

Honesty, Realism, Responsibility

Proposals for the Reform of Drugs Law

Policy Paper 47



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Summary

Scope and Applicability

It has been apparent that the drugs policies pursued by successive governments have not been working. This subject has caused great anxiety and has been the subject of great debate amongst people of all ages and in all communities up and down the country. Liberal Democrats have consistently been the only party prepared to have open debates about these issues.

In 1994, the Liberal Democrats called for a Royal Commission to look into the whole subject in a thorough and wide-ranging manner. We subsequently developed this proposal into one for a standing Royal Commission, covering alcohol, tobacco and solvents as well as currently illegal drugs. The Drugs Commission proposal in this paper builds on this approach, and remains the bedrock of our policy.

However, the publication in March 2000 of the report of Independent Inquiry into the Misuse of Drugs Act 1971, chaired by Dame Ruth Runciman on behalf of the Police Foundation (and usually known as the Runciman Report), has significantly moved forward the debate. That report is the most authoritative recent investigation into this subject. The Party decided at its Autumn 2000 Conference to respond specifically to its recommendations.

The Crime and Policing Working Group has therefore been asked to prepare a Liberal Democrat response to the Runciman Report. The Group has looked at all the Runciman recommendations. Many of these are being considered as part of the Government's review of sentencing, to which we will respond through the broader Crime and Policing paper for the Autumn 2002 party Conference. Others are being taken forward through the Proceeds of Crime Bill. We have therefore given primary attention to the remaining parts of Runciman. The Runciman report did not address related issues such as alcohol abuse, and focused strongly on the domestic UK position rather than international trafficking. Our proposals are similarly restricted.

The devolution settlement with respect to these issues is not straightforward. The classification of drugs under the Misuse of Drugs Act (MDA) 1971 remains a reserved matter for Westminster, and our recommendations on these points would therefore apply across the UK. However, policing and prosecution are devolved in Scotland, and those aspects of these recommendations would not apply in Scotland.

Main Proposals

The key proposals for changes in Liberal Democrat policy in this paper include:

- A standing Drugs Commission to take on the long-term role of the Advisory Council on Misuse of Drugs in advising on drugs policy, but with a remit extended to cover legal substances such as alcohol, solvents and tobacco. The Drugs Commission will also carry out regular audits of drugs policy, starting

immediately, and with major reports every five years. The Drugs Commission will draw on the expertise of the National Audit Office in conducting the audit.

- A proposal for a Europe-wide review of drugs policy every five years.
- A national policy of non-prosecution for possession, cultivation for own use and social supply of cannabis.
- Re-classifying cannabis, cannabinoids, and cannabis derivatives as Class C drugs.
- Permitting medical use of cannabis derivatives, subject to appropriate pharmaceutical controls and the successful conclusion of current clinical trials.
- Reclassifying ecstasy from Class A to Class B.
- Ending imprisonment as a punishment for possession for own use of any Class B or Class C drug (*also see option at 3.4.1 to end imprisonment for possession of Class A drugs*).
- The creation of a new offence of dealing as defined in the Runciman report.
- The illegal sale of drugs near schools and other sensitive locations should become an aggravating factor in sentencing the offender.
- The development and extension of pilot schemes for specialised heroin prescription and treatment clinics, and the repeal of Section 9A of the Misuse of Drugs Act, which prohibits supply of items used in intravenous drug use, in order to facilitate harm reduction programmes.
- Increased resources for treatment programmes.
- Enhanced police use of roadside sobriety tests on suspected drug-affected drivers, combined with a publicity campaign on the effects of drugs on driving ability.

We believe the proposals to be honest and realistic and show a responsible attitude to a problem which causes danger to many of our citizens, users, their families and the victims of crime. The package of measures outlined in this paper would, we believe:

- a) Reduce the impact of drug-related crime on law-abiding citizens.
- b) By ending some criminal sanctions, encourage more problem drug users to come forward for treatment.
- c) Increase the resources available for and credibility of drugs education and information and thereby reduce drug use in the long term.
- d) Provide more resources for the effective treatment of dependency and improve the quality of life of thousands of citizens.

We propose enhanced measures to combat and punish drug dealing and international drug trafficking and support effective legislation to allow the seizure of assets of drug dealers. We remain firm in our support for strong government action on these matters.

A System That Isn't Working

1.1 The Failure of Prohibition

1.1.1 The UK has one of the most punitive regimes for dealing with drugs in Europe – for example, possession of an illegal drug is punishable by a prison sentence of between 2 and 7 years, whereas in the Netherlands the maximum penalty for possession of even the 'hardest' drugs is a one year prison term. However, the prohibitionist strategy pursued over the last 30 years since 1971 Misuse of Drugs Act cannot be shown to have enjoyed much success in terms of reducing supply or use of illegal drugs. Indeed, one of the most disturbing aspects of existing policy in this field is that there has never been any rigorous official assessment of its effectiveness. After such a long period, this inevitably gives rise to the suspicion that the policy is driven by dogma and/or inertia rather than an intellectually or politically honest appraisal of the issues. The need for more research work is a subject we shall return to.

1.1.2 Nevertheless, it is possible to make some telling observations about the effectiveness of existing policy. According to the European Monitoring Centre for Drugs and Drug Abuse (EMCDDA) the UK has some of the highest levels of drug use and misuse in Europe. Over half of 16 year olds have already tried an illegal drug. The annual number of convictions for cannabis use has ballooned from under 15,000 in 1980 to over 81,000 in 1999. Surveys show that between one third and one

quarter of people aged 16-29 will have used cannabis in the last month. The number of 'hard' drug addicts has increased from around 1,000 thirty years ago to 270,000 today. In 1995-99, the number of deaths attributed to heroin or morphine use in England and Wales rose by 110%, the average age of heroin users is declining in the UK (currently 26) while it is going up in other European countries such as the Netherlands (39), and the greatest increase in 'hard' drug use in recent years is among the under 21s. It was estimated that in 1998 drug related property crime accounted for stolen goods of over £2 billion in value. The Home Office estimated the size of the UK illegal drugs market in 1998 to be £6.6 billion (equivalent to 0.66% Gross Domestic Product). The picture is one of a situation completely out of control. One of the most eloquent commentaries on the existing approach was given by former Drugs Czar Keith Hellawell in 1994 when Chief Constable of West Yorkshire police: "The current policies are not working. We seize more drugs, we arrest more people, but when you look at the availability of drugs, the use of drugs, the crime committed because of and through people who use drugs, the violence associated with drugs, it's on the increase. It can't be working."

1.1.3 The growing perception that the existing legislation is not working, and increasingly out of step with public opinion, is reflected in the practice of some police forces who have either explicit or implicit policies of not

pursuing individuals for simple own use possession of cannabis. This of course leads to an in principle undesirable variation in the way people are treated by the law in different parts of the country, or even within police force areas. The proportion of cannabis possession offences resulting only in a caution ranges across police forces in England and Wales from 87% at the highest to 29% at the lowest.

1.2 Consequences of Prohibition

1.2.1 Even in terms of the objective of suppressing use the prohibitionist strategy appears to be failing. However, we believe the policy is even more damaging in that it: (i) exacerbates the adverse consequences of drug use; (ii) brings many people, particularly young people, who would otherwise be law-abiding, into contact with both the criminal world and the criminal justice system; (iii) undermines other, more promising strategies for minimising harmful drug use; and (iv) diverts large public resources which could be better employed.

(i) Prohibition of drugs means that their supply is in the hands of criminals, who by definition operate clandestinely and beyond the scope of the law. Under the existing system it is not possible to regulate or control the supply in terms of quality, conditions of supply (e.g. age limits, sobriety), and price. In the case of hard drugs, this has very severe consequences. Most deaths from intravenous heroin use arise from overdose, adulteration or blood poisoning. Because supply is

limited, prices can be very high and this can in turn lead to property crime to support addiction. The cost of supporting a heroin habit can easily be £300 per week. Again, because drug supply is a criminal monopoly, it contributes greatly to the profits of organised crime, and leads to violent competition among criminals to control the market. This makes many neighbourhoods dangerous and undesirable places to live.

(ii) The use of criminal sanctions on 'soft' drugs such as cannabis has two main disadvantages. Firstly, it means that users often have to seek their supply from criminal dealers, who may also deal in harder drugs and try to encourage their use. Secondly, it means that many people who are in every other respect model citizens are at risk of gaining criminal records which may seriously affect their future employment prospects.

(iii) So-called 'problem' drug users, that is to say those who are addicted to hard drugs, who are at the most risk of damaging their health, and who are most likely to become involved in crime, generally experience a range of social and personal problems, including for example unemployment, poor housing and dysfunctional family relationships. Programmes to help such people break out of their drug dependence have to tackle all of these problems holistically. Even if a user comes off a drug for a time, if the underlying problems they face in

their lives, and above all the pervasive sense of hopelessness and having nothing positive to live for, are not tackled, then they are very likely to fall back into drug abuse. The criminal law has very little to offer as part of a solution to such problems, and in fact when applied will generally make them worse. A society which puts these people in prison is failing them and denying responsibility for helping them improve their lives. A spell in prison will do nothing for a drug user's employment prospects or family relationships, and given the scale of the drug problems within the prison system may expose them to even more damaging types of drug abuse. Section 9A of the Misuse of Drugs Act on drug paraphernalia has a number of undesirable consequences. Charities and other bodies working with heroin users are constrained by it in the work they can do to try to minimise the harmful effects of intravenous drug use. Distributing clean needles is legal, but other equipment, such as high quality tourniquets to enable people to inject safely without slippage, is illegal. So is giving out citric acid. In terms of general education of young people about the risks of drug use, the existing law is unhelpful in that it is seen as hypocritical to outlaw softer drugs when tobacco and alcohol are legal. Bracketing all illegal drugs together tends to undermine important messages about the very serious risks associated with 'hard' drugs.

(iv) The existing policy is enormously costly in terms of police resources and the time of the courts. Of the £1.4 billion drug-related public spending, 62% went on criminal prosecutions, and 13% on international supply reduction. Only 25% was spent on education, prevention and treatment. This balance is despite evidence from the National Treatment Outcome Research Study that every £1 spent on treatment saves £3 on criminal justice expenditure. (It should be noted the Liberal Democrat/Labour partnership in Scotland has been able to achieve a much better balance: since 1999, the percentage spent on enforcement has declined from 46% to 40%, while that spent on treatment and rehabilitation has increased from 39% to 43% and that on prevention from 15% to 17%). In 1999, 107,465 drugs possession offences went through the justice system, and 81,381 of these were for cannabis possession.

1.3 The Global 'War on Drugs'

1.3.1 Parallels can be drawn between the existing punitive approach to the drug issue in the UK, and the international 'war on drugs', conducted through the United Nations Drug Control Programme (UNDCP), which focuses overwhelmingly on seeking to ban and suppress production of drugs.

1.3.2 Crop eradication has no proven track record of success in reducing global drug production, or street price and availability in the West. Local successes simply cause production to increase elsewhere. For example,

reductions in coca fields in Bolivia and Peru from 1996 onwards led to an increase in cultivation in Colombia where it has risen steadily from 63,000ha in 1996 to 135,000ha in 2000. Colombia now supplies 80% of the world's cocaine.

1.3.3 Again in parallel to the UK situation, the profits of the global drugs trade fund broader criminal activity, including paramilitary groups and international terrorists.

1.3.4 As in the domestic sphere, there has been a lack of any assessment of the effectiveness of the UNDCP campaign. While it is surely time to consider alternative approaches, we believe the matter is beyond the scope of this paper and merely recommend a review.

1.4 European Experience

1.4.1 Many European countries have recognised that an emphasis on prevention and treatment rather than punishment is a better strategy for dealing with the harmful consequences of drug use.

1.4.2 The most commonly cited example is the Netherlands. The authorities tolerate the existence of around 1,500 cafes which sell cannabis, on certain strict conditions, including:

- A maximum sale of 5 grammes per transaction
- No sale to minors and no minors permitted on the premises
- No hard drugs are sold
- No nuisance is caused to neighbours

1.4.3 The policy on cafes is largely decided at local level by municipal authorities, police and prosecutors. The objective is to allow cannabis consumption in a safe environment, and without users having to resort to criminal dealers. Dutch law retains strong criminal penalties for supplying hard drugs and for trafficking large quantities of cannabis.

1.4.4 In July 2001 Portugal adopted new legislation decriminalising the consumption, purchase or possession of drugs (including hard drugs). The Government's objective has been to adapt legislation to reality on the grounds that the existing law was simply not being enforced. In addition, the Government also felt the need to introduce a social angle to drugs legislation in Portugal, which has been achieved by putting the emphasis on treatment rather than punishment of drug addicts and by increasing the State's responsibility in treatment.

1.4.5 The main feature of the new legislation in Portugal is that the consumption of drugs will no longer be regarded as a crime punishable with a prison sentence, but will be subject to an administrative sanction. Drug addicts will in future be regarded as patients, rather than criminals, and will not be subject to any fines or sanctions, provided they agree to undertake drug treatment. Occasional drug users will only be subject to sanctions or fines when caught by the authorities on a recurring offence. Sanctions imposed on those failing to keep to treatment programmes can include banning the individual from exercising his/her professional activity, from attending certain places, from accompanying or

accommodating certain people, from leaving the country without authorisation, and from holding or renewing firearm or shooting licences, or seizing objects (including motor vehicles) belonging to the individual which may involve a risk for the person or for the community or may encourage further offences. Community service is another option.

1.4.6 In 1999 the French Government launched a new three-year plan on drugs. This emphasises prevention, harm reduction and treatment for addicted persons. The existing criminal law has not been changed, but the Minister of Justice has invited prosecutors to avoid seeking imprisonment and to promote treatment programmes.

1.4.7 Since the advent of the 'Red/Green' coalition in Germany, the Government has encouraged further

research and discussion on drugs policy. Commitments have been made to allow 'injecting rooms' for the safe self-injection of heroin. The German equivalent of the 'Drugs Czar' has been moved from the Interior Ministry to the Health Ministry, reflecting a new emphasis on treatment rather than punishment.

1.4.8 Not all developments in Europe have been in one direction. In Spain, a 1999 decision of the Supreme Court tightened the law so that sanctions are applied to consumption of drugs in a private place.

1.4.9 Obviously it is as yet too early to assess the outcome of the newer initiatives, such as the new Portuguese policy, but in due course these varied European approaches will provide a great deal of evidence on the effectiveness of different strategies.

The Liberal Democrat Response

2.1 An Honest, Realistic and Responsible Approach

2.1.1 The failure of drug policy just described demonstrates the need for a significant rethink from first principles. The relative lack of solid data and research in the UK makes this difficult, but not impossible. There have been some significant contributions to the debate recently, most notably the Runciman Report.

2.1.2 Liberal Democrats stand in the liberal philosophical tradition of John Locke and J.S. Mill. Government policy should be based on reason rather than dogma, and the state should only use coercion against the individual to prevent harm to other individuals or society as a whole. Arising from core Liberal Democrat values, we will apply the following public policy principles to these issues:

- The high value we place on personal liberty.
- Policy should as far as possible be based on evidence of what works.
- Acceptance of the need for compliance with our international treaty obligations.
- Protection of the young and other vulnerable people, e.g. the mentally ill.

- The law should be realistically enforceable.
- The impact on society of drug use and political responses to it.
- The importance of education about the effects of drugs.
- The need to break the link between drug use and organised crime.
- The need to make the best use of resources in minimising harm.
- The law should command widespread respect.
- Drugs dependency should be addressed principally as a health issue rather than a criminal law issue.
- Policy must be appropriate to the relevant social context.
- The need to approach individual drugs according to the level of harm they cause, including their addictiveness, and their social effects.
- The need to treat individual drug users holistically.

2.1.3 It is important to emphasise that as Liberal Democrats we do not espouse an ‘anything goes’ libertarianism with respect to drugs. These are powerful substances the use of which can have serious consequences for the individual user and society in general. It is right and proper that the state should intervene to regulate and control the use of such substances, as it does the consumption of currently legal substances such as alcohol and tobacco, and both

prescription and over the counter medicines. The question is what are the most appropriate forms of intervention, in the light of experience and the characteristics of particular drugs.

2.1.4 The fact that to some extent we advocate non-criminal forms of intervention does not mean that we in any way wish to encourage drug use. Even the softest drugs have some harmful consequences. Government has a legitimate health promotion role, but for adults this can often be best carried out through education and information rather than prohibition.

2.1.5 Ultimately, it is for each individual to define for themselves what constitutes a good life. But it is our view that use of the most damaging drugs, for example crack cocaine, is in general a response to a real or perceived lack of more positive lifestyle options. In line with the Liberal Democrat philosophy of individual empowerment, we believe that, given the right educational, social and economic opportunities and appropriate forms of support at times of stress, the vast majority of people would not choose a lifestyle involving this kind of self-harming drug use.

2.2 A Range of Measured Responses

2.2.1 There is no single ‘drugs’ problem, there are in fact a number of different drugs with widely varying medical and behavioural effects and degrees of addictiveness. In applying the principles identified above to each substance, we are led to propose a range of different policy responses.

2.2.2 So that the inertia and woolly thinking of recent decades cannot re-occur, it follows that we need to establish a framework for continually developing our understanding of the effects of existing drugs, and new ones that will inevitably emerge. We agree with the Runciman report that a classification system similar to the A, B, and C categories is therefore a useful tool for setting policy. However, we think that the existing advisory process which recommends changes to the classification of drugs needs to be strengthened and made more independent of the government of the day. We would therefore re-establish the Advisory Council on the Misuse of Drugs as a Drugs Commission. Its membership should include representatives of groups such as medical and police bodies, rather than simply be appointed by the Secretary of State as at present. In line with our general view that the drug dependency is primarily a health issue, its lead departmental relationship should be with the Department of Health rather than the Home Office (although clearly a relationship with the Home Office will need to be maintained). It should have its own secretariat staff, rather than simply relying on Home Office civil servants as at present. The criteria employed in assessing drugs should be more transparent, and the process should involve comparisons with experience in other countries. The final decision on changes of classification should ultimately remain with Parliament, following proposals from the Commission. The Commission should also be able to make recommendations on policy regarding drugs outside the existing schedules, such as alcohol, tobacco and solvents.

2.2.3 The use that is made of this factual base in framing policy responses should also be more flexible. These should not just be different levels of criminal penalty, but should encompass a wide spectrum of possible measures including public health education, targeted treatment programmes for users, restrictions on the conditions of supply short of total bans, and criminal sanctions where justified.

2.3 Respecting International Commitments

2.3.1 The UK is a signatory to the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (known as the Vienna Convention), and to preceding UN agreements. The UN Conventions list all the substances covered, and these include all the principal illegal drugs in the UK including cannabis. The interpretation of the provisions of the UN Conventions is not always clear and subject to some variation between different signatory states.

2.3.2 However, there is no doubt that the Conventions clearly require that supply or possession with intent to supply drugs must be a criminal offence. At the other end of the spectrum, the Conventions are usually interpreted to mean that simple use of a drug does not have to be criminalised, although it must be 'limited' in a way short of criminalisation.

2.3.3 The most contentious area is the requirements on treatment of possession of a drug for personal use rather than trafficking. The most straightforward

reading of the Convention suggests that it is required that such possession should be a criminal offence. However, the fact that use *per se* is not criminalised, and obviously possession of a drug is necessary before anyone can use it, allows some countries to interpret the Conventions to allow use of non-criminal sanctions. Other countries retain criminal sanctions on their books for possession, but have alternative non-criminal sanctions available and in practice always use the latter, so that there is effective if not technical decriminalisation. The Conventions allow medical or scientific use of the relevant substances.

2.3.4 The report *Room for Manoeuvre* issued by the NGO Drugscope, and commissioned as part of the Runciman Inquiry, has suggested three ways in which the penalties for possession of drugs could be reformed in the UK while remaining within broadly accepted interpretations of the Convention:

1. The ending of imprisonment for possession offences.
2. The introduction of civil/administrative penalties for possession offences, while retaining the option of criminal penalties. These civil penalties would in effect be similar to the existing civil fines which exist for parking offences, and do not create a criminal record.
3. The introduction of civil penalties alongside continuing availability of criminal penalties for 'social supply' – that is where one of

a small group of friends acquires a supply on behalf of the group who then share it.

2.3.5 Immediate outright legalisation of the commercial supply of any narcotic would definitely require the UK unilaterally to repudiate the UN Conventions. Liberal Democrats do not support this as we set a high value on the UN international legal order, and have insisted firmly that the UK live up to its obligations under other UN conventions,

for example the 1951 Convention on Refugees. We therefore reject taking such a drastic step.

2.3.6 It follows therefore that we are constrained by international commitments. However, given the way policy is developing in many European countries, if the new approaches being followed in Portugal and other countries prove successful over the next five years or so, it is possible that the international context will change.

An Agenda for Reform

3.1 Cannabis

3.1.1 We accept that cannabis, although carrying certain health risks from long term use, is almost certainly less injurious to health than tobacco or than alcohol (which is legally consumed by 40 million people in the UK). Its use is extremely widespread (based on the evidence of the British Crime Survey 1998, approximately one and a half million young people aged 16-29 will have used it in the last month), and its use is a key part of certain minority cultures represented in the UK.

3.1.2 We therefore support reclassification of cannabis from B to C as recommended by Runciman and currently under investigation by the Advisory Council on the Misuse of Drugs at the request of the Home Secretary. We would also support the legalisation of cannabis derivatives for medical purposes, subject to appropriate pharmaceutical controls and the successful completion of current clinical trials.

3.1.3 However, the Home Secretary's current position of reducing the penalties for possession of cannabis while not taking action to break the link between users and criminal pushers is incoherent, and fails to remove the threat of criminal charges from the user. We would therefore go beyond the Government's plans, removing the threat of legal action from the large number of otherwise perfectly law abiding people who choose to use cannabis, and giving an opportunity to obtain cannabis without

resorting to criminal suppliers. We considered the Drugscope analysis of introducing civil as opposed to criminal penalties for cannabis possession, but this seemed to unnecessarily complicate the position by introducing a new range of sanctions.

3.1.4 While retaining the criminal penalties on the statute book, we therefore propose to issue policy guidance that it is not in the public interest to prosecute individuals for possession of cannabis for their own use, cultivation of small numbers of cannabis plants for their own use, or social supply of cannabis. As defined in the Runciman report, social supply covers a member of a small social group who supplies another member or members of that group believing he was acting on behalf of the group, which shared a common intention to use the drug for personal consumption. It would not apply to use in, or supply to, any group including minors, and we would certainly expect supply to minors to be vigorously prosecuted. We would accompany this by implementing the Runciman recommendation to repeal sections 8 (c) and (d) of the MDA, so that it would no longer be an offence for the occupier or manager of premises to allow consumption (as opposed to supply) of cannabis on their premises.

3.1.5 There is a logical argument for legalisation of the supply chain for cannabis. But current international legal obligations make this impossible. We therefore propose that, unless and until there is international agreement to

change the UN Conventions, we go no further.

3.1.6 These steps would bring many benefits, ending the huge waste of police and court time on cannabis possession charges, and lifting the threat of criminalisation from many otherwise law-abiding citizens. By permitting own use cultivation and social supply, they would allow cannabis users considerable scope to acquire cannabis without resorting to criminal pushers. This would in turn reduce the number of people who may become involved in harder drug use through contact with criminal pushers offering a range of drugs, and cut the profits of organised crime.

3.1.7 We have given consideration to extending the policy of non-prosecution to supply of cannabis through specially licensed cafes, along the lines they exist in the Netherlands. However, we have rejected this because we believe that commercial supply to customers on this basis would constitute a clear breach of the UN Conventions incompatible with our commitment to international legality. The wholesale supply to the cafes themselves would be an even more blatant Convention infringement. These cafes would also involve local authorities in regulating and licensing operations dependent on a relationship with organised crime for their continuation in business. We are also not convinced that the number of users dependent on criminal suppliers would be substantially reduced.

3.2 Ecstasy

3.2.1 Ecstasy is linked to about ten reported deaths per year, which are all individual tragedies. This must be put in

the context that it is used by very large numbers of people (there are estimates ranging from 400,000 to 2 million); it is often unclear whether deaths are related to the conditions under which it is consumed, or consumption of another substance believed to be ecstasy, rather than being caused by consumption of ecstasy *per se*; and that many legal drugs such as paracetamol cause far more accidental deaths every year through overdoses. We therefore support the Runciman Report recommendation to reclassify this drug from Class A to Class B (which was also supported by the Association of Chief Police Officers). The current very high classification of ecstasy serves to undermine the seriousness with which many young people regard other Class A drugs such as heroin and cocaine; and clearly has little or no effect in deterring ecstasy use. Such a reclassification would be subject to the advice of the Drugs Commission.

3.2.2 Although we believe there is enough evidence to reclassify ecstasy from Class A to Class B, we cannot conclude that there is sufficient evidence (particularly on possible long-term health effects) to justify reclassification to Class C. Any proposals on further reclassification should be left to the Drugs Commission.

3.3 Drug Dependency and Rehabilitation

3.3.1 As noted previously, the UK has a particularly bad record of heroin misuse compared with other European countries. The UK accounted for almost a third of all heroin/morphine seizures in the EU in 1997/98. Clearly British policy on heroin has had some success,

however, for example in limiting the number of people infected with HIV through sharing needles relative to other European countries. This success has been based on a policy of supplying clean needles – an example of a harm minimisation approach working.

3.3.2 We have also clearly linked the worst adverse health consequences for the user and the huge volume of property crime associated with heroin addiction to the current dependence on illegal supply – a clean, regulated supply would allow dependent users to avoid the risks of overdose and adulteration, and reduce the incentive to steal to fund their addiction. However there remain serious risks associated with ‘hard’ drug use. For example, while short-term health effects may not be devastating from use of pure supplies, heroin is powerfully addictive, and we have heard evidence that it is impossible to be a ‘recreational’ user of heroin – use always quickly leads to addiction. On the subject of crack cocaine, the evidence suggests that the behavioural effects are so severe and present such potential for criminal activity that its use cannot ever be regarded as an acceptable choice for the individual.

3.3.3 Because of the powerful addictiveness of heroin and the serious health consequences of withdrawal, supplying heroin to dependent users is regarded as a legitimate medical use, and is therefore permissible under the UN Conventions. In fact, there is a considerable history of legally prescribing heroin in the UK until recent years, with a heroin prescription clinic run in Wigan until 1994, and about 300-400 addicts are currently in receipt of such prescriptions. However, the recent

tendency has been to prescribe methadone as a substitute.

3.3.4 The success of the methadone programmes has not yet been fully assessed. Methadone has its problems, however. The safe dose range is narrower than for heroin, and relative to the number of users, there have been more deaths from methadone than heroin in recent years. This may relate more to the way that the supply is organised than to methadone itself – methadone is often prescribed so that users have a supply under their own control, which in some cases they sell on to buy heroin. There is also a black market in methadone. Methadone used under these conditions will be subject to many of the risks of illegal heroin use.

3.3.5 We therefore advocate the development of specialist heroin treatment clinics, where heroin or methadone could be administered under controlled conditions, with other medical treatment and testing, and counselling and withdrawal programmes available. Although the ultimate objective would be to reduce the number of dependent users, heroin could be prescribed on a maintenance rather than withdrawal basis. Some experiments with similar approaches are being undertaken at local level already, but we would implement a major programme of pilot schemes. Such specialist clinics are preferable to prescribing through GP practices, particularly as they would be better able to see dependent users on a very regular basis, and therefore avoid the problems associated with users having to be given a quantity of heroin or methadone to keep them going for periods between appointments. They also deal with the obvious difficulty of having problem

drug users visiting GP surgeries. They would be run in partnership with appropriate agencies, such as probation and social services. We would expect these pilots to show significant benefits in terms of improved health outcomes and reduced criminality by the users. Users who had previously undertaken unsuccessful methadone programmes might be prioritised for heroin prescription. The results would be monitored and the information used to inform future policy development. Subject to success in the pilot stage, we would make such facilities widely available.

3.3.6 Runciman made a technical but important recommendation that doctors who issue private prescriptions for heroin should be subject to licensing under the MDA. This would allow the creation of a comprehensive national database on heroin prescription, and we support it.

3.3.7 We would repeal Section 9A of the MDA on drug paraphernalia, as recommended by Runciman, to facilitate harm minimisation programmes across the country, for example by allowing the legal supply of tourniquets. We would also implement the Runciman recommendation to amend sections 8 (a) and (b) of the MDA. This would mean that occupiers or managers of premises would only commit an offence if they knowingly and wilfully permit production or supply of illegal drugs on their premises.

3.3.8 We are supportive of the current Drug Treatment and Testing Orders which are used as an alternative to prison for some problem drug users at present, although the scheme is

relatively new and requires further assessment. Subject to a successful completion of existing pilot schemes on Drug Abstinence Orders, we also would like to make drug treatment and testing more widely available as an alternative to other criminal sanctions.

3.3.9 However, we also want to end the situation in which some people are only likely to receive effective treatment for drug dependency after they have been convicted of a criminal offence. We would therefore re-allocate resources towards making treatment and rehabilitation facilities and programmes more generally available, not only for heroin dependency.

3.3.10 Although there is some good and improving practice in the prison service in respect of drug rehabilitation, generally the situation is poor. We intend to make further recommendations on prisons and drug rehabilitation in the Crime and Policing policy paper for the Autumn 2002 Conference.

3.4 The Use of Imprisonment for Possession

Option 1

3.4.1 The Runciman Report called for the ending of the use of imprisonment to punish possession for own use of any Class B or C drug. We support this recommendation. However, the report wished to retain imprisonment for possession of a Class A drug. We disagree with this and propose to end the use of imprisonment for possession for own use of any drug, including Class A drugs.

Or

Option 2

3.4.1 The Runciman Report called for the ending of the use of imprisonment to punish possession for own use of any Class B or C drug but wished to retain imprisonment for possession of a Class A drug. We support this recommendation.

3.4.2 Of course, users of drugs of any Class who cause harm to others by property crime or violence can still be imprisoned. Prison sentences would remain available for illegally supplying any Class of drug.

3.5 Tackling Criminal Supply

3.5.1 The recommendations of this paper are based on the principle that

dependent drug users are to be regarded as victims rather than criminals. It also includes proposals for allowing properly controlled supply in some circumstances. However, illegal and unregulated supply of drugs is a destructive and anti-social activity, directly resulting in many deaths every year. It should be treated as a serious crime and tackled accordingly.

3.5.2 The proposals on cannabis and heroin above will make an important start in removing the market from organised crime, cutting its profits and reducing its opportunities to draw cannabis users into more serious drug habits. By saving police and court time currently spent on the approximately 81,000 annual cannabis possession offences it will allow police resources to be closely targeted on major traffickers.

3.5.3 There is more that could be done however. Runciman recommended the creation of a new offence of 'dealing', where the prosecution can show that a person has been engaged in a pattern of trafficking over a period of time. This would enable such offenders to be dealt with more strongly than by charging a series of isolated offences of supply. We support the creation of this new dealing offence.

3.5.4 Runciman also identified serious flaws in the existing arrangements for the confiscation of criminal assets as a tool in the struggle with organised crime. For this reason, Liberal Democrats broadly welcomed the Government's new Proceeds of Crime legislation introduced in Parliament in October 2001. The legislation replaces separate drug trafficking and criminal justice legislation with a consolidated and

updated set of provisions on confiscation of assets and related matters and includes new provisions for the recovery of property which has been obtained through unlawful conduct. To those involved in organised crime, powers to confiscate the gains of that crime can be as much, or greater a deterrent than potential prison sentences. Liberal Democrats will continue to review and update powers to reduce the profitability of organised crime.

3.5.5 Runciman further recommended that sentencing guidelines be changed to allow trafficking in drugs in the vicinity of schools, psychiatric facilities and prisons to be an aggravating factor in sentencing offenders. We support this recommendation.

3.6 A National Audit and a European Level Review

3.6.1 As indicated earlier, we are very concerned at the lack of reliable research and data on drug use in the UK, and the effectiveness of policies designed to tackle it. We therefore propose that an audit of drugs policy be carried out by an independent body. The new Drugs Commission we have already proposed is the most suitable candidate. It would also draw on the special expertise in policy assessment of the National Audit Office. This Audit would however go much wider than simply resource efficiency issues. The Audit would seek to quantify in cash, health and social terms the costs of the current situation in relation to drug abuse, analyse the effectiveness of past policy, and consider alternatives. The Audit would need to involve extended consultation with non-

statutory agencies working in the drugs field and user groups. The Drugs Commission would of course continue its long-term role once the Audit exercise was completed. As new drugs are emerging all the time, and new data is constantly emerging on well-established drugs, we would repeat this Audit every five years.

3.6.2 We also believe there is a need to share international experience of varying approaches. As outlined earlier, there are some very ambitious new policy directions being undertaken within Europe, and it would be perverse not to seek to learn from them.

3.6.3 We therefore further propose that we seek agreement on a Europe-wide review of drugs policy, after a five year period, to allow the success of new policies in Portugal and elsewhere, and the changes we are advocating for the UK, to be assessed. The UK Audit exercise to be conducted by the Drugs Commission could feed into this European process. It makes sense for European countries to move in step on drugs policies as much as possible in order to minimise potentially undesirable 'drug tourism' from more restrictive to more liberal member states.

3.6.5 It may prove to be the case that the long term way forward may involve greater scope for a regulated and controlled legal supply of harder drugs, but we would wish to wait for the outcome of both the Audit and the European level review which we propose above before making firm proposals beyond what we have already advocated in this paper. Even if such an approach were to be taken, this would

have to be done in a very strictly controlled manner.

3.7 International Drug Trafficking

3.7.1 In the introduction to this paper, we described some of the problems with the UN Drug Control Programme. We would therefore call for a UN review of its effectiveness.

3.8 Drug Affected Driving

3.8.1 We have been very disturbed by evidence we have heard on the subject of drug-affected driving. Between a fifth and a quarter of all those who die on Britain's roads are under the influence of illegal drugs. Whatever view is taken of the legal status of any drug, a policy of zero tolerance is required for driving while under the influence of drugs.

3.8.2 However, it is not practical to introduce a roadside drugs testing regime for drivers similar to the breath test for alcohol. This is because testing body fluids or breath for drugs does not give reliable evidence of fitness to drive. The user of ecstasy will test negative after 24 hours, yet the effects of ecstasy-induced fatigue may last for several days. Cannabis, on the other hand, will show up in blood tests for weeks, yet the effects of cannabis use on driving wear off within a day.

3.8.3 The existing Road Traffic Act 1988 makes it an offence to drive whilst unfit through drink or drugs with an aggravated offence of causing death by driving without due care and attention whilst unfit to drive through drink or

drugs. Since the advent of the alcohol breath test this offence has been rarely used (the 'excess alcohol' offence being preferred), but it is clearly suitable for dealing with those made unfit by drugs other than alcohol. The RTA 1988 also gives the police a power of arrest on a person reasonably suspected of driving whilst unfit.

3.8.4 Research in Nottingham, Strathclyde, the Thames Valley and the US has shown that old-fashioned sobriety testing methods used before the advent of the breathalyser (e.g. walking in a straight line, finger to nose co-ordination) are effective in detecting drug-induced unfitness to drive. Of course, the police should only require such tests where there is reasonable justification, as we would expect in the case of the alcohol breath test.

3.8.5 We would therefore encourage the police to:

- Carry out roadside sobriety testing as a matter of course in circumstances where they have reason to suspect a driver of driving while unfit through drugs.
- Treat failure to co-operate in such testing as grounds for suspicion of driving while unfit.
- Arrest those whom sobriety testing suggests are under the influence of drugs and those who refuse to co-operate with testing and take them to a Police station for more formal medical testing and interview.

3.8.6 We also recommend a programme of advertising to publicise the dangers of driving after drug use, and the likelihood of roadside sobriety testing, arrest and prosecution. We would in particular place an obligation on holders of entertainment licenses to make available educational and information materials on the dangers of drug use.

3.8.7 There is also a lack of awareness of the dangers of driving under the influence of medicinal drugs, both prescription and over the counter. Existing warnings on labels are clearly not adequate. There is also a danger drugs which do not cause drowsiness or other impairments to driving ability in

themselves may do so in combination with other drugs. Drugs may also cause drowsiness in some individuals but not in others.

3.8.8 We would therefore introduce a traffic light system of labelling as used in Australia, Scandinavia and the Netherlands. All packaging would show a green light if the drug had no effect on driving, an amber light if the user should only drive with caution after advice, and a red light if the drug impaired driving ability. We would also require adoption of compulsory warnings of all dangers of taking a drug in combination with alcohol or any other drug, and run a publicity campaign for the new labelling system.

Glossary

Classification of drugs:	System under the 1971 Misuse of Drugs Act, whereby drugs are classified from A-C, and penalties are allocated to each class.
Class A:	These currently include cannabis oil, cocaine and crack (a form of cocaine), ecstasy, heroin, LSD, methadone, processed magic mushrooms and any Class B drug which is injected.
Class B:	These currently include amphetamines, barbiturates, cannabis (in resin or herbal form) and codeine.
Class C:	These currently include mild amphetamines, anabolic steroids and minor tranquilisers.
EMCDDA	European Monitoring Centre for Drugs and Drug Abuse.
MDA	Misuse of Drugs Act 1971.
RTA	Road Traffic Act 1988.
Runciman Report	Report of the Independent Inquiry into the Misuse of Drugs Act 1971; chaired by Dame Ruth Runciman.
UNDCP	United Nations Drugs Control Programme.
UN Conventions	There are three UN Conventions on international cooperation in the drugs field. These are: <ul style="list-style-type: none">• The 1961 Single Convention on Narcotic Drugs• The 1971 Convention on Psychotropic Drugs• The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (sometimes known as the Vienna Convention).

This paper has been approved for debate by the Federal Conference by the Federal Policy Committee under the terms of Article 5.4 of the Federal Constitution. Within the policy-making procedure of the Liberal Democrats, the Federal Party determines the policy of the Party in those areas which might reasonably be expected to fall within the remit of the federal institutions in the context of a federal United Kingdom. The Party in England, the Scottish Liberal Democrats and the Welsh Liberal Democrats determine the policy of the Party on all other issues, except that any or all of them may confer this power upon the Federal Party in any specified area or areas. If approved by Conference, this paper will form the policy of the Federal Party, except in appropriate areas where any national party policy would take precedence.

Many of the policy papers published by the Liberal Democrats imply modifications to existing government public expenditure priorities. We recognise that it may not be possible to achieve all these proposals in the lifetime of one Parliament. We intend to publish a costings programme, setting out our priorities across all policy areas, closer to the next general election.

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Note: Membership of the Working Group should not be taken to indicate that every member necessarily agrees with every statement or every proposal in this Paper.

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