THE GOVERNMENT RESPONSE TO THE
NINTH REPORT FROM THE
HOME AFFAIRS COMMITTEE
SESSION 2012-13 HC 184

Drugs: Breaking the Cycle

Presented to Parliament
by the Secretary of State for the Home Department
by Command of Her Majesty

March 2013

Cm 8567 £10.75

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Geographical Scope

The UK devolved administrations have their own approaches towards drug misuse and alcohol dependency in areas where responsibility is devolved. Some of the policy areas covered by this Command Paper such as health and education therefore only cover England. The areas relating to the work of the police and the criminal justice system apply to England and Wales and the work of the Department for Work and Pensions to England, Wales and Scotland.

The Home Office works with the devolved administrations to ensure a coordinated approach to tackling drug harms in all areas of the UK.

This Command Paper is published in response to the Home Affairs Select Committee's Ninth Report of Session 2012-13 entitled '*Drugs: Breaking the Cycle*.'

Drugs ruin lives and cause misery to families and communities and this Government is committed to breaking the vicious cycle of drug and alcohol dependency. There are no quick fixes; simply focusing on reducing the harms caused by illicit drug use is not enough. The cross-government Drug Strategy, *'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'* launched in 2010, therefore has recovery at its heart – helping individuals to be free from dependence on drugs and alcohol and to re-build their lives.

The strategy has a strong focus on prevention to reduce demand for drugs, with a particular emphasis on improved information, education and early intervention with at-risk groups. We enforce our approach through controlling harmful drugs, applying robust sanctions for their supply and possession, while diverting individuals into appropriate tailored treatment to support, encourage and challenge their behaviour and enable their recovery.

The Home Office is accountable for a cross-government programme of work to implement the strategy; the Department of Health and Department for Education play key roles, leading on the recovery and reducing demand strands respectively.

In the first two years of the strategy this Government has transformed the drugs landscape as part of an ongoing process of reform. We have:

- taken the lead internationally at the UN and EU to work more collaboratively and developed domestic early warning systems to detect new or harmful new psychoactive substances;

- incentivised and worked with the drug treatment sector to shift the focus to enable all individuals to achieve recovery;

- co-designed an innovative, world-first payment by results approach to incentivise recovery outcomes, currently being piloted in eight areas;

- supported local areas in the development of their Integrated Offender Management arrangements across England and Wales to break the cycle of offending and reoffending that impacts on individuals, families and communities; and

- devolved accountability, responsibility and resources to a local level to enable local people to take decision that impact their communities. We have introduced Police and Crime Commissioners, who will take responsibility for local action to drive down drug related crime and anti-social behaviour, and Public Health England, which will support local authorities to tackle drug and alcohol misuse as a core part of their work, including supporting recovery orientated drug treatment services and delivery of prevention and other health services.

We will also, by the end of 2013, subject to the passage of the Crime and Courts Bill, have established the National Crime Agency (NCA) to lead the fight against serious, organised and complex crime and bring strong coordination to national and international efforts to reduce the supply of drugs – from local to global. For the first time, a single agency will pull together the complete intelligence picture on serious, organised and complex crime and have the authority to coordinate and task the national response, working with the police and other law enforcement agencies.

There are promising signs that our strategy is working with continuing positive trends in a number of key areas:

- drug use in England and Wales remains at its lowest level since measurement began in 1996 across all age ranges ie children and young people as well as adults;

- record numbers in England are completing treatment free of dependence; and

- drug related deaths in England have fallen over the last three years.

This Government does not believe there is a case for fundamentally re-thinking the UK's approach to drugs – a Royal Commission on drugs is simply not necessary. Nonetheless, we must continue to listen and learn from emerging trends, new evidence and international comparators. In particular we will:

- build on the commitment in the Drug Strategy to "…review new evidence on what works in other countries and what we can learn from it" and conduct a study on international comparators to learn more from the approach in other countries; and

- continue to develop our approach to evaluating the effectiveness and value for money of the Drug Strategy. This includes publishing an update on our approach to evaluation alongside the next Annual Review in 2013. This update will set out, at a high level, the approach to evaluation – it is not the evaluation itself. The evaluation is planned to run throughout the life of the current Drug Strategy and report after the end of the Strategy.

The Government welcomes the report as a valuable contribution to policy development with positive responses in a number of areas that include: supporting the aim of the drug strategy to achieve recovery; the work of the Serious Organised Crime Agency on upstream interventions; money laundering and the recognition of the use of asset recovery; prescription drugs; drug recovery wings; and the transition from custody to community.

RT HON THERESA MAY, MP
HOME SECRETARY

Strategy

The Government's Drug Strategy 2010 is ambitious in its aims and takes a holistic approach, addressing the criminality and health issues associated with drug misuse, including an emphasis on prevention through education and early intervention.

Through our radical reforms we have devolved local accountability, responsibility and decision making to enable those who know their communities best to commission services. The new community budget areas will be able to combine resources into a locally coordinated funding pot with greater local control that will help improve services for local people.

We are leading the way as one of only a few EU Member States that have raised the level of ambition to take recovery beyond the treatment system and make it sustainable.

Aims of the strategy

HASC Recommendation 4

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

The Government's Drug Strategy is ambitious – we aim to reduce illicit and other harmful drug use and increase the numbers recovering from their dependence. We are doing this in the context of the wider criminal justice and health reforms, in particular, the election of Police and Crime Commissioners (PCCs) and the shift of accountability for local health service provision to local authorities.

The Public Health Outcomes Framework sets as its ultimate aim increased healthy life expectancy (i.e. taking account of the health quality as well as the length of life), and reduced differences in life expectancy and healthy life expectancy between communities. Drugs policy has supported this. England has a high rate of heroin users in treatment (close to 60%). This figure has remained relatively stable over the last few years – and represents a genuine success story – it has been key in keeping rates of HIV among injectors low. Only 1.3% of drug injectors in England have HIV, compared to 3% in Germany and 37% in Russia. However approximately 90% of cases diagnosed with hepatitis C are related to injecting drug use. Improving and protecting people's health remains a key component of treatment.

Strategic approach

Recommendation 15

We believe that the current, inter-departmental approach to drugs policy could be strengthened by identifying a Home Office Minister and a Department of Health

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

Recommendation 21

The Government goal of recovery will require the co-ordination of several government departments: the Department of Health to ensure that effective treatment is being funded, the Department for Work and Pensions to support patients to re-enter the workforce and local authorities which must take responsibility for ensuring that they have appropriate accommodation. We believe that giving the Home Secretary and the Secretary of State for Health joint overall responsibility for coordinating drug policy (see paragraph 83) will help to improve the focus on the goal of recovery. We recommend that the Inter-Ministerial Group works with the Recovery Committee of the Advisory Council on the Misuse of Drugs to carry out an assessment of how the situation is working once the changes have been fully implemented, and to publish its findings by July 2013. (Paragraph 109)

Recommendation 35

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

The Drug Strategy is a coherent cross-government approach that reflects the need for coordinated action to tackle the problem in all its dimensions. In order that there is effective coordination of a complex strategy it is important that there is clear accountability. For that reason the Home Secretary will continue to be accountable for the overall Drug Strategy and the central governance structures will be continue to be supported by a secretariat based in the Home Office.

Within the overall Drug Strategy the Home Office leads on action to protect society by stopping the supply of drugs, and tackling the organised crime that is associated with the drugs trade. Crime is a major component of the social and economic costs of class A drug use. Current estimates suggest that crime accounts for 90% of the total cost - and the UK's response relies on the crime fighting capabilities coordinated by the Home Office.

The UK has consistently sought to help individuals who are dependent on drugs by treatment rather than the application of criminal sanctions. Healthcare is the responsibility of the four UK administrations' Health Departments. In England, the

Department of Health leads the delivery of the Drug Strategy's ambition for more and more individuals each year to achieve and sustain recovery.

The Home Office and the Department of Health make a shared contribution in key areas. In respect of legal substances, the Home Office and Department of Health both lead respective strands of the alcohol strategy and the Department of Health leads Government's work to tackle addiction to medicines. The secretariat of the Advisory Council on the Misuse of Drugs (ACMD) draws on the resources of both departments, and both departments share responsibility, as appropriate to the nature of its advice, for responding to ACMD reports. Both Departments contribute funding to the FRANK service in order that young people and their families have access to accurate information about drugs and the harms that they can cause.

Other departments across government make their own contribution to the overall success of the Drug Strategy, as set out elsewhere in this Command Paper.

Transparency

Recommendation 16

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

We strongly support the principle of transparency of government business and place more information into the public domain than previously. In accordance with the provisions of the Freedom of Information Act 2000, a limited number of documents relating to the meetings of the Inter Ministerial Group (IMG) on Drugs have been released into the public domain. We have been unable to publish all the documents that have been requested because they have been assessed as exempt from public disclosure under the provisions of the Act.

Effective evidence based policy making

Recommendation 26

This inquiry has heard views from all sides of the argument and we believe that there is now, more than ever, a case for a fundamental review of all UK drugs policy in the international context, to establish a package of measures that will be effective in combating the harm caused by drugs, both at home and abroad. We recommend the establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs in an increasingly globalised world. In order to avoid an overly long, overly expensive review process, we recommend that such a commission be set up immediately and be required to report in 2015. (Paragraph 132)

Recommendation 25

Our predecessor Committee's recommendation for an independent assessment of the Misuse of Drugs Act 1971 was rejected on the basis that it gives effect to the UK's international obligations in this area. That is not, in our view, a compelling

reason for refusing to review our own domestic legislative framework, particularly given the growing concern about the current international regime in many producer nations. The message from Colombia and other supplier and transit states is clear—what the international community is currently doing is not working. We are not suggesting that the UK should act unilaterally in these matters, but our Government's position must be informed by a thorough understanding of the global situation and possible alternative policies. (Paragraph 131)

Recommendation 47

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

As well as reviewing the Drug Strategy on an annual basis we are committed to undertaking an evaluation to assess the effectiveness and value for money of the current Drug Strategy. This is a more stringent approach than has been adopted for any previous Drug Strategy. The evaluation is an ongoing process which will last throughout the life of the Strategy. We will be providing an update on the evaluation alongside the next Annual Review in 2013. This update will set out at a high level, our approach to evaluation – it is not the evaluation itself.

We reject the recommendations to establish a Royal Commission, a review of the Misuse of Drugs Act 1971 and the instigation of a public debate on alternatives to the current drugs policy. This is because there are promising signs that, two years since the strategy was launched, our new approach is working. We have:

- incentivised and worked with the drug sector to shift the focus beyond the treatment system in order to help users move to recovery and reintegration in to society;

- co-designed an innovative, world-first payment by result approach to incentivise recovery outcomes, currently being piloted in eight areas;

- introduced Temporary Class Drug Orders that enable us to ban newly identified harmful drugs within days and established early warning systems that enables the identification of a new substance within hours of emergence. Methoxetamine, for example, was banned in weeks rather than months;

- developed the Drug Interventions Programme (DIP) to give local areas more flexibility in the way they identify drug misusing offenders (through drug testing) to encourage more offenders into treatment. DIP ceases as a nationally funded programme from April 2013 and it will be for local areas to decide which (if any) interventions they want to utilise to address Class A drug-related offending in their area;

- supported local areas to develop and enhance their local Integrated Offender Management arrangements across England and Wales to break the cycle of

offending and reoffending that also impacts on families and communities. The link between offending behaviour and drug misuse is clear;

- rolled out family nurse partnerships, a preventive programme for vulnerable first time teenage mothers, which is showing positive signs of impact on both children and parent's outcomes; and

- initiated consultations on the National Curriculum and non-statutory Personal Social Health and Economic education.

Looking to the future, PCCs are taking responsibility and local action to drive down drug related crime and anti-social behaviour. Subject to the passage of the Crime and Courts Bill, the NCA will lead the fight against serious, organised and complex crime and bring strong coordination to national and international efforts to reduce the supply of drugs – from local to global. For the first time, a single agency will pull together the complete intelligence picture on serious, organised and complex crime and have the authority to coordinate and task the national response, working with the police and other law enforcement agencies.

Also from April 2013, Public Health England (PHE) will support local authorities to tackle drug and alcohol misuse as a core part of their work, including supporting recovery orientated drug treatment services and delivery of prevention and other health services.

While we recognise that these changes cannot necessarily be attributed to the impact of our strategy, there are promising signs that the strategy is working, with a continuation of the positive trends of recent years in England in a number of key areas:

- record numbers are recovering from dependence, with nearly 30,000 people (29,855) successfully completing their treatment in 2011-12, up from 27,969 the previous year and almost three times the level seven years ago (11,208);

- a sizeable reduction in the number of adults newly entering treatment for heroin and crack cocaine of 10,000 in two years (from 62,963 to 52,933), reflecting the reduction in the size of the user population;

- continued a high level of access to drug treatment services with average waiting times at five days; and

- falling drug-related deaths over the last three years.

In addition to this activity, drug use remains at its lowest level since measurement began in 1996 and the prevalence of drug use among 11-15 year olds has declined since 2001. These numbers from England and Wales indicate that we are moving in the right direction and enabling people to work towards being free of drugs.

The Government is committed to an evidence-based approach, informed by the expert advice of the ACMD. We invited the ACMD to establish its Recovery Committee, an expert group to advise the IMG on Drugs on the recovery strand and

enable Ministers to engage openly with the Recovery Partnership[1], other drug sector organisations and individuals, and medical professionals to inform, challenge and test our policies.

International comparators

Recommendation 42

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

Recommendation 45

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

Recommendation 43

Following the legalisation of marijuana in the states of Washington and Colorado and the proposed state monopoly of cannabis production and sale in Uruguay, we recommend that the Government fund a detailed research project to monitor the effects of each legalisation system to measure the effectiveness of each and the overall costs and benefits of cannabis legalisation. (Paragraph 248)

Recommendation 46

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

We respect the ongoing debate on the merits of different policies and approaches to tackle the global drugs problem. The UK co-sponsored the resolution on "International cooperation against the world drug problem" at the United Nations General Assembly in December 2012. We will be an active participant in the review of the implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem in 2014.

We remain open to the consideration of new evidence, learning from emerging trends and will continue to assess all available evidence on the different approaches

[1] http://www.skillsconsortium.org.uk/The%20Recovery%20Partnership.aspx

to drug policy. The UK is a leading voice in the international community with regard to drug policy and we actively participate in strategy and policy development at the EU, UN and in our engagement with a considerable number of bilateral partners. The UK continues to discuss efforts to tackle the drugs trade with our international partners.

The coalition government has no intention of decriminalising drugs. It is of course important that any debate on alternative approaches should be focussed on clear evidence and analysis. As part of our commitment to this approach, the Minister of State for Crime Prevention, who Chairs the Inter Ministerial Group on Drugs, will lead a review to look at a number of countries that cover a spectrum of approaches to drug policy, and assess their effectiveness in cutting drug use and reducing harm to individuals and communities. The review will look at best practice as well as different legal responses to new psychoactive substances. The Minister will also lead some fact-finding visits overseas. The Terms of Reference are at Annex A.

We expect to find examples of good practice that might be considered in the UK context but it is important to note that there is no internationally agreed definition of "decriminalisation" and the application of such an approach is dependent upon the legal framework in the country concerned. Equally, we are aware of examples of good practice here in which other countries are interested.

Research: Provision of expert advice

Recommendation 10

The potential for "substance displacement", where users switch from one drug to another in response to changes in supply, has clear implications for public policy. In particular, the Government must be mindful of the fact that tougher measures against one drug can lead to increased consumption of another. Where the drug that is being targeted is less harmful than its substitutes—and all recreational drugs are harmful to a greater or lesser extent—there is the clear potential for measures which are intended to tackle the supply and consumption of drugs to result in an overall increase in the harm they cause. We recommend that, where decisions about the classification of drugs are concerned, the opinion of the Advisory Council on the Misuse of Drugs should be sought on the potential for substance displacement, and the comparative risk associated with the likely substitutes. (Paragraph 44)

As the Committee acknowledges, all drugs are harmful, albeit some more harmful than others. This is broadly reflected in our drug classification system, with Class A drugs being considered the most harmful. The choices that drug users make around their drug taking can be multiple and complex, the more obvious one being ease of access and availability. Displacement is an inevitable consequence of effective supply related interventions– whether the targeting of trafficking routes and organised crime groups, specific types of drugs or through drug control itself. The UK, working collaboratively with EU and other international partners, works to pre-empt and monitor any potential displacement and will re-allocate resources accordingly.

In providing advice on drug control matters, in particular with regard to new psychoactive substances, the ACMD has been mindful of the potential for the drug

market to develop with new and emerging drugs. For this reason, the ACMD has considered not only the principal drugs of concern but also their related family of compounds. In doing so, on the expert advice of the ACMD, the Government looks to control those related substances which would arguably be those most likely for displacement of use.

The provision of credible and accurate public health messages is vital to enable potential users to understand the choices that they are making and the harms associated with drugs, including new psychoactive substances. The ACMD keeps under review harmful new psychoactive substances that are alerted to the Government via, for instance, the early warning systems, so that information can be up to date, credible and relevant to potential users. Where appropriate, and on advice from the ACMD, the Government looks to send clear public messaging through the FRANK campaign and other appropriate channels.

Research: Evidence base

Recommendation 44

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

Recommendation 48

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

The Government welcomes the Committee's focus on evidence and data and has mechanisms in place to address current policy research needs. There are a variety of funding routes for drug research and data collection, reflecting the different types and level of evidence required to support drug policy and advance the evidence base on enforcement, prevention, treatment and recovery. We do not, however, accept the need for allocated ring-fenced funding to drugs policy research. In general, we believe that individual departments are in the best position to identify and take responsibility for gathering the evidence needed to inform their policies, drawing on the specific expertise found in departments and their stakeholders.

The professional analytical community in government also has an important role to play, either through undertaking or commissioning new evidence synthesis or research, or through encouraging the engagement and participation of external

bodies such as the research councils and expert academics. For example, the Department of Health's Policy Research Programme (PRP) has a remit to commission and fund high quality policy research to meet the needs of Ministers and policymakers for research evidence, including evidence relating to drug misuse. The PRP works in close collaboration with other government departments, the research councils and other funding bodies to identify and meet priority needs for policy research on drug misuse – including those relating to prevention and recovery – to ensure best value for public money and avoid duplication.

The cross-government Drug Strategy Research Group has also been established to strengthen the coordination of drug research. It brings together analysts from all relevant departments to ensure that knowledge is shared and priorities are coordinated across policy areas. The ACMD and Medical Research Council (MRC) also sit on this group.

In addition, the MRC, in partnership with the Economic and Social Research Council (ESRC), already fund a strategy for addiction and substance misuse research. The strategy funds cross-discipline research to address the biological, medical, social and economic aspects of addiction. The overall budget for this initiative is £6.5 million made available by the MRC and the ESRC. The strategy has so far involved three calls for funding and resulted in thirteen grants being awarded. Further funds may become available. A number of key stakeholders are engaged in ongoing consultation including relevant government departments, the ACMD and research charities. The involvement of stakeholders is crucial to establish research priorities and ensure the pull-through of results into policy and practice.

At a European level the newly founded European Research Area Network on Illicit Drugs, of which the UK is a participant, has been set up to stimulate cross national research cooperation.

The requirements for evidence gathering or synthesis vary substantially across different areas of government drug policy, many of which sit outside of the ACMD's core remit of providing advice on the control of drugs under the Misuse of Drugs Act 1971.

The ACMD continues to carry out extensive evidence gathering exercises as part of its inquiries into the misuse and harms of drugs. While the ACMD is not, nor is expected to be, a research commissioning body, it influences the areas in which new research is undertaken through its recommendations that can be directed to both research councils and government departments (for example, research in the field of new psychoactive substances). In addition, the ACMD is also be responsive to the changing requirements of government where appropriate, for example by instituting its new expert group on recovery, which has been assessing the evidence in this area.

Drug Driving

Recommendation 1

The Department for Transport has set up a panel of experts to advise on those drugs which should be covered by the new offence of driving with concentrations of drugs

in excess of specified levels and, for each drug, the appropriate maximum permissible level of concentration in a person's blood or urine. We believe that this maximum should be set to have the equivalent effect on safety as the legal alcohol limit, currently 0.08 mg/ml. (Paragraph 2)

The Government welcomes the Committee's support for the new offence of driving, or being in charge of, a motor vehicle, with a concentration of a specified controlled drug in excess of the specified limit for that drug.

Alongside this Command Paper, the Government is today publishing the Report from the Expert Panel on Drug Driving "Driving Under the Influence of Drugs". The Government would like to acknowledge the hard work undertaken by the Expert Panel in seeking to tackle this complex issue.

In due course the Government will make specific proposals regarding the drugs to be specified in regulations for the new offence. These proposals will be subject to a public consultation. After taking account of any responses received, regulations containing the final proposals would then need to be approved by Parliament before they could become law.

Building Recovery

We believe recovery means being free from dependence on drugs and alcohol. Our ambition is to provide services that an individual may need in order to achieve and sustain recovery, which would also encompass housing, employment, and appropriate support to maintain a stable family life and a life free from crime.

We are making good progress implementing major reforms. We have:

- incentivised and worked with the drug treatment sector to shift the focus to enable all individuals to achieve recovery;

- co-designed an innovative, world-first payment by results approach to incentivise recovery outcomes, currently being piloted in eight areas;

- committed to creating drug free environments in prison and are therefore increasing the number of drug free wings, where increased security measures prevent access to drugs. We are also renewing our efforts to disrupt the trafficking of drugs into prisons and the activity of organised criminals coordinating the trafficking of drugs from prisons. Recent years have seen a significant decrease in the numbers of prisoners testing positive for drugs;

- made radical reforms to the social housing system with greater flexibility in the way people access social housing and the types of tenancies which are provided. The Localism Act 2011 includes: changes to the rules on tenure; the management of waiting lists; and the homelessness duty, which are designed to make the system fairer, striking a proper balance between the needs of new and existing tenants. By making full use of these new freedoms, councils will be able to target social housing on those who genuinely need it the most for as long as they need it. We have also worked with the housing and drug sectors to develop case studies to support closer working relations; and

- introduced welfare reforms so that Job Centre Plus provide further help and support to claimants with a drug or alcohol dependency. Under Universal Credit, from October 2013, benefit claimants with a drug or alcohol dependency will have their job search conditions relaxed if they take up the offer of treatment for their addiction. This will give them the time and space to focus on their recovery and move towards employment.

Recommendation 2

We recommend that the Government continue to monitor the decisions of the Health and Wellbeing Boards as to allocation of treatment places, recording each request, monitoring waiting times to enter treatment and assessing the success rate of those dependent on different drugs. The government should publish this information in an easily accessible and understandable format and consider developing a league table of Health & Wellbeing Boards' performance on local drugs provision while taking care in selecting assessment criteria not to introduce perverse incentives into the decision making process. This will allow Boards to benchmark their provision against each other, having due regard to local need. (Paragraph 7)

High quality drug treatment is the most effective way of reducing drug misuse and reducing drug related mortality. Treatment helps drug misusers to tackle their dependence and contribute productively to society. Treatment also results in improved health, stability and social functioning and crime reduction.

We are creating a public health system that will promote public health and encourage behaviour change to help people live healthier lives and help reduce mortality. The Health and Social Care Act 2012 made commissioning drug services a responsibility of local authorities from April this year. Local Health and Wellbeing Boards will oversee commissioning decisions by local authorities as part of their role in undertaking the Joint Strategic Needs Assessment and publishing the Health and Wellbeing Strategy.

Access to treatment and its effectiveness will continue to be monitored through the National Drug Treatment Monitoring System (NDTMS), which is a National Statistic assessed by the UK Statistics Authority and which will be collected by PHE. Data are collected on the treatment of adults for dependence on drugs and/or alcohol and on the treatment of substance misuse by young people. These are published monthly and are available at local level. The Public Health Outcomes Framework will enable local authorities to benchmark their effectiveness across a range of indicators related to drug use and treatment.

Prescription drugs

Recommendation 23

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

Recommendation 24

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

The Government's 2010 Drug Strategy highlighted the need to tackle all drugs of dependence, including prescription drugs. The Department of Health commissioned two reports which were published in May 2011 to inform policies and services on addiction to medicines: a literature review by the National Addiction Centre; and a survey by the NTA of service provision. A roundtable of experts, convened by the Minister for Public Health, drew up an agreed list of actions in 2012 to prevent and tackle addiction to medicines.

Department of Health officials have worked closely with the Royal College of General Practitioners and the Royal College of Psychiatrists to take forward these actions. Increasing access to psychological therapies and improved understanding of pain management are helping to prevent the initiation of long-term prescribing of medicines which can be addictive. PHE will also support local commissioning of services to treat patients who are addicted to medicines.

The Government supports the ACMD's commitment to undertake a review into the diversion of prescription medicines covered by the Misuse of Drugs Act 1971 and the harms that are caused by their misuse. In her forthcoming annual commissioning letter to the Council, the Home Secretary will ask the ACMD to start its review at the earliest opportunity in its 2013/14 work programme.

Assessing dependence on prescription drugs and its severity can only be done using local data on a case-by-case basis taking account of duration and impact of use, the condition for which the medicines were prescribed and whether withdrawal symptoms become apparent when the dose is decreased. This can only be done by individual prescribers and their patients. In the commissioning of primary care services by the NHS Commissioning Board, local pharmacy networks will deliver innovative solutions for the safest and best use of medicines.

Opioid substitution therapy

Recommendation 3

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

Recommendation 19

We make no comment on the relative merits of methadone and buprenorphine. It is for the individual prescriber to decide which drug is clinically indicated for each patient. However, we note that recent pharmacological advances in opioid substitution therapy mean that there are other options to patients being "parked" on methadone are notably treatment using buprenorphine which was less widespread when our predecessor committee published its report in 2002 and that it is possible that OST could in the future become a more effective route to abstinence than it has

been in the past. Policy makers should understand the potential for more effective OST treatments and, rather than ignoring reports of the negative side effects of current OST drugs because they are available, familiar and cost-effective, should continue to keep sight of a greater emphasis on buprenorphine relative to methadone prescription to lead to better patient and societal outcomes. (Paragraph 100)

We agree with the importance of having clear guidelines on the use of diamorphine for the treatment of addiction. The 2007 publication '*UK guidelines on clinical management of drug misuse and dependence'* contains advice on the prescription of diamorphine for heroin dependence. The Department of Health provided funding for the Randomised Injectable Opioid Treatment Trial (RIOTT) the results of which were published in *The Lancet* in May 2010. This demonstrated the clinical effectiveness of supervised injectable opioid treatment. RIOTT was one of the studies which contributed evidence to the report on '*New heroin-assisted treatment'* published by the European Monitoring Centre for Drugs and Drug Addiction in 2012. The Department of Health is building on the earlier work by funding three pilots to explore the cost-effectiveness of supervised injectable opioid treatment and its contribution to recovery-oriented care pathways. These pilots are being funded until March 2015. The Department of Health has convened an expert group to advise on the development of guidance for commissioners using the evidence from the pilot sites.

We agree that it is for the individual prescriber to decide which drug is clinically most appropriate in discussion with their client. NICE issued guidelines in 2007 on opioid substitution treatment, including the use of methadone and buprenorphine. It reviewed those again in 2010 and made no changes.

The NHS Constitution affirms the commitment that patients should receive NICE approved treatment. The NHS Constitution will continue to apply to public health services commissioned by local authorities. NICE found that methadone and buprenorphine maintenance were similarly effective and recommends both for treating opioid dependence. NICE also recommends that when methadone and buprenorphine are equally suitable for a patient, methadone should be first choice as it is more cost effective. As a first treatment methadone also has better retention rates. This evidence was built upon by the expert group led by Professor John Strang, whose report '*Medications in Recovery: re-orientating drug dependence treatment'* was published in 2012.

Individual clinicians should decide with patients whether to use methadone or buprenorphine on a case-by-case basis.

Residential rehabilitation

Recommendation 17

Different treatment regimes will work for different patients. It is clear that, for some people, residential rehabilitation is the most effective treatment, backed by proper aftercare in the community. Although it is expensive when compared to treatment entirely in the community, it is cost-effective when compared to the cost of ongoing drug addiction. While we welcome the Government's focus on recovery in the Drugs Strategy 2010, we have consistently been told that there is a shortage of provision,

and in particular provision for specific groups such as teenagers. We recommend that the Government expand the provision of residential rehabilitation places. In addition, we recommend the Government review the guidance for referrals to residential rehabilitation so that inappropriate referrals are minimised and amend the National Drug Treatment Monitoring System form so that where incidents of inappropriate referral do occur they can be captured and an accurate picture of the effectiveness of residential rehabilitation as a treatment option can still be obtained.(Paragraph 94)

Recommendation 18

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

We agree that different treatment regimes will work for different patients. As the NHS Constitution confirms, care pathways needs to be based on shared decision making and tailored to the needs of the individual.

Local authorities are best placed to meet local needs and so the Health and Social Care Act 2012 made commissioning drug services, including residential rehabilitation, a local authority responsibility. The 'Sufficiency Duty' on local authorities in relation to children also requires that they do more than simply ensure that accommodation be 'sufficient' in terms of the number of beds provided and meet the needs of children.

We recognise the importance of information to support local areas, and so the National Treatment Agency published in July 2012 '*The role of residential rehab in an integrated treatment system'*. The right residential rehabilitation placement for the right individual at the right time can be a powerful and cost-effective step on their journey to recovery from addiction, with providers and referrers working together to ensure that people are matched up to the service that can meet their needs.

Government is working closely with the sector through the Recovery Partnership to ensure that the National Drug Treatment Monitoring System reflects the work that residential rehabs undertake as part of a holistic recovery orientated treatment system. We are committed to greater transparency in order to inform better decision making. Detailed outcome data for individual residential providers is available via www.NDTMS.net.

Drug treatment in prisons

Recommendation 20

Drug treatment in prisons is a point of critical intervention—if a drug-dependent offender is treated effectively then it greatly improves their chance of rehabilitation on release. Given that drug and alcohol dependence treatment in prisons has been so heavily criticised for the lack of co-ordination with treatment in the community, we are

concerned that new structural changes may reverse the gradual improvement we have seen in treatment for drug-dependent offenders. We recommend the Government closely monitor the transition of treatment funding responsibilities to the Health and Wellbeing Boards and the NHS Commissioning Boards respectively. (Paragraph 106)

We recognise the opportunities for effective drug treatment in prisons and its importance in reducing re-offending and making communities safer. The Government has unified commissioning for all assessment and treatment of drug dependence in prisons in order to improve the efficiency and effectiveness of provision.

The agreement made between the Secretary of State for Health and the NHS Commissioning Board under Section 7A of the National Health Service Act 2006 explicitly requires "*continuity of care between secure environments and community*" as part of a fully integrated, recovery-orientated and outcome-focused service. As the National Drug Treatment Monitoring System collects data on prison, community and residential drug treatment, we will be using it to monitor the continued effectiveness and continuity of treatment in all settings.

Recommendation 40

Producing an evidence base of effective interventions is one of the most vital building blocks of drugs policy. We recommend that the Ministry of Justice introduce **mandatory drug-testing for all prisoners arriving at and leaving prison whether on conviction, transfer or release.** Tests should be carried out for both illegal and prescription drugs. This should be in addition to the existing random testing regime, the principal purpose of which is deterrence. The information obtained from such a test would be very valuable in evaluating the effectiveness of the current systems in place and identifying those prisons which have a serious problem. Prisons are a key point in the cycle of drug addiction and if addicted offenders can be got off drugs, the monetary and societal benefits would be huge. (Paragraph 211)

Recommendation 37

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

Recommendation 39

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

Recommendation 41

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

Recommendation 38

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

The Government is committed to stopping drugs entering prisons and to getting offenders off drugs. Fewer prisoners are testing positive for drugs than at any time since 1996 – around 7% of prisoners test positive for drug misuse once they are in custody – but there is more to do. The Ministry of Justice and Department of Health are working closely with service providers to create integrated, recovery orientated and outcome focused services. However, mandatory drug testing for all offenders on entry to and release from prison is not the answer.

Knowledge of a test on release may lead prisoners to avoid a positive test through remaining abstinent for that period only. Offenders can also considerably reduce their levels of drug misuse once in custody. Drug testing on release is therefore not a reliable indicator for representing need for treatment and support on release. In addition to this, the application to 'all prisoners' would mean carrying out a number of unnecessary tests on prisoners that are unlikely to have a substance misuse issue.

Investing in costly and comprehensive drug testing programmes on entry and release would be an additional funding and resource burden, with a risk of funds being diverted from treatment provision to bear the costs, without being clear of the benefits that would ensue over and above existing random testing arrangements. We therefore reject the view to introduce mandatory drug testing for all offenders on entry to and release from prison.

The Department of Health has commissioned an independent evaluation of the drug recovery wing pilots programme in prisons, which aims to assess whether or not the drug recovery wing approach is successful. The evaluation evidence will help inform future commissioning strategies. Lessons learned and best practice identified during the pilot phase will also be shared. Whilst we are supportive, it will be for local NHS

commissioners and partnerships to decide whether to resource drug recovery wings in the future, and in doing so they will need to balance the risk of funds being diverted from direct treatment provision in order to meet these costs. We partially accept recommendation 37 on the basis that, if resources permit and the evaluation clearly shows that wings where prisoners are abstinent from drugs are successful, we will extend the programme to prisons where there is operational benefit in doing so.

We agree that continuity of care is vital and the Justice Secretary has made clear his desire to see a far greater use of mentors meeting offenders at the prison gate on their release. The Transforming Rehabilitation consultation, which closed on February 22nd, set out plans to change the way we manage and rehabilitate offenders in the community, opening up rehabilitative services to a wide range of new providers in the private and voluntary sectors who will bring their creativity and innovation and be paid by results to drive down reoffending. This includes tackling offenders' broader life management issues, connecting offenders to mental health, and drug and alcohol treatment programmes. Our proposals should help bridge the gap between prison and the community and improve through the gate services. We partially accept recommendation 41 on that basis. However, we do not accept that connecting prisoners to treatment on release should be related to drug testing on release.

Payment by results

Recommendation 22

Payment by results potentially produces a very cost-effective system in which the taxpayer pays only for successful outcomes. However, past experience in other areas such as employment has shown that it is easy for the market to become dominated by a small number of large providers, leading to the marginalisation of smaller, innovative voluntary sector organisations. Another risk is that the most difficult to treat patients may be denied access to services. We recommend that the Government establish ways to create provider diversity to ensure that smaller providers and civil society are not excluded and that a wide range of services are available. This could be achieved by ring-fencing a certain proportion of expenditure for such providers. The model will also need to ensure that providers are rewarded appropriately for taking on the most difficult patients, so that those who are harder to help will not be denied services. (Paragraph 114)

We are committed to exploring the value of payment by results (PbR) as an effective approach to commissioning. One of the goals of PbR is to allow a wider range of voluntary groups, community groups, charities and social enterprises to enter the market. The Department of Health is supporting local commissioning through running a number of conferences and workshops for commissioners and providers to ensure that these small innovative providers are supported to access the market. The Inter-Ministerial Group on Drugs is also taking an active interest and Ministers have visited all PbR pilot areas. Ministers also attended a roundtable with commissioners from the eight PbR pilots hosted by the Minister for Public Health.

The extensive co-design process for the pilots put service users at the heart of the approach. Data modelling took account of the risk that a provider might focus on those service users who are nearest recovery and park those who are furthest, and the models have been developed to avoid perverse incentives. Safeguards include differential pricing, minimum contract specifications, and an independent assessment and referral service (LASARS) at the centre of each of the models. In addition, we have worked across government and with the sector to explore in detail the risks of 'gaming' and worked to mitigate against these during the development phase of the individual models. A Gaming Commission was set up in August 2011 to identify ways providers might seek to 'game' the system, such as 'parking' or delivering minimal treatment to clients, and recommended a number of safeguards which pilot areas have adopted.

The Department of Health has commissioned an independent evaluation of the Drug and Alcohol Recovery Payment by Results Pilots Programme. The evaluation started in November 2011 and will run for three years. It involves a collaborative partnership between the University of Manchester, Birkbeck College London, RAND Europe and User Voice.

The voluntary sector has an important role to play in all elements of the delivery of these services. The Ministry of Justice will be working with the voluntary sector to help design ways in which the process and system can be made accessible to them. In addition, the National Offender Management Service has issued the first part of a two part, £500,000 grant to enable a wide range of VCS organisations to develop the capacity and capability to compete on PbR contracts.

Enabling recovery

Recommendation 34

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

Enhanced criminal record certificates (which are now available from the Disclosure and Barring Service which took over the role of the Criminal Records Bureau on 1 December 2012) are available to those seeking employment in sensitive positions, often working closely with children or other vulnerable people. One of the elements which these certificates always include is all convictions recorded on the Police National Computer. The Government is carefully considering whether some older and more minor conviction information should continue to be included and is seeking to identify an appropriate and workable filtering mechanism.

While we agree with the Committee that former drug users should play an active part in society and that unreasonable barriers to employment should be removed wherever possible, we cannot address this in isolation from the broader disclosure regime operated by the Disclosure and Barring Service. However, we will keep these specific issues in mind as the work on potential filtering mechanisms continues.

Reducing Demand

Drug use remains at its lowest levels since measurement began in 1996. We will continue to do all we can to prevent people from using drugs in the first place and intervene early with those who start to develop problems. We are investing in a range of programmes which have a positive impact on vulnerable young people, giving them the confidence, resilience and risk management skills to resist drug use.

The Drug Strategy sets out how we aim to prevent drug use and reduce demand for drugs not just for children and young people but across the age range. PHE will also have a clear role in achieving demand reduction objectives both at a national and local level.

We have taken action to reduce demand and explore effective demand reduction practice. We have:

- re-launched FRANK to support young people, as well as parents, carers and others, by providing confidential, accurate and impartial information and advice about the risks and harms associated with drug use;

- issued revised, simplified guidance for schools on preventing drug and alcohol misuse;

- funded the Family Nurse Partnerships programme which has shown that parents involved in the scheme are reducing smoking in pregnancy; are more likely to breastfeed; have aspirations for the future; are taking up employment and education; are more confident as parents; and are learning how to maintain a good standard of care for their babies. Family Nurse Partnerships have also been very successful in engaging fathers.

- we have also, through the Centre for Analysis of Youth Transitions, set up a database of validated programme evaluations which support those commissioning and delivering to choose evidence-based programmes known to have an impact;

- begun the procurement of a new evidence-based drug and alcohol information and advice service for practitioners who work with young people;

- set up the Early Intervention Foundation, which will support the needs of commissioners in implementing early intervention programmes and practice in their local areas. It will be a central point to help local commissioners make decisions based on robust evidence of cost, benefits, risks and project outcomes; and

- developed the Choices programme which is focused on preventing substance misuse and related offending amongst vulnerable groups of young people aged 10-19. The programme received funding of £4m in 2011/12 and engaged over 10,000 vulnerable young people.

In addition to this, 95% of all local authorities have local joint working protocols in place between substance misuse and children and family services.

Recommendation 13

The evidence suggests that early intervention should be an integral part of any policy which is to be effective in breaking the cycle of drug dependency. We recommend that the next version of the Drugs Strategy contain a clear commitment to an effective drugs education and prevention programme, including behaviour-based interventions. (Paragraph 75)

Recommendation 14

We recommend that Public Health England commit centralised funding for preventative interventions when pilots are proven to be effective. (Paragraph 76)

We welcome the Committee's recommendation that the next version of the Drug Strategy contains a clear commitment to an effective drugs education and prevention programme. We also agree that early intervention should be an integral part of any policy, which is to be effective in breaking the cycle of drug dependency, as set out in the Drug Strategy already. Our current strategy is flexible and we will focus on this in Year 3 of implementation.

Our expectation is that targeted support and early intervention for young people is planned and organised at local authority level, funded by both the Business Rates Retention Scheme (which replaced the Early Intervention Grant) and the Public Health Grant.

It will be for Directors of Public Health and Children's Services and other relevant local partners to develop services to meet local needs in their area. At a national level, we can support local commissioners though the Centre for Analysis of Youth Transitions, the new drug and alcohol information and advice service and by promoting the learning and effective practice from the Choices prevention programmes.

PHE will provide central funding for FRANK, which provides information for young people to access directly as well as a source of information that parents and teachers can draw upon, and be a source of expertise on how to encourage young people to make healthy choices. The Department of Health and PHE will also continue to share evidence with the Department for Education to inform future work they undertake in this area. The Government expects all schools to provide a broad and balanced education that will develop young people's resilience.

Restricting Supply

Tough enforcement activity by UK law enforcement agencies to reduce the supply of drugs is a fundamental part of the Drug Strategy. The illegal drugs trade, driven by organised crime, impacts individuals, families and communities. Since the introduction of the Drug Strategy we have made real progress in targeting all points along the drug supply chain from disrupting street level dealers to tackling organised crime groups and producers' in supply countries. This is emphasised in our 2011 organised crime strategy '*Local to Global: Reducing the Risk from Organised Crime'*.

The low purity levels and high wholesale prices of both cocaine and heroin in the UK, coupled with our law enforcement activity at home and overseas, indicate that we are having a real effect on drug flows into the country.

We are making progress through:

- UK law enforcement agencies seizing significant quantities of drugs off the streets. In 2011/12[2], over 81 tonnes of Class A drugs were seized by the Serious Organised Crime Agency (SOCA) with partners at home and abroad. The police and the UK Border Force made 216,296 drug seizures in England and Wales in 2011/12 – a two per cent increase on 2010/11;

- establishing the NCA, that will lead the fight against serious, organised and complex crime, including enhancing the security of our borders. Subject to the passage of the Crime and Courts Bill, the NCA will be fully operational by the end of 2013, but a number of its commands are already operating in shadow form and driving early operational results;

- local criminal justice partners across England and Wales managing 88,000 class A drug misusing offenders into treatment and recovery services in 2011/12 through the Drug Interventions Programme (DIP). DIP is estimated to help prevent around 680,000 crimes per year[3]; and

- a range of operational successes against top-end criminals by SOCA and its partners. For example, in October 2011, 24 members of an organised crime network were handed jail terms totalling more than 250 years for their roles in plots to smuggle up to 40 tonnes of drugs into the UK, which included a significant amount of cocaine from Latin America. The complete dismantlement of the entire network was only possible because of joint working with a number of law enforcement agencies which included partners in Latin America.

International

Recommendation 9

[2] SOCA (2011) Serious Organised Crime Agency Annual Report and Accounts 2010/11.

http://www.soca.gov.uk/about-soca/library/doc_download/301-annual-report-2010-11.pdf

[3] Unpublished internal Home Office analysis based on 2010/11 data.

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

Recommendation 27

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

Recommendation 7

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

Recommendation 8

Targeting supply at an early stage is the most effective way of reducing supply, as larger amounts can be intercepted higher up the supply chain. Even so, we do not believe that it will be possible to reduce the overall volume of the international drugs trade dramatically only by tackling supply – it is too easy for narco-criminals to respond by diversifying their supply routes. (Paragraph 41)

Tackling the threat from drugs is a global challenge. Practical cooperation between international partners therefore continues to form a vital part of our response to the illegal drugs trade. Since publication of the strategy, the Home Secretary has met the Presidents of Colombia and Panama to discuss our mutual cooperation on drugs and Home Office Ministers have met the Interior Ministers of Colombia and Brazil, the Foreign Ministers of Bolivia and the Dominican Republic, and visited Peru and the Caribbean to discuss cooperation on tackling drugs. We have also signed Memoranda of Understanding outlining our drugs cooperation with Brazil and Bolivia.

SOCA has been at the forefront of driving forward activity with a wide range of international partners to improve the capacity of source and transit countries to tackle drug trafficking impacting on the UK. Our diplomatic assets and operational experts have been working to ensure that these capabilities are strong and comprehensive, particularly in relation to law enforcement (including mentoring activities), criminal justice, rule of law and tackling the proceeds of crime. Our

upstream effort forms part of the "golden thread" of law enforcement in the UK and allows end-to-end disruption of organised crime groups.

This Government acknowledges SOCA's excellent reputation, its strong relationships with partners and the excellent results that it has produced. It welcomes the Committee's recognition of SOCA's international achievements that include:

- in West Africa, SOCA leads the International Liaison Unit (ILU) in Ghana, an international platform with a mixed European and US membership, designed to help coordinate law enforcement activity and share operational or strategic intelligence. The ILU is an excellent example of joint working, sharing of intelligence and a coordinated approach to capacity building. The platform has the primary aim of exchanging technical and operational information, and coordinating technical cooperation. Through the platform there is extensive international support available to Ghana in its fight against the drugs trade. For example the Accra ILU aided the dismantling of an organised crime group trafficking cocaine to the UK from Latin America via West Africa, facilitated by corrupt airport employees in Accra and London; and

- Operation Captura is a partnership between the UK charity Crimestoppers, SOCA and the Spanish Government and Police to locate UK fugitives based in Spain and return them to face British justice. Since 2006, SOCA has identified 654 UK fugitives located in Spain. As of 31 March 2012, 48 of the 65 Captura subjects had been arrested and returned to the UK. Although the campaign is not specifically focused on drugs trafficking, 24 of the 65 serious offenders were wanted in connection with drug related crime.

This Government believes that it is SOCA's officers and the success of their work in partnership with international colleagues, and not the SOCA branding, that has been the real success story. These partnerships are important, and will continue. The NCA and its officers will be able to build on previous successes and quickly develop a strong NCA brand which is recognised by our international partners.

The Government agrees that gathering reliable intelligence on the maritime trafficking of illegal drugs is a crucial part of the international fight against the drugs trade. The Government continues to discuss this matter with other EU Member States and the Commission and continues to support the excellent work undertaken by both the Maritime Analysis and Operations Centre (Narcotics) (MAOC(N)) and Europol.

Through the EU's Standing Committee on Operational Cooperation on Internal Security (COSI), the Cypriot Presidency recently facilitated a discussion on options for Europol to potentially assume responsibility for coordinating MAOC(N) missions and around improving intelligence flows between MAOC(N) partner countries and Europol. Through the Military and Maritime Intervention Cell (MAMIC) the UK currently supplies all relevant maritime intelligence to Europol, whilst coordinating interdictions with MAOC(N). Whilst we would support and encourage increasing intelligence sharing between MAOC(N) partner countries and Europol, thereby

[4] As of 31 March 2012

utilising Europol's analytical capabilities to best effect in support of Member States' investigations and operational activity, we would not be in favour of Europol coordinating military assets or missions, which falls outside of Europol's mandate and should remain the jurisdiction of Member States.

Evidence and intelligence led approach

Recommendation 5

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

Recommendation 11

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

Recommendation 12

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

Drugs destroy lives and cause untold misery to families and communities around the world. The UK readily acknowledges its shared responsibility to tackle the drugs trade. This Government will continue to consider these important issues when developing drug policy. In November 2012, the UK participated in the High Level International Conference on Alternative Development and signed up to the Lima Declaration which sets out international guidelines and principles for tackling many of the issues that the Committee raises.

The UK Government continues to take human rights very seriously, provides clear guidance to officials to help them identify any risk of abuse, ensure the assistance we provide supports our values and is consistent with our international obligations. In December 2011, the Government published the Overseas Security and Justice Assistance (OSJA) Guidance providing a clear framework to help officials identify human rights risks, propose appropriate measures to mitigate these risks and

produce a final assessment. It also sets out when the decision to provide assistance should be taken by senior personnel or Ministers.

The UK has also lobbied the UN Office on Drugs and Crime to ensure all counter-narcotics projects include robust mechanisms to safeguard against possible violations, including the use of the death penalty. The UK requires that any UNODC activity receiving funding from the UK is in full conformity with human rights standards.

Single Convention on Narcotic Drugs of 1961

Recommendation 6

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

The Government agrees that it is important that countries remain inside the Single Convention on Narcotic Drugs 1961. The UK objected to Bolivia's reapplication with a reserve on 14 December 2012. This objection was one of principle relating to Bolivia's proposed reservation and not its re-accession. Our primary concern remains that a reserve weakens the convention by legitimising coca production and increasing the risk of diversion to the cocaine trade.

The UK did not make representations to any other Member State to object or influence their decision. 61 objections were required to block re-entry and 15 objections were deposited. Our priority now will be continuing our cooperation with the Bolivians on drugs policy.

Preventing money laundering

Recommendation 28

Like any business, the international drug trade thrives on profit. Identifying and seizing the profits of the drug trade, wherever they are in the world, must be a central part of the global fight against drugs. In that context, the UK's approach to money laundering has been far too weak. Whilst we recognise that the financial crisis has occupied the attention of the FSA since 2008, there is little evidence that it treated the issue of money laundering sufficiently seriously prior to that time. We welcome the creation of the Financial Conduct Agency and we recommend that it produce annual reports which show the prevalence of money laundering within the UK financial sector. (Paragraph 151)

Recommendation 29

Being fined by a regulatory body is an inadequate a sanction for complicity – however peripheral, and whether it is wilful or negligent – in an international criminal network which causes many thousands of deaths each year. We recommend that the Government bring forward new legislation to extend the personal, criminal liability

of those who hold the most senior posts in the banks involved where they are found to have been involved in money laundering. (Paragraph 152)

We welcome the support of the Committee on the importance of tackling money laundering and the recognition of the use of asset recovery as an effective tool for tackling those involved in the drugs trade. The cross Government multi-agency strategy – '*Local to Global: Reducing the Risk from Organised Crime'* – puts the need to tackle criminal finances and money laundering at the heart of our approach to organised crime.

We agree that it is important that we understand better the risks the UK financial sector faces. To this end, in addition to the Financial Conduct Agency (FCA) working more closely with SOCA and the NCA to identify threats and share intelligence, the FCA will also be contributing to a National Money Laundering and Terrorist Financing Risk Assessment being developed by the Treasury and Home Office. This assessment will be used to strengthen the co-ordination of actions to assess risks, apply resources and mitigate those risks in the UK.

We do not however accept that the Government should bring forward new legislation to extend the personal, criminal liability as anyone found to have been involved in money laundering is already subject to criminal investigation and prosecution under the Proceeds of Crime Act 2002. In addition, personal criminal liability exists for those found to have failed to comply with the Money Laundering Regulations that require businesses to know their customers and conduct ongoing monitoring. This includes individuals working for banks, lawyers, accountants and others.

The response from the majority of stakeholders to a public consultation on the Money Laundering Regulations in 2011 was that these criminal penalties were important and should be retained and the Government agreed to do so. As such, there is no evidence to suggest new criminal penalties are required.

Enforcement

Recommendation 30

Drug-related policing is a vital component of reducing supply and the intelligence aspect, whether it be data on supply routes, the trend in available products or the location of markets, assists not just local police forces but other law enforcement agencies. Following the election of Police and Crime Commissioners, the use of police budgets will be decided with increased community input and local accountability. There is a risk that significant variations in the local approach to drugs could lead to geographical displacement of the drugs trade within the UK. Commissioners will therefore need to be fully briefed on the wider impact of decisions which they might take locally. We recommend that the National Crime Agency submit to every Police and Crime Commissioner and Chief Constable an annual, confidential briefing setting out the measures they could take to contribute to disrupting the drugs trade nationally and internationally. (Paragraph 157)

Recommendation 31

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

Recommendation 32

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

The NCA will lead the fight against serious, organised and complex crime and bring strong coordination to national and international efforts to reduce the supply of drugs – from local to global . For the first time, a single agency will pull together the complete intelligence picture on serious, organised and complex crime and have the authority to coordinate and task the national response, working with the police and other law enforcement agencies.

The NCA will regularly update chief constables on the intelligence picture on serious, organised and complex crime in the course of their work together, including specifically on the drugs threat, and will work with them to identify operational opportunities to tackle it. The NCA will also ensure that PCCs have an overview of the range of serious organised and complex crime, including specifically on the drugs threat, and determine the best format for these updates, working with chief constables and PCCs. However, the Government does not consider it appropriate to mandate the production of a specific annual drugs briefing for PCCs and chief constables along the lines proposed.

Since 2003 the Drug Interventions Programme (DIP) has operated in every local area in England and Wales; in 2011/12 DIP managed 88,000 individuals into drug treatment and recovery services. DIP operates under the umbrella of Integrated Offender Management (IOM). It ceases as a nationally funded and managed programme on 31st March 2013. Over the past decade, Drug Action Teams and some 21 police forces have received central government funding for the implementation of DIP.

From April 2013 it will be for local areas to decide which (if any) interventions they want to utilise to address Class A drug-related offending in their area. The police provisional funding for 2013-14 (announced on 19th December 2012) included an unringfenced Community Safety Fund (CSF) totalling £90 million for PCCs to address crime, drugs and community safety priorities.

Local IOM arrangements will help to ensure that locally identified priority offenders do not fall between the gaps. This may mean that more offenders are “in scope”

locally, as a consequence of IOM, and the benefits of a more dynamic approach to bringing together existing programmes and approaches.

Prisons

Recommendation 36

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

We are renewing our efforts to disrupt the trafficking of drugs into prisons and the activity of organised criminals coordinating the trafficking of drugs from prisons. Recent years have seen a significant decrease in the numbers of prisoners testing positive for drugs.

We are committed to creating drug free environments in prison and are therefore increasing the number of drug free wings, where increased security measures prevent access to drugs. But the cost and regime implications of these measures have to be part of the picture.

We have strengthened our intelligence capability to improve the range, quality and security of the intelligence collated about prisoners and their known criminal associates. We will also deploy signal denial technology in prisons, to disrupt prisoners' use of illicit mobile phones.

We agree with the Committee that these measures are important and are committed to provide them where they are appropriate and represent good value for money. It is, however, for Governors and Deputy Directors of Custody to determine which security measures are most appropriate, and are affordable, depending on the specific physical layout and design and security risks at each prison.

New Psychoactive Substances (NPS)

Recommendation 33

The market in new psychoactive substances is changing quickly, too quickly for the current system of temporary banning orders to keep up. Forty-nine new substances were found in Europe last year, a rate of development which makes additional measures critical. At the moment, businesses are legally able to sell these products until such time as they are banned with apparently no legal consequences when they lead to death or long-term illness. We recommend that the Government issue guidance to Local Authority trading standards departments, citizens advice bureaux and other interested parties on the action which might be taken under existing trading standards and consumer protection legislation to tackle the sale of these untested substances. A restaurant which gave its diners food poisoning, a garage

which left cars in a dangerous state, or a shop which sold dangerously defective goods could all be prosecuted for their negligence. Retailers who sell untested psychoactive substances must be liable for any harm the products they have sold cause. It is unacceptable that retailers should be able to use false descriptions and disclaimers such as “plant food” and “not for human consumption” as a defence where it is clear to all concerned that the substance is being sold for its psychoactive properties and the law should be amended. (Paragraph 170)

We have already taken a range of actions to tackle the supply and reduce demand for NPS, often referred to as ‘legal highs.’ The Committee’s recommendations broadly align and build on the Government’s action plan[5] to tackle NPS.

Our approach to tackle NPS mirrors the broader Drug Strategy focus on reducing demand, restricting supply, and establishing risks, harms and enabling recovery. We have taken swift and robust action to tackle this fast moving market that include:

- leading the way internationally on this issue in the UN and EU; and
- enhancing existing and establishing new warning systems to give us real time information on the emergence of NPS to ensure that we have an evidence base for the ACMD to make recommendations.

We are committed to keeping the effectiveness of the legal framework in relation to NPS under review and to looking at new evidence on what works in other countries, including the use elsewhere of different types of legislation.

We continue to assess the scale of the threat to the UK from NPS to improve our understanding of the UK drug market. Whilst not under-estimating the nature of the market, counting the number of NPS identified should not be a single barometer to judge the extent of the problem in the UK. The Committee refers to the 49 new substances reported by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 2011. Only 17 of these have been encountered more than once in the UK by the Forensic Early Warning System, of which 14 are already controlled under the Misuse of Drugs Act 1971.

It is the deployment of generic definitions whereby entire families of drugs are brought under the Misuse of Drugs 1971 Act that has placed the UK in a much stronger and more durable position. Temporary Class Drug Orders are intended to supplement this where a more rapid response is needed for an emerging NPS which is causing sufficient concern about both their harms and increased prevalence, as in the case of methoxetamine.

The government welcomes the Committee’s suggestions about the use of wider legislative options to address the supply of NPS. Following publication of the NPS Action Plan in May 2012 we have already stepped up our response to tackle NPS supply, with SOCA leading a multi-agency working group with the police and Border Force to develop new approaches to identify importers, distributors and sellers of NPS.

[5] http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/drug-strategy2010-review-may2012?view=Binary (page 11)

Products available to the general public should be safe for their intended purpose. We agree with the Committee that those selling harmful substances should face the force of the law. False and deceptive descriptions and disclaimers should be challenged.

Whilst current consumer protection was not specifically designed to deal with NPS or other substances of misuse, Trading Standards Officers across the UK are exploring the use of criminal law under the General Product Safety Regulations 2005, Consumer Protection from Unfair Trading Regulations 2008, and the use of civil enforcement orders for breach of a duty of care under the Enterprise Act 2002. Our understanding of the circumstances in which this type of legislation can be used effectively to tackle NPS sales continues to be informed by this ongoing work. We are also looking for opportunities across government to encourage consideration of this issue at European Union level as much of our consumer protection legislation implements EU legislation.

The Government will work closely with Trading Standards Services to develop guidance for local areas, and we will encourage the Trading Standards Institute, which now has responsibility for advising on enforcement matters, to ensure that local authorities are aware of the harms of NPS and the tools available to tackle their sale.

Annex A

International Comparators Study: Terms of Reference

The 2010 Drug Strategy commits us to "…review new evidence on what works in other countries and what we can learn from it". Drug policy needs to be based on the best available evidence and take account of the developing evidence base on different approaches and interventions.

The Minister of State for Crime Prevention, who Chairs the Inter Ministerial Group on Drugs, will conduct a study of national drug policies adopted by a range of countries to tackle drug misuse and dependency including their legal and operational responses, as well as treatment and health related approaches, within each country's social and legal context. It will cover alternative approaches taken by these countries to tackle drug use as well as regulatory responses to new psychoactive substances.

The study will:

- consider the effectiveness of the policy and operational responses adopted in each of the identified countries in terms of impact on individuals, communities, harm reduction and criminality (where evidence is available);

- identify benefits and negative consequences of each of these approaches; and

- compare the approaches against those being implemented via the coalition's 2010 Drug Strategy.

The study will be presented to the Inter Ministerial Group on Drugs where Ministers will consider the evidence to inform policy development. The study will also be one aspect of our preparation for the UN General Assembly Special Session on drugs in 2016, which will review progress in the implementation of the Political Declaration and Plan of Action on international cooperation to counter the world drug problem.

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