the available treatment services.

Follow up assessment: Clause 10 would require an individual who has attended an initial assessment of their drug misuse problem to attend a follow-up assessment unless they are informed at the initial assessment that follow-up will not be required. The same age and notification conditions would apply.

The follow-up assessment would again be conducted by a suitably qualified person. The purpose of the assessment would be to ensure that all the information required at the

initial assessment had been obtained, and then, if appropriate to draw up a treatment care plan for the drug-misusing offender.

Attendance: If the offender fails to attend either the initial or follow-up assessment, the person conducting the interview would have a duty to inform the police (clauses 12 and 14). Failure to attend an interview is an offence that would carry a fine or sentence or both.

Disclosure of information: Information obtained from either the initial or follow-up assessment may not be disclosed without the written consent of the person concerned except for the purpose of information sharing between the drugs workers conducting the assessments.

Samples: If the sample submitted for the testing of the presence of class A drugs is found to be negative after further analysis the person would not be required to attend the assessments.

Relationship with the Bail Act 1976: Clause 17 provides that if a person is granted bail by the court, after being charged with the offence that triggered the drug test, a requirement to attend either an initial or a follow-up assessment, under clauses 9 and 10, would cease to have effect. This would apply only where the bail was granted on the condition that the person undergoes a relevant assessment and participates in any relevant follow-up proposed to him under the *Bail Act 1976*. A relevant assessment is one which would determine if the offender is dependent on drugs and whether they could benefit from either further assessment of their drug problem or access to treatment. A suitably qualified person must carry out the assessment. The Home Office states that the assessment should be a level 2 assessment, as defined in the National Treatment Agency's treatment framework, *Models of Care*, and should include the following:

- Risk assessment: identification of immediate risks (e.g. self-harm, harm to others, physical and/or mental health emergencies);
- An assessment of the urgency of referral;
- A brief assessment of class A drug misuse problems
- A brief assessment of client readiness to engage in types of treatment;
- An assessment of whether or not the client meets the criteria for needing more comprehensive (Level 3) assessment and care co-ordination.

Other provisions: There are a number of other requirements relating to the assessment of the misuse of drugs contained in part 3 of the Bill. Clause 11 imposes a number of obligations on police officers where they require a person to attend an initial assessment under clause 9 or both an initial assessment and a follow-up assessment under clause 10.

- The police must inform the individual who is to undergo assessment, of the time and place of the assessment, and confirm this in writing.

- The police must warn the offender that they will be required to stay for the duration of the assessment and that they would be liable to prosecution if they either fail to attend the interview, or leave before it is completed.

- Details of the requirement to attend assessment, the explanation given and the information provided must be made in the custody record.

D. Part 4

This details a number of miscellaneous provisions relating to issues which include the creation of a new community order, an intervention order, and the inclusion of all forms of magic mushrooms as class A drugs.

1. Anti-social behaviour orders: Intervention orders

A new drug intervention order would be introduced to address drug misuse by people committing anti-social acts

a. Current position and background

Anti social behaviour orders were introduced in the *Crime and Disorder Act 1998*. They were one of a number of several community based orders created under the Act to deal with crime and disorder in the community. The orders were intended to deal with the problems of disruptive individuals or households who created a nuisance for other people living in the area.

Section 1 of the *Crime and Disorder Act 1998* enabled local authorities and the police to apply for an anti-social behaviour order (ASBO) for any person aged 10 or over who had acted in an anti-social manner and who is likely to do so again in the local government area. The term 'anti-social behaviour' was not closely defined beyond the Act which describes it as any behaviour likely to cause harassment, alarm or distress. Anti-social behaviour orders have been used to tackle a range of problems including noisy neighbours, abandoned cars, vandalism, graffiti, litter and youth nuisance.

An ASBO contains conditions prohibiting the offender from specific anti-social acts or entering defined areas and may be imposed for a minimum of two years, but there is no statutory maximum and no provision for interim orders. Either the person subject to an order, or the person who sought it, can apply to the court to have the order varied or discharged. However, an order will only be discharged before two years have passed if both parties consent. Breach of an order is a criminal offence. The procedure for obtaining ASBOs was amended by the *Police Reform Act 2002*.

ASBOs have been supplemented by non-statutory Acceptable Behaviour Contracts (ABCs) pioneered by local authorities. Guidance on ASBOs and ABCs with good practice examples was published by the Home Office in November 2002.

The Government recognises that drug misuse causes damage to both individuals and society. The Drug Strategy Progress Report 2004 includes, as one of the future actions plans, measures to address the problem of drug misuse by people committing anti-social acts: 'The introduction of a new civil order that will run alongside anti-social behaviour order (ASBO) for adults to tackle drug issues'.[67]

b. The Bill

Clause 20 amends the *Crime and Disorder Act 1998* and will allow a new order, called an intervention order, to be made alongside an ASBO when drug misuse has been a cause of the behaviour that led to the imposition of the ASBO.

Application for an intervention order: A new section 1G would be inserted after section 1F of the Act,[68] and would set out when an application for an intervention order can be made. An intervention order could be applied for by the relevant authority, as defined under the *Crime and Disorder Act 1998* provided:

- An application has been made for an anti-social behaviour order
- A qualified drug worker has assessed and reported on the drug misuse behaviour of the person
- There are appropriate services available to manage the drug misuse behaviour.

Conditions of an intervention order: In order to apply for an intervention order the following conditions would need to be met:

- An intervention order would help prevent a repeat of the behaviour that led to the ASBO being made
- Appropriate activities to manage the drug misuse behaviour are available in the area
- The defendant is not already subject to an intervention order, or any other treatment order relating to the trigger offence.
- The court has been notified by the Secretary of State that arrangements for implementing the order are available in the area.

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67 Drugs Strategy Progress Report 2004, "Tackling Drugs. Changing Lives", November2004

68 Section 1F will be inserted by section 128 of the *Serious Organised Crime and Police Act* 2005

Requirements of an intervention order: The intervention order would require the defendant to comply with the provisions of the order for a period not greater than 6 months, which could include attending specific treatment services. If possible any arranged activities or treatment should be timed so as not to conflict with the defendant's religious beliefs, or work or educational commitments. If the defendant fails to meet the requirements of the order they would be liable for a fine.

Intervention orders: explanation, breach and, amendment: A new section 1H would be inserted after section 1F of the *Crime and Disorder Act 1998*[69] and would set out a number of additional provisions including:

- A requirement on the court to make the defendant aware of the effects of the order and the consequences of non-compliance. They must also be made aware that the court would have the power to amend the order at a later date.

- The intervention order would cease to have effect when the ASBO is discharged.

- An application could be made by the defendant, or the relevant authority, to change or discharge the order.

- The courts may change the order if the ASBO is being amended.

2. Inclusion of mushrooms containing Psilocin as class A drugs

a. Background

At present a mushroom containing Psilocin is only classified as a class A drug if it is in a form that constitutes a preparation of Psilocin. This has enabled fresh mushrooms to be legally sold.

The drugs charity *Transform* provides the following summary on the current legal situation concerning mushrooms that contain Psilocin or an ester of Psilocin.

> The past two years has witnessed the appearance of fresh 'magic' mushrooms - containing the active substances psilocybin and psilocin (various spellings) – on sale in an estimated 300 shops and market stalls across the UK (1), as well as mail order sales from numerous websites. Although the law, set out in the Misuse of Drugs Act 1971 (MDA), has not changed, traders have latched onto the specific wording in the Act which classifies the active ingredients in the

[69] Section 1F would be inserted by section 128 of the *Serious Organised Crime and Police Bill* 2005

> mushrooms (psilocybin and psilocin) as Class A drugs, but not the fresh mushrooms themselves.
>
> A widely circulated letter from Ian Breadmore (Home Office drug licensing section, 17 February 2003) stated that 'it is not illegal sell or give away a freshly picked mushroom provided that it has not been prepared in any way' and has been taken by vendors as official permission for their activities (2). In July 2004 Customs and Excise confirmed that psylocybe mushrooms were taxable at 17.5% VAT because they are not a food but a drug.
>
> The psylocybe mushrooms now widely on sale are rarely, if ever, the varieties that grow wild in the UK (most commonly the liberty cap) but are a number of varieties from around the world that are larger and easier to cultivate. Until recently most were grown in Holland and imported, but increasingly, as the market has expanded, they are being cultivated in the UK.
>
> At present fresh psylocybe mushroom sales are effectively unregulated. Sales are not covered by any kind of legally binding regulatory framework, other than various informal and patchily applied voluntary codes devised by vendors. This lack of regulation and licensing means that:
>
> - There are no (or voluntary only) controls on age of purchaser.
> - Anyone can set up as vendor, with no license, qualifications or registration required.
> - There are no quality controls (or voluntary only) over the mushrooms sold, including those familiar to other foods such as sell by / use by dates.
> - There is no requirement for information to be provided on the strength (psilocybin/psilocin content) relevant to dosage.
> - There is no requirement for health and safety information to be provided with the mushrooms that would include details of dosage, effects, contra-indications, risks, harm reduction, where to access help and advice services and so on.[70]

The issue was highlighted by a recent court case relating to a prosecution for the selling of fresh mushrooms containing psilocin, which was widely reported in the media.

> The law on the distribution and sale of magic mushrooms was thrown into disarray yesterday after a court decision to stay the prosecution of two men accused of illegally selling the hallucinogenic fungi at a record shop in Gloucester.
>
> Arguing that Home Office advice to importers and distributors was "fudged", the crown court recorder Claire Miskin told Dennis Mardle and Colin Evans that the law was so ambiguous that to put them on trial amounted to an "abuse of

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[70] "The Magic Roundabout…How to deal with Psylocybe Mushrooms", A briefing from Transform Drug Policy Foundation, at: http://www.tdpf.org.uk/Policy_General_Mushrooms.htm

process". She recommended that parliament consider new legislation to clarify the legal position.
It is the first time the issue of magic mushrooms has reached the crown court, though potential court actions are pending in Birmingham and Canterbury.

Mr Mardle, 52, and Mr Evans, 57, both from Gloucester, began selling magic mushrooms after reading an article in the Guardian last November which cited Home Office advice that while psilocin and psilocybin, the psychoactive constituents of the mushrooms, were illegal, it was "not illegal to sell or give away a freshly picked mushroom".

But earlier this year the Home Office wrote to mushroom importers saying that hallucinogenic mushrooms might constitute a "product" under the Misuse of Drugs Act if they had been "cultivated, transported to the marketplace, packaged, weighed and labelled".

Although the courts had previously ruled that it was legal to possess magic mushrooms except where they had been "altered by the hand of man", the Home Office also advised that merely chilling the mushrooms might constitute alteration.
The local prosecutor, Phillip Warren, told the court that while the law prohibited the freezing of the mushrooms, the legality of cooling or storing them in a fridge had never been tested and the case should go to trial in order to clarify the situation.

However, after hearing from experts that chilling did not alter the chemical makeup of the mushrooms, Ms Miskin ruled that to bring the case to trial would be a breach of the men's rights.[71]

b. The Bill

Clause 21 would insert into Part 1 of Schedule 2 to the *Misuse of Drugs Act 1971* a fungus of any kind that contains the drug Psilocin or an ester of that drug. This would mean that a fungus of this type, more usually known as magic mushrooms, would become a class A drug, irrespective of the form in which it was sold. This would close the legal loophole that exists at present in relation to fresh mushrooms.

III Response to the Bill

At this stage there has been limited comment on the Bill. However, two leading drug and social care charities have joined together to outline an alternative Bill based on their view of the most effective responses to drug misuse. DrugScope and social care charity Turning Point criticise the Government's over-emphasis on forcing people into treatment

[71] "Magic mushroom case judge tells prosecutor: chill out", *The Guardian*, 15 December 2004

that underlies the current Bill. They highlight the need to improve current treatment programmes to retain people within treatment services and increase the effectiveness of these services.[72]

> The Government's Drugs Bill has outlined a raft of new criminal justice legislation on drugs and drug policy.
>
> The criminal justice system has an important role to play in reducing drug-related crime and in getting drug users into treatment. However, we are concerned by the increasing punitive approach to tackling drug misuse. We recommend that the key priority for government should be to focus on making treatment more effective, rather than widening the net of the criminal justice interventions as the means to get people into treatment.
>
> It is important to ensure that the right people are being placed on the right programmes. However, a recent report from the Audit Commission estimates that 34 per cent of drug users who leave treatment drop out within the first 12 weeks According to the National Audit Office, of those offenders who have received a community sentence such as a drug testing and treatment order (DTTO) in 2003 - which requires them to undergo treatment instead of custody - only 28% completed the programme. We do not believe that the proposed measures in the Drugs Bill alone will lead to an improvement in the success rate of referrals into treatment or a reduction in drop out rates on DTTOs.
>
> We also feel that the measures in the Drugs Bill do not address the need to provide treatment to drug users in the community, who have not committed a crime and who can be prevented from committing a crime in the future by prompt access to treatment. The war on drugs is too easily interpreted as a war on drug users. Instead, tackling substance misuse must be central to a broader social welfare and health agenda that addresses and matches the complex and different needs of many problem drug users.
>
> For these reasons, we are proposing an **alternative Drugs Bill**. These would address the following priorities:
>
> *1. Meeting complex needs more effectively*
>
> - Half of people in drug or alcohol services also have a mental health problem.
> - Around one-third of patients in mental health services also have a drug or alcohol problem.
>
> Many users are still falling through the gaps, going without help or being passed from one agency to another because of disagreements who should be the lead agency or because agencies are not involved at the stage when a person is assessed and referred to services. Services should be commissioned more

[72] "Charities set out pragmatic and effective drugs bill", News Release, Drugscope, 17 December 2004, at: http://www.drugscope.org.uk/uploads/homepage/documents/drugsbill.htm

strategically across the drugs, alcohol and mental health fields. Treatment for young people must acknowledge the wider social factors and some of the catalysts of drug misuse such as poor school attendance, school exclusion, or a history of violence and disturbance in childhood.

2. *Better support and after-care services to back up treatment and sustain recovery*

- One in three problem drug users are homeless or in need of housing support.
- Services must be able to deal with all aspects of a person's life such as housing, finance, education, employment, as well as their substance misuse problems.

Unless more is done to tackle the catalysts that lead to problem drug use the revolving door of drugs and crime will continue. We want the Government to place greater priority on providing after care for people when they leave treatment in the community or in the criminal justice system. There should be greater priority on commissioning treatment services in combination with long term support such as housing, employment and day-care provision – and these services must be available and working with the drug treatment sector – not in isolation. This will ensure that every support to an individual is made available in order to help them rebuild their lives and reintegrate back into the community rather than simply returning an individual to the environment which first contributed to their misuse.

3. A pilot of safer injecting areas and greater use of heroin prescribing

- There is still an urgent need for harm reduction – a way to bridge users into treatment. We need to bring heroin use above ground so that those who wish to be helped can be, and those who are not ready do not risk their own health and that of the public.
- Heroin prescribing and safer injecting areas are needed as just part of the mix of getting – often some of the most chaotic users – to access treatment services.

We recommend the introduction of safer injecting areas. An area where people can go without fear of arrest, where practical advice is available and there is a safe disposal of needles. As well as helping users to reduce the risks to their health, safe injecting areas can make a significant impact on the nuisance caused to others by injecting in public, discarding needles in the street and other public places which is a health and safety risk, particularly to children.

Heroin prescribing is currently only available to some of the most chaotic users – only about 450 in the country. We think that prescribing is a useful tool to stabilise heroin users and to maintain them, within a strict reduction in harm agenda.

4. Greater investment in training and encouraging GPs to work with clients with drug problems.

- GPs are a key resource in the treatment of drug misuse and can help people to access other services.
- There is a shortage of trained GPs to deal with drug misuse and there is no co-ordinated infrastructure to support them.

There is an urgent need to share the care arrangements of drug users. This means more partnerships between GPs and specialist agencies, including voluntary sector agencies, psychiatrists and community pharmacists working together in support of clients. There is a clear need for Government to invest in improving drug misusers access to shared care arrangements and promoting better models of good practice.

5. Investment in the training of staff

- There is a significant problem with recruitment and retention of staff at all levels and an estimated shortage of at least 3,000 drug staff with specialist knowledge in the management of drug users
- Shortfalls in staff are greatest among those working with young people, women, families, black and ethnic minority groups and people with mental health problems.

All staff that work with drug misusers and front line staff in mainstream services who come into contact with these people need to be trained and supported to develop the skills to do their job effectively. The Government must continue to invest to improve the status of all staff who work with substance misusers, so that it becomes a more attractive career option in terms of rewards, personal development, career progression and public standing. This demands a collective workforce strategy that promotes a greater investment in the training, development and retention of staff and provides more incentives for all staff to continuously develop their expertise and to work collaboratively across agencies.[73]

[73] "Charities set out pragmatic and effective drugs bill", News Release, DrugScope, 17 December 2004 http://www.drugscope.org.uk/wip/7/PDFs/drugs%20bill.pdf