CRACKPOT

A FRESH APPROACH TO DRUGS POLICY

Policy Brief from the Bow Group by Humfrey Malins, CBE, MP

27 December, 2006

FOREWORD

My father was an Army Chaplain. One Sunday in the winter of 1958 we were living in Wiltshire – I was 13 – he was asked to take Evensong in a local village church. He drove me there (Church was compulsory). It was a foul, rainy evening, dark and miserable, and not a single person other my father and me was present. I thought we would turn around and go straight home, but not a bit of it. My father sat me in the front pew, put on his robes, conducted the service, and preached a lengthy sermon.

He and I both sang a hymn, during which, can you believe it, he bore down on me with the collection plate, and I was obliged to part with my weekly pocket money, a shilling as I recall, which I had only been given that day.

We drove home in silence until he asked me if I had absorbed (not if I had enjoyed) his sermon. I had – it was on the parable of the Good Samaritan and its relevance in the modern world of 1958.

I was reminded of that Sunday recently when I visited Sweden so that I could better understand that Country's Drugs policy. Whilst there, I was told the words of their Drugs Minister, who famously and, I believe so wisely, said:

"A society should be judged on the basis of its ability to take care of its most vulnerable citizens."

Among Britain's most vulnerable citizens are those many thousands – some so very young – who are addicted to hard drugs, whose lives lie in tatters.

True, many of them are criminals, but they are victims too and need help from the Criminal Justice System. When a court sentences a person for a drug related crime, the emphasis should be on treatment as well as (or sometimes instead of) punishment.

In this pamphlet I have three main purposes.

First, to demonstrate that much of current and recent court sentencing practice is completely ineffective in dealing with the drug addict criminal.

Second, to stress that a treatment based punishment is more often than not the best way to deal with such a criminal.

Third, to point out the scandalous lack of provision of one of the most useful and successful sentencing options – a residential drug rehabilitation bed, and to argue that only by dramatically increasing this provision will we bring sense and decency into sentencing and help to reduce drug related crime.

In this pamphlet I have drawn on my experience over the years sitting as a judge in the criminal courts, having to deal with drug addict criminals day after day, and I have looked at the issue with my Parliamentary hat on, trying to decide what the problem is (easy) and what we in Parliament can and should do (difficult). I am conscious that I

do not have many of the answers, but my aim is to take the debate forward and if I do, that will be enough.

I am grateful to those who have helped me: my assistant Philip Walters (not to mention his mother Minette), several colleagues on the Bench, Peter French, a former senior policeman, who knows his way round better than most, and finally to a few who exist in semi darkness and prefer anonymity, and if I were them, I would too.

PROLOGUE

A defendant stands in the dock at Camberwell Green magistrates' court in South East London and, in a broken voice, enters a plea of guilty to a charge of theft by shoplifting. The facts are simple. The previous day, making no attempt to hide what he was doing, he stole £60 worth of razor blades from the local supermarket and walked out. He was arrested immediately.

Grey faced and clearly unwell, he has the trembling whisper and unsteady bearing of an old man. He clings to the dock with shaking hands and stares at his feet because he hasn't the strength to hold up his head. Every so often he scratches relentlessly at his arm. The District Judge asks him to confirm his age. Twenty-six.

This is the defendant's twenty-eighth conviction for theft or burglary in the last seven years. It's a certainty that he got away with crimes at the beginning of his career, but now he lacks the skill and insight to get away with anything. Where understanding once influenced his actions, now holes exist. There's no linkage anymore between theft and the consequences of capture. Need comes before caution.

The District Judge invites the defendant's solicitor to speak in mitigation. It's a familiar story. The Court has heard it a thousand times before. Inner City Council – Estate - dysfunctional family background - violent, drunk father - Prozac addicted mother - parental neglect - truancy from school – illiteracy - no qualifications - bad company - and a downward spiral into physical addiction through glue sniffing and cannabis.

Now dependent on heroin, the defendant has become a compulsive thief and burglar, selling the stolen goods to feed his habit. After being abandoned by his family who can no longer cope with his dependency, he has no fixed abode and cannot give the name of anyone willing to take him in. Speaking on his behalf the solicitor says that his client is motivated to kick his habit – *yet again* – but the court is reminded that the defendant has used this excuse on every previous appearance.

Imagine you are the District Judge and you had heard all this before and would hear it all again tomorrow. What sentence should you pass on this once young man?

Illegal Drugs and the Scale of the Problem

In Britain, the number of people using drugs is rising. The age of Class A drug users is falling. Our streets are awash with heroin from Afghanistan, cocaine from Columbia, and cannabis from Holland and Turkey. Our country's services are stretched thin containing the drugs problem. The cost to society from drug abuse is overbearing. Be in no doubt, we have an enormous problem on our hands.

The British Crime Survey estimates that the number of 16-59 year olds using Class A drugs (which include heroin, LSD, ecstasy, cocaine, and crack) in 2004/5, in England and Wales, was1,012,000[1].

More alarming perhaps is that drug users are getting younger and younger. The same survey estimated that 494,000 of those Class A drug users were aged between 16 and 24. A survey four years ago confirms the point. It showed that nearly half of all 16-24 year olds had at some point taken drugs and that 17% of them had taken a Class A drug in the previous year.

How easy is it to get hold of drugs? In short, easy. As the availability of illegal drugs increases so its price falls. In five years the price of heroin has fallen from £70/g to £53/g[2]. Cocaine and crack are both now considerably cheaper than they were in 2000. For those intent on doing so, buying illegal drugs does not pose a problem.

Problematic Drug Users

Before we go any further, we must understand that there are two broad categories of users.

One consists of the group who take banned substances infrequently, or perhaps frequently, but otherwise commit no offence and live relatively normal lives.

The second category comprises what are often called "problematic drug users" – our young defendant is one of these – and they may amount to 250,000 in total[3]. These are Class A drug users who are most likely dependant on crack cocaine or heroin. They lead desperate and chaotic lives; they take huge risks with their health; many of them commit crime to fund their habit, and they probably come from very disturbed backgrounds. In my experience most of them have had a minimal education, coming from broken homes on poor estates, have uncertain accommodation and find it hard to hold down a job. Almost invariably they lack any form of self-esteem. They haven't had a good start in life, and it is all too easy for them to drift into hard drugs (often via solvents and cannabis) and crime.

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[1] *Drug Misuse Declard: Findings from the 2004/05 British Crime Survey*, p.g. 13, by Stephen Roe, October 2005

[2] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Paul Goggins MP, 15th February 2006

[3] *The Government's Drugs Policy: Is it working?*, by House of Commons Home Affairs Select Committee, Third Report of Session 2001-2002, December 2001

What is more, there seems no escape from the utterly miserable lives they have in utterly miserable areas. This is the group that is most at risk, and from them emerge those thousands of people who have to commit crime non-stop in order to fund their craving. The cost of all this to society, both in human and cash terms, is enormous, not least to the Criminal Justice System.

The Drugs Prevention Advisory Service and Drugs Scope estimate that there are probably upwards of 100, 000 problematic drug users who finance their habits through persistent crime. Many surveys indicate that the majority of those are spending around £15, 000 per year on their habit.

An experienced District Judge in London takes the view that many such problematic drug takers who indulge in crime need to steal up to £500 worth of goods a day in order to make what they need, namely £100, through fencing the goods. They mostly steal from supermarkets or chain stores, targeting clothes, razorblades, batteries, alcohol and fresh meat, and many burgle houses and offices.

One criminal addict in his mid twenties confirmed to me that for every occasion that he was caught committing a crime he had got away with a crime at least 25 times.

Most of them start on cannabis. I quote the words of a fellow district judge, "Every crack or heroin addict I see in court has started on cannabis or solvents somewhere between the ages of 10 or 12. By the time I see them, they are in their mid 20s and have had 10 years of addiction. They have never had a job, are usually on incapacity benefit, the work ethic has gone, and addiction is a full time occupation, a complete way of life. They live in a parallel universe. Hepatitis, HIV, Deep Vein Thrombosis, some or all of these are usually present."

The latest figure that I can get from the Home Office suggests that £2.3 billion was the total cost to the Criminal Justice system associated with the criminal activity of problematic users in the year 2000; more recent estimates are hard to find.

Even more alarming figures were quoted by the Downing Street Strategy Unit Report headed by the former BBC Director General Lord Birt in June 2003, much of which was inexplicably held back from the public domain until mid 2005[4].The report says that the annual cost of crimes committed by an estimated 280,000 "high harm" drug users to support their cocaine and heroin habits has reached £16 billion a year, a figure which rises to £24 billion if the cost to the nations health and "social functioning harms" are included.

It is on the problematic drug users, and in particular on those many thousands within that group who destroy other people's lives as well as their own through crime committed to fund their habit, that I wish to concentrate. Yes, these people are indeed criminals, but I suggest in many cases they are also victims who need help as much, if not more, than punishment.

[4] Strategy Unit Dugs Project, by Lord Birt, 11th December 2003

The Courts

Forget, for the moment, the Crown court, where a robed Judge sits with a jury and cases actually take time. Not many cases go there; some do because plainly they are too serious to be tried at Magistrates court level (e.g. murder); some go for sentence when for one reason or another (usually the defendants record) the magistrates feel that their maximum sentence is not enough (six months), and some go because the defendant wants to exercise his right to a jury trial on, for example, a theft charge.

We journey instead to the Magistrates courts, where all cases begin and most are concluded. In the inner London area, there are about ten major magistrates' court centres. Let us consider the three broad categories of drug related offences and offenders.

Our first offender may be charged with simple possession of a controlled drug of Class A, B or C under the Misuse of Drugs Act 1971. The three classes are:

Class A (including cocaine, crack, heroin, LSD, and ecstasy).

Class B (including amphetamines).

Class C (including cannabis, and cannabis resin).

Possession means being caught in possession of the substance in a quantity entirely consistent with personal use. In the Crown Court, penalties for possession for each of the three Classes range from 2 years to 7 years custody. In the Magistrates courts, maximum penalties are 6 months (Class B) and 3 months (Class C).

The second broad category of drug offender is the man charged with possession with intent to supply. Here our defendant, a large scale or small scale dealer, is caught in the act of supply, or perhaps caught in possession of a large amount of drugs inconsistent with personal use, and probably the paraphernalia associated with dealing, like scales and wraps. The penalties are rightly much higher.

Life imprisonment if it's Class A, 14 years if it's Class B, and 5 years for Class C – these are the sentences available in the Crown Court. Correspondingly, the sentences in the Magistrates court are 6 months, 6 months, and 3 months, respectively.

Given that very few dealers, particularly those dealing in large volumes, are themselves drug takers, there isn't much difficulty imposing a harsh custodial sentence on such people.

The third category of offender is the drug addict, one of the problematic drug users who is in court not charged with possession, or possession with intent to supply, but for the umpteenth time charged with burglary, theft, or robbery committed to fund their habit.

This is the one who causes the most difficulties in sentencing and the sad truth is that we have not recognised sufficiently that this offender, a criminal yes, but also a victim, may need help as well as, or instead of, punishment.

Cannabis – What do we need to do?

An examination of current sentencing practice in relation to possession of cannabis illustrates a real problem. For a first, second, or even third offence for simple cannabis possession, the courts tend to take a remarkably relaxed attitude. Although, as I said earlier, all penalties, including a custodial penalty, are available in a magistrates' court, the end result is much more likely to be this:

"Stand up Smith. Fined £50 and the drug to be forfeited and destroyed. Next case please."

Spare a thought for the defendant who is up next, who crossed a red traffic light and was fined twice as much.

It is disappointing that the courts take such a relaxed attitude to the possession of cannabis, which can be a deeply damaging drug, particularly so to young and vulnerable people. The higher courts have themselves indicated that custody need not be considered for this offence until it has been committed a number of times (by which time, it may be too late). What is more, sentences involving some sort of treatment are rarely handed out to cannabis smokers and are almost unheard of for a first or second conviction for cannabis possession.

I suggest this is wrong. Cannabis is a far more serious drug in the hands of vulnerable people than has hitherto been thought. We need to understand that there different varieties of cannabis. In Holland for example, 12 year old children are being treated for an addiction to a powerful home grown variety of marijuana (skunk), which is up to twenty times stronger than the imported type. Today's skunk is not quite the same as it was thirty years ago – it is often more harmful and addictive. It can, and regularly does, lead to much worse.

Cannabis is a drug with mind altering properties. It influences thoughts, emotions, and affects almost every part of the brain. It is indeed the most widely used illicit drug in the world today. The most important mind altering component of the cannabis plant is known as Delta-9-Tetrahydrocanabinol, but mercifully it has the common name of THC. Studies have confirmed that most of the cannabis of today contains higher concentrations than cannabis of twenty or thirty years ago. In the early sixties, the average amount of THC in cannabis was thought to be 5% or lower, but today particularly potent versions of the drug can contain up to 20% of THC. We are not dealing with the same drug, and in the UK cannabis is not considered dangerous by sufficient numbers of people.

Cannabis is a gateway drug – something confirmed by the vast majority of the judiciary with whom I talk.

We may all remember the tale of a former pop star, who, it was said, smoked up to 20 super strength cannabis joints a day. A friend claimed that the drug had turned him into a "stoned waster". He added," When you smoke as many spliffs as he has done you simply cease to function."

If, as I believe, cannabis (in many of it forms) is very dangerous – two consequences should follow.

First, the courts must intervene early. That means on first court appearance. Never mind a fine, or a conditional discharge, surely there should be a sentence which recognises the dangers. A community order, with a requirement to attend in one's spare time a short but intensive "dangers of cannabis course", with group sessions and help from drug workers, with an option of 2 weeks imprisonment if one does not consent to this disposal, seems to me the best approach.

Second, we must recognise the dangers of the drug. I am told that the average number of people in the EU who say that they perceive cannabis as very dangerous is 20.6%, but in the North of Europe the figure is much higher – in Sweden 45% perceive the drug as very dangerous, but here in the UK only 17% do. I believe that the more people regard cannabis as relatively harmless the more likely they are to take it.

Politicians spend a lot of time debating whether cannabis should be transferred back from Class C to Class B (where it used to be). Would transferring it up a Class to Class B be sensible? I think it would. At least it would send a strong message that cannabis can be harmful and can be a gateway to more serious drugs. This approach would be consistent with what I want to see, namely a zero-tolerance attitude to cannabis, and lifting it a Class may help

What results when the message gets out that cannabis possession is not too serious? Let me just point at an experiment in South London in 2001 where police in Lambeth were allowed to give warnings to those caught with cannabis for personal use. What happened? Cases of drug possession rocketed up, with all the ensuing problems to the community associated with that development.

In the 12 months from March 2001 to March 2002 a significant rise in drug related offences occurred in that borough.

- Incidents of drug trafficking increased from 18 to 36
- Cases of drug possession went up from 76 to 242
- Total drugs offences rose from 95to 282

Although the Lambeth experiment saved 1,350 hours of police work (by avoiding custody procedures and interviewing time), that was the equivalent of just 1.8 full time officers[5].

So, cannabis (particularly modern strong forms) is undoubtedly a horribly dangerous drug, and more dangerous than it was, and everyone, but especially young people, need to know this fact. A zero tolerance attitude is important, and I suggest that a rapid transfer of the drug back into Class B is an important step. At least it would send the right message.

I pause just to say that the use of cannabis for medicinal purposes (for example to help sufferers from Multiple Sclerosis) is something of which I greatly approve.

[5] MPA Report, 11th April 2002

I suggested in a Parliamentary Question to the Home Secretary that the Government should reclassify cannabis by moving it from Class C to Class B. Here is the answer from the Minister dated17th May 2006[6].

"No. Cannabis will not be reclassified from a Class C to Class B drug. On 19th January, the former Home Secretary announced in Parliament that he had considered the advice that he had asked for from the Advisory Council on the Misuse of Drugs and on behalf of the Government had accepted the Council's recommendation to keep the current classification of cannabis as a Class C drug under the Misuse of Drugs Act 1971."

This is a decision the Government will come to regret. If they have to keep it in the same Class, which of course they don't, then at least they could ensure that the police, schools, and courts, take the whole issue of cannabis much more seriously. Fat chance of that!

[6] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Vernon Coaker MP, 17th May 2006

Some Ineffective Sentencing Options

Back to our grey faced, 26 year old defendant at Camberwell Green Court. What are the sentencing options?

A fine? A waste of time and ineffective. It does not address his addiction, he says he has no money and he can't or won't pay.

A conditional discharge for, say, 6 months? This merely says, "If you re-offend in the next 6 months, you'll be sentenced for today's offence as well as the later one" - again in my view a waste of an opportunity to sort the problem out - most people breach their conditional discharge.

How about 3 months in prison? Remember he'll be out in 6 weeks under the early release provisions – not enough prison places! Anyway, he will get plenty of drugs whilst he's inside prison - a point confirmed to me by the many barristers who use this as a reason not to send a drug addict to prison.

We can send him in custody to the Crown Court for a longer prison sentence (because of his bad record) who can impose a longer prison sentence. Again, easy enough to do but the same problems remain.

Very few options are left to the court.

One is a new Community Order under the Criminal Justice Act 2003 with a supervision requirement – rather like the old Probation Order. This involves supervision in the community by the probation service, but for a drug offender, it is not enough. It is well known that the probation service is in disarray – hopelessly under funded – and even the best officers fail to get reports to court on time and few ever attend court. I sat in a court in South East London not long ago when the probation report on a defendant read as follows:

"I'm afraid that because of staff shortages I have not had time to prepare a report on this man. I must add that because of those shortages there is no realistic prospect of our producing any report in the course of the foreseeable future."

This is a sad state of affairs – damaging to defendants and the whole legal system - and it is not surprising the probation service, so short of workers and money, have not been able to provide the level of supervision required in a drugs case. Probation Officers are few in number and short of morale, and have no great expertise in drug matters. A Parliamentary Answer dated 13th June 2006 told me that in the Greater London Magistrates' Courts area whereas there were 874 probation officers in the second quarter of 2004/5, that number had dropped to 820 by the first quarter of 2005/6[7].

Further evidence of under-funding is the fact that the Government are continually delaying introduction of new "Custody Plus" sentencing provisions, originally

[7] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Gerry Sutcliffe MP, 13th June 2006

introduced in the 2003 Criminal Justice Act. The sentence of Custody Plus will consist of a custodial period of up to 13 weeks and a licence term of at least 26 weeks. The licence term will be subject to onerous conditions imposed by the court, which may include hours of unpaid work, a strict supervision requirement, or an electronic monitoring requirement, all of which require intensive supervision. The reason the Government will not introduce these provisions is quite simple: they don't have the money to fund the Probation Service sufficiently to do so.

Then there is the possibility of a Community Order with an unpaid work requirement added on. This is the equivalent of the old Community Service Order, then renamed Community Punishment Order. Quite simply, a defendant is ordered to do unpaid work in the community. This would be irrelevant for our grey faced defendant. He wouldn't turn up, and if by some miracle he did, he would not do the work and it would not help his addiction.

An alternative was introduced by "The Crime and Disorder Act of 1998 – this was a sentence called the Drug Treatment and Testing Order (DTTO). Here, where the court believed that the defendant had a propensity to misuse drugs which could be susceptible to treatment, the appropriate DTTO could be made. The defendant would be told to submit to drug testing at specified times each month, and would receive counselling. He would have to appear before the court from time to time, who would measure progress. The probation service would (if they had time) produce a report evaluating his progress. The order would last from between 6 months and 3 years. The important point is that the orders did not have a residential requirement, and throughout the defendant would remain in the community which was in part responsible for his addiction.

How would the success, or otherwise, of a DTTO be judged? Should it be being drug free for six months with no reoffending, or is it a success if drug use is reduced and offending also reduced? Different courts have different approaches.

In 2004/5, some 9,700 DTTOs were made by our courts. But proceedings for breach of the order were instigated in 8,450 of those cases. The courts revoked. 2,453 for failures to comply and a further 2,238 were revoked following a conviction for another offence during the period of the DTTO[8].

Further proof of their failure comes from an answer to a Parliamentary Question I asked in February 2006, which confirmed that the 2 year reoffending rate for those convicted of drug offences and given DTTOs was 78.1%[9].

This is failure on a grand scale – and it is time to look at a real solution.

[8] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Fiona Mactaggart MP, 26th January 2006

[9] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Fiona Mactaggart MP, 16th February 2006

Drugs Courts and the New Sentence of a Drug Rehabilitation Requirement

DTTOs have, not surprisingly, had their day and have been replaced under the Criminal Justice Act 2003 by a Community Penalty with a Drug Rehabilitation Requirement (DRR).

This is a tougher version of the old DTTO and, especially when administered by a Drugs Court (of which more later), gives some cause for optimism. Under a DRR the defendant is required to submit to treatment and to regular testing for drugs. This treatment can be as a resident in an institution, or, more likely, in the community. One possible plus is that other requirements may be bolted on to a DRR such as a Curfew Order or compulsory attendance at a crack day programme. The supervision is intended to be more intensive than hitherto.

This sentence is likely to be at its most effective when it is passed by a Drugs Court. It is to Drugs Courts that I now wish to turn.

Specialised Drugs Courts were first established in the USA in the late 1980s. Under pressure to find a solution to rising drug related crime, it was suggested that drug treatment, which had hitherto proved ineffective, would work better if there was an element of compulsion and if a particular judge had ownership of a particular defendant. Drug courts vary between states, but the central premise is that treatment should be the "sentence" for non-violent criminal drug addicts. As of 2001, there were 420 adult drug courts in operation across the United States and from a survey of 372 of them 77, 000 individuals were receiving treatment with a retention rate of some 70%[10]. Drug courts are now operating world wide.

Just under a year ago, two pilot Drugs Courts were established in London and Leeds, which are being closely monitored.

The London court operates at West London Magistrates Court, near Barons Court underground station, and the principal judge is District Judge Justin Philips. Here is how it works.

Imagine an adult is arrested for an offence of theft. This is what is known as a, "Trigger offence", and prompts an immediate drugs test. A mandatory drugs test by mouth swab takes place. If positive, the offender will probably not get bail, and gets to court in custody. He is immediately seen by a DIP (Drug Intervention Programme) worker attached to the court, who assesses the problem and the bail risk. Our defendant may be bailed by the court (there will have to be stringent bail conditions if he has tested positive for drugs, e.g. daily meetings with the DIP worker) or more likely he will be kept in custody. He enters a guilty plea to the charge, and a probation officer writes a pre-sentence report, helped by the DIP worker, recommending a Community Order with a DRR (Drug Rehabilitation Requirement).

Now the addict is passed straight on to the drugs court and Judge Phillips or his colleagues. It sits every Tuesday. A treatment plan has been prepared for our defendant. Typically this may involve twice weekly testing, attendance at a day

[10]National Drug Court Institute, http://www.nadcp.org/

project run by some wonderful drugs charity like Blenheim, Drug line or Drug Link, and it may involve group counselling and acupuncture.

Having passed a sentence of a Community Penalty with a DRR (assume non-residential), the drugs court judge or bench of Justices "owns" this defendant: and sees him regularly, at six weekly intervals. It encourages him, cajoles him, talks to him in non court like language, and may even be on first name terms with him. Above all the Judge works with him, rather than against him.

A DRR can last for between 6 months and 2 years, but the best length is about 18 months - long enough for the addict to become drug-free, but not so long that it is daunting.

There are regular reviews by Judge Philips or the Bench of Justices. He describes his role as being like a psychiatrist, but with authority. The review is informal, and Judge Philips even conducts his reviews in a football shirt!

But, the Judge has sharp teeth if needed, and can revoke the DRR if the defendant re-offends while on it and re-sentence to prison.

How successful is the drug court in London?

Judge Philips explained, when analysing the success of the drug courts and the DRR one must accept the inevitability of relapse. Drug addiction is complex and very difficult to overcome. What should not be tolerated is drug fuelled offending. If you are expecting everyone who finishes their DRR to be totally drug free and never to go near drugs again, you will be disappointed. The Department for Constitutional Affairs says that success is reduced offending and the stabilisation of drug use. This is not very inspiring. But, Justin Philips has his own rule. He says that success is 3 months totally drug free with no re-offending and Justin believes that he has about a 40% success rate according to his rule. When analysing the success of the drug courts and the DRR one must accept the inevitability of relapse.

As he says, "I don't expect perfection, I expect progress "

I conclude that specialised drug courts have a real role to play. In setting them up we are recognising that drug offenders often need help. But I suggest some changes to the present system.

First, it is the probation service which currently supervises the DRR. But, as I have explained earlier, the service is woefully under funded.

There is scope for much greater involvement of the great drug charities, who are both committed and expert, and who provide many of the excellent day programmes. Why not delegate the DRR supervision and day to day work to these charities? I have mentioned three but here they are again. The Blenheim project, Drug line and Druglink.

Next, bring in a power to operate mandatory daily testing, or random testing - the USA courts do this - much better than twice a week, which is our current practice. On

a twice a week test, most tests are taken on Monday and Thursday. Cocaine stays in the body for 3 days, so if the defendant is tested on Thursday he take cocaine that day and still test negative the following Monday.

Next, ensure that the Judge visits the drug charity premises regularly, and he might even want to set up the court there – a potentially good idea. This could be a powerful stimulant to the defendant addict especially if the judge, fed up with what he saw and heard one day, could himself immediately instigate breach proceedings.

Good luck to the drugs court: it is an innovative idea, but needs to be yet more involved and intensive in its work. That court has the potential to outperform all other existing strategies being tried on drug addicts who are being treated other than in residential rehab centres.

What is more, if American experience is anything to go by, the Drugs Court will save money in the short and long term. A study of six drugs courts in Washington State reports that a "Country's investment in Drug Courts pays off through lower crime rates among participants and graduates."[11]

[11] National Drug Court Institute, http://www.nadcp.org/

Residential Rehabilitation Centres

Our once young defendant from Camberwell Green (remember him?) needs real help. He needs a serious detoxification programme and then in-patient residential treatment for a prolonged period. He needs to go to a place akin to a hospital, which is drug free, well away from his previous environment (this is critical) and stay there for weeks or months, during which he commits himself a complete course of rehabilitation. In short, a residential drug treatment centre.

Let us assume he is fortunate, and is sentenced to a Community Penalty with a DRR and in-patient treatment a rehab centre. What will happen?

He will make his own way to the centre – let us assume that it is "The Clouds", an excellent residential treatment centre in Wiltshire. The Clouds believe in total abstinence – and believe addiction is a disease and should be treated as such. He will stay there for 6 weeks – the first of which will be given over to detox. There are 38 beds and people come from different social backgrounds (which is a plus point). As well as treating addiction, the causes of addiction – low self esteem, marital difficulties, poor education, housing problems, etc, are all tackled. He will be assessed by trained nurses and drug experts and a suitable regime devised. He will share a room with another patient to promote sociability and prevent isolation. He will have a minder, who is also a patient, who will settle him in. The aims of treatment in the short term are to facilitate withdrawal, achieve abstinence, reduce suffering, improve understanding, and promote change. The long term goal is to promote life and good health.

From the beginning he is given a packed time table of treatment, counselling, exercise, and relaxation therapy. Treatment focuses on the physical, emotional, spiritual, and psychological aspects of addiction. The programme is based on the "12 Steps" theory, originally introduced in America for alcoholics. But it is appropriate for all forms of addiction and is known to be successful. The 12 Steps process to recovery include honesty – admitting the problem: making a decision to change one's life, making a searching and fearless inventory of one's self: making a list of people one has harmed. There will be proper food, group therapy lectures, acupuncture, possibly head massage, intensive counselling and discussion.

Our young defendant has a two in three chance of finishing the programme and leaving drug free after which he may go on to secondary treatment in a less intensive establishment, then move to a half-way house and gradually back into the community. The Clouds is a privately run centre, which accepts referrals from the Criminal Justice System as well as private clients. For our client the cost will be £150 a day. A private client will pay up to £300 a day. They are pleased to accept clients from very different backgrounds.

How many of these drug treatment centres are there?

I asked a Parliamentary Question on this in 2006. There are 119 English Residential Drug Rehabilitation Units with a total of 2,530 beds. The Government does not run them – they are private or run by charities[12].

Based on anecdotal evidence (which is nevertheless excellent) mostly from judges, drug addicts, and police, I believe that this approach has a much higher chance of success than any other. Unfortunately the Government don't appear to have any figures. When I asked the Home Secretary in February 2006 about the reconviction rates for those convicted of drug related offences who enter drug residential places, he answered, "Information on reconviction rates for offenders entering drug residential rehabilitation places are not routinely available."[13]

In court, some while ago, I came across a rare example of where a residential rehabilitation bed was made available. This was a young women aged 28, a hopeless heroin addict with 3 children. By a miracle, funding was available not just for her but, also for her three youngsters to live in the detox unit for a while and then live together in a residential rehab unit. The family stayed together and 6 months later she was free of drugs and, as far as I know, has not offended since. Before she went to that unit, she had run up a total of over twenty convictions for dishonesty to fund her heroin habit (she told me that she had committed at least 150 offences, but had only been caught for 20!).

What about the comparative cost of a residential rehab unit compared with prison? Quite simply the rehab unit is cheaper – not least because it is more effective.

A Parliamentary Question I asked in April 2006 told me that the average cost of a prison place in 2004/5 was almost £800 per week. The average weekly cost for residential drug treatment is £674.10 (The Clouds costs more than the average but there are other centres which are less). Money is saved on all fronts. Anguish is reduced because there are fewer victims of crime.

[12] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Caroline Flint MP, 1st February 2006

[13] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Fiona Mactaggart MP, 16th February 2006

The Scandal of Under Funding of Residential Rehabilitation

We must now address a central problem which is becoming a scandal, namely the under provision and under funding of residential rehabilitation places.

What follows is based on a discussion with a typical residential rehab centre outside London. The centre in question is one of many that has contracts with Drug Action Teams (DATs). Drug Action Teams are the partnerships which combine representatives from Local Authorities, health, the Probation Service, the Prison Service, and the voluntary sector who are responsible for delivering the drugs strategy at the local level.

There are about 150 DATs country wide, one of whose purposes is to refer convicted criminals to the rehab centres[14]. Their money comes from Local Authorities, Health Authorities, and the Criminal Justice System. The funding method is hideously complicated and bureaucratic and needs simplification.

The "Outside London" centre to whom I spoke told me they had spare beds, and when they ring the DAT team to ask why they are not sending more people, the response is, "We do not have the money to pay for places."

One London Borough I know has funding for only 15 defendants a year when the courts within that Borough will have at least 15 suitable clients for treatment a week.

I have spoken to many other residential rehab centres who tell the same story.

One, a few hours west of London, told me they have 42 beds of which 17 are vacant. They reserve 15 beds for convicted defendants mostly from London, but the numbers coming are diminishing. They currently have 8 spare Criminal Justice beds. The only reason for that is lack of funds.

Another, from the Home Counties, told me "We are not full and haven't been for a while. That is due to a lack of finances."

Another, in North London, said "I know money is not going into residential rehab - if it is going anywhere it is going to day services which do not work as well."

The manager of a residential rehab centre in South London said the problem is general. He added "Lots of residential rehab centres are concerned whether they can stay viable or not because they are not getting referrals. The Government say they are spending much more money, but what is happening to it I simply do not know."

All the anecdotal evidence confirms that a high proportion of beds are not being taken up, and that most residential rehab providers are working considerably under, some as much as 50% under, their full capacity quite simply because the DAT teams and Social Services are desperately short of money. Many of the centres are finding it increasingly hard to discover what is going on.

[14] http://www.drugs.gov.uk/dat/

What is needed is an immediate and efficient audit of beds spaces – which has not been done and must be done forthwith.

We are told that the National Treatment Agency is getting just over £50 million funding for capital developments which means new beds and refurbishing. But the criteria are so complex, relying on multiple chains of partnerships, that only a third of that has been bid for.

But what is the point of a new bed if there is no money to pay for the patient to get into it?

The Government are missing the real need which is a cash injection into the system to fill existing vacant beds. New beds are an irrelevant issue until there is sufficient funding to fill the current beds that are available. Providers across the country feel the same.

Proof of the problem? St Luke's Kensington, a renowned residential rehab centre, closed earlier this year because of lack of funds.

It is time that the Government got to grips with this issue. They should recognise that the right solution would be to quadruple, at least, the number of residential beds over the course of 5 years – but meanwhile they MUST find the funding for current beds as well as future ones and introduce more transparency in the funding process.

That's it. More beds, more funding: it is the only way forward. It is the humane approach and the sensible one. It will save lives and money in the long-term and must be a priority.

Nothing less will do.

The Swedish Experience

In April 2006 I travelled to Stockholm to see at first hand something of Sweden's drug policy. It is a large country with a small population and with a Lutheran background which has developed a national culture of conformity and a distain for deviant behaviour. Coupled with this is Sweden's long history of social democracy and its extensive welfare system. As a result, the Swedes have created a drugs policy which is both restrictive and humane

Their aspiration is to achieve a drug free society and their model is based on four pillars: prevention, control, treatment and research. The drugs issue is high on every Government's agenda, with much public support and cross-party consensus.

I commend a visit to the Maria Youth Clinic on the outskirts of Stockholm which treats young people with all types of addictions. Its central theme is early and heavy intervention.

Take an example: a youngster is arrested on the Stockholm streets in possession of drugs. He is taken to the Juvenile Drug Unit which is a police room actually inside the Maria Clinic. He is compelled to give blood and urine samples and interviewed. If he has taken drugs, he is charged and offered immediate treatment. He does not go to court – instead his case is assessed by a state prosecutor and is given a modest fine. The drug offence stays on his record for five years but if he behaves himself it is removed completely. Treatment is available immediately. This is key. Almost inevitably he accepts the treatment. He is moved over to the clinic side of the building and begins to undertake rehab. Let's assume it was cannabis. The clinic's cannabis programme aims to achieve permanent sobriety in the young patient and straight away he is on to one to one counselling and his parents and the school are brought in. Nobody in the police station or the clinic wears a uniform. Quite often our youngster will stay in the clinic for a number of days but our youngster will be required to undergo counselling for up to 10 weeks. The emphasis in the counselling is the rebuilding of self esteem and the tackling of depression – something that is often at the heart of drug addiction in teenagers. Time after time the head of the clinic stressed to me the importance of youngsters receiving treatment immediately – waiting lists are not acceptable.

The Maria Clinic deals with drink and gambling addiction as well. It started a year ago, is fully state funded, has 110 staff and sees 2,000 families a year. This insistence on early treatment for addiction is much admired across Sweden and similar clinics are being set up. I greatly approve of the principle of expunging a drugs possession conviction from your record if you take treatment and go off drugs as a result. Carrot and stick – well worth looking at.

I talked to their experts about naltrexone, a chemical drug used with some success in stopping addiction. It is, in short, an orally active and long acting potent pure narcotic antagonist. Many experts say that it is an ideal opiod antagonist treatment medication. Taken by mouth, it has minimal side effects, is not addictive and has no potential for abuse. Trials in the USA involving heroin addicts taking a course of naltrexone have shown remarkable success rates.

In Sweden they are positive about naltrexone. I hope we will be here. I asked a Parliamentary question in January 2006, and the ministerial answer keeps the door open[15]:

"The Department of Health has asked the National Institute for Clinical and Health Excellence (NICE) to review the evidence on naltrexone and, by March 2007, deliver a technical appraisal on naltrexone as a treatment for relapse prevention."

However, two former drug addicts told me that in London, both in their thirties, were not so sure about naltrexone. They both said it stopped their heroine use, but added that their alcohol consumption thereafter went through the roof!

On the 27th April 2006, whilst I was in Stockholm, the Swedish Parliament voted to reconfirm their goal of achieving a drug free society, and most importantly a majority of their Parliamentarians had voted for the introduction of the first needle exchange programme in Sweden. A brave move, but in my judgment the right one. If a Swedish County wishes to provide a needle exchange programme it will be mandatory to provide control and treatment programmes at the same time. The number of clean needles supplied at the needle exchange depot will equate exactly with the number of old needles handed in. Any addict handing in used needles will have to meet and discuss their addiction with a drug counsellor before they can walk away with a new needle.

These are sensitive subjects in the UK but we must discuss them and develop policies on them. I personally hope that before long the use of naltrexone as a heroin antagonist will be widespread, and that needle exchanges along the lines of the Swedish plans will be firmly established.

The problem is that many people find it difficult to reconcile the need to introduce effective harm reduction strategies with the implicit drug endorsement messages that such strategies appear to send out. To me there is no problem - concentrate on the harm reduction strategy please.

An important message from parliamentarians and clinicians alike in Sweden was this. "Here in Sweden illicit drugs are not differentiated from one another as they are in the UK. We have just one list of banned substances, and we send out a consistent message. If something is illegal, it's illegal, full stop." One single clear message. This contrasts with the position in the UK where we have confused messages. We spend more time talking of the evils of cigarettes, and banning them in so many places, than we do talking of the evils of cannabis. We should not on the one hand persecute cigarette smokers, and on the other hand turn a blind eye to cannabis smokers, because "it's not so bad ", or there are too many to arrest and deal with.

[15] Written Parliamentary Question, tabled by Humfrey Malins CBE MP, answered by Jane Kennedy MP, 31st January 2006

Conclusions

No one has all the answers to the problems I have raised. The question, "How should I sentence this once young man?" remains very difficult.

There are those who say that decriminalising all drug use would bring the crime rate down dramatically, and solve many of our problems, but I cannot bring myself yet to embrace that view.

I do, however, think there is much to be said for the following proposals:

1) **Stop drug use early by not tolerating cannabis, and detecting drug use in schools**

    - Deal more carefully, thoughtfully, thoroughly with those in court for a first drug possession offence;
    - Reclassify cannabis
    - Use powerful marketing techniques in schools to teach youngsters the dangers of cannabis – adopt a zero tolerance approach;
    - Focus on youngsters and introduce compulsory and random drug tests in all schools – if you fail you're straight off to treatment.

2) **Introduce sentencing that aims to solve the problem**

    - Change the law so that every under 18 year old arrested for a trigger offence undergoes a compulsory drugs test (currently this requirement only applies to over 18s);
    - Outsource much of the work done by probation agencies to private drug charities;
    - Experiment more widely with Drugs Courts.

3) **Radically expand and improve drug rehabilitation**

    - Pour resources into drug residential rehabilitation beds – they work – and properly fund existing empty ones and simplify the financing process;
    - Add residential treatment centres onto prisons. Many prison estates have the space to accommodate such developments;
    - Speed up the research on naltraxone and other drug antagonists, and consider introducing sensible needle exchange programmes;

- Explore the possibility of paying other countries to help treat our addicts. South Africa, for example, offers the same residential rehab the UK provides, but at a fraction of the cost

More than anything, try to understand the issue and understand the importance of treatment. A cured drug addict is better for society than a punished one. This is my central message.

How often have you and I said something to this effect, "It must be difficult being a youngster growing up in today's society. There are so many problems for these children to face which we never faced."

Hard drugs are one such problem.

Imagine you are a teenager today, with a group of friends the same age, all doing your best in life. You get together for a chat and one says "Why don't we try some of this skunk my mate gave me?"

No harm, surely?