A Report by

JUSTICE

Drugs and the Law

Chairman of Committee

His Hon. Judge
Peter Crawford QC

£4.00

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JUSTICE

Extracts from the Constitution

PREAMBLE

Whereas JUSTICE was formed through a common endeavour of lawyers representing the three main political parties to uphold the principles of justice and the right to a fair trial, it is hereby agreed and declared by us, the Founder Members of the Council, that we will faithfully pursue the objects set out in the Constitution of the Society without regard to consideration of party or creed or the political character of governments whose actions may be under review.

We further declare it to be our intention that a fair representation of the main political parties be maintained on the Council in perpetuity and we enjoin our successors and all members of the Society to accept and fulfil this aim.

OBJECTS

The objects of JUSTICE, as set out in the Constitution, are:

to uphold and strengthen the principles of the Rule of Law in the territories for which the British Parliament is directly or ultimately responsible; in particular to assist in the maintenance of the highest standards of the administration of justice and in the preservation of the fundamental liberties of the individual;

to assist the International Commission of Jurists as and when requested in giving help to peoples to whom the Rule of Law is denied and in giving advice and encouragement to those who are seeking to secure the fundamental liberties of the individual;

to keep under review all aspects of the Rule of Law and to publish such material as will be of assistance to lawyers in strengthening it;

to co-operate with any national or international body which pursues the aforementioned objects.

THE COMMITTEE

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Detective Constable Geoff Monaghan	(Police)
Dr Paul T d'Orban	(Forensic Psychiatrist)
Detective Chief Superintendent Derek Todd	(Police)

The Committee had a useful discussion with Dr David Jenkins - a past President of the Association of Police Surgeons.

Representatives of the following organisations participated in the work of the Committee:-

Criminal Bar Association
Institute for the Study of Drug Dependency (ISDD)
Institute of Psychiatry
JUSTICE
Law Society
Metropolitan Police
RELEASE
Royal College of Psychiatrists
Standing Conference on Drug Abuse (SCODA)

This report has been endorsed and approved for publication by the Council of JUSTICE

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CHAPTER ONE

INTRODUCTION

1.1. There has been national and international concern about the misuse of drugs for most of the 20th century. Since the 1960s, drug misuse within the United Kingdom has been regarded as a major social problem.

1.2 The criminal law is involved directly where there are breaches of the Misuse of Drugs Act 1971 (as amended), the Drug Trafficking Offences Act 1986, the Criminal Justice (International Co-operation) Act 1990 and Customs and Excise legislation; or of their associated regulations. The criminal law is also involved where there are drug related offences, for instance, those committed to obtain supplies of drugs or to obtain money to purchase drugs. In some parts of the country, research shows that a significant proportion of thefts and burglaries are committed by users of illicit drugs.

1.3 In the light of these considerations, and following initial discussion with interested bodies, it was decided to establish a committee of experts in different aspects of the drug problem in the United Kingdom; staff working in specialist drug services, both statutory and non- statutory; police officers and lawyers. Assistance was sought from other organisations where members of the committee did not themselves have sufficient knowledge. The objectives of the committee were to consider all aspects of the law relating to drugs that might require revision and improvement.

1.4 The committee has met on 16 occasions. It has considered working papers prepared by members of the committee and reviewed the relevant legislation, international conventions, current practice and case law. This report represents the consensus views of the committee.

1.5 There were some aspects of the drug problem which the committee considered it could not effectively comment on. These were primarily those areas of legislation concerned with the tracing, freezing and seizure of assets derived from drug trafficking and related offences and international activity designed to cut off sources of supply of drugs overseas.

CHAPTER TWO

THE RATIONALE AND HISTORY OF DRUG CONTROL

Background

2.1 The subject of this discussion is the role of the criminal law in controlling the supply and use of narcotic and psychotropic drugs. The committee took the main question to be 'Is the control of drug use a proper field for the criminal law?'.

2.2 International agreements to control the trade in drugs began with the International Opium Convention of 1912. Since then a number of international conventions have been agreed. There are now three principal conventions designed to establish an international basis for the control of production, supply and use of narcotic and psychotropic drugs and to trace, freeze and seize assets obtained through drug trafficking and facilitate investigation and arrest for offences. The conventions are the Single Convention on Narcotic Drugs 1961, the 1972 Protocol amending the Single Convention and the Convention on Psychotropic Substances 1971. The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 came into force on 11th November 1990.

2.3 The United Kingdom is a signatory to the Single Convention, the 1972 Protocol and the Psychotropic Substances Convention. It is a requirement for countries which are signatories to the conventions to impose national controls on listed drugs to at least the same degree as that required by the conventions. The Misuse of Drugs Act 1971 ('MDA') and its associated regulations provide domestic controls for drugs in line with those required under the conventions.

The MDA lists all controlled drugs in Schedule 2. These are divided into three categories A, B and C according to their perceived degree of dangerousness. Maximum punishments are determined by the category of drugs involved. These are set out in Schedule 4 to the Act (see para. 3.21 post). The Advisory Council on the Misuse of Drugs appointed by the Home Secretary under Section 1 of the Act is made up of members of the medical, dental, veterinary and pharmaceutical professions. Its functions include keeping under review drugs which are, or are likely to be, misused.

2.4 In addition to controls provided under the MDA, medicinal products are controlled by the Medicines Act 1968. This provides for products to be available on prescription only, on sale from a retail pharmacy only, or on general sale. Drugs controlled under the MDA, therefore, where they are in the form of a medicinal product, are also controlled by the Medicines Act.

2.5 The Intoxicating Substances (Supply) Act 1985 prohibits the sale of an intoxicating substance to or for the use of a person under eighteen where it is known, or where there is reason to believe, that the substance or its fumes are likely to be ingested or inhaled by the young person.

Discussion

2.6 We considered at length whether there was sufficient justification for the criminal law to interfere in the liberty of the individual to use drugs and, if there was, what this justification might be. We concluded that the justification is the avoidance or reduction of the potential or actual harm to individuals and to society arising from drug use. Whilst harm may arise from many aspects of drug use, it is less common for harm to be attributed solely to the specific qualities of a particular drug than to a combination of factors.

The most obvious example of a psychotropic drug which, taken in excess, is by its very nature harmful is alcohol. Quite apart from influencing an individual's behaviour, alcohol can damage the liver and the brain.

2.7 Harm to the individual from drug-taking may result from:

(a) the route of administration of a drug - self- injection and unsterile injection practices - can result in infections, abscesses, collapsed veins, and, where the injection equipment is shared, hepatitis and HIV infection;
(b) the physical complications of use - effects on, e.g. the nervous system, the respiratory system, organic damage and the general effects of overdose.
(c) physical and/or psychological dependence and abnormal mental states.

2.8 Harm to society may arise from:

(a) the public health consequences of drug use;
(b) the break up of families and/or child neglect;
(c) accidents or errors as a result of intoxication;
(d) criminal behaviour resulting from drug use;
(e) the loss of the economic usefulness of an individual.

2.9 The drugs controlled under the MDA vary greatly in their composition and their effects. Some substances which can have many if not all of the harmful effects listed above are not controlled. At the same time, a substantial part of the resources devoted by the State in trying to impose controls on the supply and use of drugs is taken up with control of one of the less harmful drugs, cannabis.

2.10 Moreover, the harm which may result from taking a specific drug is not absolute. How the drug is used, the circumstances in which it is used and the personality of the drug user all play a part. Some users are able to function effectively in employment and at home although they may be physically dependent. The majority of people who use drugs do so occasionally and many people may experiment with them without continuing into long term or dependent use.

2.11 It can be argued that many harmful effects are a result of drug prohibition. Illicit drugs are often adulterated and the adulterants can themselves cause harm to the individual. Criminalisation of possession can result in drug use occurring in settings which increase the likelihood of harm. Obtaining supplies for use becomes itself a criminal enterprise and the expense of regular drug use results in drug-related crime.

2.12 We think that it is neither politically nor practically appropriate to call for the effective withdrawal of the United Kingdom from the international drug control conventions. Further, that to adopt a policy of allowing unrestricted access to psychotropic drugs would be to risk an explosion of drug misuse. There is a worldwide increase in such misuse.

2.13 We conclude that the State is justified in exercising control over the production, import and export, and supply of narcotic drugs and psychotropic substances and in imposing criminal sanctions for contravention of these controls. The criminalisation of simple possession is considered in Chapter Three.

Objectives

2.14 The objectives of the State's policy vis-à-vis the use of psychotropic drugs must be to reduce the occurrence of harm resulting from the misuse of such drugs. The overall objectives must be prevention, containment and reduction of misuse, and the provision of adequate treatment for those misusers who require it.

2.15 Legislation must seek to provide for:

(a) apprehension of those who offend against that legislation;

(b) disposal of offenders in such a way as to prevent or discourage re-offending;

(c) prevention and reduction of drug-related crimes - those crimes committed under the influence of drugs, in order to acquire drugs, and by drug traffickers in the course of their trade.

CHAPTER THREE

THE CRIMINALISATION OF SIMPLE POSSESSION

The subject of discussion in this chapter is whether there are sufficient grounds for retaining the possession of small quantities of drugs for consumption by the possessor as a criminal offence.

Background

3.1 Article 36 of the Single Convention on Narcotic Drugs 1961 states:

(a) '... possession ... distribution ... sale, delivery shall be a punishable offence when committed intentionally ...'

(b) 'Notwithstanding the preceding sub-paragraph, when abusers of drugs have committed such offences the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after- care, rehabilitation and social re-integration...'

3.2 The Convention on Psychotropic Substances does not specifically require simple possession to be a criminal offence. It does, however, repeat the provisions of Article 36(b) above.

3.3 We now consider Class A and other Class **B** drugs separately from cannabis and Class C drugs.

Class A and Class B Drugs other than Cannabis

3.4 The justification for criminalisation of simple possession of drugs contained in these classes is essentially the same as for applying criminal sanctions to the production and supply of these drugs. Their use is likely to harm the individual, his family and society.

3.5 It may be argued that drug abusers are helpless victims of their own addiction who are not responsible for their own plight and should not therefore be prosecuted for the necessary concomitant of possession of their chosen drug. The committee does not share this view. Even in the case of physical dependency-producing drugs such as heroin it is possible for drug users to change their behaviour. Although the will of the user is weakened by the effects of drug use it cannot be said that his free will is completely destroyed. The whole drugs supply network would not exist in the absence of customers.

3.6 There are specific risks associated with the use of Class A and B drugs, including physical and psychological dependence, health related problems arising from both the drug and the way it is used, and harm to society arising from use. We take the view, in line with the objectives at 2.14 above, that the criminal law has a role in reducing harm to the individual and to society.

3.7 We also think that the penalties which should be applied to simple possession should be in line with these objectives. That is, that they should seek to discourage re-offending and decrease the amount of harm that any continued drug use might involve. Health and social problems as a result of drug use place burdens on the individual, his or her family and society as a whole. The advent of HIV infection has increased this burden. Public policy and drug service practice has focused on strategies designed to minimise harm. These have included drugs education and prevention work to reduce the likelihood of someone's becoming involved in drug use, the prescription of substitute drugs, increasing the availabilty of sterile needles and syringes, the provision of community-based advice and counselling services and of detoxification and rehabilitation facilities.

3.8 The role of the criminal law should, therefore, be to support preventive efforts through deterring drug use by criminal sanctions against use and to help reduce harm to a minimum by disposing of offenders in ways which can lead them into alternatives to continued harmful drug use.

3.9 Removing the offence of unlawful possession of a controlled drug might have some beneficial effects for those with serious drug problems. It might also have some benefit to their immediate community. However, this may be at the cost of increased harm to a larger number of people who are not at present drug users. To legalise possession and use of drugs would carry the message that drug use was harmless and respectable. It might also lead to an influx of drug users from countries which maintain prohibition.

Class C Drugs

3.10 Most Class C drugs have only recently been added to the list of controlled drugs. The majority comprises the benzodiazepines, which have been in medical use for many years as tranquillisers and for night sedation, but a number of drugs included in the list are ones which have

been of concern to other countries but are not available in the United Kingdom in the form of medicinal products. Controls over these in the United Kingdom satisfy obligations under the international conventions.

3.11 There is harm to both the individual and to society arising from the uncontrolled use of these drugs. Physical dependence and consequent problems have arisen as a result of injudicious medical prescription of benzodiazepines. There has been increasing use of these drugs, in particular temazepan, by people with multiple drug problems.

3.12 There are legitimate medical uses for these drugs and no person in possession of a controlled drug lawfully prescribed is committing a criminal offence. Most Class C drugs are in any case excepted from the prohibition on possession when they are in the form of a medical product. Although most of these drugs are not designed to be administered by injection, there is evidence of misuse by this method, particularly of temazepan.

3.13 We are not aware of any difficulties arising from the fact that some drugs in Class C are exempted from the prohibition on possession while others are not.

Cannabis

3.14 Herbal cannabis and cannabis resin are at present Class B drugs whilst cannabinol and cannabinol derivatives are Class A drugs.

3.15 In 1979, and again in 1981, the Advisory Council on the Misuse of Drugs recommended that herbal cannabis and cannabis resin should be reclassified to Class C and that possession should not be an arrestable offence. The Council took the view that cannabis was less harmful than was previously thought and that in comparison to the potential for harm of other Class B drugs its inclusion in that class was not justified. This recommendation has not been implemented.

3.16 We are aware that much work has been undertaken to investigate the harmful effects of cannabis use (Negrete 1988).[1] It is established that cannabis impairs driving peformance, is associated with lung problems, and has adverse effects on the course of pregnancy without causing foetal malformation. As regards mental effects, cannabis can cause a short-lived toxic psychosis, but longer term disturbance generally relates to continued consumption of the drug. Cannabis can, however, precipitate relapse in individuals with schizophrenia. For these reasons, cannabis cannot be regarded as a safe drug, but there is little evidence of long-term harmful effects. [1]

[1] Ref: Negrete J.C. 'What's happened to the cannabis debate ?' *British Journal of Addiction* 83, 359- 72.

3.17 The Single Convention on Narcotic Drugs 1961 places cannabis in Schedule 1 of the Convention as a drug for which there is no medical use. The convention requires that unauthorised possession of cannabis distribution, sale, delivery etc. be treated as punishable offences. In these circumstances, it is not possible to remove criminal sanctions on the possession and distribution of cannabis without the United Kingdom's withdrawing from the convention.

3.18 Decriminalisation of possession would not make sense without the setting up of supply lines which would be in clear breach of international law. Unless the state were to undertake distribution, this would involve commercial exploitation of the existing market together with the motive and opportunity to expand the market. It would also imply that the Government had given cannabis a clean bill of health.

3.19 For many years there has been a substantial body of opinion which has argued for the decriminalisation of simple possession of cannabis. A number of countries in Europe and North America have adopted measures within the Single Convention whereby possession of cannabis remains a criminal offence but a reduction in penalties and a tacit lack of enforcement have in effect decriminalised possession. We know of no country which has decriminalised supply, or sanctioned commercial sale, of cannabis.

Recommendations relating to Cannabis

3.20 We consider that it is not feasible or desirable to remove cannabis from control under the MDA. At the same time, we think that it is inappropriate for such a high proportion of public resources to be focused on its use when by comparison with Class A and other Class B drugs it is significantly less harmful. We accordingly recommend that cannabis and cannabis resin should be re- classified as Class C drugs.

Cannabis as a Class C Drug

Penalties

3.21 The maximum penalties for offences against the MDA are set out in Schedule 4 to the Act. The relevant entries are:

SCHEDULE 4
(Section 25)
As amended by the Criminal Law Act 1977 s. 27, s. 28 and Sch. 5, the Magistrates Courts Act 1980 s. 32 (2) and (5), the Criminal Justice Act 1982, s. 46 and the Controlled Drugs (Penalties) Act 1985

PROSECUTION AND PUNISHMENT OF OFFENCES

*(The prescribed sum is at present £2,000 S.I. 1984/447)

Section Creating Offence	General Nature of Offence	Mode of Prosecution	Punishment			
			Class A drug involved	Class B drug involved	Class C drug involved	General
Section 4(2)	Production, or being concerned in the production, of a controlled drug.	(a) Summary	6 months or the prescribed sum, or both.	6 months or the prescribed sum, or both.	3 months or £500, or both.	
		(b) On indictment	Life or a fine, or both.	14 years or a fine, or both.	5 years or a fine, or both.	
Section 4(3)	Supplying or offering to supply a controlled drug or being concerned in the doing of either activity by another.	(a) Summary	6 months or the prescribed sum, or both.	6 months or the prescribed sum, or both.	3 months or £500, or both.	
		(b) On indictment	Life or a fine, or both.	14 years or a fine, or both.	5 years or a fine, or both.	
Section 5(2)	Having possession of a controlled drug.	(a) Summary	6 months or the prescribed sum, or both.	3 months or £500, or both	3 months or £200, or both.	
		(b) On indictment	7 years or a fine, or both.	5 years or a fine, or both.	2 years or a fine, or both.	
Section 5(3)	Having possession of a controlled drug with intent to supply it to another.	(a) Summary	6 months or the prescribed sum or both.	6 months or the prescribed sum or both.	3 months or £500, or both.	
		(b) On indictment	Life or a fine, or both.	14 years or a fine, or both.	5 years or a fine, or both.	
Section 6(2)	Cultivation of cannabis plant.	(a) Summary	—	—	—	6 months or the prescribed sum or both.
		(b) On indictment	—	—	—	14 years or a fine, or both.
Section 8	Being the occupier, or concerned in the management, of premises and permitting or suffering certain activities to take place there.	(a) Summary	6 months or the prescribed sum or both.	6 months or the prescribed sum or both.	3 months or £500, both.	
		(b) On indictment	14 years or a fine, or both.	14 years or a fine, or both.	5 years or a fine, or both.	

3.22 It is apparent that the removal of cannabis from Class B to Class C will result in a substantial reduction in maximum penalties except in the case of summary trial for simple possession (Section 5(2)) and for cultivation (Section 6(2)). A defendant would still have the right to elect trial at the Crown Court.

Cultivation

3.23 The penalties for cultivation of cannabis are the same as for production of a Class B drug. It is now the practice to prosecute growers for producing a drug under Section 4(2), so that Section 6 no longer serves a useful purpose. Rather than amend the maximum penalties we recommend the repeal of Section 6.

Arrestable Offence

3.24 Whereas possession of Class A or Class B drugs constitutes an arrestable offence under section 24 of the Police and Criminal Evidence Act 1984 (PACE), possession of a Class C drug is not an arrestable offence. If cannabis is moved into category C, possession (but not supply) will automatically cease to be an arrestable offence unless other amendments are made to the law.

3.25 The main effect of possession not being an arrestable offence will be that when a person is searched under the powers of Section 23 of the MDA, a police officer will not be able to arrest him or take him back to the police station if he finds something he suspects to be cannabis. The police will have to fall back on section 25 of PACE, which gives a power of arrest where the name or address of a suspected offender cannot be readily ascertained or the officer has reasonable grounds to suspect that he has been given a false name or address. This provision would be very difficult to operate in the sort of circumstances which normally exist at street level, and impossible in circumstances such as a raid on premises containing a large number of suspects.

3.26 There are special difficulties in the case of drugs offences. Suspected substances have to be packed up and sent away for analysis (many existing Class C drugs resemble Class A or Class B drugs in appearance). It is desirable that an accused person should be present when items alleged to have been found on him are sealed in exhibit bags. There are always dangers that allegations of misconduct will be made against the police in relation to exhibits.

3.27 Officers have to make up their minds on the spot whether to arrest for supply, possession with intent or simple possession. If simple possession is not an arrestable offence there will be strong temptation to 'bump up' the charge.

3.28 Where a person is under arrest for an arrestable offence, the police have power, under s.18 of PACE, to search his premises for evidence relating to that or any other offence. When a person is arrested in the street with a small quantity of a drug that is prima facie evidence of simple possession, search of his premises may reveal the presence of larger quantities, or scales etc., proving that he is a supplier. He may also have quantities of other drugs. If cannabis were a Class C drug, this useful power would cease to be available where a person was searched in the street and found in possession of a small quantity of cannabis. A search warrant is unlikely to be as successful. The person who had been stopped would be likely to go home and dispose of the evidence.

3.29 The position in regard to cautioning is not clear. If a person had been searched in the street and allowed to go, there would seem to be no power to require him to attend at a police station to be cautioned if it was decided not to proceed against him. There would also be difficulties concerning proof of identity by means of fingerprints. Cautioning is not a satisfactory procedure unless the police can be certain of the identity of the person cautioned.

Recommendation

3.30 It seems to us that the law relating to possession of cannabis would be unenforceable unless it has the status of an arrestable offence. We are not aware of any problems caused by the fact that possession of Class C drugs is not at present an arrestable offence.

3.31 We accordingly recommend that Class C drugs other than cannabis and cannabis resin should be moved into a new class - Class D and that possession of cannabis and cannabis resin should be an arrestable offence. The penalties for Class C and Class D offences would be identical.

CHAPTER FOUR

COMMERCIAL AND SOCIAL SUPPLY OF DRUGS

Background

4.1 Offences connected with the importation, production, supply and possession with intent to supply of Class A drugs attract the highest maximum penalties known to the criminal law, including life imprisonment. The maximum penalty in the case of Class B drugs is 14 years imprisonment and in the case of Class C drugs 5 years' imprisonment. Cultivation of the cannabis plant attracts a maximum penalty of 14 years imprisonment. With the exception of cannabis cultivation, these offences are defined as drug trafficking. All convicted offenders must be investigated under the provisions of the Drug Trafficking Offences Act 1986. The offences are 'serious arrestable offences' for the purposes of PACE. It is clear that the various provisions creating and dealing with these offences are directed against drug traders and commercial suppliers.

Social Supply

4.2 We are concerned that these provisions are also used against those who supply drugs socially to friends and acquaintances or who grow cannabis for their own use. The courts have given the widest interpretation to the word 'supply'. It is held to mean the passing of possession from one person to another for the purpose of the transferee.[1] A person sent out by his flatmates to buy a supply of drugs for the evening 'supplies' the drugs when he returns and distributes the drugs. A person who returns drugs to a passenger who left them in his car 'supplies' them. It is probably a 'supply' to hand a reefer around a group of friends[2] . It was even held at first instance to be a 'supply' when a husband gave his wife lawfully prescribed drugs to hold whilst he went into a lavatory to inject himself, although this was reversed on appeal[3] .

[1] *R. v. Maggins* (1987) 85 Cr App R 127 HL.
[2] *R. v. Moore* (1979) Crim L R 789.
[3] *R. v. Dempsey and Dempsey* (1986) Crim L R 171.

4.3 It is our view that these interpretations of 'supply' all relate to social settings where there is no trafficking in drugs in the sense in which this term is normally used. The normal concomitants of drug use can put the user at risk of falling into the same category as commercial exploiters.

Supply for Gain

4.4 Our concern is that the existing interpretation of supply does not distinguish between supply in the course of social intercourse and supply as a business concern. This situation could be remedied by the creation of new offences of supplying drugs for gain and possession of drugs with intent to supply for gain. Since section 4(2) of the MDA is now normally used to prosecute people who grow cannabis plants, a similar provision will be required for the production of controlled drugs. The maximum penalties outlined above would then attach to the new provisions and lesser penalties would be provided for the existing provisions. We therefore propose that the MDA should be amended by the addition of a new section 5A in the following terms :

'5A. Where it is proved that an offence under subsection (2) or (3) of section 4 or subsection (3) of section 5 has been committed for gain, it shall be an aggravated offence and punishable accordingly'

Schedule 4 would then be amended to secure that the present penalties attach only to 'aggravated offences' and reduced penalties would be provided for simple offences. These should obviously be higher than those provided for simple possession.

Importers

4.5 Penalties for importing or exporting controlled drugs are provided in Schedule 1 of the Customs and Excise Management Act 1979 (the Customs Act) by way of modification of and increase in the usual penalties under the Act. These modifications should apply only where the import or export is proved to be for gain. If that element cannot be proved, the penalties available under the ordinary provisions of the Act should apply (this is normally a maximum of 7 years' imprisonment).

4.6 The words 'for gain' are already used in other legislation. For example:

- Section 17 of the Theft Act 1968 (relating to false accounting) and
- Section 21 (relating to blackmail)

Both use the wording 'with a view to gain for himself or another'.

4.7 Section 2 (1) of the Obscene Publications Act 1959 makes it an offence to have an obscene article for publication for gain (whether gain to oneself or gain to another).

4.8 The words 'for gain' would require some measure of definition. We propose that this should be ' 'gain' includes gain to oneself or another (not including the recipient) and shall extend to the obtaining of services'. In framing this definition we have in mind that drugs are not infrequently supplied in return for sexual services.

Recommendations

4.9 A new section 5A should be added to the MDA to allow a distinction to be made between drug trafficking and social supply.

4.10 We propose that gain should be defined as 'gain to oneself or another (not being the recipient) and shall extend to the obtaining of services.'.

4.11 Section 6 of the MDA should be repealed.

4.12 Schedule 1 of the Customs Act should apply only where importation or exportation 'for gain' is proved. In all other cases, the ordinary penalties provided for under the Act should apply.

CHAPTER FIVE

SECTION 28 of the THE MISUSE OF DRUGS ACT 1971 and CUSTOMS OFFENCES

Introduction

5.1 For the purposes of various provisions of the MDA, the Act makes plain that it is for the accused to discover for himself the nature of the substance which he has. He will not be liable if he neither believed, nor suspected, nor had any reason to suspect that the substance in question was a controlled drug (section 28(3)(b)(i)). By contrast, a mistake of fact as to the precise controlled drug possessed is no defence: see section 28 (3)(a).

5.2 Section 28 of the MDA provides as follows:-

'(1) This section applies to offences under any of the following provisions of this Act, that is to say section 4 (2) [production] and (3) [supplying], section 5(2) [possession] and (3) [possession with intent to supply], section 6(2) [cultivation of cannabis] and section 9 [opium smoking].

(2) Subject to subsection (3) below, in any proceedings for an offence to which this section applies it shall be a defence for the accused to prove that he neither knew of nor suspected nor had reason to suspect the existence of some fact alleged by the prosecution which it is necessary for the prosecution to prove if he is to be convicted of the offence charged.

(3) Where in any proceedings for an offence to which this section applies it is necessary, if the accused is to be convicted of the offence charged, for the prosecution to prove that some substance or product involved in the alleged offence was the controlled drug which the prosecution alleges it to have been, and it is proved that the substance or product in question was that controlled drug, the accused:-

(a) shall not be acquitted of the offence charged by reason only of proving that he neither knew nor suspected nor had reason to suspect that the substance or product in question was the particular controlled drug alleged; but

(b) shall be acquitted thereof-

(i) if he proves that he neither believed nor suspected nor had reason to suspect that the substance or product in question was a controlled drug; or

(ii) if he proves that he believed the substance or product in question to be a controlled drug, or a controlled drug of a description, such that, if it had in fact been that controlled drug or a controlled drug of that description, he would not at the material time have been committing any offence to which this section applies.

(4) Nothing in this section shall prejudice any defence which it is open to a person charged with an offence to which this section applies to raise apart from this section.'

5.3 Without section 28, each of the offences to which this section relates would be absolute offences: see *Warner* [1969] 2 AC 256. Section 28 was intended to ameliorate the harshness of the previous law. Nothing in section 28 was intended to alter established principles: the object was to create defences where none had existed previously: *Ashton-Rickhardt* [1978] 1 ALL E.R. 173.

Customs Offences

5.4 Section 3 of the MDA merely prohibits (with exceptions) the importation or exportation of controlled drugs. Section 3 does not itself create offences. The penalties for contravening section 3 appear in the Customs Act namely, improper importation (section 50): unlawful exportation (section 68); and fraudulent evasion of the restriction on importation or exportation of prohibited goods (section 170).

5.5 However, section 28 of the MDA does not apply to section 3 of that Act and accordingly, section 28 cannot apply to 'customs offences'.

5.6 The reason why there is no corresponding provision applied to sections 50, 68 and 170 of the Customs Act must be that Parliament considered it unnecessary: the difficulty lies in understanding why Parliament took that view. The basic explanation favoured by many lawyers is that Parliament was satisfied that existing case law already governed the position and therefore statutory intervention was not required.

The Existing Case Law

5.7 In *R v Hussain* (1969) 53 Crim.App.R. 448 the Court of Appeal held that it is essential that the accused should know that the imported goods are subject to a prohibition on importation, but:

> '...it is not necessary he should know the precise category of the goods the importation of which has been prohibited'.

5.8 *Hussain* has been held to have been correctly decided in a number of subsequent cases. In *Hennessey* (1978) 68 Cr.App.R. 419. Lawton L.J., giving the judgement of the court, said:

> 'It matters not for the purpose of conviction what the goods were as long as he knew that he was bringing into the United Kingdom goods which he should not have been bringing in'.

5.9 The House of Lords reviewed these decisions in *Shivpuri* [1986] 2 WLR 988. Lord Bridge traced the history of the legislation, with particular reference to section 28, pointing out that Parliament overcame the 'almost insurmountable difficulty ...of proving the appropriate guilty knowledge ...' for the purposes of offences under that Act by placing the burden of proving a lack of knowledge on the accused. Lord Bridge wondered (page 996F) why section 28 did not apply to section 3(1) and concluded that *Hussain* made such a provision unnecessary for the following reasons:-

> 'Irrespective of the different penalties attached to offences in connection with the importation of different categories of prohibited goods *Hussain* established that the only mens rea necessary for any such offence was knowledge that the goods were subject to a prohibition on importation'.

He added:-

> 'Had [*Hussain*] been decided otherwise...it is surely inconceivable that Parliament, in the 1971 Act, would not have made provision...such as...section 28(3) applicable to drug-related offences connected with importation'.

5.10 However, this observation is not, with respect, a complete answer because, by section 28(3) of the MDA, it is a defence for the accused to prove that he did not believe or suspect or have reason to suspect that the substance was a controlled drug at all. This is very different from the effect of *Hussain* and *Hennessey*, which affords a defendant charged with customs offences no such defence in these circumstances.

The Practice

5.11 In practice, where drugs have been imported by an accused, the charges he may face will often depend on whether it is the police or the Customs and Excise who are dealing with the matter. The Commissioners of Customs and Excise tend to prosecute offences committed under the Customs Act, while the police tend to bring charges under the MDA. Accordingly, an importer of cannabis who establishes that he was misled into believing that the substance was pornography will have a defence to a charge of possession with intent to supply (s.5(3) MDA) by virtue of s.28, but he will have no defence if he is charged with an offence under s.170 of the Customs Act.

5.12 On the question of sentence, a defendant is entitled to be sentenced on the basis of what is proved. This objective can be achieved only if charges accurately establish the nature (and preferably the extent) of a defendant's involvement. The effect of *Hussain* and *Hennessey* derogates from this principle. For example, is the court to sentence a defendant on the basis that he imported, say, pornography (see *Hennessey*) or that he knowingly imported heroin (maximum sentence life imprisonment)? Much greater clarification of the issues would be attained by the application of section 28 to section 3 of the MDA. It would still be no defence however, to a charge of importing heroin (a Class A drug) to establish a belief that the drug was cannabis (a Class B drug).

Recommendation

5.13 Was it Parliament's intention to place a particularly heavy burden on those who intend to smuggle prohibited goods, i.e. a duty to investigate the nature of the goods to be smuggled and thus to penalise those who fail to do so? Should section 28 be open to smugglers at all or would such an extension merely encourage potential smugglers to 'work out a 'section 28 story' in advance and to 'give it a go'?

5.14 Clearly the prosecution would be put in immense difficulty if they had to prove in every case that the accused knew that the goods imported were subject to a particular prohibition. However, the law should strive to be consistent and even-handed. To this end, there can be nothing wrong in principle in imposing a presumption of knowledge on the accused and to shift the burden on to him to prove (on a balance of probabilities) that he neither believed, suspected nor had reason to suspect that the goods he was importing were the goods alleged eg. controlled drugs. In other words, the solution is to direct that section 28 of the MDA applies to drug-related importations and exportations and we so recommend.

Alternative Counts

5.15 When a defendant claims that he believed that he was importing not drugs but some other contraband, the prosecution can lay an alternative count of attempting to import that contraband. The jury can then choose between the prosecution and the defence case. If the defence is only revealed during the trial an application can be made to add an appropriate count. If this is refused and the defendant gives evidence that he believed he was importing contraband other than drugs and he is acquitted, then he can be re-arrested and charged on the basis of his confession in open court.

CHAPTER SIX

SECTION 28 of the MISUSE OF DRUGS ACT 1971 and CONSPIRACY AND ATTEMPT

Introduction

6.1 Section 28(1) of the MDA is exclusive. It does not include conspiracy or attempting to commit a specified offence. This is probably because conspiracy and attempt both require a specific intention. It can produce inconsistencies where an indictment includes counts of substantive offences and of conspiracy or attempt; the jury will then have to be given different directions on knowledge. On a trial for conspiracy to supply cannabis it would be a defence for a conspirator to prove that he thought the substance was cocaine although that would be no defence to a charge of supply or possession with *intent* to supply cannabis.

Recommendation

6.2 We cannot see that a defendant would suffer any injustice if section 28 was extended to conspiracy and attempts to commit the specified offences. It would remove possible anomalies and we recommend accordingly.

CHAPTER SEVEN

SECTION 8 of the MISUSE OF DRUGS ACT 1971
LIABILITY OF OCCUPIERS

Introduction

7.1 Section 8 of the MDA makes it an offence for the occupier or a person concerned in the management of premises knowingly to permit anyone:

(a) to produce, or attempt to produce a controlled drug;
(b) to supply or attempt to supply a controlled drug to another in contraventon of section 4(1) of the Act, or offer to supply a controlled drug to another in contravention of section 4(1);
(c) to prepare opium for smoking;
(d) to smoke cannabis, cannabis resin or prepared opium.

Discussion

7.2 Paragraphs (a) and (b) in section 8 apply to all controlled drugs but paragraphs (c) and (d) apply only to specified drugs. The original target of paragraph (c) was the opium den, although it is doubtful if this has any relevance at the present day.

7.3 While we see no grounds to change the effect of paragraphs (a) to (c), there seems to be no logical reason why paragraph (d) should not apply to all controlled drugs.

7.4 Under the present law, a spouse or joint occupier may be guilty in respect of the other's offence, or parents in respect of their children. It is unrealistic to expect any of these to be in a position to exert control over other adults to the degree required. Moreover, it may be thought preferable to permit drug use at home in preference to its use in the street or other unsatisfactory settings.

7.5 In the past, many drug services provided hygienic settings where drug users could consume their drugs. More recently, drug services have developed needle and syringe exchange schemes and have sought to teach drug users safer techniques, including safer methods of injecting. To create a criminal offence which might deprive potential users of these services would seem to contradict the role of the criminal law which we have suggested earlier.

7.6 We have considered a number of possibilities to allow an extension of the offence set out in paragraph (d) of Section 8 to all controlled drugs without giving rise to the difficulties outlined above.

Recommendations

7.7 We think Section 8 of the MDA should be amended by the repeal of paragraph (d) and the renumbering of the section as 8(1).

7.8 New subsections (2) (3) and (4) should be inserted as follows:

'(2) A person commits an offence if, being the occupier (lawful or otherwise) or concerned in the management of any premises, he knowingly and for gain permits the premises to be used for the ingesting of any controlled drug.

(3) Subsection (2) shall not apply when the controlled drug is lawfully in the possession of the person who uses it or where the drug is administered in the course of medical treatment.

(4) The words 'for gain' include gain to the offender or to another and extend to the obtaining of services.'

7.9 The courts have experienced difficulties in applying the word 'premises' to actual situations. It is not defined in the Act. Particular difficulties arise in connection with structures which are not necessarily fixed to the ground. For example, a cruiser on the Thames might be considered premises if it is connected to services on the shore but not premises while moving up or down the river. This difficulty could be remedied by incorporating the definition from section 23 of PACE as subsection '(5)'. This is in the following terms : 'premises' includes any place and, in particular, includes -

(a) any vehicle, vessel, aircraft or hovercraft;
(b) any offshore installation; and
(c) any tent or movable structure; and

'offshore installation' has the meaning given to it by section 1 of the Mineral Workings (Offshore Installations) Act 1971.'

CHAPTER EIGHT

SECTION 20 of the MISUSE OF DRUGS ACT 1971 ASSISTING IN COMMISSION OF OFFENCES ABROAD and SECTION 5(3) - POSSESSION WITH INTENT TO SUPPLY

Discussion

8.1 Section 20 of the MDA should enable the United Kingdom to carry out its obligations under the various conventions. At present it does not bite if no-one gets so far as to commit an offence outside the United Kingdom. If people conspire in the United Kingdom to commit an offence abroad their actions are caught only if (a) conspiracy is an offence in that country and (b) the conspiracy is one existing in that country as well as in the United Kingdom. If, for example, the police arrest persons in the United Kingdom who have collected together the necessary apparatus to manufacture a controlled drug in another country but have got no further, it is probable that they cannot be prosecuted. Section 5(3) does not apply if the defendant can establish that his intent is to supply to persons outside the jurisdiction.

Recommendation

8.2 We recommend that Section 20 should extend to an offer or attempt and to a conspiracy to commit an offence abroad. Section 5(3) should be amended by the addition of the words 'whether within or outside the United Kingdom' after the words 'to another'.

CHAPTER NINE

DRUG USERS AT THE POLICE STATION

Introduction

9.1 The questioning of people intoxicated by or dependent on drugs raises particular difficulties. In the case of intoxication it may require a delay in police questioning. Responses to questions whilst intoxicated could be unreliable. In the case of dependence, the suspect may experience withdrawal symptoms whilst detained at the police station. The discomfort of withdrawal may cause the drug user to respond to questioning in a way which is most likely to secure an early release or to his receiving treatment.

Codes of Practice

9.2 The Codes of Practice associated with PACE do not specifically deal with the proper course to be taken when a drug user is to be questioned. C9.2 requires the custody officer to call a police surgeon 'if a person in custody appears to be suffering from a physical or mental illness or otherwise appears to need medical attention.'. C9.4 entitles a detained person to request a police surgeon or a practitioner of his choice. C12.3 deals only with a detained person who is unfit through drink or drugs to the extent that he cannot appreciate the significance of questions. C13.1 deals with persons, inter alia, who are mentally ill. Neither of the last two provisions applies to the motivation constituted by increasing symptoms of withdrawal.

The notes for guidance contain the following paragraphs :

'9B It is important to remember that a person who appears to be drunk or behaving abnormally may be suffering from illness or the effects of drugs or may have sustained injury (particularly head injury) which is not apparent, and that someone needing or addicted to certain drugs may experience harmful effects within a short time of being deprived of their supply. Police should therefore always call the police surgeon when in any doubt, and act with all due speed.'

'12B The police surgeon can give advice about whether or not a person is fit to be interviewed in accordance with paragraph 12.3 above."

Treatment

9.3 Under the Codes of Practice, if someone detained at a police station shows signs of being ill or complains of withdrawal symptoms a police surgeon, or more rarely his own doctor, will be called. While many police surgeons are used to dealing with drug users, some are relatively inexperienced in this field. In consequence, mis- diagnosis may occur, along with inappropriate prescribing.

9.4 The police surgeon may conclude that a prescription is necessary to control withdrawal symptoms. He is then likely to prescribe mild symptomatic medication. The doctor will then either certify that the suspect is fit to be detained or will refer him to a hospital.

9.5 The Metropolitan Police Force has introduced a new form in its area. This has provision for the doctor to certify that the suspect is fit to be questioned or that he will be fit to be questioned after a specified time lapse. Appropriate entries are made in the custody record.

9.6 It is desirable that a detained person who is dependent on drugs should be supplied with appropriate medication before being questioned. Some have argued that if any medication is required, then the suspect should not be questioned. In our view this is a mistaken position as it confuses dependence with intoxication. A person may be intoxicated without being dependent or dependent without being intoxicated. In the former instance, medical supervision may be necessary along with time for the intoxication to pass. In the latter case, medical treatment will be required which will permit the suspect to achieve a stable state and be fit for questioning.

9.7 We consider that this subject requires urgent attention. At present, without clear guidance, trials within trials are required consuming many hours and the time of scarce expert witnesses to determine the admissibility of evidence. In less important trials the judge is required to make a decision without proper instruction on the scientific issues in question. This does not serve the interest of justice and may be detrimental to the defence or the prosecution.

Training for Police Surgeons

9.8 In our experience, police surgeons are not always adequately informed or trained in the management of drug problems. Although training programmes have now been introduced in the Metropolitan Police area, in Manchester and in Cardiff and the Association of Chief Police Officers has set up a training programme for new police surgeons, this is still a limited response to a pressing problem.

9.9 The Association of Police Surgeons of Great Britain and Northern Ireland has acknowledged the need for training in the recognition and management of drug problems. We understand that the Association is taking steps to ensure that all police surgeons have the requisite knowledge. We would urge that training for all police surgeons, both new and those already in post, should be introduced at the earliest possible date. It would be advantageous if the contents of the training programme were discussed with the Royal College of Psychiatrists.

9.10 In the meantime we recommend that the Association should circulate to its members a copy of the Guidelines of Good Clinical Practice in the Treatment of Drug Misuse, published by the Department of Health, a check list on the properties of the various controlled drugs, the symptoms of drug abuse and withdrawals, together with approved methods of treatment.

De-toxification Centres

9.11 In areas where there is a substantial drug dependent population, it is likely that a significant number of people detained for questioning will experience withdrawal symptoms. In such circumstances, it would be beneficial if these suspects were transferred to a police station equipped to manage withdrawal. A police surgeon trained in the management of drug problems would supervise treatment and certify when a suspect was fit to be questioned. If numbers justified it, a trained nurse could be in full time attendance at the police station and could make a preliminary assessment of the treatment needs of the suspect. In such a centre it would be easier to make a proper assessment of a person's fitness for interview.

Recommendation

9.12 Paragraph C12 of the Codes of Practice should be amended to include specific reference to the interviewing of suspects under the influence of, or withdrawing from, a drug. This should be to the effect that when a detained person appears to be under the influence of, or withdrawing from, a drug, he may not be interviewed, or further interviewed, unless he has been examined by a doctor who has certified that he is fit to be interviewed.

CHAPTER TEN

DRUG USERS AT THE INTERSECTION OF TREATMENT AND THE LAW

Introduction

10.1 The problems of drug users vary according to the type of drug taken, the pattern of drug taking and history of drug use, and also the personality and situation of the individual. Whether an individual seeks help or not is dependent on the extent to which he perceives his drug use as causing problems in his life.

10.2 Apprehension for unlawful possession of any controlled drug will have legal consequences for the possessor. However, cannabis users rarely perceive themselves as having a drug problem, stimulant users more often seek help, but heroin users represent the majority of those attending at services providing help. Thus the pattern is a skewed reflection of the pattern of drug use in any community and does not reflect the pattern of arrests for drug offences in the same community.

10.3 The diversity of problems presented to drug services indicates that no single approach is possible. With different clients there will be a need to develop different goals and to use different approaches adapted to the individual. Nevertheless, for most drug problems there are recognised stages in the helping process.

Initial Assessment

10.4 A drug user attending a drug service will be assessed in order to identify his specific problems, needs and treatment goals. The assessment may involve several staff from different disciplines and in many cases more than one service may be involved. For instance, a community drugs service may wish to involve a general practitioner or a hospital-based treatment service. Where a court case is pending, it may involve the probation service. Although withdrawal from drugs, prolonged abstinence and the development of a healthy life style are the ultimate goals, assessment is a process of identifying what, if any, intermediate goals are necessary to assist the individual reach this ultimate goal. It is important

that the drug user himself is involved in the assessment in order that he is committed to the objectives of his treatment and can be actively engaged in the treatment programme.

Treatment

10.5 Following initial assessment, the agreed treatment programme may involve in- or out-patient detoxification, followed by support through recovery or a period of residence in a drug-free rehabilitation house. Alternatively, it may involve more limited goals, such as breaking from drug injecting, containing and controlling drug consumption and the like. A variety of medications may be prescribed over fixed periods of time in order to achieve some stability before attacking the next goal. Many drug services offer long term substitute drug prescriptions for carefully selected clients as a means of engaging them in treatment, maintaining health and with the aim of persuading the drug user towards abstinence.

10.6 Withdrawal from drugs of dependence may require medical supervision. This may be in an in-patient setting, although this is relatively uncommon and is usually reserved only for the most difficult cases. The majority of withdrawals are handled in the community by general practitioners, often supported by a local community-based specialist drug service. A significant number of drug users are withdrawn as out-patients attending hospital- based drug treatment centres. Out-patient withdrawal generally involves appropriate prescribing, with counselling and support, extending over a period of several weeks.

10.7 Substitute drug prescribing is often used as an intermediate goal to allow time to deal with other personal and social problems which can militate against achieving abstinence. These may include health problems, housing problems, relationship problems, etc. For many drug users, there is no physical dependence. There may be psychological dependence or there may be problems associated with persistent and inappropriate drug use. Advice, counselling and support provided by community based drug services play an important role in working with drug users either in conjunction with hospital drug treatment centres or with other generic community services. Many provide advice on safer drug use, strategies for limiting harm and moving away from the most dangerous drug-using practices, and links with a wide range of other services.

Recovery and Rehabilitation

10.8 Giving up drugs involves more than just stopping drug use; it involves giving up a way of life. Although supervised withdrawal is rarely difficult, without adequate post-withdrawal support a significant majority relapse into drug use.

10.9 The nature of the support needed is dependent to a large extent on the reasons for drug use and the learning of strategies to avoid relapse. It may be provided in day or residential settings. Some rehabilitation houses offer intensive support over a period of months.

10.10 Many rehabilitation houses operate on the basis of self-help with residents giving mutual support and undertaking the day-to-day maintenance and management of the house. Staff supervise the operation of the rehabilitation programme and the administration of the organisation. It is common for a number of the staff to be former residents, thus providing a positive role model of successful rehabilitation to the residents. It is not uncommon for residents in these houses to be under probation supervision either as part of a community sentence or under parole licence. Few houses will accept residents on a direct court order but accept them on the basis of residing as directed by a probation officer.

10.11 Community support is provided by both specialist drug services utilising other specialist services in education, work training, social skills and the like and by self-help groups, of which the most prominent is Narcotics Anonymous. This latter group is now well established and provides a 'buddy' system of personal support along with group meetings and activities which offer an alternative drug and alcohol-free social setting for former drug users. It now operates groups with the probation service and in many prisons.

Treatment Outcomes

10.12 There is a generally pessimistic and unfounded view that treatment is ineffective. This appears to be based on a misunderstanding of the nature of drug problems and unrealistic expectations that the sole goal of treatment should be abstinence.

10.13 Compulsive drug use, by its very nature, is a relapsing condition. Long term success may not follow a single and first intervention. It is for this very reason that intermediate goals have been adopted to achieve sustained change over time.

10.14 Nevertheless, over the course of an individual's contact with a helping agency, the majority will be helped towards a more healthy, stable and ultimately abstinent lifestyle. A study has demonstrated that six months after in-patient treatment for opiate dependence, 50% of patients are abstinent, and that a total of 68% fall into a good outcome category. [1]

[1] Ref: Gossop M. (1988) 'Addiction and After' *British Journal of Psychiatry* 152, 307 - 309

Studies of behaviour change, linked to intermediate treatment goals, have also shown that intervention has been effective in reducing both individual and social harm.

Law Enforcement Agencies

10.15 When drug users come into contact with law enforcement agencies, opportunities occur to introduce them to agencies for advice, counselling and possible referral to a wide range of drug specialist or other services. Such contacts may occur informally in the course of talks about drugs given by police officers or more formally when a person has been arrested for a drugs offence. Increasingly the police caution minor offenders rather than charging them. This is a practice we would encourage in appropriate cases, regardless of the class of drug involved. Opportunities for referral also occur at the court stage of a drug or drug-related prosecution.

Pre-trial

10.16 Here the method is to make use of drug referral schemes. Two early British schemes were set up by the Merseyside Police and Mersey Regional Drug Training and Information Unit and by the police in Southwark, south London, Southwark Council Drug Misuse Unit and the Standing Conference on Drug Abuse (SCODA). They provide a means for the drug user to seek independent and confidential advice by telephone or by personal contact with a specialist drugs worker. The Institute for the Study of Drug Dependence (ISDD), which had initiated a family referral scheme for juveniles arrested for a drug related offence, wrote in autumn 1989 to all Chief Constables suggesting that every force might like to consider operating a drug referral scheme. This suggestion has been taken up by an increasing number of police forces.

10.17 The schemes vary in the details of their aims and methods. The common element is that a referral is made by giving a card with the address and telephone number of a specialist service. Referral cards can be given out in any of the following circumstances:

(i) when a police officer is talking about treatment facilities to groups of people or to an individual;
(ii) at cautioning or pre-trial stages, when a drug user has been arrested and whilst a decision is being taken on how to proceed;
(iii) at the sentencing stage.

10.18 The original schemes in Merseyside and Southwark are being monitored. ISDD, the Association of Chief Police Officers and Ruskin College (Oxford), along with other agencies and individuals, are monitoring the progress of the other drug referral schemes.

Court Stage

10.19 Probation officers already have a high degree of awareness of drug problems. They may initiate an interview with a defendant pleading guilty prior to any court request for a Social Enquiry Report. This can, on occasion, be followed by assessment at a specialist drug service providing an opportunity for appropriate recommendations on disposal of the offender to be made to the court. Proposals in the Criminal Justice Bill are for the courts to give reasons for a sentence of imprisonment and for the production of Social Enquiry Reports to national standards. These emphasise the need for adequate arrangements to be established for assessing drug users and sentencing which meets the objectives we have proposed at 2.14.

10.20 SCODA has proposed that a drugs worker should be attached to magistrates courts to work alongside the services offered to offenders by the probation service.

The court (before or after conviction), probation officers, the police and defence solicitors would all be able to refer an offender to the drugs worker for assessment. Such an appointment might be on a full time basis for a group of courts or on an agency basis where such an appointment could not be justified.

10.21 The drugs worker would be responsible for assessing the needs of the drug user, preparing a treatment plan and presenting his findings to the court.

A finding of not guilty would allow the drug user to take up the plan on a voluntary basis. A finding of guilty would provide the court with a realistic non-custodial disposal. Where a prison sentence was imposed, the plan could accompany the drug user to prison to be implemented or further adapted as appropriate. Funds have now been secured to initiate a pilot court referral scheme.

Enquiries initiated by Defence Solicitors

10.22 Defence solicitors already initiate assessments of their clients by hospital and/or community based drug services. Legal aid can be extended to pay for assessment of clients and the preparation of reports. This has most commonly been used for psychiatric assessment although there is no reason why it should not be used more widely. This is especially so when the majority of drug services are community based and do not involve the presence of a psychiatrist. The wider use of expert assessments and reports would provide a second opinion and offer assistance to the probation service in considering its recommendation to the courts, and to the courts themselves in determining the appropriate sentence.

10.23 Disposals by the courts with the expectation of immediate abstention are destined to fail. It is important for sentencers to appreciate that qualified success towards abstinence may be a major success for the compulsive drug user. Reduction in drug use, or a period of abstinence, or a stable lifestyle may represent a success on behalf of a drug user. It will be the result of a very great effort by him and his helpers. These steps in themselves will lead to a reduction in criminal behaviour.

10.24 It is generally agreed within specialist drug services and the probation service that compulsory treatment has little prospect of success. Most agencies would be unwilling to undertake it. This is not to say that the imminent prospect of an unpleasant event, such as the prospect of a prison sentence, may not help to supply a motivating force. There can be no objection to a defendant being asked if he is willing to undergo a course of treatment in the same way as defendants must consent to a probation or community service order. However, if that treatment is specifically defined by the court, it is of a different nature to these latter two. They are general orders which do not specify what the supervision should involve or what service should be undertaken. On the same basis, any order should aim to direct the drug-using offender to undertake treatment for his drug problem as directed by the probation officer, not specify a particular form of treatment.

The Sentencing Stage

10.25 The first essential for a court sentencing a drug offender, whether convicted of a drug offence or of some other offence related to his abuse of drugs, is sufficient information. For this it relies on the Probation Service supplemented on an ad hoc basis by drug dependence treatment units and voluntary agencies. The appointment of a drugs worker would obviously be helpful not only to the magistrates' courts but to Crown Courts as well.

The second essential is adequate sentencing options to secure the maximum prospect of reducing future offending by appropriate treatment of the offender's dependence.

These options are :

(a) **Suspended sentences, probation orders and community service orders**
(b) **Imprisonment**

10.26 The Government proposes to extend the range of options for punishment in the community and to clarify the powers available to make treatment a requirement of a probation order. At present this is limited to treatment by a named psychiatrist or residence in a named hostel. It is intended to extend the power to include a wider range of treatment options.

We consider that the imposition of treatment, for the reasons stated above, will be unsatisfactory and believe that such a new power should only be used as a last resort. The defendant will be required to consent to such a treatment order, but the order should not be imposed with the implicit assumption that refusal will result in a prison sentence. This would not serve the interests of justice, nor would it provide an effective means of reducing offences and affecting drug-using behaviour. We would not wish the usefulness of the present range of non-custodial penalties to be overlooked. In many cases these would continue to be used without any condition of treatment.

10.27 It is desirable that steps should be taken to acquaint the judiciary and the magistracy about the nature of drug use and the intervention options which are available. We would wish to draw the attention of the Judicial Studies Board to this subject. It is in the best position to inform the judiciary of the current state of expert knowledge and of new developments through its courses and through the Bulletin of Judicial Studies. One day courses could be devised both for the judiciary and the magistracy.

Imprisonment

10.28 It is likely that, even with the changes proposed to reduce the number of non-violent offenders sentenced to imprisonment, a significant number of drug users will be imprisoned. Such a setting can no longer be assumed to provide a drug-free environment. Nor can a period of imprisonment, without any additional help, be assumed to have solved the pre-existing drug problem. The provision of help for drug users in prison is relatively scarce, although there has been an increase in specialist input. The prison probation service and specialist drug services have increasingly become involved in work with drug-using prisoners. This is a welcome development and should be actively encouraged. The establishment of a working group to develop guidelines for work with drug- using offenders by the Director of the Prison Medical Service is welcome, as is the proposal from the Royal College of Physicians to develop a Diploma in Prison Medicine. We would hope that the Royal College of Psychiatrists would be actively involved in the development of the curriculum for this diploma.

10.29 Preparation for release from prison is of equal importance. The Prison Medical Service and the Probation Service have an agreement on throughcare for drug-using offenders, and this has been of some assistance. The increasing presence of specialist drug services and self-help groups in work with drug-using offenders will more readily allow throughcare arrangements to be implemented effectively.

10.30 The Parole Board at present inserts an additional clause to the standard parole licence conditions requiring the person paroled to undertake treatment for his drug problem as directed by the supervising probation officer. This is a useful condition which allows a flexible treatment approach to be adopted which is appropriate to the circumstances of the individual. Under the new arrangements for release proposed in the Criminal Justice Bill, it may be helpful to have such a general condition attached for the period of statutory after-care.

Conclusions

11.1 It is likely that drug users will continue to offend against drugs legislation or against other legislation when they seek to finance their drug use. The criminal law has an important but limited role in limiting the likelihood of drug use and of reducing the harm to the individual and society arising from drug use.

11.2 The proposals which we have made for amendments to the current legislation are designed to support a common objective. They should allow those responsible for enforcement to focus on the most harmful activities arising from the misuse of drugs. Disposal of offenders should be in line with the objectives we have described and with the broad strategy against drug abuse adopted by the Government.

11.3 At various points in their contact with the criminal justice system, there is the opportunity to intervene. This section of our report has reviewed a number of these opportunities and we recommend that those with responsibility for the various stages of the application of the criminal law should utilise these opportunities fully.

APPENDIX I
DRUG USE, CRIME AND COMPULSORY TREATMENT -
A discussion document by Dr Andrew Johns
Senior Lecturer in psychiatry of addictive behaviour
St. George's Hospital Medical School

CONTENTS
Section 1 - Current Psychiatric Views on the Nature of Drug Use.
Section 2 - Current Treatment and its Outcome.
Section 3 - The Relationship Between Drug Use and Crime.
Section 4 - Present Legal Provisions for the Treatment of Drug-Using Offenders.
Section 5 - Diversion from the Criminal Justice system.
Section 6 - A Review of Relevant Legislation in other Countries.

SECTION 1 - CURRENT PSYCHIATRIC VIEWS ON THE NATURE OF DRUG USE.

Behaviour associated with the use of drugs ranges from occasional and recreational consumption to severe dependence with frequent use. Though some drugs have a greater potential for dependence than others, no drug is 'instantly addictive' as has been claimed for cocaine and crack cocaine. The likelihood of dependence arising depends not only on the biological effects of the drug, but also on the personal make-up, experiences and life-situation of the individual and the society or culture to which he relates.

'Dependence' on drugs is not easy to define but has these components - physical adaptation as shown by the ability to tolerate increased doses of a drug and a characteristic withdrawl state with cessation of use, psychological craving for the drug, which may be reawakened even after prolonged abstinence, all occurring in a social context which influences the availability of the drug and its pattern of use.

In all of these behaviours drug taking is regarded as a voluntary act and its cessation as equally so. To give an example, addiction to opiates or cocaine may be severe and yet at any time the individual retains the choice of stopping his drug use with or without the help of treatment. Indeed it is very likely that the majority of drug and alcohol dependent persons give up their habit voluntarily, that is after some internal decision to change. There is no evidence that in the majority of drug-users, compulsion improves motivation for change, or the outcome.

SECTION 2 - CURRENT TREATMENT OF DRUG-USE AND ITS OUTCOME

The very diversity of those using drugs indicates that there is no single approach to treatment. Treatment interventions for various clients may have differing goals, and be applied in differing settings by a variety of means. Nevertheless, for most drugs of dependence there are recognised states of treatment.

(i) An initial process of engagement assessment followed by detoxification or withdrawal. Detoxification from opiates, benzodiazepines, barbiturates, and alcohol often require supervision in a medical setting if they are to be successful. This need not be an inpatient unit though this is often necessary for the more difficult cases. By far the majority of withdrawals from drugs of dependence are handled in the community by non-specialist medical practitioners - however a significant number of drug users are withdrawn as outpatients in the drug dependency clinics. Detoxification generally involves appropriate prescribing with counselling and support, extending over a period of some weeks.

(ii) Recovery and rehabilitation. Giving up a drug involves more than just stopping the drug itself; it involves giving up a habit, and habits are not easily changed. Although supervised withdrawal from drugs is often not problematic, without adequate provision of recovery and rehabilitative care, then a significant majority relapse. This care involves detailed consideration of reasons for drug use together with learning methods of avoiding relapse. This may be carried out in an outpatient or a residential setting - some rehabilitative hostels offer intensive care over a period of many months. A wide range of non-statutory and voluntary organisations play an important role in treatment. Chief among these are the non-profit making rehabilitation houses such as 'Phoenix', 'Clouds', 'Alpha House' and also support organisations such as Narcotics Anonymous. Although withdrawal from drugs, prolonged abstinence and the development of a healthy life-style are often the main goal of treatment, intermediary steps are often necessary. To this end a variety of medications may be prescribed over fixed periods in order to achieve some stability before negotiating the next goal. Many drug units offer a form of long term or maintenance prescribing for carefully selected clients, as a means of engaging them in treatment, maintaining health, but generally with the aim of 'nudging' the drug user towards abstinence.

There is a generally pessimistic and unfounded view about the value of treatment. It should be borne in mind that addictions are of their nature relapsing conditions and that long term success may not follow the single and first intervention. Nevertheless, over the course of an individuals contact with a treatment agency, the majority of individuals may be helped towards a more healthy, stable and abstinent life-style. Studies have demonstrated abstinence rates varying from 45% abstinent 6 months after inpatient treatment (Gossop 1989) to higher figures in more recent but unpublished work.

It must nevertheless be acknowledged that the treatment of drug users is an uncertain business and it is very difficult to predict the outcome with any individual. It follows from this, and given that the majority of drug users show high rates of criminality before their first drug use, that it is unrealistic to expect that engagement in treatment will lead to a reduction in criminality. It is frequently claimed that prescribing drugs for opiate users will lead to reduced frequency of criminal behaviour, but this has not been demonstrated in this country.

SECTION 3 - THE RELATIONSHIP BETWEEN DRUG USE AND CRIME

A simple classification of the relationship between criminality and drug use is as follows:

(i) Offences committed against the various Acts established to control the possession, distribution and consumption of drugs. These are mainly the Pharmacy Act 1933, The Medicines Act 1968 and the Misuse of Drugs Act 1971 and subsequent legislation. Offences under the MDA 1971 include unlawful possession, possession with intent to supply, and others. In 1989 there were 35,635 convictions or cautions for drug offences, most of which related to possession (Home Office 1991). Over 80% of all drug offences concern cannabis.

(ii) Offences committed in order to obtain drugs. These largely comprise acquisitive crimes, such as burglary or shoplifting and also breaking and entering and stealing from premises where drugs are to be found. The real rate of acquisitive crime related to drug use is hard to determine, because the purposes for which these offences are carried out is not recorded in the criminal statistics. Nevertheless, a study conducted in an area of high prevalence of drug use, found that 50% of a sample of young adults convicted of domestic burglaries were also known heroin uses. (Parker & Newcombe 1987).

(iii) Offences carried out in an abnormal mental state due to drug intoxication or less commonly, withdrawal. These include motoring offences, assault and cases of serious violence or damage to property.

Although many studies have demonstrated a high rate of offending among drug users, the relationship between drug use and crime is very complex. A study of Liverpool drug users showed that only a quarter had no criminal convictions. Of the 75% with convictions, 3/4 of these received their convictions before the onset of dependence. (Fazey 1988) While these figures may be taken as suggesting that a minority of drug users become criminalised solely because of their drug use, Hammersley (1989) found that for the majority of users of drugs of all types, criminal behaviour and drug use tended to influence each other. For example, an opioid user may commit a crime to buy drugs, which if successful could yield enough money to buy a greatly increased quantity of drugs and so lead to greater opioid use.

SECTION 4 - THE PRESENT LEGAL POSITION FOR THE TREATMENT OF DRUG USERS.

The Mental Health Act 1983 specifically excludes from its provisions those who show 'dependence on alcohol or drugs'. This has the effect of not allowing compulsory detention for the treatment of dependence on alcohol or drugs alone. Should however, the use of alcohol or drugs lead to such an abnormal mental state (such as that which may be found in some states of intoxication or withdrawal) that the person is a danger to self or to others, then the Mental Health Act may be applied. In practice this is rarely done as these mental states are generally short-lived and other interventions become possible.

The Courts have powers to postpone sentences, to discharge, to make a probation order with or without an attached condition, or in more serious cases to pass a suspended sentence of imprisonment. In 1989 the methods of disposal of those found guilty, cautioned or dealt with by compounding for drugs offences were as follows: cautioned 36%, fine 62%, imprisonment 16%, suspended imprisonment 5%, absolute or conditional discharge 8%, probation or supervision 5%, community service order 3%.

SECTION 5 - DIVERSIONARY SCHEMES

There is the widespread belief that drug using offenders need help and that they should be diverted 'from the criminal justice system'. The word diversion is also used in a very different sense in the context of proposals to reduce the prison population by an increased use of noncustodial alternatives.

Diversion from the criminal justice system has recently been achieved by an increased use of cautioning powers by police forces with regard to simple possession for cannabis and in some areas for possession of small amounts of heroin intended for personal use. This is clearly a pragmatic response by local police authorities which allows them to direct scarce resources to better effect.

The diversion of drug using offenders from custody has received further support from the Home Office Green Paper "Punishment, Custody and the Community", (Home Office 1988).

This states:-

> 'the programme for the offender could also include regular attendance at work, education or training and treatment for misuse of alcohol or drugs... Although more co-ordinated and intensified effort is being put into the care of drug misusers that go to prison, the chances of dealing effectively with the drug problem are much greater if the offender can remain in the community and undertakes to co-operate in a sensibly planned programme to help him or her to come off drugs'.
>
> 'Such a programme would aim in the first instance to secure a transition from a legal consumption to a medically supervised regime designed to reduce the harm caused to the individual by drug taking and would be based on a realistic plan for tackling the addiction in the context of his or her other problems. Monitoring by urine tests by the agency providing the treatment could be part of the regime'.

These proposals have been welcomed by the Advisory Council on the Misuse of Drugs ("ACMD") as a valuable measure for preventing the spread of HIV infection within prisons and enabling such individuals to receive the medical and other care that they require. The Advisory Council continues ...

> '...however even before any legislative changes are made, sentencers should be encouraged to make the most of existing noncustodial sentences for drug misusers'. '...many drug agencies have been reluctant in the past to accept clients under Court Orders. A change in attitude is needed so that services are willing to adopt an alternative-to-custody role'. (ACMD 1989)

Although proposals to divert drug using offenders from custody as suggested by the Home Office received broad endorsement from the ACMD, the practical implications of this have yet to be considered. The Drug Treatment services have a long tradition of working with the drug using offender who wishes to change and are likely to resist compulsory entry to treatment programme, for there is no evidence that this improves outcome.

It would be far more acceptable for 'treatment' and 'punishment' to be seen as going hand-in-hand. A practical scheme could be for the Courts to decide on the guilt of the offender and whether a custodial sentence is appropriate. Whatever the punishment setting, full treatment facilities should be made available. This would require a great expansion in drug treatment facilities within the community and in the prison system. Regarding alternatives to custody, the Home Office will undoubtedly devise ways and means of making probation orders and community treatment orders more widely available. However it is unlikely that the treatment agencies will agree that these options should include an element of compulsory treatment. To give an example, a drug using offender who is on probationary supervision or a community treatment order has at least the option of attending for treatment and the Courts may wish to check if he has done so. This is quite different from the Courts requiring a drug user to attend for treatment and imposing some further sanction should that treatment not be effective. Indeed the Probation Service has voiced fears that a client who fails a strict court-imposed programme is highly likely to be imprisoned as a sanction for failure (Hayes 1989).

SECTION 6 - SUMMARY AND RECOMMENDATIONS

It should be appreciated that the vast majority of drug related crime is carried out in a normal mental state and the offender retains culpability for his actions and also personal responsibility for changing his drug using habits. The essential voluntary nature of a decision to stop drug use is rarely aided by coercive forces. Nevertheless, the high rate of drug use and crime causes concern in many communities and an appropriate judicial and medical response has to be determined.

The greater adoption of noncustodial sentences should serve to reduce pressure on the prison system, and also allows drug using offenders to seek treatment. However compulsory treatment in a noncustodial setting cannot be supported. Within the prison system there should be a far greater availability of drug treatment programmes to encourage rehabilitation of the offender.

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APPENDIX II
A SUMMARY OF RELEVANT LEGISLATION IN OTHER COUNTRIES

REF: PORTER, L. ARIF, A.E. CURRAN, W.J. (1986)
(WHO-GENEVA)
THE LAW AND THE TREATMENT OF DRUG AND ALCOHOL-DEPENDENT PERSONS

TABLE 1. COMPULSORY CIVIL COMMITMENT

Type of legislation	Countries
Mental Health	Bangladesh, Federal Republic of Germany (Bavaria, Hamburg), Japan, Norway, Pakistan, Somalia, Trinidad and Tobago, United Kingdom (England and Wales), United States of America (Massachusetts, Wisconsin)
Drug dependence	Argentina, Burma, Canada (British Columbia, Nova Scotia), Colombia, Indonesia, Italy, Japan, Malaysia, Mexico, Peru, Singapore, Tunisia, Thailand, USSR (RSFSR), United States of America (Federal)
Alcohol dependence	Finland, Hungary, Norway, Sweden, Switzerland (Geneva, St Gallen), USSR (RSFSR), United Kingdom (England and Wales), United States of America (Massachusetts, Wisconsin)
Drug or alcohol dependence	Australia (Victoria), Colombia, Finland, Sweden

TABLE 2. DIVERSION FROM THE CRIMINAL JUSTICE SYSTEM[1]

Type	Jurisdictions
Treatment pending or in lieu of trial	Egypt, France, Federal Republic of Germany[2], Philippines, Sweden, Thailand, United Kingdom[2], United States of America (Federal, Massachusetts[3], Wisconsin[3])
Treatment in lieu of imprisonment	Federal Republic of Germany, Hong Kong, Indonesia, Malaysia, Senegal, Sweden, Switzerland (Federal)[2], United States of America (Federal)
Treatment concurrent with sentence	Argentina, Brazil, Burma, Hong Kong, Israel, Mauritius, Philippines, Poland[2], USSR (RSFSR)[2], United States of America (Masachusetts)[3]

[1] For drug dependence only unless otherwise indicated.
[2] Only for persons dependent on alcohol or other intoxicants.
[3] Separate legislation for drug dependants and alcohol dependants.

TABLE 3. COMPULSORY NOTIFICATION, CENTRAL REGISTRIES, LABORATORY TESTING AND COMMUNITY SURVEILLANCE

Requirement	Jurisdictions
Compulsory notification	Burma, Colombia, Cyprus, Finland, France, Hong Kong, Indonesia, Italy, Japan, Malaysia, Mexico, Norway, Philippines, Senegal, Singapore, Somalia, Sweden, Switzerland (St Gallen), Tunisia, United Kingdom (England and Wales), Zambia
Central registries	Burma, Colombia, Hong Kong, Pakistan[1], USSR (RSFSR)
Laboratory testing	Hong Kong, Japan, Norway, Singapore, United States of America (Massachusetts)
Community surveillance	Finland, France, Hong Kong, Malaysia, Norway, Senegal, Sweden, Switzerland (Federal), USSR (RSFSR), United States of America (Massachusetts)

[1] Applies only to 'opium addicts'.

SUMMARY OF RECOMMENDATIONS

1. It is not feasible or desirable to remove cannabis from the Misuse of Drugs Act 1971, but because of its less harmful nature, cannabis and cannabis resin should be re-classified as Class C drugs. (Paras. 3.14 - 3.20)

2. Other Class C drugs should be moved into a new class - Class D, and possession of Class C drugs (cannabis and cannabis resin) should be an arrestable offence. The penalties for Class C and Class D offences should be identical. (Paras. 3.21 - 3.31)

3. i) A new section should be added to the Misuse of Drugs Act to allow a distinction to be made between drug trafficking and social supply, based on the concept of 'gain'.

   ii) Section 6 of the Misuse of Drugs Act (Restriction of cultivation of the cannabis plant) should be repealed.

   iii) Schedule 1 of the Customs and Excise Management Act 1979 should only apply where import or export 'for gain' is proved. In all other cases, the ordinary penalties provided for under the Act should apply.
   (Paras. 4.1 - 4.9)

4. Section 28 of the Misuse of Drugs Act (Lack of knowledge to be a defence in proceedings for certain offences) should be extended to drug smuggling offences, conspiracy and attempted offences. (Paras. 5.1 - 5.14)

5. Occupiers and managers of premises (as redefined) should be liable for the unlawful consumption of drugs on those premises only if they knowingly permit them to be so used for gain. (Paras. 7.1 - 7.9)

6. i) Section 20 of the Misuse of Drugs Act (assisting or inducing the commission outside the United Kingdom of an offence punishable under a corresponding law) should be extended to an offer or attempt and to a conspiracy to commit an offence abroad.

   ii) Section 5(3) of the Misuse of Drugs Act (offence for a person to have a controlled drug with intent to supply to another) should be amended by the addition of the words 'whether within or outside the United Kingdom' after the words 'to another'. (Paras. 8.1 - 8.2)

7. Paragraph C12 of the Codes of Practice issued under the Police and Criminal Evidence Act 1984 should be amended to include specific reference to the interviewing of suspects under the influence of, or withdrawing from, a drug. This should be to the effect that when a detained person appears to be under the influence of, or withdrawing from, a drug, he may not be interviewed, or further interviewed, unless he has been examined by a doctor who has certified that he is fit to be interviewed.

(Paras. 9.1–9.12)

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