



Home Office

Drugs: International Comparators

October 2014

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Foreword

The Coalition Government is delivering on the commitments in our 2010 Drugs Strategy, and there are positive signs that our approach is working. Levels of drug use are on a long term downward trend, the number of heroin and cocaine users in England has fallen below 300,000 for the first time, and drug users going into treatment are more likely than ever to leave free from addiction.

In our 2010 Strategy, we made a commitment to review evidence about what works in other countries. It makes sense to see what we can learn from the experiences of others. During the course of 2013 and 2014, ministers and officials honoured this commitment in a programme of international fact-finding visits and discussions. We set out to review different approaches to the misuse of drugs – in policymaking and on the ground – and consider them against the approaches taken in the UK. In this report, we present the findings of that work.

Our fact-finding work has demonstrated that countries are dealing with similar issues. There are common elements to the way they are responding. Many countries are to a large extent acting along the lines of the three strands at the core of our own Drugs Strategy: reducing the demand for drugs, restricting supply, and supporting drug users towards recovery. However, there are sometimes stark differences in emphasis and variations in policy and operational responses.

Where there are differences in practice between one country and another, these are often informed by different social and legal contexts. What works in one country may not be appropriate in another. We explore these differences in this report. In many cases, they illustrate the complexity of the challenge, and demonstrate why we cannot simply adopt another country's approach wholesale. The UK continues to pursue a balanced, evidence-based approach to the misuse of drugs. We promote this approach internationally, and we seek to engage and learn from other countries as the challenges evolve.

Our legislative approach to drugs misuse, based in the Misuse of Drugs Act, provides us with the flexibility to control emerging harmful drugs and target illicit supply. Police and the courts have discretion to take an informed and proportionate approach to an individual caught in possession of controlled drugs.

To tackle the challenge of New Psychoactive Substances, we appointed an expert panel late last year to look in detail at this aspect of drug policy. The panel has had access to the evidence gathered in the course of this study. Their report and the Government's response to the panel's recommendations are today published in tandem with this report.

Drugs: International Comparators

This study has provided us with a sound base of evidence on approaches to drugs misuse and drug addiction in other countries, and we hope that this report makes a useful contribution to the global debate on drug policy. Based on what we have learned, the UK will continue to advocate a balanced, evidence-based approach to the misuse of drugs internationally.

**The Right Honourable Theresa May MP
Home Secretary**

**The Right Honourable Norman Baker MP
Minister of State for Crime Prevention
and Chair of the Inter-Ministerial Group on Drugs**

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1. Executive Summary

This report describes the findings of the Coalition Government's international comparators study of approaches to drugs misuse and drug addiction. The Government has considered a range of policy and operational responses to drugs in other countries and reviewed the evidence of their impacts, where possible drawing out contrasts and similarities with the Government's own Drug Strategy.

During 2013 and 2014, ministers and officials from the Home Office took part in fact-finding visits to, and discussions with, eleven countries: Canada, the Czech Republic, Denmark, Japan, New Zealand, Portugal, South Korea, Sweden, Switzerland, the United States of America and Uruguay. Home Office officials also undertook desk-based research on policies in a number of other countries including the Netherlands. Based on what we saw during our fact-finding, and grounded in an understanding of the drugs situation in the UK, we identified a set of themes to focus on – responses to drugs which stood out as particularly innovative, widely discussed, or relevant to the UK situation. We undertook further research and analysis of the evidence base around each of these themes. In this report, we present the outcomes of this work.

The UK situation

There is robust evidence that drug use among adults has been on a downward trend in England and Wales since the mid-2000s. This trend seems to be reflected in drug use among children of school age. While, historically, levels of drug use in the UK have been relatively high, there are signs that, following several years of declining use, levels of drug use in this country are close to the European average.

The 2010 Drug Strategy sets out our response to drugs misuse and drug addiction. It is a balanced approach, encompassing activity across three strands: reducing the demand for drugs, restricting the supply of illegal drugs, and supporting users into recovery. Our legislative response to drugs is based in the 1971 Misuse of Drugs Act, which continues to provide a flexible yet consistent legislative framework to control emerging harmful drugs and target illegal suppliers, while supporting our public health messages and the delivery of our Drug Strategy.

Drugs present us with a continually evolving set of challenges. Changes over time in the types of people who use certain drugs, the types of drugs that are available, and the methods of supply, mean that we must adjust our responses. Through our Drugs Strategy and our Serious and Organised Crime Strategy, we are meeting new and longstanding challenges such as: the crime and public health harm associated with opiate and crack cocaine addiction; the variety of ways in which illegal drugs can reach the UK; the threat of prescription drug abuse; and the emergence of many New Psychoactive Substances, some of which are openly sold, often inaccurately, as 'legal highs'.

Responses to drug use in other countries

Just as the UK has arrived at its current approach in response to an evolving set of challenges, the responses we saw in each country are a product of that country's own issues. It is a common aim of every country to reduce drug misuse. The variety of ways in which countries seek to achieve this aim reflects the sometimes stark differences between legal frameworks and cultures.

Drug consumption rooms

In Canada, Switzerland and Denmark, we visited facilities into which drug users can bring illicitly purchased drugs – typically heroin or cocaine – for consumption under supervision. These ‘drug consumption rooms’ have emerged as a response to the public health risks associated with open drug scenes: public areas where drug users congregate in large numbers to purchase and inject or smoke drugs. There is some evidence for the effectiveness of drug consumption rooms in addressing the problems of public nuisance associated with open drug scenes, and in reducing health risks for drug users. Drug consumption rooms overseas have been controversial and legally problematic, and have been most successful where they have been a locally-led initiative to local problems. We do not experience scenes of public drug taking on the same scale in this country.

Heroin assisted treatment

We visited a clinic in Switzerland where patients are given injections of pure heroin under medical supervision, as part of their treatment for opiate dependency. Heroin assisted treatment is an emerging form of treatment which uses injections of medical-quality heroin, where traditional substitution treatment would administer oral methadone or buprenorphine. The evidence from trials in several countries, including the UK, shows that this form of treatment can be effective in reducing illicit drug use and improving retention in treatment among people deeply entrenched in opiate dependency, for whom other forms of substitution treatment have been ineffective. A limited pilot of this approach is underway in three sites in England.

Dissuasion commissions

A cornerstone of Portugal’s decriminalisation policy is the use of dissuasion commissions: lay panels which sit outside the criminal justice system, consider cases of drug possession, and decide whether individuals should be given administrative penalties or referred into treatment for addiction. Although dissuasion commissions are held in the context of decriminalisation, the concept of signposting treatment in drug possession cases can and does apply in the criminal justice system in this country.

Drug courts

We visited a drug court in Baltimore, Maryland, where people charged with a drug-related offence have the option of pleading guilty and entering a treatment programme overseen by a judge, in lieu of a traditional (possibly custodial) sentence. Drug courts apply a range of sanctions and rewards to encourage offenders to successful completion of treatment, with the aim of reducing their chances of reoffending. There are more than 2,500 drug courts in the USA, and the model has been exported to Canada, Australia and the UK. Drug court pilots in England and Wales have been affected by differences in court systems, sentencing practices and cultures. Crucially, there is a lack of evidence for their effectiveness, and drug court models in the UK (including Scotland) have shown no impact on reoffending rates.

Prison-based treatment

We visited prisons in Japan and Denmark, to look at how people are treated for drug dependency in different cultural contexts. Our consideration of the evidence for the effectiveness of prison-based treatment programmes confirmed the potential for these programmes to reduce reoffending. It also highlighted the vulnerability of offenders with a history of drug use during the transition from custody to the community. In the UK context, we are developing an approach to improve access to treatment for people with drug and/or alcohol dependency in custody to existing substance misuse treatment and associated health services in the community.

Prison-based harm reduction

In Switzerland, we discussed with officials the country's prison-based needle exchange programmes. Needle exchanges started operating in Swiss prisons in 1992 during a surge in heroin use, and have since been adopted in a number of countries, including Spain and Germany. There is a body of international evidence indicating that needle exchanges are an effective way to reduce needle sharing and the transmission of blood-borne viruses in prisons. UK law prohibits the transportation of drug paraphernalia into prisons. In tackling drug use in prisons, we focus on measures that address the breadth of drug-taking behaviour, rather than injecting alone. We are committed to reducing drug use among offenders and provide a range of low, medium and high intensity drug treatment for prisoners.

New Psychoactive Substances

New Psychoactive Substances (NPS), or so-called 'legal highs', are synthetic substances designed to mimic the effects of established drugs. Unlike established drugs, NPS are not covered by the established international conventions which underpin the approach of most countries to controlling drug supply and drug use. We encountered a variety of approaches to NPS. In New Zealand, a regulatory regime will be established, similar to the regime for medicines in this country, under which producers must prove the safety of substances before they can be sold in licensed premises. In the Republic of Ireland, the supply of any new psychoactive substance is illegal. The legislative framework in the USA ensures that any substances designed to mimic existing controlled drugs are also subject to the same controls by default. The Minister for Crime Prevention appointed an expert panel to consider legislative options for controlling NPS in this country. The Government's response to the panel's recommendations is published concurrently with this report.

Supply-side regulation of cannabis

Uruguay and the American states of Colorado and Washington are adopting experimental policies which legalise and regulate the production, supply and recreational use of cannabis. These policies have common aims – disrupting organised crime and exercising greater control over the use of cannabis – but practices differ. The American states have a market-driven approach, with lighter regulation than Uruguay and fewer limitations on consumption and use. Uruguay, which has growing concerns about organised crime, has a stronger role for the state, with limitations to the size of the market, the strains and potency of cannabis, and the quantity of cannabis an individual can purchase in a month. It is too early to know how these experiments will play out, but we will monitor the impacts of these new policies in the coming years.

Decriminalising the possession of drugs for personal use

We encountered a range of approaches to drug possession, from 'zero-tolerance' to decriminalisation. The evidence from other countries show that levels of drug use are influenced by factors more complex and nuanced than legislation and enforcement alone. Levels of drug use vary considerably between countries with similar policies. With regard to Portugal, where decriminalisation was followed by improvements in health outcomes for drug users, it is difficult to disentangle the effect of decriminalisation from wider improvements in treatment and harm reduction during the same period.

2. Introduction

Background

In 2012, after a wide-ranging inquiry into the UK drugs situation, the Home Affairs Select Committee published its report, *Breaking the Cycle*. In its report, the Committee welcomed progress made in delivering the 2010 drug strategy – increased numbers of people accessing treatment for their drug use, improvements in prison-based treatment, and a new focus on lasting recovery from drug use – but highlighted that there was more that could be done to ‘break the cycle’ of drug addiction.

The Coalition Government did not agree with the Committee’s recommendation of a Royal Commission to fundamentally re-think approaches to drugs, but recognised the need to stay abreast of emerging approaches and trends. The International Comparators Study on drugs was established to examine national drug policies adopted by a range of countries to tackle drug misuse and dependency.

We published the aims of the study in March 2013, in the Government response to the Committee’s report:

- To 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);
- To identify benefits and negative consequences of each of these approaches; and
- To compare the approaches against those being implemented via the coalition’s 2010 Drug Strategy.

Context: The UK situation

In the course of this study, Home Office ministers and officials participated in visits, interviews and desk-based research to explore responses to drug misuse and drug addiction in thirteen countries. Through these fact-finding activities, we learned that every country is working hard to tackle drug use and to minimise the health and social harms that drugs can cause. Our fact-finding work made equally clear that, while countries may have common goals, policies and operational responses differ. Most countries, though not all, approach drug misuse through a combination of: enforcement to restrict the supply of illicit drugs, education and other targeted interventions to prevent misuse, treatment to reduce drug use, and measures to reduce the social and public-health impacts of misuse and addiction. There are sometimes stark differences in emphasis, but each country clearly believes that their own approach is delivering results. Often, the context has a significant part to play. Each country we studied arrived at its strategy in the context of its own culture, legal framework, and in response to its own unique issues.

The UK is no different. From the Misuse of Drugs Act 1971 through to the Drugs Strategy 2010, the UK’s approach to drugs has adapted to meet an evolving problem. Drugs continue to present new challenges. The rapid emergence of New Psychoactive Substances (NPS) in recent years has been a test of the flexibility of our legislative framework, and of the responsiveness of our enforcement and demand-reduction activities. Our expert-led review on NPS, which the Minister for Crime Prevention commissioned in December 2013, is an example of the sort of response to an emerging issue that has shaped UK drug policy over the years.

This study considers some of the responses we have seen to drug misuse and drug addiction around the world.

Understanding drug use in the UK

There is robust evidence that adult drug use in England and Wales has been on a downward trend since a peak in the early 2000s. The independent Crime Survey for England and Wales tells us that ‘last year’ adult drug use (the percentage of 16–59 year olds who report having used a drug in the last year) peaked at 12.3% in 2003/04. This figure has since fallen and the latest survey shows adult drug use at 8.8%.¹ (Figure 2.1)

The largest contributing factor to this downward trend is cannabis use, which declined from 10.6% to 6.6% over the last ten years. There have been reductions over the last ten years in the use of ecstasy, amphetamines, alkyl nitrate and magic mushrooms.

There has been an overall downward trend in the estimated number of users of opiates (such as heroin) and/or crack cocaine since current estimates began in 2004/05.² In 2010/11 the number of opiate and/or crack cocaine users in England fell below 300,000 for the first time. Evidence suggests that heroin and crack cocaine users are ageing and that fewer young people are starting to use these drugs.

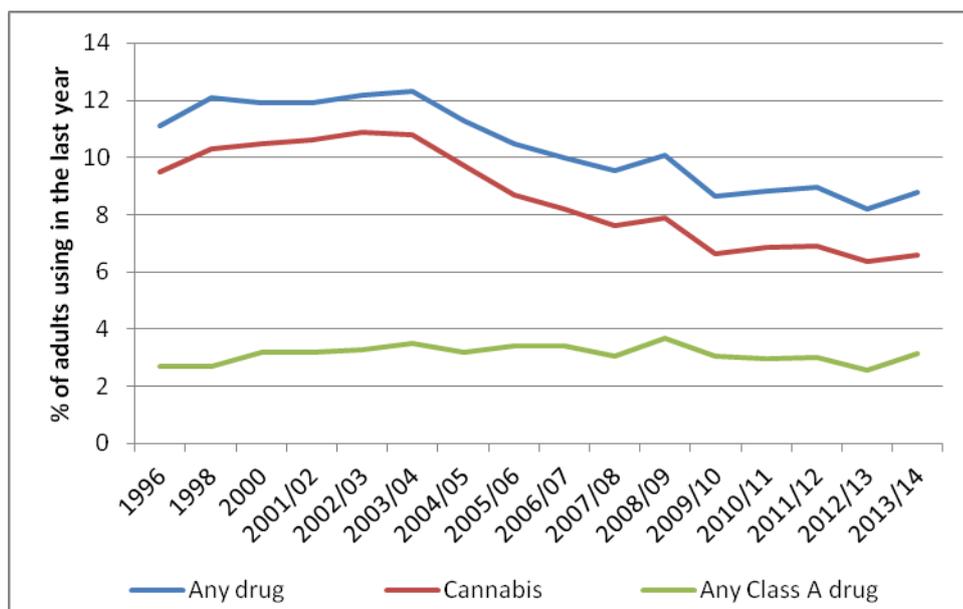


Figure 2.1: Trends in illicit drug use among adults aged 16–59 in England and Wales, 1996 to 2013/14 (Source: Crime Survey for England and Wales)

Trends in drug use among young people (those aged 11 to 15 years) also show declines. The Smoking, Drinking and Drug Use survey shows that ‘last year’ use of any drug among 11 to 15 year old pupils in England has fallen from 20% in 2001 to 11% in 2013. As with adults, these downward trends are primarily driven by falls in the use of cannabis. In 2013,

¹ Home Office (2014) Drug misuse: findings from the 2012 to 2013 crime survey for England and Wales. <https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2012-to-2013-csew>

² Hay, G., Santos, A.R., and Worsley, J. (2014) Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 report London: Public Health England <http://www.nta.nhs.uk/uploads/estimates-of-the-prevalence-of-opiate-use-and-or-crack-cocaine-use-2011-12.pdf>

7.0% of 11 to 15 year olds reported having used cannabis in the last year, a figure which had fallen from 13.4% in 2001.³

In 2013, the number of drug misuse deaths (those involving illegal drugs) reported in England and Wales increased after several years of decline. Between 2009 and 2012, drugs misuse deaths fell from 1,976 to 1,636. The number of deaths registered in 2013 was 1,957, an increase of 21% on the previous year. These trends are driven by trends in the deaths of male drug users, which constitute the largest proportion of drug misuse deaths; drug misuse deaths among female users have generally increased throughout this period.⁴

Although it is difficult to make direct comparisons with other countries (due to the different methodologies used to collect data and the varying quality of such data), data suggests that the UK has historically had relatively high levels of drug use. Following the declines in use seen since the early 2000s, and increases in use seen in some other countries, the UK appears now to be nearing the European average for overall levels of drug use. The UK, however, is not the only European country to have seen recent declines in drug use and its levels of heroin and crack cocaine use remain relatively high.

While recent data paints a broadly positive picture, it is important to recognise that there is a range of factors which can contribute to overall levels of drug use. Some factors exert an upward pressure, others exert a downward pressure. Falling levels of drug use over a period of time tell us that the effects of the downward pressures outweighed those of the upward pressures during that period. As well as state interventions such as reducing demand, disrupting supply and providing treatment, downward pressures might include a decline in risky and criminal behaviour, or changes to economic and social conditions. Upward pressures might include the availability of new substances and new supply routes.

Emerging and evolving challenges

We continually work to develop and refresh our understanding of the full range of factors and in particular on those which, even in the context of falling drug use, have the potential to exert an upward pressure. We also work to understand the types of drug use which are particularly harmful to individuals and to society.

Social and demographic trend data can indicate changes in the types of people who use certain drugs, and the types of drugs which certain groups of people use. We know, for instance, that the heroin using population is ageing (Figure 2.2).⁵ While fewer young people are taking up heroin use, a number of people who became addicted to heroin during the 1980s and 1990s continue to use heroin now. These are people who have not died as a result of their drug use, but have failed to move through treatment and into full recovery. For many of these individuals, 'recovery capital' is significantly diminished. This means that the stabilising influences of family, employment, housing and life skills, which are critical to recovery, may have been eroded through many years of dependency.

³ Health and Social Care Information Centre (2014) Smoking, drinking and drug use among young people in England in 2013 Available at: <http://www.hscic.gov.uk/catalogue/PUB14579>

⁴ Office for National Statistics. (2014). Deaths related to drug poisoning in England and Wales, 2013. Newport: Office for National Statistics. <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2013/index.html>

⁵ Public Health England (2013). Drug Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2012 to 31 March 2013. <http://www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf>

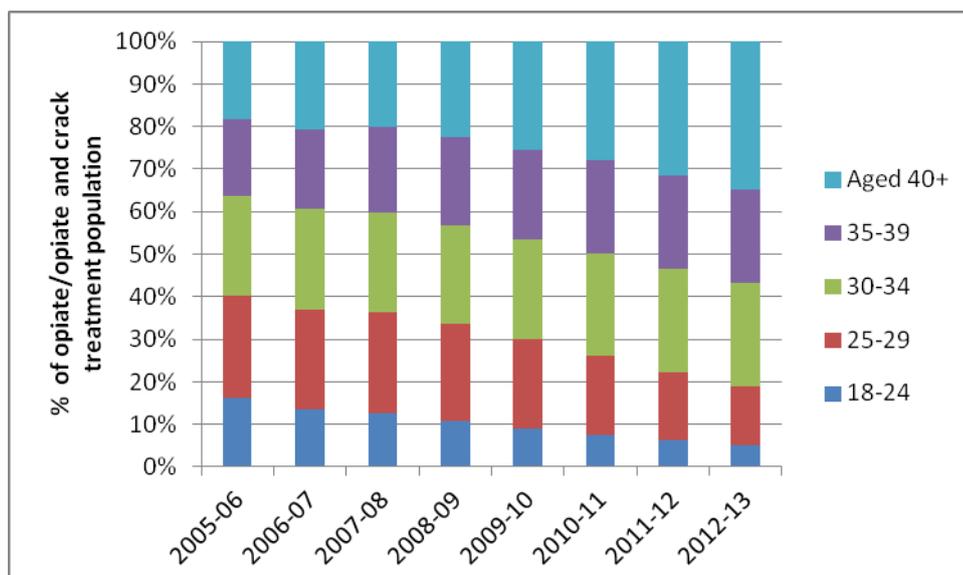


Figure 2.2: Trends in age among the opiate/opiate and crack treatment population in England, 2005/06 to 2012/13 (Source: Public Health England)

There are other sub-groups of the population who tend to have higher levels of drug use and may be at particular risk of harms. Research indicates that drug use among gay men is significantly higher than among heterosexual men, and there are recent reports which suggest that high-risk practices, such as intravenous drug use, and the use of crystalline methamphetamine, are more prevalent among drug-using men who have sex with men.

We need to respond to the way technology changes the nature of the drugs threat. Online markets have an impact on the supply of drugs, but they also have the potential to create new vulnerable groups, people for whom online drugs sales are more accessible or less intimidating than the established drug markets. Alongside the online markets, the internet provides a variety of sources of information on drugs and drug taking, not all of which may be credible. All of these factors will change the way the UK tackles drug supply and prevents drug use.

Our wider work to disrupt drugs supply is continually evolving. The majority of illicit drugs in the UK are trafficked into the country. The Government's 2013 Serious and Organised Crime Strategy outlines some of the associated challenges. We work with other countries to develop our understanding of supply routes, so that we can direct our law enforcement interventions to where they will have the biggest impact on the UK. The Serious and Organised Crime Strategy recognises the importance of the National Crime Agency and Border Force in tackling the emerging threats of New Psychoactive Substances, which can be harder to test for and therefore more difficult to identify at the border, and the use of fast parcel services to smuggle drugs into the UK. There are changes also to patterns of domestic drugs supply. Domestic cannabis production has seen a shift towards greater use of small scale cultivation, often in residential properties, making the production and supply of drugs increasingly an issue in local communities.

We look at the evidence of the threats different substances present, and adapt our response. For example, heroin is not the most prevalent illegal drug, and its use is gradually declining, but it is still associated with some of the most severe health and social

harms of any drug. In 2013, 39% of drug misuse deaths involved heroin or morphine.⁶ We estimate that heroin and crack cocaine users are involved in around 45% of acquisitive crimes.⁷ A recent study indicates a strong link between large increases in heroin use in the 1980s and 1990s and increases in crime during the same period.⁸ Our response needs to reflect the risks posed by even small amounts of heroin use, and the far greater risks if heroin use begins to grow again.

Largely because of differing controls and healthcare practices, prescription drugs are less widely misused in this country than in the USA, where they are the most frequently abused type of drug after cannabis. Nevertheless, we continue to shape our response based on the evidence.

New Psychoactive Substances are a growing challenge, in terms of health, legislation, enforcement and our ability to monitor and prevent drug use. Their availability and the perception that they are legal, and therefore safe, mean that they are a growing organised crime and public health issue, associated with increasing harm. The range and number of these substances that are available continues to increase, and there is little research from which to draw any conclusions about their long term harms. This, and the fact that products sold as 'legal highs' may contain a number of substances, including some which are controlled, challenge our ability to monitor patterns of use. In the face of such a rapidly growing and changing threat, we need to adapt our established responses. The coalition government has already permanently banned 350 new substances on the independent advice of the Advisory Council on the Misuse of Drugs, and our expert-led review on NPS will inform the way we adapt our legislative, policy and operational responses to meet the challenge.

⁶ Office for National Statistics. (2014). Deaths related to drug poisoning in England and Wales, 2013. Newport: Office for National Statistics. <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/england-and-wales---2013/index.html>

⁷ Mills, H., Skodbo, S. and Blyth, P. (2013). Understanding the organised crime: estimating the scale and the social and economic costs. Home Office Research Report 73. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf

⁸ Home Office (2014) The heroin epidemic of the 1980s and 1990s and its effect on crime trends then and now. Available at: <https://www.gov.uk/government/publications/the-heroin-epidemic-of-the-1980s-and-1990s-and-its-effect-on-crime-trends-then-and-now>

3. Approach

Fact-finding

Home Office ministers and officials took part in fact-finding and evidence gathering throughout 2013 and early 2014. Fact-finding visits and meetings, led by the Minister of State for Crime Prevention, explored strategic, policy and operational responses to drug misuse in countries across Europe and the wider world. Approaches to drugs vary in terms of the balance between public health and enforcement. To gain a view of a broad range of approaches, the study has considered countries within a variety of cultural, legal and geographical contexts, and a spectrum of policies. Although we aimed to consider a broad range of approaches, we did not attempt an exhaustive exploration of approaches to drugs around the world, but looked instead for a selection of interesting and innovative practices in a range of different contexts. The fact-finding phase of the study looked at: Portugal, Sweden, Denmark, Switzerland, the Czech Republic, USA, Canada, New Zealand, Japan, South Korea and Uruguay. The study also undertook desk-based research on Brazil and the Netherlands.

Themes

In the course of the fact-finding and evidence gathering, we saw a range of policy and operational responses to drugs misuse. For example, we have seen examples of good practice in preventing the supply of drugs, and in working with users and potential users to reduce the demand for drugs. This report is not intended to be a comprehensive description of approaches to drugs around the world.

Evidence review

Alongside fact-finding activities, the Home Office undertook a review of the available evidence for the policies and operational interventions described within this report.

This should not be regarded as an exhaustive review of the evidence in these areas. The availability and quality of evidence varied greatly across the different policies and interventions and a variety of research designs had been adopted, with various levels of scientific robustness. However, the strengths and weaknesses of the studies within each area were considered when making overall assessments of the existing evidence. Preference has been given to the consideration of meta-analyses and peer-reviewed studies, as these were viewed as being of higher quality than one-off pieces of research.

Where available, trend data from the countries visited has also been considered, including trends in drug use, drug related deaths and drug related crime. It is important to note that it is not always possible or helpful to make direct comparisons between drug statistics in different countries due to the different methodologies used to collect data and the differences in the regularity of data collection. We have made direct comparisons where possible, and have indicated where direct comparisons cannot be made.

4. Approaches to drugs misuse and drug addiction in other countries

4.1 Drug Consumption Rooms

Description

Drug consumption rooms (DCR) are facilities into which drug users can bring their own drugs for consumption under supervision in a clinical, hygienic setting, away from public spaces. Although not well documented, it is widely thought that the first DCRs to operate openly were established in Switzerland in the 1980s, in response to concerns about the widespread use of heroin in public, although drug consumption facilities had been operating in a legal 'grey area' in many countries before then.

In the course of the study we have considered a number of variations on the DCR model. Features can vary between sites according to the nature and scale of the problems that a facility has been set up to address. Most DCRs facilitate injection. Sites may also, or alternatively, offer facilities for smoking or sniffing of powdered drugs. After-care may be provided, and users may be provided with counselling or advice on treatment, welfare and housing onsite.

Features common to most DCRs are:

- the (usually light-touch) screening or assessment of users on entry;
- the free provision of sterile equipment, such as needles;
- the availability of medically trained staff;
- the consent and co-operation of local police;
- connections with other key services such as treatment, counselling, legal advice and housing.

Because of these features, DCRs are distinct from illicit 'shooting galleries' or 'crack dens'. The injecting facilities in the DCRs we visited were not comfortable places to spend time, being sparsely furnished in a similar manner to a hospital or clinic, but they were carefully managed, medically staffed, clean and hygienic.

We visited DCRs in Switzerland, Denmark and Canada. Other countries that have allowed the establishment of DCRs include Germany, Australia, the Netherlands, Norway, Spain and Luxembourg.

The primary common aim of the DCRs we visited is to reduce the public health and social impacts of drug use. While efforts are often made to connect users with treatment, advice and social services, these goals are secondary to reducing rates of overdose and infection, avoiding the safety risks associated with hasty public injections, and minimising public nuisance. This reflects the fact that DCRs are seen as a harm reduction measure aimed mainly at reaching the most chaotic, marginalised, hard to reach drug users. The Cloud, the facility we visited in Denmark, is attached to a shelter, and estimates that 80% of its users are homeless. More than a third of the users of the facility we visited in Canada are involved in the sex trade.

Case Study: Drug Consumption Rooms in Copenhagen

Following a 10 year debate, in July 2012, legislation was passed which enabled the introduction of drug consumption rooms in Denmark. The legislation was a response to requests from local authorities to the Government following high-profile lobbying by prominent members of the local community in the Vesterbro area of Copenhagen, the location of a large and historically problematic open drugs scene. Vesterbro attracts between 600 and 800 drug users each day. Residents of the newly gentrified area were encountering social, health and environmental damage as a result of open and public injecting and smoking of cocaine and heroin. We visited Skyen ('The Cloud'), Copenhagen's newest drug consumption room, which is co-located with Men's Home, a shelter for homeless people in Vesterbro. The Cloud was opened by the then Danish health minister in August 2013.

Copenhagen's approach to drug treatment has three aims:

- Support drug users towards abstinence;
- Where abstinence is not a current objective for a user, reduce the harm to that user from using drugs; and
- Reduce the harm for the surrounding society and families of drug users.

The Cloud, and Copenhagen's other drug consumption facilities, address the first of these aims indirectly, by providing counselling onsite and by putting users in touch with other services which will support them in moving towards recovery. This is referred to as 'bridge-building'. They address the second aim more directly, by offering a safe and sterile environment, clean equipment, and washing facilities. The third aim is addressed by the reduction in public drug-taking which these facilities enable.

The Cloud provides facilities for injecting and smoking. Injecting users are provided with clean syringes and needles, and a clean and sterile booth at which to inject. Each booth contains a vein finder (a light which when directed at the skin illuminates the users' veins, enabling them to inject more safely), a sterile surface and a safe bin for disposal of waste. Booths are kept clean and sterile. The smokers' room is air conditioned to prevent build-up of fumes, and smokers are also provided with sterile equipment. Medically trained staff are on hand constantly, and are equipped to deal with overdoses and any accidental injuries, but do not interfere in ordinary circumstances.

Users arrive at The Cloud with their own supply of drugs. They are asked to sign in before using the facilities. Users are not required to sign in under their own name, but are encouraged to use any nicknames consistently, so that patterns of use can be monitored. At sign-in, users are also asked to provide some personal details, which are used for monitoring how the facility is used. Members of staff do not block users from entering the facility on the basis of the information they provide. This reflects Copenhagen's view that drug consumption rooms are a 'low-threshold' measure, aimed at bringing some degree of stability to the most chaotic and hard-to-reach drug users. Members of staff at The Cloud told us that Vesterbro is 'not where drug users start out, but it is where they often end up.'

The information collected at sign-in has provided Copenhagen with an indication of the way their drug consumption rooms are used:

- About half of users are not from Copenhagen. Some users come from as far as the Jutland peninsula and Sweden.

- 66% use the facility to consume cocaine alone, 11% to consume cocaine and heroin, and 10% to consume heroin alone. This is broadly consistent with patterns of opiate and cocaine consumption in Denmark as a whole.
- Much of the capacity is used by a small number of frequent visitors.
- Fewer women are using the facility than hoped. It is believed that this is because women feel insecure about visiting the facility.
- Demand for the smoking facilities is outstripping supply.
- Demand for the facilities has grown (Figure 4.1), and is now broadly stable with around 3800 incidences of use per week.

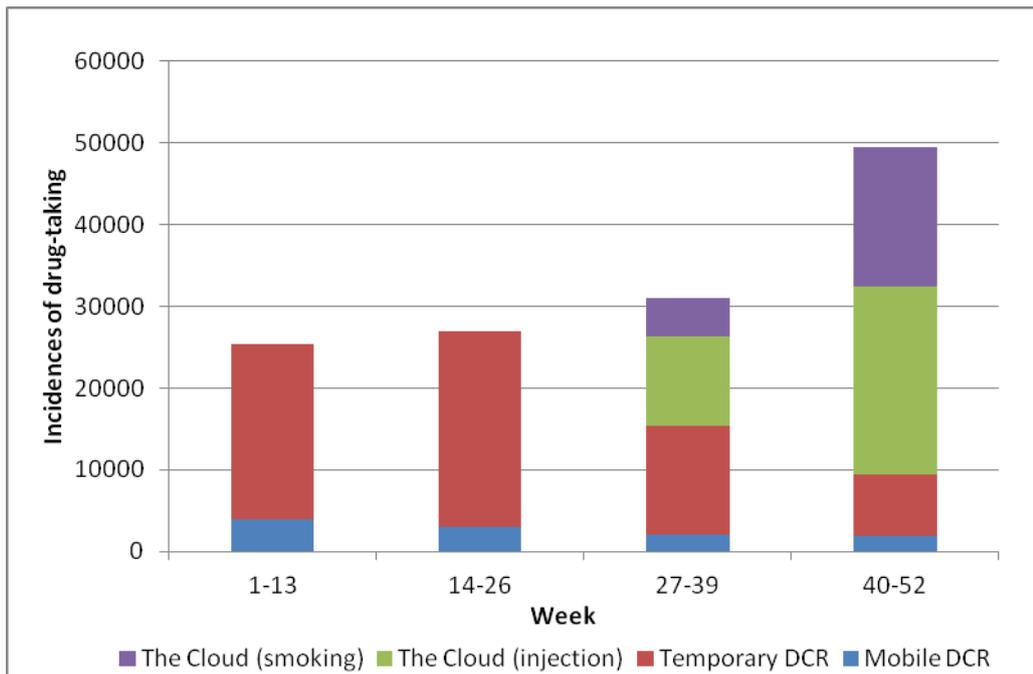


Figure 4.1: Incidences of drug-taking in Copenhagen’s DCRs during 2013 (Source: City of Copenhagen, Dept of Social Services)

We found that the co-operation of local police was vital to the success of The Cloud. Members of staff told us that minor disturbances are a regular occurrence and police are called to attend the facility daily. In order to enable the facility to operate, police do not normally prosecute drug possession for personal use, as long as the offender is aged 18 or over, with a long-term and severe drug dependency. Relationships with the police are good. Two officers are designated liaisons, and attend meetings of the facility’s management board. The designated liaisons have a good understanding of the area and know many of the users well. We were told that the facility is supported by local police because it helps to facilitate a more co-operative relationship with drug users. There are indications that acquisitive crime has fallen in the area. The police officers we spoke to were keen to stress that drug consumption rooms have not solved all of the social problems associated with drugs, but were a useful part of the solution.

Residents of Vesterbro have welcomed some of the positive changes that drug consumption rooms have brought to the area. We heard that the volume of drug-related litter collected from the streets around the drug consumption room has dropped by around four-fifths. Some concerns remain. Residents have been pressing for longer opening hours, as disturbances and public drug-taking remain prevalent outside opening hours.

Copenhagen also has a temporary drug consumption room, and a converted ambulance provides an additional mobile drug consumption room. On our visit, we heard that the temporary drug consumption room, which was established to provide services until The Cloud was ready to open, has remained open due to overwhelming demand. A further integrated site providing further drug consumption facilities alongside access to outreach services will be ready in 2016.

Review of Evidence

In its 2013 report on harm reduction, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reviewed the evidence from a range of studies from across Europe, Canada and Australia.⁹ The report acknowledges that DCRs have not been widely evaluated with robust scientific methods due to ethical considerations, though their impacts have been studied using less rigorous research designs. The report considers there to be sufficient evidence to conclude that DCRs are generally successful in meeting their primary aims (to provide an environment for safer drug use, to improve the health status of the target group and to reduce public disorder) without incurring serious risk.

- **Reduce public drug use and associated nuisance:** the report considers that DCR's effectiveness in reducing levels of public drug use and nuisance are largely dependent on accessibility, opening hours and capacity, but that within these constraints, DCRs are effective. This was reflected in our visit to Copenhagen, where we heard that residents in the neighbourhood of a drug consumption room were pressing for 24 hour opening times. The report finds no evidence that acquisitive crime increases in the neighbourhood of a facility, but that small-scale drug dealing is often found in the vicinity.
- **Provide a safer injecting environment:** the report finds that DCRs provide a lower-risk, more hygienic environment for drug consumption than public spaces, and do not increase levels of use or risky patterns of consumption. People who use DCRs claim that they engage in risky injecting behaviour less when using a DCR.
- **Target difficult, hard-to-reach drug users:** the report concludes that DCRs are successful in reaching their target population, principally street users and older long-term users who have never been in treatment. The report finds no evidence that DCRs recruit new users into injecting.
- **Decrease the incidence of drug-related infection:** the report finds insufficient evidence to make any conclusions on the effectiveness of DCRs in reducing HIV and hepatitis C infections.
- **Increase access to social, health and drug treatment services:** the report finds that DCRs increase access to drug treatment services and are associated with increased uptake of these services. The report also suggests that DCRs help to reduce stigma around drug addiction.

Overall, the EMCDDA report considers that on the basis of available evidence, DCRs can be an effective local harm reduction measure in places where there is demonstrable need, but only within a conducive social and policy context. To be effective, DCRs require broad local support and good integration with a wider network of services, and should be seen as a specific intervention for hard-to-reach drug users who are at risk of overdose, injury and infection.

⁹ EMCDDA (2013) Harm reduction: evidence, impacts and challenges. Available at: <http://www.dldocs.stir.ac.uk/documents/EMCDDA-monograph10-harm%20reduction.pdf>

In Switzerland, between 1993 and 2006, five national surveys were conducted among injecting drug users attending facilities that offered needle and syringe programmes, in order to measure trends in injecting behaviour.¹⁰ In 2006, half of these facilities included a DCR. The research showed reductions in injecting and improvements in health outcomes among those using the facilities. Although these changes cannot solely be attributed to the availability of needle and syringe programmes and DCRs, the evidence suggests that DCRs may have contributed to the improvement in intravenous drug users' health in Switzerland.

Insite, the facility we visited in Vancouver, Canada, was established as a pilot and has been studied more rigorously than many facilities in Europe. An analysis in 2004 found that Insite had significantly reduced levels of public injecting and drug-related litter such as discarded syringes.¹¹ Analysis of local crime statistics before and after the opening of Insite also showed that it had not exacerbated drug-related crime in the area.¹² A 2010 cost-benefit and cost-effectiveness analysis of Insite found that the facility prevents 35 new cases of HIV and 2 to 3 deaths per year, and provides benefits at a value of around \$6 million once programme costs are taken into account (a benefit to cost ratio of 5.12 to 1).¹³ The study concluded that Insite was a cost-effective public health measure on this basis.

Social and legal context

DCRs in other countries have most often been established as a response to the acute social and public health issues that arise when drug misuse is concentrated in a small area. DCRs in Berne and Frankfurt were set up to deal with open 'drug scenes' where large numbers of users were injecting in public squares, city parks and streets. When we visited The Cloud in Copenhagen, we were told of the group of drug users at whom the facility was aimed:

'They lived their lives in public. They went to the toilet, took drugs and had personal conflicts in the public domain.'

DCRs have most often been a locally-driven response, with much of the pressure and motivation for the response coming 'from the bottom up'. DCRs in Copenhagen came about largely as a result of pressure from local residents of the Vesterbro area, the location of Copenhagen's drug scene, following a period of urban gentrification. Enabling legislation was developed by the Government in response to requests from local authorities. Insite in Vancouver was established by the city as a response to an open drug scene, with high rates of HIV and Hepatitis infection, in the Downtown Eastside area. In circumstances such as these, where an area is already experiencing the effects of high levels of drug use, we found concerns that the DCR might act as a 'honeypot' for drug users were minimal. The chief concern of residents and local authorities in these areas is reducing the impacts of the problem on the local community.

¹⁰ Dubois-Arber, F., Balthasar, H., Huissoud, T., et al. (2008), 'Trends in drug consumption and risk of transmission of HIV and hepatitis C virus among injecting drug users in Switzerland, 1993–2006', *Eurosurveillance* 22 May, 13 (21).

¹¹ Wood, E., Kerr, T., Small, W., et al. (2004), 'Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users', Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC517857/>

¹² Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S. and Kerr, T. (2006), 'Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime', Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1471778/>

¹³ Andresen, M. A., & Boyd, N. A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy* (2009), doi:10.1016/j.drugpo.2009.03.004.

In the countries where they have been established, DCRs have often been legally problematic. Facilities in Canada and Australia have been the subject of legal challenges, and at least one facility in Canada has been forced to close on the instruction of the local health authority, which was concerned that the user-run facility did not meet safety standards. For a facility to operate effectively, staff and police officers are required to allow the possession and consumption of illicit drugs. In Denmark, we heard how enabling legislation was required before DCRs could operate legitimately. The legislation empowers the Minister for Health to permit, at the request of the local authorities, the establishment and operation of DCRs for persons aged 18 or above with a severe and long-term drug dependency. It is a prerequisite that such a request from a local authority is prepared in cooperation with the local branch of the national police. Prohibition against possession of narcotic drugs for other than medical and scientific purposes is maintained, but in and close to a DCR, the police will normally not prosecute possession for personal use if the offender is aged 18 or above with a severe and long-term addiction. In Switzerland, we heard that low-level dealing is even permitted on the premises. The United Nations International Narcotics Control Board (INCB) objects to the sanctioning of DCRs on the basis that they facilitate illicit drug use and thereby enable dealing and trafficking.¹⁴

Reflections

The DCRs we have seen in other countries are locally-led approaches to local problems. As set out in the EMCDDA's report, the effective operation of a DCR requires broad consensus among local residents and agencies, including a degree of collusion from staff and local police. Under UK laws the sort of collusion we have seen in other countries would be illegal. Since the provisions in the Serious Crime Act 2007 came into force, people working in DCRs may be guilty of the 'assisting and encouraging' of drug offences defined in the Misuse of Drugs Act. For medical staff this question of collusion might also be an ethical one, as the substances brought into a facility are likely to be highly impure and might be dangerous. Staff would potentially risk civil action as a result of any harms sustained by users in the facility.

Where local consideration has been given to the introduction of drug consumption facilities in the UK there has been local opposition from residents. The proposal of an independent commission on drugs in Brighton and Hove to investigate the feasibility of a DCR attracted concern from local people. This is in contrast to Denmark, for instance, where the strongest voices in support of the drug consumption room we visited had come from residents of the area. Such differences may reflect the fact that the UK does not experience open drug scenes of the kind which prompted the creation of the DCRs we saw in Switzerland and Denmark.

¹⁴ International Narcotics Control Board (2012) Annual Report 2012, page 99/100.

4.2 Heroin Assisted Treatment

Description

Distinct from drug consumption rooms (in which drug users inject illicitly obtained drugs under supervision) the provision of injectable diamorphine (pure heroin) under medical supervision is increasingly prevalent internationally as part of the treatment of opiate dependency. This form of treatment, often described internationally as Heroin Assisted Treatment (HAT), is typically used only in the treatment of deeply entrenched users for whom opioid substitution (for example, using methadone) has been ineffective. Opioid substitution therapy is usually preferred because the effects of substitutes such as methadone are felt over a longer period, allowing more infrequent appointments, which in turn allows patients to develop a more stable lifestyle.

HAT places people who are dependent on heroin in a regime of regular injections of diamorphine. Patients are required to report to a clinic where they are given injections by a doctor, usually two or three times each day, for the duration of the programme. Injections need to be frequent due to the short-term nature of the effects of injected diamorphine.

HAT, as described in this section, is distinct from the prescription of a 'takeaway' supply of diamorphine to patients for unsupervised self-administration. The element of supervision is key to this approach as it ensures compliance, minimises risk, and ensures that diamorphine is not diverted to the black market.

As a second-line treatment, thresholds typically apply, determining which patients should be offered HAT. These might include:

- a minimum age;
- a minimum period of time over which the patient has been drug dependent;
- evidence that other forms of treatment have not been effective.

HAT is expensive because of the high degree of clinical supervision required, because of the cost of the injectable drugs, because doses need to be frequent, and because clinics need to be open 365 days per year.

We visited a HAT clinic in Switzerland. The provision of injectable diamorphine under supervision has also been trialled in the Netherlands, Spain, Canada, Germany, Belgium, Denmark and the UK.

HAT patients are typically deeply entrenched in addiction. Rather than focus on recovery from addiction, trials of HAT have attempted to show progress toward this eventual aim in terms of other intermediate goals such as reduced use of illicit drugs, reduced offending, improved health and social functioning. The clinic we visited in Switzerland aims to create stability in users' lives by establishing a structure around the regular appointments and facilitating contact with social services and wider health advice and support.

Review of Evidence

As a form of drug treatment administered in a clinical context, HAT has been trialled and studied widely. The first notable trial was the 'PROVE' study which ran in Switzerland between 1994 and 1996, involving 1,000 patients across 18 treatment centres. The trial focused on the effectiveness of HAT in improving outcomes for injecting heroin users who

had not benefited from other forms of treatment. The trial demonstrated reductions in illicit heroin and cocaine use, criminal activity, and improvements in social integration.¹⁵ While the 'PROVE' study was not a Randomised Controlled Trial, and therefore not as robust as subsequent trials elsewhere, it paved the way for further clinical studies of HAT.

In 2012 the European Monitoring Centre for Drugs and Drug Addiction reviewed recent studies of HAT in Switzerland, the Netherlands, Germany, Spain, Canada and the UK.¹⁶ The review concluded that there is strong evidence for the efficacy of HAT, when compared with methadone treatment, for long term, heroin-dependent individuals who do not respond to other forms of treatment. Specifically:

- marked reductions in the continued use of illicit 'street' heroin, and to a lesser extent in the use of other drugs such as cocaine and alcohol;
- improvements in physical and mental health;
- reductions in criminal activity compared with levels prior to entering treatment.

The review found that while the evidence was less strong for improved retention of patients in treatment, retention was similar or greater for patients in HAT than in oral methadone substitution. Although this effect varied considerably, trials consistently reported good retention among HAT patients. The report found greater incidences of serious adverse health events for patients given HAT, compared with oral methadone, and suggested that more resources and clinical attention was needed for HAT in order to manage greater safety issues.

The review also looked at three trials which considered the economic impacts of HAT. Different trials used different assumptions in calculating the costs and benefits. Costs typically included the clinical and psychosocial resource needed to provide daily treatment all-year-round, and the buildings and administrative costs of facilitating such a service. Benefits included the reduction in medical expenditure associated with improved health and the reduced costs to police and criminal justice systems of reduced crime. Overall, HAT was found to be significantly more costly than methadone, but there was evidence that these costs were compensated for by savings to society due to the effectiveness of the treatment in reducing criminality and improving patients' health and social engagement.

Social and legal context

HAT is used primarily in the treatment of long-term entrenched heroin users. As part of the study, we looked at a number of countries with well established systems for the treatment of drug addiction and found that a common issue in many of these countries has been the emergence of a small, ageing cohort of heroin users who have not progressed from treatment into full recovery. The recent growth in the use of HAT could be seen as a response to this issue. Staff at the clinic we visited in Switzerland told us that their average client is 37 years of age.

Perhaps because it is administered in a treatment context, HAT has aroused less controversy than primarily harm-reduction focused measures such as drug consumption

¹⁵ Uchtenhagen, A., Dobler-Mikola, A., Steffen, T., et al. (1999), Prescription of narcotics for heroin addicts: Main results of the Swiss National Cohort Study, Karger, Basel.

¹⁶ EMCDDA. (2012). New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond. Available at: <http://www.emcdda.europa.eu/publications/insights/heroin-assisted-treatment>

rooms. It is consistent with UN Conventions because the diamorphine provided to patients is legally sourced. Providing heroin to heroin users is nevertheless a sensitive and controversial topic. A trial in Australia was halted following public and political concerns.

HAT is expensive to administer – ongoing UK pilots cost around 5 times more per patient than methadone – and will generally only be used for a small number of users. We did not, in the course of our fact-finding, encounter any serious consideration of HAT as a comprehensive alternative to opiate substitution. Rather, it is seen as an addition to the range of treatment options available.

Reflections

The UK population of heroin users includes some who are entrenched in addiction, and have not succeeded in achieving progress towards recovery through the standard forms of treatment. This makes HAT worth considering. In the UK, the option of prescribing diamorphine to people with opiate dependency has been available since the 1920s. From the 1960s, concerns that diamorphine prescription was fuelling illicit supply, coupled with new evidence on the effectiveness of opiate substitution, led to an increase in the use of methadone in treatment. Prescription of diamorphine as treatment for addiction remains a legal option. The use of injectable diamorphine under medical supervision was trialled in the UK between 2005 and 2008.¹⁷ The trial, consistent with the international body of evidence, demonstrated that for the most deeply entrenched heroin users, this form of treatment reduces the extent to which users fall back on illicit sources of heroin.

The 2010 Drug Strategy recognises the potential of injectable diamorphine, with its commitment to ‘continue to examine the potential role of diamorphine prescribing for the small number who may benefit, and in the light of this consider what further steps could be taken, particularly to help reduce their re-offending.’ A limited pilot is underway to determine the best way to make provision of injectable diamorphine under supervision a practicable option for local treatment commissioners. An interim report by the expert group convened to oversee the pilot states:

‘There is already some evidence of the cost-effectiveness of IOT [Injectable Opiate Treatment] compared to optimised oral methadone, for those not responding to the oral treatment option, from the 2005–8 randomised controlled trial... The current pilots are exploring cost effectiveness in greater detail. Although considerably more expensive as an intervention, IOT may be cost-effective where it delivers more benefits than standard treatments, especially in relation to community safety.’¹⁸

To make HAT a cost-effective option for commissioners, any benefits to society due to reduced offending will need to be sizable enough to offset the significant extra cost. The current pilots will run until March 2015, allowing Public Health England and the expert group to use the emerging lessons to explore commissioning arrangements beyond the period of the pilots. This includes consideration of how the treatment can be delivered as efficiently as possible, and how different local interests, including those of police and crime commissioners, can be factored into commissioning models.

¹⁷ Strang, J., Metrebian, N., Lintzeris, N., et al. (2010), ‘Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial’, *Lancet* 375, pp. 1885–1895.

¹⁸ Public Health England (2013) *Injectable opioid treatment: interim report by expert group* Available at: <http://www.nta.nhs.uk/uploads/iot-int-rep-20jan13.pdf>

4.3 Dissuasion commissions

Description

In Portugal, a person caught in possession of a small quantity (defined as the amount an average user would consume in a ten-day period) of any illegal drug for personal use is referred to a local Commission for Dissuasion of Drug Addiction (dissuasion commission), composed of a lawyer, a doctor and a social worker. Sanctions can be applied, but the main objective is to explore the need for treatment and to promote healthy recovery.

Portuguese law classifies drug possession and use as a misdemeanour, but for use and possession-only offences, no criminal sanctions are applied. Police issue users with a notice, requiring them to present themselves to a dissuasion commission. A police report is filed and sent to the relevant commission. If the user fails to attend, an administrative penalty such as a fine can be issued.

Dissuasion commissions in Portugal are linked to a nationwide network of support services. For users who are deemed to be dependent, they can recommend treatment and education. They can also take action if a user is not dependent, referring the user to education or psychological assessment, or imposing sanctions such as fines or community service.

Dissuasion commissions aim to relieve the burden on the criminal justice system of use and possession-only offences (which since 2001 in Portugal have been treated as administrative offences, rather than criminal acts) and direct more drug users into treatment and eventually away from drug use altogether. A key aim of Portugal's long-term drug strategy is to ensure that treatment for addiction is freely available to anyone who needs it.

Review of Evidence

While Portugal's overall approach to drugs since the reforms of the early 2000s has been the subject of a number of reviews, none has focused exclusively on the impacts of dissuasion commissions. It is unclear therefore whether the changes in drug use and related harms in Portugal since decriminalisation and dissuasion commissions were established in 2001 can be attributed to the availability of dissuasion commissions, to decriminalisation, or to the considerable improvements in access to treatment.

The caseload of Portugal's dissuasion commissions has increased steadily since they were introduced (Figure 4.2). In the years after their introduction, the proportion of referrals to dissuasion commissions that resulted in a decision was relatively low (less than half in 2006). The proportion is now considerably higher (7,394 decisions against 8,573 processes commenced). This reflects improvements to the administration and resourcing of commissions.¹⁹

¹⁹ Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (2012) Relatório anual 2012: A situação do país em matéria de drogas e toxicodependências.

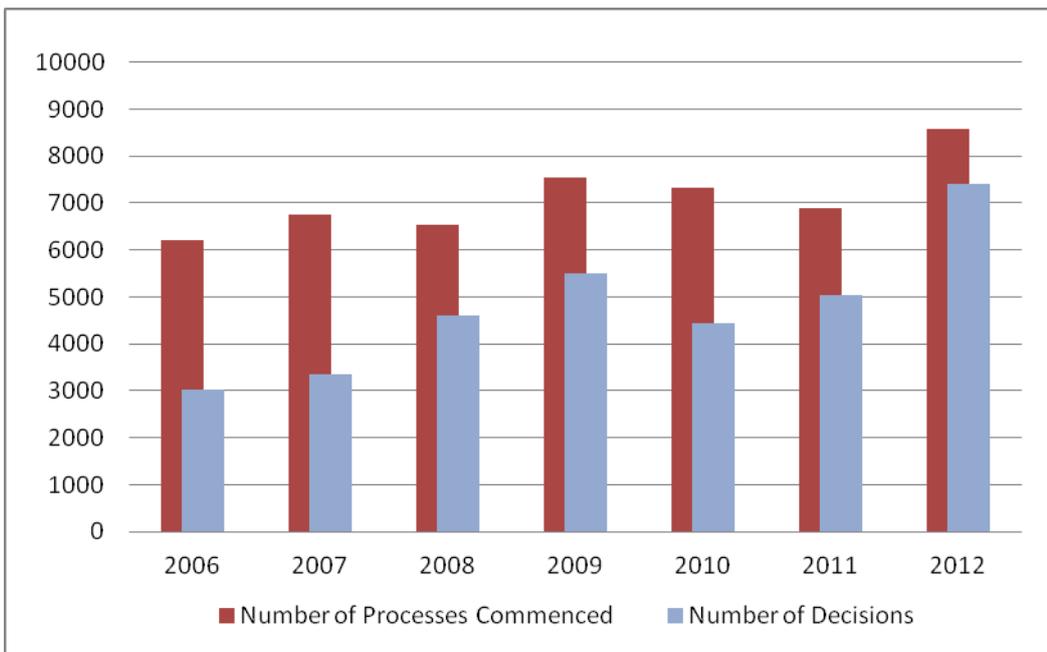


Figure 4.2: Number of processes commenced and decisions taken in Portugal's dissuasion commissions, 2006–2012 (Source: Reitox National Reports, EMCDDA)

In 2012, 78% of cases referred to dissuasion commissions involved cannabis only, 8% of cases involved heroin only and 8% involved cocaine only. 6% of cases involved more than one drug, of these, the most common combination was heroin and cocaine. Individuals were predominantly male (93%) with a mean age of 27.

While dissuasion commissions aim to explore the need for treatment, a recommendation to attend treatment is only made in a minority of cases. In most cases, people referred to the panels are not drug-dependent. The most common outcome of the dissuasion commission process is a provisional suspension, where the individual is deemed not to be drug-dependent: 67% of rulings in 2012. In these cases education may be a more appropriate intervention. Suspension of proceedings, with a recommendation to undergo drug treatment, accounted for 14% of decisions in 2012 and punitive sanctions accounted for 15% of decisions.

Social and legal context

Dissuasion commissions are part of a broader strategy in Portugal which focuses on prevention and treatment. Portugal's drug strategy has been in place since 1999, when it marked a significant change in the country's approach to drugs. During our visit, we were told that in the late 1990s, though levels of drug use were not as high as in many other European countries, drugs were among the issues of greatest concern to the Portuguese public, due in part to widespread alarm around the visibility of intravenous drug use and growing levels of HIV infection. An expert-led review recommended a change in Portugal's approach, maintaining efforts to reduce the supply of drugs, but increasing funding for treatment while removing criminal sanctions for individual possession and use.

Ministers and officials told us that drug misuse is seen primarily as a health problem in Portugal. The availability of treatment is seen as crucial to the success of initiatives such as dissuasion commissions, which aim to steer users towards treatment and into a drug-free life.

Reflections

Dissuasion commissions demonstrate an alternative to court and prison for minor drug possession offences. In the UK, offender diversion takes place within the context of a criminal justice process, and many of those drug users who receive treatment will also receive a criminal record and a criminal sanction such as a fine, community punishment or, in a small number of cases, a prison sentence. While drug possession is often handled with criminal sanctions in the UK, the 2010 Drug Strategy, in common with the Portuguese approach, recognises that drug users who come into contact with the justice system should be encouraged to seek treatment if it is needed. Criminal justice referrals are a key route into treatment in the UK, accounting for 28% of all new treatment journeys in 2012/13.

The UK also recognises that the application of criminal justice resources should be proportionate. For instance, police and the criminal justice system have a range of ways to deal with cannabis offences, from simple warnings, to penalty notices, to court proceedings. This allows police and prosecutors to take a proportionate approach, taking into account the circumstances of an offence and of the offender, and giving due regard to the public interest. In 2012, out-of-court disposals were applied in around 80% of cannabis possession cases. In common with the dissuasion commission approach, such disposals avoid unnecessary and expensive court proceedings.

4.4 Drug courts

Description

Drug courts operate in various forms in the USA, Australia, Canada and the UK. The drug court model provides judge-led oversight of drug treatment in lieu of traditional justice system routes. Participants are typically people who are addicted to drugs or alcohol and have been charged with a non-violent, drug-related offence, such as theft, driving under the influence, or anti-social behaviour. Although drug courts vary in terms of their target population and the types of services provided, they are generally based on a similar model. America's National Association of Drug Court Professionals describes the American model as having four key features:

- Increasing the offender's likelihood of successful rehabilitation through early, continuous, and intense judicially supervised treatment;
- Mandatory periodic drug testing;
- Community supervision;
- The use of appropriate sanctions and other rehabilitation services.

Judges work with treatment providers to establish a regime of sanctions and rewards, and users are held to account by the judge for their progress. Rewards include simple praise, tokens of achievement, or advancement through the programme. Sanctions can include fines, community service or short custodial spells. At the drug court we visited in Baltimore, Maryland, we heard that the use of rewards is considered just as important to the success of the drug court model as the use of sanctions. Successful completion of the court-ordered programme is celebrated in a graduation ceremony. Individuals who complete their programme are referred to as 'graduates'.

Drug courts are not a simple alternative to adjudication in a traditional court. The drug court programme can be offered as a diversion (the pre-adjudication model), where criminal charges are waived on condition of successful completion of the treatment programme, or as a sentencing option (the post-adjudication model), where the treatment programme is ordered by the court as an alternative to a custodial sentence. In both cases, the scope of the judge's role, and the degree of contact between the offender and the court, is significantly greater than in a traditional court.

We visited drug courts in Canada and the USA. The aims of the drug courts we looked at are: to improve treatment outcomes for drug dependent offenders; and to reduce re-offending, thereby minimising the costs to society, and to the criminal justice system, of drug-related crimes. Advocates of drug courts told us that drug courts also provide better outcomes for drug users through the use of rewards and sanctions for managing progress through drug treatment.

Case study: A Drug Court in Baltimore

In October 2013, we visited the District Court in northwest Baltimore, Maryland, USA, to look at a well-established and successful Drug Treatment Court.

In the early 1990s, there were concerns that Baltimore's legal and criminal justice systems were not only struggling to cope with high levels of drug related crime, but were failing to rehabilitate drug-addicted offenders. At the time, around 80% of offenders in Baltimore's

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prisons had a history of substance abuse, and 71% of the prison population were not first-time offenders.²⁰

The drug court programme in Baltimore was established in 1994, and can process more than 300 offenders at any time. Participants are adults who are dependent on drugs (heroin and crack cocaine being the most prevalent in Baltimore) and have committed a non-violent offence, typically acquisitive crime to fund addiction. The court operates a post-adjudication model, meaning that to participate in the programme offenders must plead guilty, and the programme is offered in lieu of prison or other sentencing options. The court is typical of a drug court in the USA, in terms of the therapeutic nature of the judge's role and the application of sanctions and rewards.

The programme consists of five steps. At each step, candidates' supervision requirements become less stringent, indicating to them that they have earned lighter supervision by remaining drug-free. We heard that sanctions and rewards are considered equally important in steering participants through the programme. Rewards do not have to be substantial to be effective: applause and verbal praise are both considered important, as are tokens of achievement such as 'step pens'. Participants who are performing well are described as being 'on the A-Team'. Progress to the next step can be a powerful incentive. Sanctions can include verbal reprimands, or writing a reflective essay, but can also be firm: 'shock incarcerations' of up to a week can be used if participants fail to follow their treatment requirements.

We heard that participants in Baltimore's drug court programme are three times less likely to reoffend than offenders given traditional criminal justice sanctions.

Review of Evidence

The experience of drug courts in the USA provides generally positive evidence for their effectiveness there. The US Government Accountability Office reviewed the performance of adult drug courts in a report to congressional committees in 2011.²¹ The review looked at evaluations of 32 drug court programmes and 11 cost-benefit studies. It found that in 18 of the 32 evaluations reviewed, participation in drug court programmes was generally associated with lower rates of reoffending compared with those from criminal courts. Relapse data available from eight of the programmes reviewed showed that drug court participants were less likely to use drugs after completing the programme than individuals in comparison groups, although the differences were not always statistically significant. Cost-benefit studies showed mixed results, with large ranges of net benefits identified from +\$47,852 to -\$7,108 per participant.

Academic reviews of drug court evaluations in the USA have found similar results. A 2010 analysis²² of the results of four systematic reviews and two meta-analyses in drug court evaluation literature concluded that overall, studies lean towards endorsing the beneficial effects of drug courts, but noted that they were neither universally nor unconditionally positive. A review in 2006 concluded that evaluations of drug courts have led to mixed results, but that consideration of findings across fifty studies tentatively suggests that drug court participants are less likely to reoffend than offenders sentenced to traditional

²⁰ William D. McColl, *Baltimore City's Drug Treatment Court: Theory and Practice in an Emerging Field*, 55 Md. L. Rev. 467 (1996) Available at: <http://digitalcommons.law.umaryland.edu/mwg-internal/de5fs23hu73ds/progress?id=MzbVv+xWvY&dl>

²¹ <http://www.gao.gov/assets/590/586793.pdf>

²² Stinchcomb, J.B. (2010). Drug courts: Conceptual foundation, empirical findings, and policy implications. *Drugs: education, prevention and policy*, 17(2), 148–167.

correctional options. Both reviews highlight that the mixed results seen across evaluations may, in part, be due to the generally weak methodology used and the lack of consistency across evaluations.

Two major evaluations of drug courts in Canada were reviewed in 2007. Similar to the reviews in the USA, the authors found methodological problems with both evaluations and found that they did not demonstrate the effectiveness of drug courts in reducing drug use and reoffending.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has considered the evidence for drug courts' potential to improve employment-related outcomes.²³ The EMCDDA cites a 2011 multi-site study which found that drug court participants at 18 months were significantly less likely than comparison offenders to report a need for employment, educational services and financial assistance. Although, the study found that drug court participants averaged a higher income, the difference was modest and not found to be statistically significant.

There is little quantitative evidence for the effectiveness of drug courts as implemented in the UK. Two evaluations (in 2008 and 2011) have provided some qualitative evidence which shows that the ability of the drug court model to reduce reoffending depends greatly on the significant role played by the type and quality of treatment received and other ongoing issues in offenders' lives.

Social and legal context

The first drug courts in the USA were proposed in the late 1980s, when crack cocaine addiction and its impacts on society had become matters of significant public concern, following a surge in the prevalence of crack cocaine use in major cities. Drug-related offences then, as now, accounted for a large proportion of incarcerations. Incarceration rates were high. Drug courts were established as a way of diverting people with drug dependencies from prison and reducing the likelihood that they would re-offend. There are now more than 2,500 drug courts operating in the USA, with at least one court in every state. The perceived success of drug courts has led to a wider trend in the USA for problem-solving courts, in which judges with specialist knowledge work directly with defendants (often referred to as 'clients') to address the underlying causes of crimes.

Drug courts in Canada and Australia have adapted the model to their own legal systems and cultures. Drug courts in these countries are aimed at addressing the same underlying problems, but there are differences in terms of the nature of judges' participation and the role of other services. While Canada and Australia have, in adapting the USA model, retained a more pastoral, therapeutic role for the judge, their models tend to represent less of a departure from existing criminal justice systems. Judges are more constrained and formal in the way they address offenders and in their application of sanctions. Probation also plays a greater role in managing the offenders' journey through treatment than in the USA, where the judge acts as a case manager.

²³ EMCDDA (2013) Current evidence on the effectiveness of the available criminal justice interventions for improving the employability of drug users. Available at: <http://www.emcdda.europa.eu/best-practice/social-reintegration/criminal-justice>

Reflections

The drug court model was adapted to the justice system of England and Wales as part of the Dedicated Drug Courts (DDC) Pilot Evaluation Programme. This looked at models introduced in two magistrates' courts in 2004 (Leeds and London).²⁴ The DDC model used in England and Wales included special sessions held in mainstream courts in front of a magistrates' bench or a district judge. The application of the drug court model to British justice systems was affected by practical and cultural differences. The nature of the magistracy, with lay magistrates sitting as little as 13 days each year, makes it harder to provide the judicial continuity that is central to the model. In the US, where the model is often used as an alternative to a criminal charge in a mainstream court 'docket', the model employs a wide range of sanctions and incentives for encouraging engagement with treatment programmes. Instead, the UK model builds on powers already available to the courts through the Drug Rehabilitation Requirement of a community sentence. The DDC pilots in the UK, as well as similar pilots evaluated in Scotland (Glasgow and Fife), showed no impact on reoffending.

In contrast to the US in the 1980s and 1990s when drug courts first emerged, where imprisonment for drug-related crime was perhaps the norm, community-based sentences are already a significant part of the sentencing framework in the UK today. The 2010 Drug Strategy recognises that the sentencing framework 'must support the courts to identify options, other than prison, which will help an offender tackle their drug or alcohol dependence, whilst recognising that, for some offenders, custody is necessary.' Drug Rehabilitation Requirements are one such option, providing a robust structure for treatment and testing in the context of a community sentence. As with drug courts, the success of Drug Rehabilitation Requirements depends on the availability and quality of drug treatment, and on the consent and willingness of the offender to participate in treatment.

In England, liaison and diversion schemes provide a means of identifying those who come into contact with the police or criminal justice system with a range of health issues, including drug dependence, and signposting them towards treatment and support. Having these services in the police custody suite means earlier identification with the possibility for intervention than exists with the US drug court model. The service is also available at court so that progress with engagement can be fed into the court process and inform decision making. A national liaison and diversion programme is currently being piloted across England. In April 2014 we launched 10 schemes (covering 13 police forces) which operate to an enhanced core model. An evaluation of the 10 schemes is currently underway and, if successful, we aim to roll out the enhanced liaison and diversion services nationally by 2017.

²⁴ There are other courts, including courts in Barnsley, Bristol, Salford and Cardiff, that bring some of the elements of the model together (for example, dedicated court lists).

4.5 Prison-based treatment

Description

Drug use and drug dependence are consistent issues of concern for prison systems around the world. For example,

- Across Europe, possession and supply offences are the main reasons for incarceration of between 10% and 25% of prisoners.²⁵
- In the UK, 81% of prisoners reporting having used an illicit drug at some time prior to their incarceration, based on a survey of 1,435 adult prisoners sentenced to between one month and four years in England and Wales in 2005 and 2006.²⁶
- In the USA, 65% of offenders reportedly meet the criteria for substance use disorder.²⁷

With consistently high proportions of people entering prison systems with problems of drug addiction or because of drug related crimes, common aims of prison-based treatment approaches are to improve offender health and reduce the levels of drug use in prisons. We visited prisons in Denmark and Japan and saw two different abstinence-based approaches to drug use and drug addiction.

We visited Statsfængslet ved Horserød, an open prison in Denmark, where 70% of the national prison population have a history of substance misuse. To tackle this, the prison has introduced 'Projekt Menneske' ('Project People'), which has created a strictly drug-free environment in a motivational unit within the prison. In the unit, inmates live alongside staff to prevent access to drugs, and are given recovery-focused drug treatment in the form of motivational interviewing, cognitive-behavioural therapy, education, health and fitness, trauma treatment, and family treatment. Alongside treatment, prisoners engage in activities like cooking, painting and swimming.

We also visited a prison in Japan, a country which operates far stricter regimes in which inmates work for 8 to 9 hours per day and are in bed by 9 p.m. Of a total prison population of around 75,000 in Japan, around 5,000 prisoners (7%) participate in prison based drug treatment programmes each year. Most drug users seeking treatment in Japan have an addiction to methamphetamine (rather than opioids and cocaine, as is more typical in Europe). Prisons work with private-sector self-help agencies to support offenders in addressing the emotional and psychological issues behind their drug use.

Internationally, prison-based drug treatment practices vary and can include the kind of abstinence-based approaches we saw in Denmark and Japan as well as maintenance approaches. The European Monitoring Centre for Drugs and Drug Addiction categorises programmes in European prisons into three types:

- **low-intensity drug treatment**, which covers counselling interventions as well as short-term treatment conducted in an outpatient regime within the prison setting;

²⁵ EMCDDA (2012) Prisons and Drugs in Europe: the Problem and Responses Available at: http://www.emcdda.europa.eu/attachements.cfm/att_191812_EN_TDSI12002ENC.pdf

²⁶ Light, M., Grant, E., & Hopkins, K. (2013) Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners. London: Ministry of Justice.

²⁷ EMCDDA (2012) Prisons and Drugs in Europe: the Problem and Responses.

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- **medium or high-intensity drug-free treatment**, defined as including inpatient wards for the delivery of drug treatment in a residential setting, e.g. therapeutic communities in prison;
- **medium or long-term opioid substitution treatment**, covering methadone or buprenorphine substitution programmes.

Even within these categories, the range of prison-based interventions is broad. Low-intensity treatments might include counselling, cognitive-behavioural therapy, life-skills training, sport and fitness, and spiritual services. Medium-intensity treatments might be based on a 12-step model or use cognitive-behavioural therapy.

There are many international examples of innovative practice. The United Nations Office on Drugs and Crime highlights examples of good practice in its report, *Drug Dependence Treatment: Interventions for Drug Users in Prison*. Further examples of best practice are available at the European Monitoring Centre for Drugs and Drug Addiction's Best Practice Portal, including:

- A project in Belgium which supports offenders in achieving abstinence through group activities (including social skills training and conversation groups) and one-to-one guidance from psychologists and social workers.
- The adoption of pre-release units in France, which provide offenders with a four-week programme of preparation for release from prison by increasing their autonomy.
- A project in the Czech Republic which supports drug-addicted offenders in preparation for release, working with their family members and close friends.

Case Study: Projekt Menneske at Horserød State Prison

We visited Horserød State Prison in Denmark to look at a motivational unit run by Projekt Menneske (Project People). Horserød is an open prison where, we were told, up to 70% of the prison population has a drug addiction. Projekt Menneske provides a strictly drug-free environment in which inmates live alongside staff to prevent access to drugs, and are provided with drug treatment, with the aim of achieving a drug-free life in preparation for, and after, release.

Prisoners volunteer to enter the unit, and are expected to be drug-free, but if they are not, prisoners can agree a 'phasing out' plan with prison staff and clinicians. Prisoners work with prison staff to develop their treatment programme, which is based primarily on cognitive behavioural therapy and can include: motivational interviewing, education, health and fitness, trauma treatment, and family treatment, alongside activities like cooking, painting and swimming.

Daily life on the unit is organised to prepare prisoners for life outside of prison, revolving around a structured timetable of: an 8-hour working day (which includes time spent on therapeutic activities), 8-hours of leisure time and 8-hours of sleep. Prisoners contribute to cleaning, cooking and shopping for food and, with support, are expected to develop life skills like household budgeting.

Another aspect of preparation for life outside of prison is the importance attached to the prisoner's family, friends and social network. Prisoners are offered the opportunity to develop and, if needed, repair relationships with friends and relatives in preparation for their release.

We spoke to one prisoner, Gru, who told us:

'I joined Projekt Menneske because otherwise I thought I would die. It has helped me get off drugs and develop coping mechanisms for when I am ready to be released from prison.'

Although there has been no formal evaluation of the project, we heard from project managers that the project is thought to have led reduced reoffending rates, and costs less to run per prisoner than a traditional secure prison wing.

Review of Evidence

In its report on prison-based approaches to drugs, the European Monitoring Centre for Drugs and Drug Addiction notes:

'There is a lack of research and evaluation of prison-based treatment programmes and too little is known about their effectiveness.'

The programmes we visited provided some anecdotal evidence of their effectiveness. We heard that participants in 'Project People' in Denmark are less likely to reoffend than other drug-dependent offenders.

A 2005 systematic review concluded that drug treatment programmes in prison are effective in reducing reoffending, and that programmes with intensive supervision tend to produce stronger evidence of success than programmes with lighter-touch supervision.²⁸

Internationally, opioid substitution treatment is widely available in prisons, although availability in prisons has lagged behind availability in the community. The United Nations Office on Drugs and Crime reports that in-prison methadone provision is now available in Canada, Australia, Poland, Indonesia, Iran, New Zealand, Puerto Rico and the majority of Western Europe, but is still unavailable in a significant number of other countries.²⁹

A 2012 review of data from 21 studies of the effectiveness of opioid substitution treatment in prisons concluded that the benefits of substitution treatment in prison are similar to those in the community: the opportunity to recruit problem opioid users into treatment, to reduce illicit opioid use and risk behaviours in prison and potentially minimise overdose risks on release. The study found that longer-term benefits can be achieved if continuity of treatment is provided through productive liaison with community-based programmes.³⁰

The importance of supporting drug-using offenders through their release into the community is made clear in one study, which found that in England and Wales, relative to the general population, offenders are around 40 times more likely to die in the first week after release, with 92% of deaths related to drugs. In the second week of release, prisoners were found to be around 19 times more likely to die than the general population, with 67% of deaths due to drugs.³¹

²⁸ Holloway, K., Bennett, T., Farrington, D. (2005) The effectiveness of Criminal Justice and Treatment Programmes in Reducing Drug-Related Crime: A Systematic Review. *Home Office*.

²⁹ UNODC (2008) Drug Dependence Treatment: Interventions for Drug Users in Prison. Available at: https://www.unodc.org/docs/treatment/111_PRISON.pdf

³⁰ Hedrich, D. and Farrell, M. (2012), 'Opioid maintenance in European prisons: is the treatment gap closing?', *Addiction* 107(3), pp. 461–3.

³¹ Home Office (2003) Drug-related mortality among newly released offenders. London, Home Office.

Social and legal context

Our fact-finding work in this area suggests that prison environments differ in reflection of wider societal attitudes to offending. There were clear differences between the prisons we visited in Japan and Denmark. In Japan, the misuse of drugs is seen primarily as a criminal justice issue, with an emphasis on reducing supply. There is often a stigma attached to drug use, with relatively low numbers of people (15,695 admissions per year) seeking treatment.³² In contrast, Denmark has a public-health focused approach to drugs, with a guarantee of treatment to all who need it, and around 16,000 of an estimated 33,000 'problem' drug users receiving treatment.³³ Despite these cultural differences, and a stark difference between the prison settings, there are similarities in the nature of the prison-based programmes we looked at in the two countries. Both were abstinence-based, recovery-focused and take place in a strictly drug-free environment.

Reflections

A key consideration in the provision of prison-based drug treatment is the equivalence-of-care principle, by which healthcare in prisons should be equivalent to healthcare in the community. The 2009–2012 EU action plan on drugs called for the development of prevention, harm reduction and treatment services in prison that are equivalent to services outside of prison. Prisons in the UK employ low-, medium- and high-intensity drug-free treatment for offenders, and opioid substitution is widely available.

Drug Recovery Wings were piloted in five adult prisons from 2011, and a further six prisons in 2012, which also included women and young offenders. The piloting activity is now complete. Following a feasibility and scoping study which was published in March 2014, an independent evaluation of the Drug Recovery Wing pilots is now underway and is due for completion in 2015. It remains for local health commissioners to decide if they wish to commission drug recovery wings when considering how best to meet the needs of their population. A number of establishments in partnership with Drug Treatment Providers have established their own local recovery wing models outside of the original pilot areas.

The learning from the Drug Recovery Wing pilots is being used to inform the wider roll-out of substance misuse treatment and recovery focused services as part of the Transforming Rehabilitation reforms. Building on the Drug Recovery Wing ethos, NOMS is working with the Department of Health, NHS England, Public Health England and a wide range of local partners to develop and test end-to-end approaches to tackling addiction for people with drug and/or alcohol dependency in the adult resettlement prisons for Cheshire, Greater Manchester, Cumbria and Lancashire and through the prison gate into the community.

We are also seeking to widen the availability of drug free environments in prison. Drug free wings can benefit both those prisoners who have completed drug treatment and those prisoners who have never had a substance misuse problem and want to avoid the temptation to use. As such, they will have less emphasis on substance misuse treatment than drug recovery wings and are likely to be open to a wider group of prisoners.

³² UNODC (2013) Patterns and trends of amphetamine type stimulants and other drugs, Asia and the Pacific. Available at: http://www.unodc.org/documents/southeastasiaandpacific//Publications/2013/ats-2013/2013_Regional_ATS_Report_web.pdf

³³ Sundhedsstyrelsen (2012) 2012 National Report to the EMCDDA. Available at: http://sundhedsstyrelsen.dk/publ/Publ2012/11nov/NR2012_DK_EMCCDDA_EN.pdf

The risk of fatal overdose among those leaving custody can be reduced through the more widespread provision of the opioid antagonist, naloxone, which reverses the respiratory depression caused by opioids like heroin. The Advisory Council on the Misuse of Drugs (ACMD) has recommended a relaxation of the restrictions on who can be provided with naloxone, to make it more easily available to those who live and work with opiate users, and to make provision for those people to be trained in administering naloxone. The government has accepted this recommendation and the changes are due to take effect from October 2015.

4.6 Prison-based harm-reduction

Description

In Switzerland we looked at a harm-reduction approach to drugs in prison. Harm reduction measures aim to minimise the health risks associated with drug use, and are usually employed alongside other measures which are aimed at reducing the incidence of drug use. Switzerland became the first country to introduce needle exchanges in prisons in 1992. Opioid substitution treatment and needle exchanges are both now widely available in Swiss prisons.

Needle exchange programmes seek to reduce the incidence of blood-borne infections such as HIV and hepatitis B and C by providing injecting drug users with sterile syringes in exchange for used ones, and thereby reducing the temptation to share injecting equipment. Using clean needles also reduces the risk of ulcers. Although primarily aimed at reducing the risk of infection for drug users, in the prison setting, needle exchanges also seek to reduce the risk of infection for prison staff, who may encounter used syringes while cleaning or carrying out searches.

In prison-based needle-exchange programmes, clean injecting equipment can be provided by a member of prison staff. An alternative approach is to provide vending machines which dispense a clean syringe when a used syringe is deposited.

Since the first prison-based needle exchange programmes began in Switzerland, programmes have been established in prisons in Germany, Spain and Portugal.

Review of evidence

Needle-exchange programmes in prisons have been widely evaluated in the countries where they have been introduced.

A 2006 review of international evidence looked at the findings of a number of needle-exchange programmes in Switzerland, Germany and Spain.³⁴

In summary, the review concluded that needle exchanges in prisons:

- Do not endanger staff or prisoner safety and, in fact, make prisons safer places to live and work;
- Do not increase drug consumption or injecting;
- Reduce risky behaviour and disease (including HIV, hepatitis B and C) transmission;
- Have other positive outcomes for the health of prisoners;
- Have been effective in a wide range of prisons; and
- Have successfully employed different methods of needle distribution to meet the needs of staff and prisoners in a range of prisons.

Overall, although the evidence is limited to a small number of countries and prisons, the evidence of the effectiveness of needle-exchanges as a health and safety measure in those places is strong.

³⁴ Line, R. et al. (2006). Prison Needle Exchange: Lessons from a comprehensive review of international evidence and experience. Canadian HIV/AIDS legal network.

Social and legal context

The introduction of needle exchanges in Swiss prisons reflects the fact that rates of HIV infection in Switzerland during the late 1980s and early 1990s were the highest in Europe. The first programme was started by a prison doctor without the knowledge or approval of prison authorities. Independently, around the same time, plans for a pilot programme were made at a second prison. The success of that pilot led to programmes being developed and implemented elsewhere in Switzerland and in Germany. Both Switzerland and Germany recognise the value of harm reduction in their national approaches to drugs.

Although there is no evidence that needle exchanges increase drug use, such programmes require authorities to acknowledge that drug use is taking place in prisons, and could be viewed as supporting intravenous drug use. A number of programmes have been shut down in Germany following controversies around such issues.

Reflections

Prison-based needle exchanges have been piloted in Europe and elsewhere, but not extensively. No such schemes exist in England and Wales and there is no evidence for their effectiveness in the context of English and Welsh prisons. However, the evidence from Germany and Switzerland is strong, particularly in regard to reductions in needle-sharing.

In the UK, there is evidence of higher rates of HIV and hepatitis infections among the prison population than in the general population, likely because of the relatively high numbers of offenders with a history of opiate use. We are committed to reducing drug misuse amongst offenders. While it is recognised that drug use does take place in prisons there is little evidence that injecting behaviour is widespread in prisons in England and Wales. There is evidence of changing patterns of substance misuse in prisons which mirror trends seen in the community. For example, we are aware of the growing risks around New Psychoactive Substances and prescription drugs. In tackling drug misuse in our prisons, we therefore focus on partnerships between the health and justice sectors to provide a wide range of interventions that support sustained recovery from addiction.

4.7 New Psychoactive Substances

New Psychoactive Substances (NPS), or so-called 'legal highs', are substances designed to mimic the effects of established drugs such as cocaine, ecstasy and cannabis. Unlike those established drugs, NPS are not covered by the established international conventions which underpin the approach of most countries to controlling drug supply and drug use. Driven by the globalisation of drug markets and advancement in technology, NPS are a growing threat.

The international community is increasingly aware of the harms and challenges posed by NPS. Information collected by the United Nations Office on Drugs and Crime (UNODC) demonstrates both the global and dynamic nature of the market. The UNODC has identified 348 separate NPS available in 70 countries worldwide – of which 97 substances were identified in 2013 alone.

The Coalition Government is taking sustained and comprehensive action to guide the international response to NPS. We have worked in collaboration with the UN and international partners to establish a global early warning advisory system to facilitate the sharing of evidence and forensic data. We have worked to re-vitalise the international scheduling process to include NPS, and have taken action that should lead to the international control of the dangerous substance mephedrone. We used our Presidency of the G8 in 2013 to build consensus on the need for a balanced and evidence based international response to NPS, and negotiated agreements to increase international law enforcement collaboration and to support the development of national prevention and recovery systems.

The UK Response

In this country, we recognise that the emergence of NPS presents us with a range of challenges. NPS test the flexibility of our legislative approach to controlling harmful psychoactive substances. They challenge the ability of our police forces and Border Force to identify and disrupt the supply of controlled substances. They present a new challenge to our ability to prevent drug use through education: many of these products are presented as legal, when they may contain controlled substances and may be more harmful than the substances they are designed to mimic.

We have been taking action on all of these fronts. For example, our Forensic Early Warning System takes a co-ordinated UK wide approach, bringing together forensic intelligence from law enforcement seizures and test purchasing to identify new substances as they emerge. The FRANK service, which provides facts to young people on drugs and their effects, draws on advice from our experts, the Advisory Council on the Misuse of Drugs, to provide up-to-date information. We work with police and Trading Standards officers to tackle the sale of NPS in 'headshops'. Using our existing legislative framework we have banned 350 new substances.

Frontline services have also made an important contribution raising awareness of the problems of NPS and rapidly developing clinical and other responses to them. For example, through Project NEPTUNE (Novel Psychoactive Treatment UK Network) the Health Foundation is supporting the development of evidence based clinical guidelines led by Central and North West London NHS Foundation Trust. These cover the assessment and treatment needs of users of NPS, as well as information on clinical management of harms resulting from acute and chronic use of 'club drugs' and NPS including intoxication, withdrawal and dependence.

International Approaches

As part of this study, we looked in particular at legislative responses to NPS in other countries. We were struck by the disparity in how different countries are tackling this threat. There is no clear emerging consensus on the right approach.

- **USA** – The USA has adopted an ‘analogue’ approach to enforcement against the misuse of new substances. The Controlled Substance Analogue Enforcement Act of 1986 prohibits the supply for human consumption of substances which are chemically similar to existing controlled substances and produce similar effects. More recently, the Synthetic Drug Abuse Prevention Act 2012 aims to control new substances based on their effects on the brain.
- **Republic of Ireland** – The Irish Criminal Justice (Psychoactive Substances) Act 2010 was introduced in response to growing concern around the trade of NPS. The Act makes it a criminal offence to advertise, sell, supply, import or export a psychoactive substance (not otherwise excluded), knowing or being reckless that it is for human consumption. The Act codifies a blanket ban on the trade of NPS, and has resulted in the closure of many headshops and all Irish-based websites supplying NPS.
- **New Zealand** – New Zealand saw a large rise in the use of benzylpiperazine “party pills” during the early 2000s. In response, new legislation in 2005 established a restricted substances regime to provide regulatory controls on psychoactive substances that posed a “less than moderate risk of harm” (“Class D”). However, manufacturers introduced other synthetic compounds that produced similar effects but fell outside regulation. New Zealand responded by introducing the Psychoactive Substances Act 2013, which establishes a full regulatory regime around the production, supply and sale of all NPS. Until the new regime is fully implemented, New Zealand is operating an effective blanket ban on NPS.

Expert panel review

Recognising that the challenges around NPS continue to evolve, and that no international consensus has emerged on the appropriate legislative response, the Government announced in December 2013 the appointment of an expert panel to look at how the UK’s response can be enhanced to maximise its impact and to ensure law enforcement agencies have the best powers at their disposal to tackle NPS. The expert panel has considered the opportunities and risks of each approach, as well as whether a new approach, combining elements of more than one regime, might be appropriate in the UK. The panel’s findings, and the Government’s response to the panel’s recommendations, are published concurrently with this report.

4.8 Supply-side regulation of cannabis

Description

In Uruguay and the American states of Colorado and Washington, legislation has enabled the legitimate production and trade of cannabis for legal, recreational use. This approach is distinct from the decriminalisation of individual possession and use because unlike decriminalisation (in which supply retains an illicit element and possession is usually treated as a misdemeanour) in Uruguay, and under state law in Colorado and Washington, production and supply of cannabis will be conducted openly and regulated by the state, and possession will be legal but subject to restrictions.

During the period in which we undertook our fact finding discussions, only Colorado had implemented its new law, but this study included discussions with legislators and officials from Colorado, Washington and Uruguay, to understand the aims of these initiatives and to explore the regulatory mechanisms needed to ensure the production and supply of cannabis remains legitimate.

The aim of supply-side regulation is to circumvent and eventually destroy the black market for cannabis, separating entirely those involved in producing and using the drug from criminality. In this respect, the approach has a similar goal to the Netherlands' tolerance policy, which aims to keep users of 'soft' drugs away from 'hard' drug markets. In our discussions with legislators and officials from Uruguay and the USA, there was no suggestion that regulation would move beyond cannabis to other drugs.

Legality and fit with international conventions

Allowing the recreational use of cannabis runs contrary to international conventions. In response to Uruguay's decision to allow a legal, regulated cannabis market, the International Narcotics Control Board (INCB) issued a statement stating that it regrets Uruguay's decision, which it maintains contravenes the 1961 Single Convention on Narcotic Drugs.³⁵ The statement was supported by the United Nations Office on Drugs and Crime.³⁶

In the USA federal law still bans the production, sale and possession of cannabis for non-medical use. People involved in the supply and consumption of cannabis in the states of Washington and Colorado, while doing so legitimately under state law, are breaking federal law. Guidance from the US Department of Justice clarifies how federal resources should be prioritised in tackling cannabis supply and use in these states. Priorities include sale to minors and diversion of the drug to other states. The inconsistency in the law presents some practical issues. For instance, cannabis producers in Colorado are unable to place revenues in banks not based in the state, as doing so would place the banks in breach of federal laws. At the time of writing, some of these issues have yet to be resolved.

³⁵ International Narcotics Control Board (2013) Press Release: Uruguay is breaking the International Conventions on Drug Control with the Cannabis Legislation approved by its Congress. Available at: http://incb.org/documents/Publications/PressRelease/PR2013/press_release_111213.pdf

³⁶ United Nations Office on Drugs and Crime (2013) Statement attributable to the UNODC Spokesperson on the Uruguay bill on regulation of the cannabis market. Available at: <http://www.unodc.org/unodc/en/press/releases/2013/statement-attributable-to-the-unodc-spokesperson-on-the-uruguay-bill-on-regulation-of-the-cannabis-market.html>

Keeping supply legitimate

There are a number of risks around the relationship between legitimate and black markets which regulatory systems need to address:

- Cannabis may be diverted from legitimate markets to an unregulated black market, either domestically or to other states where possession and use remains illegal.
- Black market production and supply may continue, undercutting the legitimate market and the ability of state authorities to use taxes as a means of deterring consumption.
- Producers may move from black market production and supply to legitimate production and supply, but retain their connections with criminality.
- Consumption may become more widespread, presenting a greater danger to public health and safety.

The diversion of cannabis products into black markets is a common concern. In Colorado, where the medical cannabis industry has been growing since cannabis was legalised for medical use under state law in 2000, a regulatory framework was in place before the legalisation of recreational cannabis. The framework has been enhanced for the retail market to include a system for tracking cannabis products ‘from seed to sale’. The new system ensures that cannabis plants are registered on a database and tracked using radio tagging. Products are weighed when harvested and at every stage of supply to ensure they stay in the legitimate supply chain. Washington plans to use a similar system. In Uruguay, radio tagging and a centralised database will also be used to track the location of all registered plants. In addition, the Uruguayan government is planning a system in which only five strains of cannabis will be licensed, and all cannabis products will be traceable to their source by their genetic code.

The risk of a continuation of the black market in some form was acknowledged in our discussions with officials. Colorado and Uruguay will allow limited domestic production of cannabis, and acknowledged that ensuring the products of these small-scale cultivations remain in legitimate use will be a challenge for police. For this reason, Washington will not allow domestic cultivation for recreational use. Washington will allow registered medical users of cannabis to grow up to six plants at home, though this will be a reduction from the previous limit of fifteen plants.

To mitigate the risk that black market producers will move into legitimate markets, the licensing of producers in Colorado and Washington will include character and background checks. The US Department of Justice will allow the states to use information held by federal agencies in the course of these checks, despite the inconsistency with federal law. This risk is mitigated further in Uruguay’s state-run system in which a limited number of private contractors will be authorised to carry out large-scale production on behalf of the state.

Controlling cannabis use

When this study discussed these new cannabis laws with legislators and officials in Colorado, Washington and Uruguay, all were mindful of the fact that cannabis use is harmful. The risks to the health of users are heightened by the fact that commercialising cannabis might normalise cannabis use, potentially create more users and greater harms. As well as the controls to the supply of cannabis, the new laws include restrictions to how and where cannabis can be used.

In Uruguay, cannabis will be sold in pharmacies. Cannabis users will be registered on a database, which will be checked at point of sale. This will allow the state to enforce a

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personal purchase limit of 40 grams (1.4 ounces) per month. Users will be required to be adult (over 18) residents of Uruguay, to mitigate the possibility of ‘drug tourism’ and reduce the risk of purchased cannabis leaving the country. Advertising of cannabis products will not be allowed. The limited number of legitimate strains of cannabis will aim to ensure improved control on potency over illicit markets.

In Colorado and Washington, in an extension to the existing arrangements for medical cannabis, products will be sold from licensed stores in various forms from smokeable products to infused confectionary, snacks and energy drinks. Officials in Washington are not planning to have a register of users and Colorado's state law specifically prohibits such a register, but the states will ban sales to people under the age of 21. Public consumption of cannabis products (including infused edible products) will be banned. As federal law bans cannabis, possession and consumption will not be allowed in areas owned by the federal government and agencies, including national parks and government housing projects. Enforcement against drug driving will be strengthened. There will be no limitations to the potency of smokeable cannabis and potency will not need to be disclosed, but there will be controls on the packaging, labelling and potency of cannabis-infused edible products.

Fiscal impact

Sales of cannabis for recreational use have been underway in Colorado since 1 January 2014. Sales are subject to the same 2.9% sales tax as other goods and services that are sold in the state. For cannabis, there is an additional 10% tax rate imposed on sales, and a 15% excise rate on wholesale. In January, production and sale of medical and recreational cannabis produced tax revenues of \$2.9 million (\$2 million of which was for recreational cannabis). Sales have increased during the year and in April the cannabis industry produced tax revenues of \$4.5 million (\$3.6 million for recreational cannabis).³⁷ The Colorado Legislative Council has predicted that the new recreational cannabis industry will generate around \$65.3 million in the first full fiscal year of implementation³⁸ – around 0.85% of the state's total annual tax income.

Social and legal context

While the regulatory systems are similar, the new laws in Uruguay and the two American states are to be implemented in quite different contexts.

In contrast to the market-led model seen in the US, which has relatively light-touch regulation, Uruguay's approach is state-run, with a larger role for the state not only in regulating the market but as the primary commissioner of production and supply. Uruguay experienced political turmoil during the 1960s and was under civilian-military dictatorship for much of the 1970s and 1980s. Drug possession for personal use has never been prohibited, and decriminalisation was formally legislated for in 1974. Prevalence of drug use has historically been low, but cannabis use has increased sharply since 2001 (Figure 4.3). Uruguayan legislators told us that they believe this increase may be due to an increase in living standards during the same period.³⁹

³⁷ Colorado Department of Revenue (2014) Colorado Marijuana Tax Data. Available at: <http://www.colorado.gov/cs/Satellite/Revenue-Main/XRM/1251633259746>

³⁸ Colorado Legislative Council (2014) Focus Colorado: Economic and Revenue Forecast. Available at: [http://www.leg.state.co.us/lcs/econforecast.nsf/vwFile/1403/\\$file/14MarchForecast.pdf](http://www.leg.state.co.us/lcs/econforecast.nsf/vwFile/1403/$file/14MarchForecast.pdf)

³⁹ Junta Nacional de Drogas, Uruguay (2012) Quinta Encuesta Nacional sobre Consumo de Drogas en Hogares Available at: http://www.infodrogas.gub.uy/images/stories/pdf/v_enc_hogares_2011.pdf

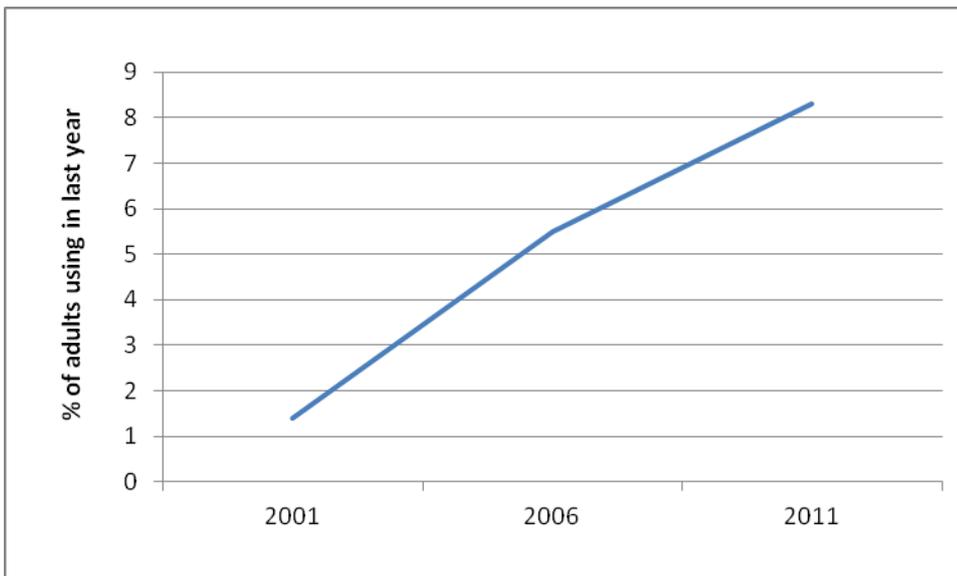


Figure 4.3: Cannabis use in adults in Uruguay, aged 15–65, 2001–2011
 (Source: Junta Nacional de Drogas, Uruguay)

In common with many Central and South American states, drug trafficking is an issue of major concern in Uruguay. Although it is not a major narcotics producing country, its position as a small, coastal state means that it is targeted by organised traffickers as a location for logistics and transit operations. While crime rates are low relative to the region, Uruguay has in recent years experienced an increase in organised crime. In the course of this study we heard that organised criminals had become embedded in local communities and had begun to develop some support among local people. We were told by those jurisdictions which are trying it that an aim of establishing a legitimate cannabis trade is to break the connection between organised crime and the growing number of law-abiding people who use cannabis.

The legalisation and regulation of cannabis is unpopular with members of the public in some of those places where it is being done (Figure 4.4). Polls indicate that the majority of Uruguayans are not in favour of the new law, with the most recent poll in September 2013 indicating that 61% of the public remain opposed.⁴⁰ These figures reflect the fact that cannabis regulation is not seen as a priority issue for many Uruguayans.

⁴⁰ CIFRA (2013) Los uruguayos y la marihuana Available at: <http://www.cifra.com.uy/novedades.php?idNoticia=205>

Drugs: International Comparators

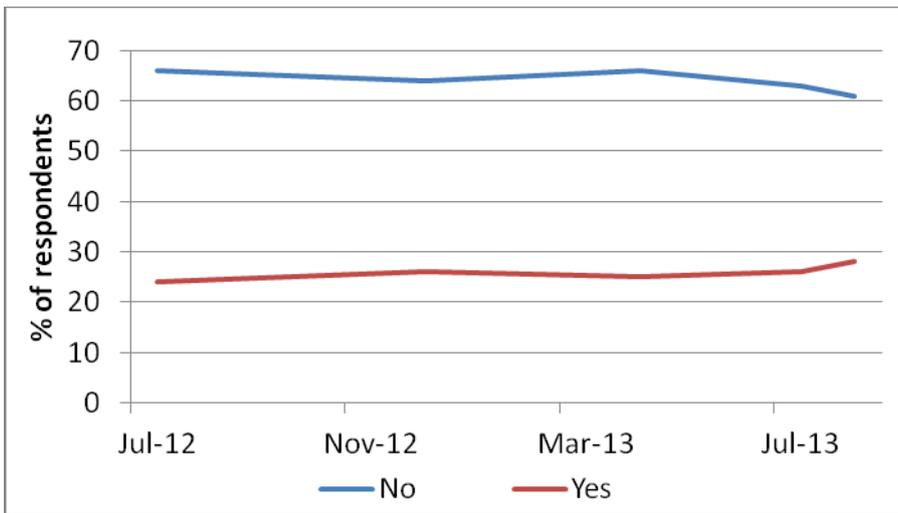


Figure 4.4: Uruguay polls: Do you agree with the the regulation of marijuana cultivation and consumption? (Source: CIFRA)

In contrast to Uruguay, there has been significant public support for the new laws in Colorado and Washington. Both laws were mandated by public ballot, with 56% of people in Washington and 55% of people in Colorado voting for the measures.

Polls indicate that these results are broadly consistent with public opinion across the USA as a whole, where support for cannabis legalisation appears to have risen steadily over several decades (Figure 4.5).⁴¹

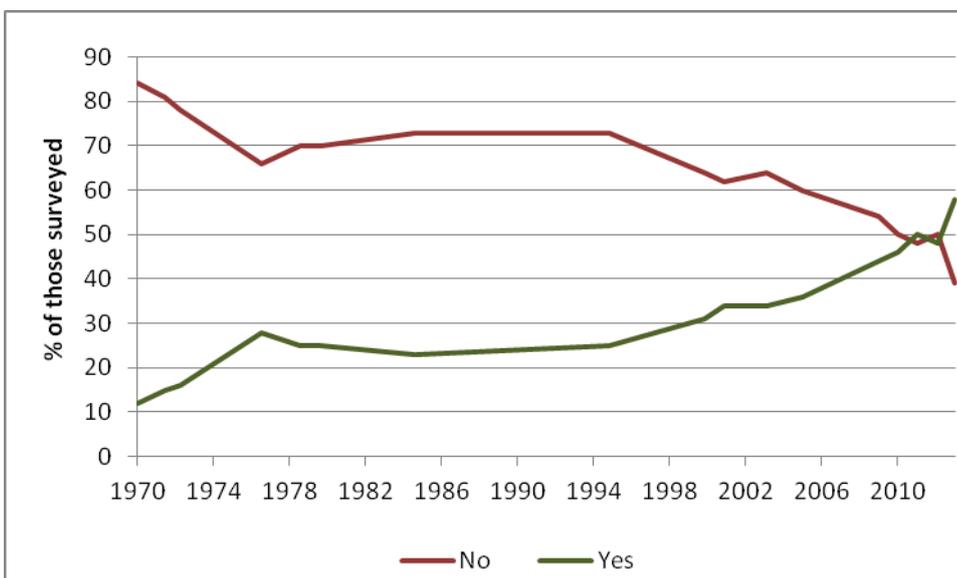


Figure 4.5: USA polls, 'Should marijuana be legal?' (Source: Gallup)

While the US public is generally supportive, these new laws run contrary to the national approach to drugs. The USA has been a consistent supporter of international conventions and has favoured a balanced approach, with an emphasis on enforcement, demand reduction, and treatment.

⁴¹ Gallup (2013) Available at: <http://www.gallup.com/poll/150149/record-high-americans-favor-legalizing-marijuana.aspx>

Cannabis is the USA's most commonly misused drug (as it is in most other Western countries). While prevalence has not shown the stark upward trend seen in Uruguay, it has stayed consistently high, with around 10–12% of adults (aged 12 years or older) having used the drug in the last year between 2001 and 2012.⁴² In 2010/11, cannabis prevalence was slightly higher than the national average (12%) both in Washington (15%) and Colorado (16%).

Reflections

Although differing methodologies mean direct comparisons cannot be made, the data suggests that cannabis use in the UK is lower than in Colorado and Washington, and on a long-term downward trend (Figure 4.6), unlike in Uruguay. In England and Wales, cannabis use among adults (16 to 59 years olds) has fallen from 10.9% in 2003/04 and now stands at 6.6%.⁴³ Among young people, cannabis use has also fallen sharply since the early 2000s, with the number of 11 to 15 year olds reporting last year cannabis use falling from 13.4% in 2001 to 7% in 2013.⁴⁴

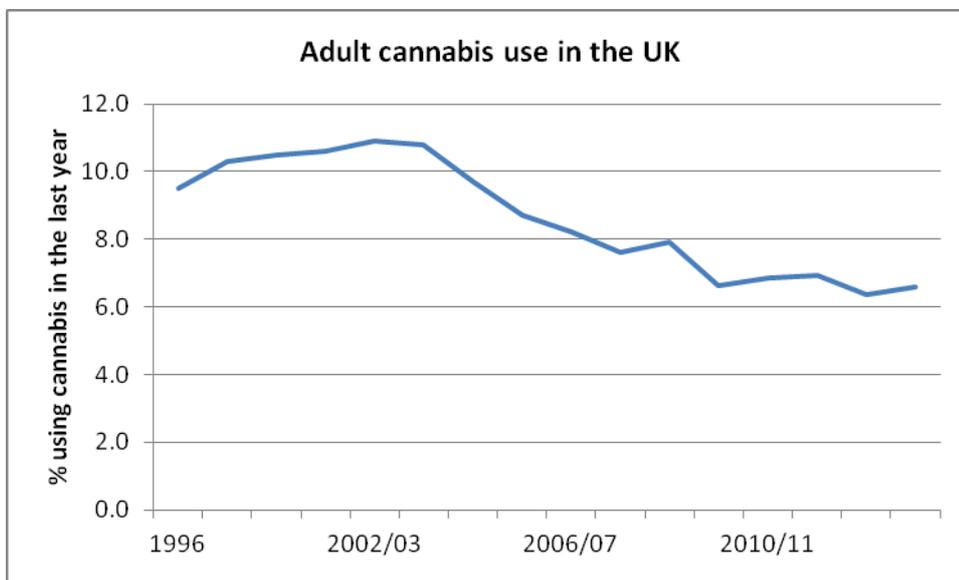


Figure 4.6: Adult cannabis use in the UK, 1996 – 2013/14 (Source: Crime Survey for England and Wales)

We should note that the policies in Uruguay and the USA are highly experimental, and there is no evidence yet to indicate whether or not they will be successful in reducing the criminality associated with the drug trade.

Nevertheless, the adoption of these policies provides an opportunity to establish an evidence base as to the efficacy of such approaches.

⁴² Substance Abuse and Mental Health Services Administration (2012) Results from the 2012 National Survey on Drug Use and Health Available at: <http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/Index.aspx>

⁴³ Home Office (2014) Drug misuse: findings from the 2013 to 2014 Crime Survey for England and Wales. <https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales>

⁴⁴ Health and Social Care Information Centre (2014) Smoking, drinking and drug use among young people in England in 2013. Available at: <http://www.hscic.gov.uk/catalogue/PUB14579>

Cannabis as a medicine

When we visited Colorado in 2013, before the regulations on recreational use of cannabis took effect, we saw cannabis dispensaries, where cannabis-based products are sold to users with a prescription, ostensibly for medicinal purposes. Cannabis, in its herbal form, is available as a medicine in a number of countries, including Canada and the Netherlands, and there are a range of regulatory approaches.

Cannabis was commonly used as a medicine in this country during the late 19th and early 20th Century, for conditions as wide-ranging as insomnia and menstrual cramps. Since then, herbal medicines have declined in prevalence. The potency of herbal products can vary between plants and strains, and even depending on the conditions in which the plant is grown. It can be difficult therefore to provide reliable doses with predictable effects that can be tested for safety and efficacy. Instead modern medicines isolate or synthesise the active ingredient in herbal cures. Medical use of herbal cannabis declined during the 20th Century. Under the Misuse of Drugs Act 1971 cannabis became a controlled substance and its medical use was discontinued in 1973.

There is a growing body of research into the medicinal properties of some chemical components in cannabis (cannabinoids), principally tetrahydrocannabinol (THC) and cannabidiol (CBD). Researchers are considering the efficacy of cannabinoids in treating the symptoms of a range of conditions, including:

- nausea and appetite loss (such as is associated with chemotherapy and the treatment for HIV/AIDS);
- spasticity experienced by people with Multiple Sclerosis;
- glaucoma;
- chronic and neurogenic pain.

In the UK this research has recently led to the availability of a cannabis-based medicine, Sativex, which can be prescribed for the symptoms of Multiple Sclerosis. Sativex is an extract of cannabis, produced under standardised conditions to ensure a precise dosage, and is now available for administration as an oral spray in the UK and many countries around the world. Other medicines such as dronabinol and nabilone, which are based on specific cannabinoids, have been available for some decades.

Cannabis in raw plant form is not available as a medicine in the UK, but in our fact-finding we observed that herbal cannabis can be obtained for medical use in many countries. Regulators in those countries need to consider the potential for recreational use, for diversion into black markets, and the relative ease with which cannabis can be grown domestically. There are various regulatory approaches:

- In Canada, the Netherlands, Israel, and a number of states in the USA, cannabis is produced for medicinal use by a limited number of licensed producers. The extent to which the potency and packaging of products is controlled varies, as does the number of licensed producers. In the Netherlands, there is only one licensed producer (Bedrocan), producing four specific strains with levels of potency carefully controlled through genetics and standardised growing conditions;
- A number of countries do not allow the production of cannabis, but do allow doctors to prescribe cannabis for medical use, which must then be imported either by the users themselves or by pharmacies. This is the approach taken by some German states, Italy, Finland and Switzerland, where cannabis is imported from the Dutch manufacturer, Bedrocan, under licence.

- Spain, Germany, and the laws of some states in the USA allow for people with a certified medical need to grow their own cannabis, or for caregivers to grow cannabis for patients. This approach was also used in Canada until this year, when production was restricted to licensed producers only.

The cannabis products we saw in Colorado were not branded like medicines in the UK. They came in the form of confectionary and infused fizzy drinks and were sold in 'dispensaries' rather than pharmacists. The names of products we saw included *Death Star* and *Couch Lock*. There was great variation in potency and dosage. Officials we spoke to recognised concerns that these products were being used recreationally. There is some evidence from the USA to suggest that the availability of cannabis for medical purposes can lead to higher levels of illicit recreational use. Cannabis is not recognised as a medicine by federal regulators.

The cannabis produced by Bedrocan in the Netherlands is packaged similarly to medicines, is subject to independent checks to control potency, contains standardised amounts of THC and CBD, and is provided by pharmacists to people with prescriptions. Bedrocan does not, however, have marketing authorisation as a medicine (as Sativex does) and is not therefore provided as a medicine. This does not prohibit doctors in the Netherlands and other European countries from issuing prescriptions for Bedrocan, as they might for other herbal, therapeutic products.

In the UK, the Misuse of Drugs Act 1971 enables the availability of controlled drugs for medicinal purposes through Home Office licensing under schedules 2–4 to the Misuse of Drugs Regulations 2001. Cannabis is listed in schedule 1 to the Regulations. This means that it has no recognised medicinal use and is subject to the strictest control restrictions. This reflects the lack of evidence of its medicinal value. The Misuse of Drugs Act 1971 provides a flexible legal framework which is able to adjust to new evidence of both harms and any therapeutic benefits of a drug. Marketing authorisation for medicines is granted by the Medicines and Healthcare Products Regulatory Agency (MHRA) to products whose manufacturer can demonstrate, with evidence of sufficient quality, both the efficacy and safety of a product. It is this evidence-based process which allows Sativex to be sold as a medicine in the UK.

4.9 Decriminalising the possession of drugs for personal use

Description

Without exception, every country we considered sees drug use as undesirable. While all are taking steps to disrupt, reduce, or regulate the supply of drugs, the study encountered a variety of responses to the individual user. In the UK, drug possession is a crime under the Misuse of Drugs Act 1971, and a range of sanctions can be applied in drug possession cases. There is great diversity in how possession offences are handled in other countries. The study looked at countries like Portugal, the Netherlands and the Czech Republic, where varying forms of decriminalisation are in effect, and countries like Japan and Sweden, where criminal sanctions are tougher than in the UK.

In particular, the study considered:

- levels of drug use, and outcomes for drug users;
- police and criminal justice resources.

The study looked at a range of approaches:

- **Portugal:** Portugal removed criminal sanctions for the possession and use of small amounts of any drug in 2001. Possession of any drug is considered illegal but will not result in criminal proceedings if the amount possessed is less than an average user would consume over ten days. Threshold quantities are defined in law for each substance. When police find an individual to be in possession of a small amount of a drug, they refer the individual to a lay panel (a dissuasion commission), whose main concern is to evaluate the personal circumstances of the individual and refer them to appropriate services, which may include treatment.
- **Czech Republic:** The Czech Republic has a system in which possession of drugs is illegal, but possession of small amounts of drugs is treated as an administrative offence, punishable with a fine. The thresholds for 'small amounts' were formalised in the Czech penal code in 2010.
- **Netherlands:** We looked at the Netherlands' approach which tolerates the use of 'soft' drugs, including cannabis. While drug possession remains illegal, enforcement and prosecution guidance codifies a policy of tolerance towards the possession of up to 5 grams of cannabis for one's own use. The explicit aim of this policy is keeping users of cannabis insulated from markets for more harmful substances.
- **Japan:** We visited Japan, which operates a strong enforcement-led approach to drug misuse, often regarded as a 'zero tolerance' policy. Substances are more strictly controlled than in many other countries. Some products that are available over the counter as cold and flu remedies in the UK are banned. Possession of even small amounts of drugs is punishable by lengthy imprisonment.
- **Sweden:** In Sweden we saw how a long-term policy goal of a drug-free society has informed an approach to drug possession which has grown stricter over several decades. Drug offences in Sweden can be categorised as minor, ordinary or serious. The categorisation of 'minor', which can only be applied in the mildest cases, can still be punished by up to six months imprisonment. Ordinary offences can result in three years' imprisonment, and serious offences up to ten years'.⁴⁵

⁴⁵ European Monitoring Centre for Drugs and Drug Addiction (2014) Situation summary for Sweden. Available at: <http://www.emcdda.europa.eu/publications/country-overviews/se#nlaws>

There is a clear distinction to be made between decriminalisation of drug possession and legalisation. Decriminalisation retains the recognition that drug possession is illegal, but removes criminal penalties in most cases. Legislators and officials in countries with decriminalisation policies stressed to us that their approaches were not an indication that drug use is seen as desirable. Enforcement against the supply of drugs is still a key element of the approach to drugs in these countries, and reduction of drug use is a common aim. For example, Portuguese officials told this study that the removal of criminal penalties for drug possession is seen as a means of enabling other measures, such as Portugal's dissuasion commissions, which are aimed at reducing drug use overall.

Review of evidence

In our fact-finding, we heard arguments both for decriminalisation and 'zero tolerance' policies. All of the legislators and officials with whom we spoke had a justification for their own approach, and all were able to demonstrate some success. This reflects the fact that the misuse of drugs is a complex problem with many contributing factors, of which the impact of legislation and enforcement is only one. For the same reason, the extent to which firm conclusions can be drawn from a comparison of broad approaches and trends is limited.

Much of the most relevant data in this area comes from Portugal, as its reforms were fairly recent, and data from before, during and after implementation is easily available. It is important to note, however, that Portugal made a number of changes to its approach to drugs around the same time as implementing decriminalisation, including widespread implementation of harm-reduction programmes and an increase in investment in drug treatment. It is extremely challenging to disentangle the effects of decriminalisation from the effects of these wider changes.

Prevalence of drug use

Different countries have different means of collecting data, and the availability of data varies, so it is difficult to compare levels of use directly, but we did not in our fact-finding observe any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country. The Czech Republic and Portugal have similar approaches to possession, where possession of small amounts of any drug does not lead to criminal proceedings, but while levels of drug use in Portugal appear to be relatively low, reported levels of cannabis use in the Czech Republic are among the highest in Europe. Indicators of levels of drug use in Sweden, which has one of the toughest approaches we saw, point to relatively low levels of use, but not markedly lower than countries with different approaches.

Trend data from Portugal shows how levels of drug use changed in the years following decriminalisation in 2001 (Figure 4.7). Although levels of drug use rose between 2001 and 2007, use of most drugs has since fallen to below-2001 levels.⁴⁶ It is clear that there has not been a lasting and significant increase in drug use in Portugal since 2001.

⁴⁶ European Monitoring Centre for Drugs and Drug Addiction (2013) *2013 Statistical Bulletin*. Available at: <http://www.emcdda.europa.eu/stats13>

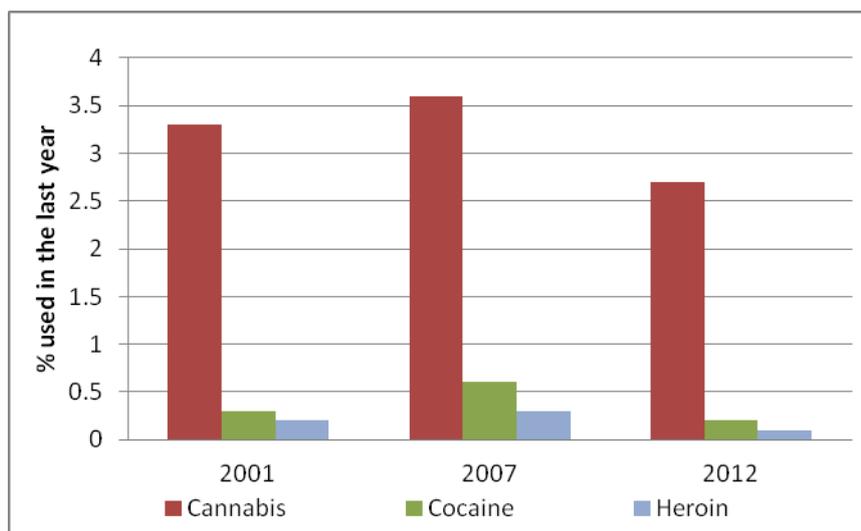


Figure 4.7: Portugal – trends in adult drug use, 2001–2012
(Source: EMCDDA Statistical Bulletin)

In the Czech Republic, prior to decriminalisation, the previous stricter drug possession laws were subjected to rigorous evaluation. The evaluation found that following implementation of the stricter laws, there was no significant decline in the availability of drugs.⁴⁷ This would further indicate that the levels of availability and use of drugs is driven by wider factors than the approach to possession alone.

Outcomes for users

Proponents assert that decriminalisation can have a range of positive impacts on the prospects of drug users. Academics have investigated these assertions. A study by academics at the University of Essex on the economics of cannabis regulation attempted to quantify the effects of criminal justice ‘scarring’: the economic impacts on the individual of having a criminal record. Based on assumptions about employability and income, the study estimated that the result of a criminal record was a 19% reduction in average earnings.⁴⁸

One of the clearest changes in Portugal since 2001 has been a considerable improvement in the indicators of health outcomes for drug users. There have been significant reductions in the number of new diagnoses of HIV and AIDS among drug users (Figure 4.8). Variations in the numbers of recorded drug-related deaths may be attributable to variations in the numbers of toxicological autopsies performed,⁴⁹ but overall drug-related deaths have been stable since 2001. These outcomes can not be attributed to decriminalisation alone, and are likely to have been influenced by increases in the use of treatment and harm reduction.

⁴⁷ Zábanský, T et al. (2001) PAD: Impact analysis project of new drugs legislation. *Prague: Office of the Czech Government, Secretariat of the National Drug Commission.*

⁴⁸ Bryan, Del Bono, Pudney (2011) Licensing and regulation of the cannabis market in England and Wales: Towards a cost-benefit analysis. Available at: <https://www.iser.essex.ac.uk/d/153>

⁴⁹ Hughes, CE & Stevens, A (2010) What can we learn from the Portuguese Decriminalisation of Illicit Drugs? *British Journal of Criminology.*

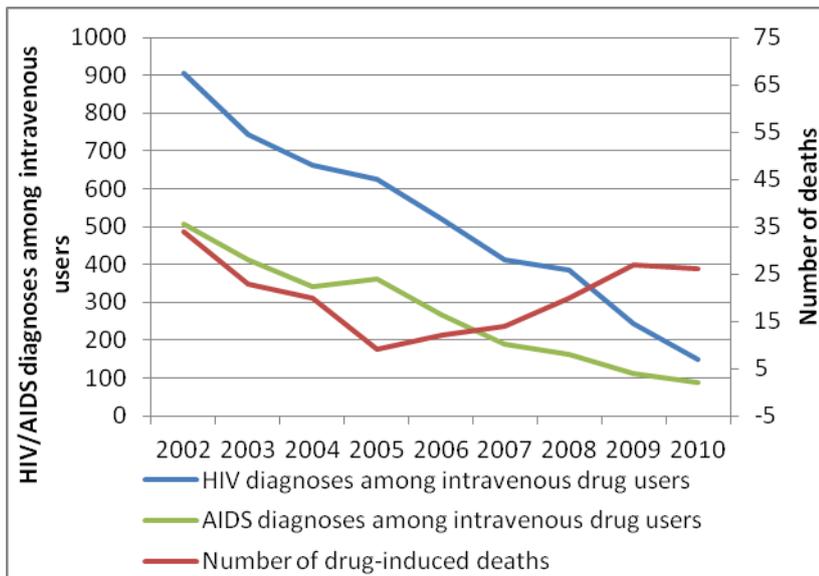


Figure 4.8: Portugal – Indicators of health among drug users, 2002–2011
(Source: Reitox National Reports, EMCDDA)

Conversely, the evaluation of the criminalisation of drug possession in the Czech Republic observed that adverse health outcomes for users increased following criminalisation.⁵⁰ This finding informed a policy shift towards greater focus on treatment and public health responses, although the evaluation acknowledged that the changes could not be attributed to the approach to possession alone.

Impact on criminal justice system resources

A 2010 report⁵¹ looked at changes in the use of criminal justice system resources in Portugal since decriminalisation and concluded that there had been a reduced burden of drug offenders on the criminal justice system. The report highlighted data which showed that the proportion of drug-related offenders in the prison system (including people convicted of crimes to fund drug consumption) fell from 44% in 1999 to 21% in 2008.

The report also noted that the number of drug law cases being brought to court fell sharply following decriminalisation, due to possession cases falling outside the criminal justice process. This is reflected in sentencing data, which shows a stark reduction in convictions for drug-law offences following decriminalisation (Figure 4.9) although convictions for supply offences are broadly unchanged. It is not known the extent to which court savings on drug possession cases may have been effectively passed onto the administrative processing around possession cases and the use of dissuasion commissions, so in this respect the overall impact on the public purse is unclear.

⁵⁰ Zábanský, T et al. (2001) PAD: Impact analysis project of new drugs legislation. Prague: Office of the Czech Government, Secretariat of the National Drug Commission.

⁵¹ Hughes, CE & Stevens, A (2010) What can we learn from the Portuguese decriminalisation of illicit drugs? *British Journal of Criminology* 50, pp. 999-1022.

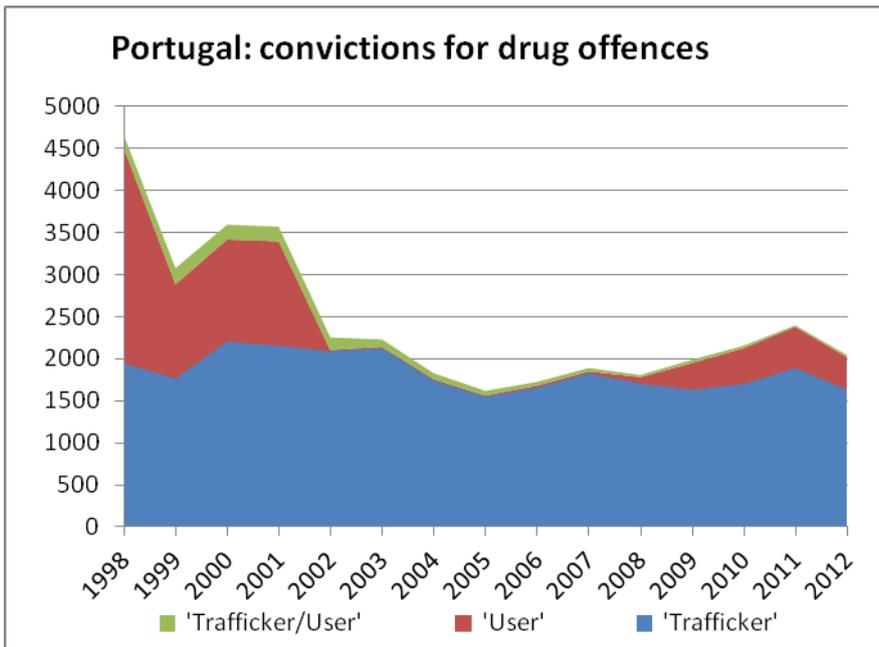


Figure 4.9: Convictions for drug offences in Portugal, 1998–2012 (Source: Reitox National Reports, EMCDDA)

Data from Portugal also provides some indication of the impact of decriminalisation on police resources (Figure 4.10). Although since 2001 police have referred possession offenders to an administrative, rather than criminal, process the number of people coming into formal contact with the police for possession offences has remained broadly stable at around 6,000, notwithstanding a brief spike immediately before the implementation of decriminalisation. The number of people coming into contact with police for supply offences has also remained stable.

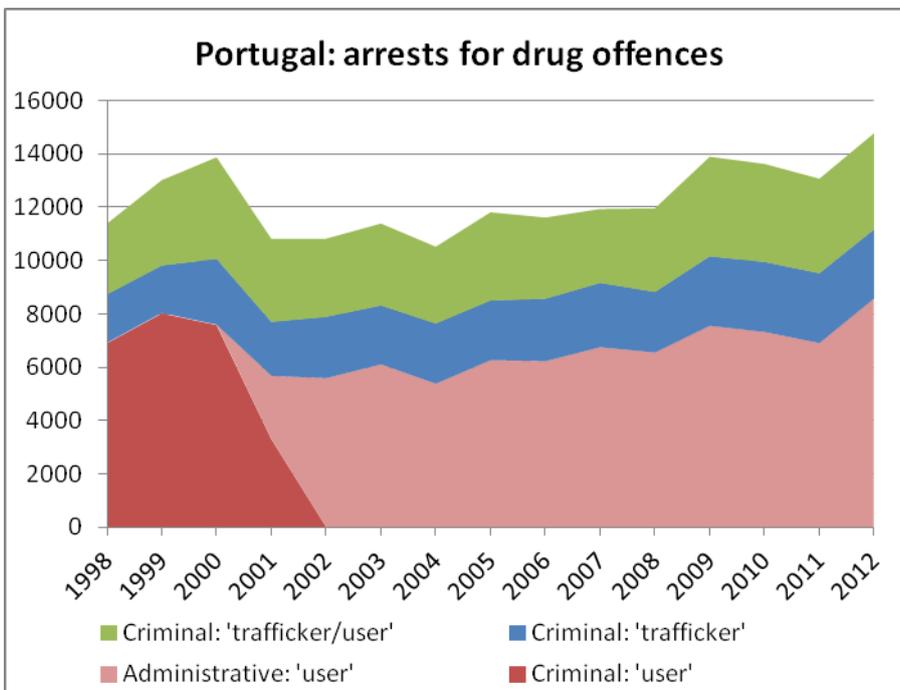


Figure 4.10: Arrests for drug offences in Portugal, 1998–2012 (Source: Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências, Annual reports on the Drugs Situation)

Observations

It would be inappropriate to compare the success of drug policies in different countries based solely on trends which are subject to differences in data collection, and are affected by various cultural, social and political factors besides legislation, policing and sentencing. However, some observations can be made:

- It is not clear that decriminalisation has an impact on levels of drug use. Following decriminalisation in Portugal there has not been a lasting increase in adult drug use. Looking across different countries, there is no apparent correlation between the ‘toughness’ of a country’s approach and the prevalence of adult drug use.
- There is evidence from Portugal of improved health prospects for users, though these cannot be attributed to decriminalisation alone.
- It is not clear that decriminalisation reduces the burden on the police. Portugal appeared to apply similar police resourcing to drugs after decriminalisation as before.
- There are indications that decriminalisation can reduce the burden on criminal justice systems. Since decriminalisation, Portugal has reduced the proportion of drug related offenders in its prison population. There has been a reduction in cases going through the courts, but it is not clear if the impact of this is balanced by the administrative burden of the dissuasion commission process.

Social and legal context

The legislative and enforcement approach to drug possession is only one strand of any country’s response to drug misuse, which may be informed by wider social and cultural factors. In our fact-finding, we saw that each country arrived at its current approach in response to its own issues and in the context of its own cultural attitudes. We also saw the impact of a range of other factors such as the availability and quality of drug treatment and variations in the types of drugs that are most commonly used.

The ‘zero tolerance’ policies in Sweden and Japan reflect strong cultural disapproval of drug taking. In Sweden, successive reforms which have toughened the legislative response to drug use have been guided by public opinion and by influential lobby groups such as the ‘Association for a Drug-free Society’. In Japan, where cultural conformity is traditionally valued, drug use is subject to a degree of stigma. In this context, it is difficult to tell whether low levels of drug use are a consequence of legislation, or a product of the same cultural attitudes that have informed the zero-tolerance approach.

Decriminalisation in Portugal (in the early 2000s) and the development of tolerance policies in the Netherlands (in the 1970s) were direct responses to public concerns about the misuse of drugs. In the Netherlands, the approach focuses on tackling proportionately the drugs which cause the most harm. It is not a sign that drug use is seen as acceptable. This is perhaps reflected in the fact that tolerance policies have become more nuanced over time. The conditions under which cannabis supply will be tolerated have become more finely tuned in recent years, and the Netherlands has seen reductions in the number of coffee shops in operation. Newer restrictions also include a proposed potency limit (15% THC), above which cannabis would be considered a ‘hard drug’.

In Portugal, decriminalisation provides a means to direct more users towards the support they need to stop using drugs. These approaches can be seen as a different route to the same overall goal as the policies adopted in Sweden and Japan. As discussed previously, the successes of Portugal’s reforms (lower drug prevalence than in 2000, significant

declines in drug deaths and HIV infections⁵²) cannot be attributed to decriminalisation alone.

Reflections

Close consideration of countries with quite different approaches to drug possession demonstrates that the issue is more complex and nuanced than legislation and enforcement alone. Reflecting on the approach taken in the UK, there are elements in common with a range of other countries. As in Sweden, the UK's legislative framework reflects the fact that drugs cause harm to individuals and wider society. Possession of any amount of a controlled drug is treated as a criminal offence in the UK. The UK's classification system aims to ensure penalties are proportionate to the amount of harm associated with a substance. Like the Netherlands and many other countries, the UK applies different enforcement practices in cases of cannabis possession to those applied in possession of other drugs. As in Portugal, prevention and treatment are a key element of responses to drugs in the UK.

The disparity in drug use trends and criminal justice statistics between countries with similar approaches, and the lack of any clear correlation between the 'toughness' of an approach and levels of drug use demonstrates the complexity of the issue. Historical patterns of drug use, cultural attitudes, and the wider range of policy and operational responses to drugs misuse in a country, such as treatment provision, are all likely to have an impact. Similarly, achieving better health outcomes for drug users cannot be shown to be a direct result of the enforcement approach. The UK's balanced approach enables targeted demand-reduction activity, and good availability and quality of treatment. Indeed, while in Portugal, we were encouraged to hear that drug treatment in the UK is well-regarded internationally.

⁵² 2012 National Report (2011 data) to the EMCDDA by the Reitox National Focal Point on Portugal. Available at: http://www.emcdda.europa.eu/attachements.cfm/att_191617_EN_Portugal_2011.pdf

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Maria Larsson (State Secretary for Health); Martin Valifridsson (State Secretary for Justice); Martin Kåberg (Medical Director, St Göran's Clinic); Erik Wennerström (Director General, National Council for Crime Prevention); Magdalena El-Sayed (Social Services Coordinator, Borough of Rinkeby-Kista); Frida Nordlöf, Södra Järva, Dolly Toma (Rinkeby Community Police); Alison Thorpe.

Switzerland

Pascal Strupler, Markus Jann, Tania Dussey-Cavassini, Diane Steber Büchli, René Stamm (Swiss Federal Office of Public Health); Daniel Kauer (Interdisciplinary Prison Health Board); Henriette Hänggi (Solothurn Department of Justice); Bubi Rufener (*K+A Contact Point*); Cpt. Thomas Zwahlen (Head of the Drugs Unit, Cantonal Police of Berne); Barbara Muhleim (Co-head of Centre, *KODA-1*).

United Kingdom

D/Supt Lloyd Gardner, DCI Tim Champion (Metropolitan Police Service); Karen Biggs (Phoenix Futures); Andy Brown, Melanie Smith (London Borough of Brent); Oswald Yemoah (B3); Charlotte Davies.

United States of America

Washington D.C.

Senator Patrick Leahy (Senate Judiciary Committee Chairman); Gil Kerlikowske (Director, Office of National Drug Control Policy); Michael Botticelli (Deputy Director, Office of National Drug Control Policy); Mythili Ramen (Assistant Attorney General, Criminal Division); Bruce Swartz (Deputy Assistant Attorney General); Michelle Leonhart (Director, Drug Enforcement Agency).

State of Colorado

Senator Jonathan Singer (State Senator); Senator Al White (State Senator); Representative Dan Pabon (State Representative); David Blake (Deputy Attorney General, State of Colorado); Ron Hyman (Colorado Department of Public Health and the Environment); Barbara Brohl, Lewis Koski, Julie Postlethwait (Colorado Department of Revenue); Jack Finlaw (Chief Legal Counsel to the Governor of Colorado); Kelly Perez (Drug Policy Advisor to the Governor of Colorado); Michael Hancock (Mayor of Denver); Mitchell R. Morrissey (District Attorney, City of Denver); Scott Martinez (Denver City Attorney); Janice Sinden (Chief of Staff to the Mayor of Denver); Kim Day (Manager of Aviation, Denver City Airport); Chief Robert White (Chief of Police, City of Denver); David Quiñones (Deputy Chief of Operations, City of Denver); Mark Fleecs (Commander of the Investigative Support Division, City of Denver); Chief Peter Carey (Chief of Police, City of Colorado Springs); Chief John Jackson (Chief of Police, City of Greenwood Village); Barbra Roach (Special Agent in Charge, US Drug Enforcement Administration); Jim Davis (Executive Director, Colorado Department of Public Safety); Tim Allport (Drug Treatment Specialist and Former Correctional Officer); Dr Alan Shackelford (Physician, Amarimed); Betty Aldworth (National Cannabis Industry Association); Brian Vicente, Christian Sederberg (Vicente Sederberg LLC); Leonard Frieling (Imhoff & Associates); Sandra Solin (Capital Solutions); Roger Sherman (CRL Associates); Tony Salazar (Colorado Education Association); Ryan Schaeffer (Chrisland Commercial); Sandi Moilanen (Colorado Office of Economic Development); Beverley Simpson (British Consul General, Denver).

State of Washington

Senator Jeanne Kohl-Wells (State Senator); Representative Roger Goodman (State Representative); Bob Ferguson (Attorney General, Washington State); Bruce Turcott (Assistant Attorney General, Washington State); Chris Imhoff, Michael Langer, Dennis Malmer (Washington State Department of Social and Human Services); Jim Pugel (Seattle Police Department); Peter Holmes (Seattle City Attorney); Chief Deputy Anne Kirkpatrick (King County Chief Deputy (Undersheriff)); Alison Holcomb (American Civil Liberties Union Washington); Derek Franklin (Washington Association for Substance Abuse and Violence Prevention); Steve Freng (North West High Intensity Drug Trafficking Area); Sharon Foster, Chris Marr, Ruthann Kurose, Rick Garza, Randy Simmons (Washington State Liquor Control Board); Ron Jackson (University of Washington); Lisa Daugaard (The Defender Association).

City of Baltimore

Hon. Jamey H. Hueston (National Association of Drug Court Professionals); Judge Robert G. Rancourt (National Association of Drug Court Professionals); Kristen Daugherty (National Association of Drug Court Professionals); the staff at Borgerding District Court Building.

Uruguay

Digeo Canepa (Prosecretary in the Presidency); HM Ambassador Ben Lyster-Binns (HM Ambassador to Uruguay) Jane Silverwood, Katherine Felton (British Embassy, Montevideo).

