

Independent Working Group on Drug Consumption Rooms

Paper E

Harm reduction and the law of the United Kingdom

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Introduction

It is not the aim of this paper to advocate the case for, or against, ‘harm reduction’, either as a policy or in respect of projects whose purpose is the reduction of harms associated with drug use. Instead, the paper seeks to put harm reduction approaches¹ into a legal context and thus identify areas where approaches comply (or fail to comply) with legal requirements of the United Kingdom.² Compliance with our international obligations under treaty is also considered, particularly in connection with the three main UN Conventions.³

Such a paper seems needed because, despite the importance of the topic, surprisingly little commentary exists in the public domain regarding the legal status of harm reduction schemes. This may be because Government Departments, NGOs, and international agencies are feeling their way, and thus tend to make only bare assertions as to the law. The *Alcohol And Drugs Council Of Australia* state that the “legality of supervised injecting centres has been questioned”, yet the basis on which doubt arises is not canvassed.⁴ Similarly, the INCB has repeatedly suggested that drug injection rooms, where addicts can abuse drugs obtained from illicit sources, is “contrary to the international drug control treaties” irrespective of whether the scheme is under direct/indirect supervision of the government.⁵ However, the reasons cited by the INCB in support of that contention are minimal.⁶ In its 2002 Report, the INCB pulls no punches in its criticism of governments that introduce drug injection rooms:

The board therefore encourages Governments to provide a wider range of facilities for the treatment of drug abuse that are in line with sound medical practice and the international drug control treaties, *instead of aiding and abetting drug abuse (and possibly illicit drug*

¹ The author has adopted the expression ‘harm reduction approaches’ as it appears in Neil Hunt’s *Review of the Evidence-base for Harm Reduction Approaches*.

² The Misuse of Drugs Act 1971 applies to England, Wales, Scotland, and Northern Ireland, but the latter jurisdiction has its own Regulations and orders. Scotland has its own legal system.

³ Namely, the *Single Convention 1961*; the *1971 UN Convention on Psychotropic Substances*; and the *1988 Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances*. AEDCA, September 2003, 2.8.

⁵ INCB 1999, paragraph 451; INCB 2001, paragraph 510; INCB 2002, paragraph 503.

⁶ “176. Drug injection rooms, where addicts may inject themselves with illicit substances, are being established in a number of developed countries, often with the approval of national and/or local authorities. The Board believes that any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking. The Board reminds Governments that they have an obligation to combat illicit drug trafficking in all its forms. Parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal (non-medical) consumption. By permitting drug injection rooms, a Government could be considered to be in contravention of the international drug control treaties by facilitating in, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking. The international drug control treaties were established many decades ago precisely to eliminate places, such as opium dens, where drugs could be abused with impunity.

177. The Board, recognizing that the spread of drug abuse, human immunodeficiency virus (HIV) infection and hepatitis are serious concerns, encourages Governments to provide a wide range of facilities for the treatment of drug abuse, including the medically supervised administration of prescription drugs in line with sound medical practice and the international drug control treaties, instead of establishing drug injection rooms or similar outlets that facilitate drug abuse.” [INCB Report 1999, pages 26/27]

*trafficking) through drug injection rooms and similar outlets.*⁷ [Emphasis added.]

Not only are these bold statements made without further analysis, they are also at variance with the written opinion of the Legal Affairs Section to the UNDCP.⁸ This matter is considered more fully later in this paper.

In November 2003, a detailed legal study of harm reduction programmes in Russia (principally in connection with needle exchange schemes) was published. There is much in that work that is relevant to those who operate harm reduction schemes in States other than Russia.⁹ There is also in the public domain a concise academic legal opinion of the Swiss Institute of Comparative Law, on the *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*.¹⁰ Both texts are well reasoned; both texts offer criteria by which some aspects of harm reduction can be reconciled with the language of the three UN Conventions, yet both texts expose areas where the Conventions are deficient, due in large measure to the use of language that has been out-paced by events. There remains no consensus as to whether:

- (i) the provision of health services by a State is a matter for professionals in those services and therefore involves no question of law at all in the context of the three main UN Conventions;
- (ii) Article 3.2 of the 1988 UN Convention requires Parties to make the unlawful possession of scheduled drugs *for personal consumption* a criminal offence, and if so, in what circumstances;
- (iii) Articles of the UN Conventions are breached if, looking behind appearances, a scheme is driven primarily by motives other than harm reduction (e.g. law enforcement resources or priorities).

It is not proposed to dwell on issues such as the reach of the three UN Conventions, or the extent to which they impose prohibitions, or the extent to which they are permissive of actions. There is already a wealth of legal commentary concerning those matters.¹¹ However, a few general observations may be useful.

First observation: neither the lack of legal commentary, nor the absence of notable legal challenges to particular schemes, should be taken as indicating that such schemes are legal. Nor should these features be used to fortify a decision to replicate similar schemes in another jurisdiction (or district) without first seeking professional legal advice in the relevant area.¹² A legal challenge is usually a last-stop option. Many schemes wither or survive following the receipt of legal advice.

Second observation: the fact that a scheme is legal by the laws of one State will not necessarily

⁷ E/INCB/2002/1, para.504.

⁸ E/INCB/2002/W.13/SS.5; a copy of which is found in Appendix 13 to the Report of Professor Butler, "Harm Reduction Programmes and the Russian Legal System".

⁹ Professor William Butler, "Harm Reduction Programmes and the Russian Legal System", *International Family Health*, Nov 2003. A helpful digest of harm reduction initiatives, based on 15 scenarios, in the context of English criminal law, the Russian Criminal Code, and the UN Conventions, was devised and prepared by Detective Sergeant Geoffrey Monahan, at Appendix 15.

¹⁰ AVIS 99-121c January 7 2000 (Bertil Cottier, Deputy Director) (Internet paper).

¹¹ See the *Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (March 2000, chairman Viscountess Ruth Runciman DBE; and see 'Room to Manoeuvre', Drugscope [work originally commissioned by and on behalf of the *Independent Inquiry*; *Decriminalising the personal use of cannabis in the United Kingdom: does international law leave room to manoeuvre?* Neil Boister, [2001] Crim. L.R. 171. See Fortson, *Misuse of Drugs: Offences, Confiscation and Money Laundering*, 5th ed., 2005, Sweet & Maxwell Ltd.

¹² See "Supervised Injecting Centres", *Alcohol and Drugs Council of Australia*, September 2003; 2.8.

mean that it is likely to be legal in another State, even though both States are signatories to the same international treaty. The existence of different legal systems may also make it impossible for one State to copy harm reduction models that exist elsewhere.¹³

Third observation: whereas *nations* are rightly concerned about fulfilling their international obligations, *individuals and organisations* must first look to domestic law for opinion as to whether a particular scheme is lawful there. So far as the United Kingdom is concerned, the courts will endeavour to give effect to the will of Parliament as expressed in the legislative instrument passed in that jurisdiction. Each of the three UN Conventions expressly provides that it is open to Parties to enact measures more severe than those required under the Convention in question.¹⁴

Fourth observation: even in the absence of such provision, there is no principle of United Kingdom law that requires statutes to be construed no wider than the purpose of an international treaty. This remains true notwithstanding that one of the main aims of the three UN Conventions is to promote the “treatment, education, after-care, rehabilitation and social reintegration” of drug users.¹⁵

Fifth observation: as a consequence of the third and fourth points, an individual or organisation is unlikely to persuade a court that it should disregard an unambiguous statutory provision, or to read such a provision ‘up’ or ‘down’, on the strength of the court’s assessment of the purpose of a provision in a treaty or Convention.

Sixth observation: on matters of law reform, or the taking of a decision by the State as to whether it should act in a particular way, the State must consider its international obligations.

Seventh observation: although lawyers will apply legal reasoning in the construction of a Convention, this might not always be appropriate. This is because conventions and treaties often represent political or diplomatic consensus, so that the language of such instruments tends to be diplomatic or political rather than legalistic. The language used in the preamble to the 1961 Convention would not be used today: “*Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind*” and “*Conscious of their duty to prevent and combat this evil.*”

Eighth observation: although the language of a Convention might be appropriate for the period in which the Convention was signed, there will be occasions when it becomes necessary to give its Articles a purposive meaning rather than be construed literally. In this way, conventions become ‘living’, and evolve.¹⁶

At the time the MDA 1971 was enacted, some senior and distinguished members of the Legislature expressed hope that recreational drug use, and problematic drug use, would not be a long-term social issue. In any event, the threat posed to public health by HIV was then unknown. Harm reduction, and the reasons for it, appear not to have been anticipated when the 1961 and 1971 Conventions were signed. The same is probably true in respect of the 1988 Convention. Had these

¹³ See *Australian Drug Policy Expert Committee Stage 1*, April 2000, para.4.5.2; Drugs. Responding to the issues: engaging the community, Stage 1 report 2000.

¹⁴ See Article 23, UNC 1971; Article 24, UNC 1988.

¹⁵ See Article 36.1 (b), UNC 1961.

¹⁶ That such evolution is possible, is demonstrated by the ECHR, the provisions of which were drafted soon after the Second World War in order to prevent gross acts of inhumanity, and abuse of power, but which were not then intended to be used to scrutinise actions of public authorities or domestic legal systems of Member States.

matters been anticipated in the 1960s (or earlier), the Conventions, the MDA and its corresponding instruments, are likely to have been drafted in terms significantly different from current versions.

The Legal Affairs Section to the UNDCP state:¹⁷

36...The unfortunate facts that illicit drug markets are taking over parts of urban areas or of drug abusers poisoning themselves with adulterated substances do not invalidate the Parties obligation to combat drug abuse. If anything, *these new trends make it all the more urgent for them to find new ways to substantially reduce the illicit demand for drugs*. Even leaving the definition of treatment, rehabilitation or social reintegration to Parties, it seems clear that fulfilling their obligations under the treaties should be more comprehensive than just alleviating the harm associated with drug abuse. [Emphasis added.]

The Legal Affairs Section of the UNDCP prepared an opinion for the INCB dated the 30th September 2002 entitled, *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches*.¹⁸ It states that the UNDCP has yet to adopt an official position on harm reduction, but that it would “support a balanced approach that would match supply reduction measures and prevention, treatment, and rehabilitation initiatives, with programmes aimed at reducing the overall health and social consequences and costs of drug abuse for both the individuals and their communities”.¹⁹

Whether ‘balance’ as opposed to ‘proportionality’ is the appropriate approach, is a matter for others to judge, but the result is achievable and permissible by construing the Conventions in the manner suggested by this paper. Unfortunately, unlike the ECHR (European Convention on Human Rights), the three UN Conventions lack an evolving body of jurisprudence. However, a similar result could be achieved at a political level, but responses need to be coordinated and harmonised.

What follows is worth setting out in some detail. Under the heading of ‘Legal Consideration’ the Legal Affairs Section to the UNDCP say:

7. Already in their preambles, the international drug-control treaties set a general obligation on Parties, to limit the use of drugs to medical and scientific purposes. This is not only one of the main purposes of the Conventions, but also a substantial part of the spirit in which they were negotiated and brought into force. The opponents of *harm reduction* may find this fundamental obligation difficult to reconcile with some, if not most, of the programmes and practices undertaken as part of *harm reduction* policies.

Construed narrowly, the words “limit the use of drugs to medical and scientific purposes” might mean imposing an embargo on all other forms of use. However, ‘limit’ may also mean ‘to restrict’ or ‘to curb’. This suggests schemes somewhat more forgiving of human failings. The Legal Affairs Section therefore goes on to summarise the main specific obligations of States under the Conventions:

8. Admittedly, articles 33, 36 and 38 of the 1961 Convention, articles 20 and 22 of the 1971 Convention, and article 3 of the 1988 Convention, create even more specific obligations on Parties. Among them:
- a. Not to allow the possession of drugs except under legal authority.

¹⁷ E/INCB/2002/W.13/SS.5.

¹⁸ E/INCB/2002/W.13/SS.5.

¹⁹ E/INCB/2002/W.13/SS.5, para.6.

- b. To make criminal offences the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the Conventions.
- c. To make criminal offences the public incitement or induction of others, by any means, to commit any of the above offences, or to use narcotic drugs or psychotropic substances illicitly.
- d. To make criminal offences the participation in, association or conspiracy to commit, attempts to commit and aiding, abetting, facilitating and counselling the commission of any of the above offences.
- e. To take all practicable measures for the prevention of drug abuse and for the early identification, treatment, education, after care, rehabilitation and social reintegration of drug addicts.

As the Legal Affairs Section points out (below) the last obligation is less clear as to action States may take that would be convention-compliant. However, that obligation should be considered against the background of what was then known, against health issues that society is likely to face for some time:

- 9. The first four are very straightforward, and lend themselves to few contradicting interpretations, for instance on the issue of penalties. The last one is not so clear cut, since given its very nature, compliance with this obligation will necessarily depend on the interpretation by the Parties of concepts like prevention, treatment, rehabilitation and social reintegration, which are not defined by the treaties. State practice has shown that such interpretation may vary greatly from country to country and with it their understanding of how best to handle their respective drug abuse related problems, while complying with their treaty based obligations.
- 10. On the latter, it is worth noting that the treaties, also in their preambles, express their concern for the health and welfare of mankind, and for the health and social problems resulting from abuse. This might easily be construed as clear intent on the part of the treaties to combat drug abuse out of concern for its health and welfare consequences. Proponents of harm reduction might view this, in combination with the provisions of article 14, paragraph 4 of the 1988 Convention, as an express consent to alleviate the human suffering associated with drug abuse through harm reduction policies.
- 11. The provisions in article 14 go even further, authorizing Parties to base their demand reduction measures on recommendations of, inter alia, the United Nations. General Assembly resolution A/RES/S 20/4 (Declaration on the Guiding Principles of Drug Demand Reduction) would no doubt qualify as a United Nation's recommendation. In this respect, it should be noted that this resolution clearly states that:
 - “(b) Demand reduction policies shall:
 - (i) Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse;
 - (ii) ...
 - (iii) Be sensitive to both culture and gender;
 - (iv) Contribute to developing and sustaining supportive environments.”
- 12. From this, it could easily be argued that the Guiding Principles of Drug Demand Reduction provide a clear mandate for the institution of harm reduction policies that, respecting cultural and gender differences, provide for a more supportive environment for drug users. The implementation of such a mandate would of course be open to the Parties interpretation.

13. Although General Assembly resolution A/RES/S-20/4 does not carry the legal weight of a treaty, and is in fact non-legally binding, it does reflect the evolution in the outlook of Parties on the drug abuse problem and the best means to cope with it. It also reflects a consensus of the international community on how to deal with drug abuse prevention and treatment. [Emphasis added.]

Much of the above is descriptive of possible arguments rather than expressing a concluded view as to whether the interpretation of the Conventions suggested by the ‘proponents’ of harm reduction is correct. However, it is when the Legal Affairs Section goes on to consider particular programmes that we see strong indications that a number of current projects are likely to be convention compliant (for example, substitution and maintenance treatment, drug injection rooms, and needle/syringe exchanges). These will be considered in greater detail in this paper, but it is important to stress at this stage that a scheme being convention compliant does not mean that the scheme will be lawful by the laws of the United Kingdom.

A point correctly made by the Legal Affairs Section,²⁰ is that it is not appropriate to make generalised assertions about the legality of harm reduction approaches. It is not possible to devise criteria by which harm reduction programmes are self-authenticating. Legal implications of harm reduction must be considered on a case-by-case, scheme-by-scheme, basis. This is largely because no definitive term of ‘harm reduction’ exists. In a seminal work for the initiative, *Forward Thinking on Drugs*, Neil Hunt described ‘harm reduction’ as a term “used to refer to both a set of general principles used to underpin policies concerning the way that societies respond to drug problems, and simultaneously, to some specific types of intervention, such as needle and syringe programmes and methadone treatment, which are often seen as being synonymous with ‘harm reduction’”.²¹

The phrase ‘harm reduction’ is descriptive of policy and programmes, but the latter does not necessarily help to define the former, or vice versa. In the creation, application, and enforcement of legal rules, definitions matter.

Ninth observation: although this country is not free to legislate entirely as it pleases (by reason of the three main UN Conventions), the Conventions give more room to manoeuvre than might be supposed.²² The drafting of offences, the mental ingredient required to be proven by the prosecution, the classification of drugs, the penalties that can be imposed on offenders (or even whether there should be a prosecution at all) are matters left largely to the discretion of States.

Tenth observation: there is a view – perhaps gaining currency – that decisions made in the provision of health services do not, or ought not, to give rise to legal questions under the three main UNC’s (United Nations Conventions). Thus, in the context of Art. 14 of the 1988 Convention entitled, “Measures to... eliminate illicit demand for narcotic drugs and psychotropic substances”, the *Swiss Institute of Comparative Law* says that this provision “might be expected to contain concrete policy choices”. Its opinion continues:

²⁰ E/INCB/2002/W.13/SS.5, para.37.

²¹ Hunt cites the definition framed by the International Harm Reduction Association, but a very similar and more concise definition is that provided by Riley *et al*: “a policy or programme directed toward decreasing the adverse health, social, and economic consequences of drug misuse without requiring abstinence from drug use”. See D. Riley *et al.*, “Harm Reduction: Concepts and Practice. A Policy Discussion Paper”, *Substance Use and Misuse*, XXXIV (1999), 9–24. Professor William Butler tells us that this definition has been widely used at international conferences and in specialist literature. “*HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programmes and the Russian Legal System*”, Professor William Butler, International Family Health, DFID, 2003, p. 20.

²² Note the views of the *Independent Inquiry into the Misuse of Drugs Act 1971*.

Unfortunately, para. 4 simply exhorts States Parties to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic” and the choice of such measures is left entirely to the discretion of States Parties. No guidance at all is provided to the persons who must decide whether or not state-controlled public injection rooms are conducive to the rehabilitation and social reintegration of addicts, to the reduction of human suffering and to the elimination of financial incentives for illicit traffic. *This is indeed not a legal question at all, in the sense that medical experts, social workers and health policy makers are much better equipped than lawyers to provide reliable responses. Our Institute is certainly not in any position to provide a concrete response.* [Emphasis added.]

Although it may well be true that health service providers are much better equipped than lawyers to provide reliable responses, that is not to say that a decision taken to introduce a health scheme, including a harm reduction scheme, is not a legal question. The trend (at least in Europe) is for all actions by public authorities to operate according to law. Even if it is not a question that arises as a matter of international law, it is likely to be a legal question as a matter of domestic law.

Eleventh observation: it follows from the above that a distinction should be drawn between the role of the State, and that of an individual or an organisation (whether public or private). The latter must comply with local laws. States on the other hand, have choices as to whether (i) to seek to modify a Convention, (ii) to disregard a provision of a Convention, or (iii) to seek to justify a policy/programme by giving a provision a purposive construction. States will tend to adopt the third approach for the reasons given above.

Twelfth observation: there is a wealth of material expressing conflicting views as to whether, or in what circumstances, States are required to make the possession of drugs for personal consumption a criminal offence.²³ Despite the language of Articles 4(c),²⁴ 33,²⁵ and 36.1(a), of the 1961 Convention, it would appear that these provisions were not intended to be directed against ‘use’ for personal consumption.²⁶

There is no definitive view as to whether the 1971 UN Convention requires States to make possession or use of drugs specified in that instrument, a criminal offence. This turns on Articles 4, 5,²⁷ and 22.1(a).²⁸ One argument is that notwithstanding that Article 5.3 makes it “desirable” that

²³ See the Swiss Institute of Comparative Law, *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*, AVIS 99–121c January 7, 2000; and see Fortson, R., *Misuse of Drugs: Offences, Confiscation and Money Laundering*, 2005, 5th ed., Sweet & Maxwell.

²⁴ “The parties shall take such legislative and administrative measures as may be necessary...(c) to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.”

²⁵ “The Parties shall not permit the possession of drugs except under legal authority”.

²⁶ See the Report prepared by the Secretariat for the 5th United Nations Congress on the *Prevention of Crime and the Treatment of Offenders* (A/Conf.56/10); and see the *Report on the 11th International Conference on International Law*, 1974; and Noll, *Drug Abuse and Penal Provisions of the International Drug Control Treaties*, Bulletin on Narcotics, Issue 4-003, 1977.

²⁷ “5.3. It is desirable that the Parties do not permit the possession of substances in Schedules II, III and IV except under legal authority.”

²⁸ “22.1.(a) Subject to its constitutional limitations, each Party shall treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations

possession of substances should not be permitted except under legal authority, Article 22.1(a) requires any action to be a punishable offence if it is contrary to a law adopted in pursuance of its obligations under the 1971 Convention. One interpretation of this provision is that if a State makes possession for personal consumption unlawful (i.e. forbidden) then that action should also be a 'punishable offence' (some commentators might equate that phrase with 'criminal offence'). A contrary argument is that Article 5.3 does not give rise to an 'obligation', and therefore a law relating to possession is not caught by Article 22.1(a) at all.

More difficult is the effect of Article 3.2 of the 1988 UN Convention.²⁹ At first sight, this provision could not be clearer in requiring States to make possession 'for personal consumption' a 'criminal offence'. However, the Swiss Institute of Comparative Law points out that "this obligation exists only in so far as the relevant activities are 'contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention'". Their argument is that if (as they contend) possession was not in fact contrary to the earlier UN Conventions then Article 3.2 of the 1988 UN Convention does not alter the position. The Swiss Institute draws attention to Article 25 that states the provisions of the 1988 Convention "shall not derogate from any rights enjoyed or obligations undertaken by Parties to this Convention under the 1961 Convention, the 1961 Convention as amended and the 1971 Convention". However, the analysis is not infallible because Article 25 refers to "obligations undertaken by the Parties", so that if States did regard themselves bound by the UN Conventions to forbid the possession of drugs for personal consumption, then this action must also be made a criminal offence by virtue of the 1988 Convention.

Leaving those arguments aside, the United Kingdom has made it a criminal offence for any person to be in unlawful possession of a controlled drug (s.5(3), MDA 1971). It is sometimes said that this excludes use, so that use is not criminalised under the MDA 1971. That is wrong. 'Use' is not specifically mentioned in the Act because a person cannot use a drug without first being in possession of it. A person who has ingested a drug can (in theory) be charged on the basis that s/he possessed it at some earlier time. The fact that such prosecutions are rare has more to say about the exercise of discretion rather than the literal construction of the MDA.

Harm reduction as 'back-door legalisation', or 'going soft on drugs'

An argument sometimes deployed by opponents of harm reduction is that it represents a back-door approach to 'decriminalising' drug use, or 'legalising' drug use (or even drug supply).

The terms 'decriminalisation', 'legalisation', and 'depenalisation' are often not defined by those who use them, and mean different things to different people. 'Decriminalisation' is sometimes subdivided into 'de facto' or 'de jure' decriminalisation. Commentators and debaters would be well advised to define what *they* mean by those terms – or better still, not to use them at all. Even if the MDA was repealed in its entirety, the Medicines Act 1968 with its array of offences would be likely to remain in place and be enforced.

The suggestion that the United Kingdom is 'going soft on drugs' is not supported by the history of drug control legislation in the United Kingdom. The number of drugs controlled under the Misuse

under this Convention, and shall ensure that serious offences shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty."

²⁹ "3.2. Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention."

of Drugs Act is at an all-time high. The offence of permitting premises to be used for any activity contrary to section 8 of the Misuse of Drugs Act is now a ‘drug trafficking offence’ for the purposes of the Proceeds of Crime Act 2002. One act of ‘drug trafficking’ is deemed to be ‘criminal lifestyle’ for the purpose of the confiscation regime under the 2002 Act.³⁰ *Cannabis* and *cannabis resin* are to be reclassified as Class C drugs, but the unlawful possession of either drug will remain an arrestable offence – although the possession of other Class C drugs will (now) continue not to be arrestable.³¹ The power of arrest has been carried over to Class C only because the drug in question is *cannabis*.³²

Penalties for trafficking in any Class C drug have sharply increased under the Criminal Justice Act 2003, from 5 years’ imprisonment to 14 years’ and/or an unlimited fine (if convicted on indictment). Once again this change was driven by the reclassification of cannabis and cannabis resin to Class C.

On the other hand, the provision of swaps, utensils for the preparation of a controlled drug, citric acid, filters, water ampoules for injection when supplied or offered for supply in accordance with the Medicines Act 1968, by practitioners, pharmacists, and “persons employed or engaged in the lawful provision of drug treatment services”, is now exempt from section 9A of the Misuse of Drugs Act 1971.³³ It would seem that ampoules of water for injection continue to be Prescription Only Medicines and thus subject to the prescription requirements under the Medicines Act 1968,³⁴ – not, be it noted, under the MDA 1971.

A wider group of persons may now prescribe, supply, possess, and administer specified controlled drugs in certain circumstances only.³⁵

There is of course a difference between actions public authorities are *empowered* to take (e.g. by statute) and actions that are *appropriate* for public authorities to take in all the circumstances (i.e. as a proportionate response). The use of ‘discretion’ in the criminal justice process is a good example. Discretion is one way to mitigate the harshness of legal rules, and one method by which legal responses are kept ‘proportionate’. As the intensity of legal controls increases, so the area of discretion tends to widen. Too little has been said by legal commentators concerning the importance of discretion as a legal concept or tool.

³⁰ Statutory assumptions are automatically triggered if a defendant has a ‘criminal lifestyle’, so that all wealth held by him at the time of his conviction, and all property passing through his hands in the six-year period before he was charged, will be assumed to be his proceeds from criminal conduct unless he proves otherwise (note: the civil standard of proof is applicable at all stages of confiscation proceedings).

³¹ As a result of Government amendments introduced at a late stage in the history of the Criminal Justice Bill (now the Criminal Justice Act 2003).

³² One might wish to pause to consider what it is about *cannabis* that has taken Parliament to these lengths. The police have argued that the power of arrest in respect of cannabis is a useful law-enforcement tool. Perhaps it is – but not in the reduction or prevention of cannabis use. The power may well enable the police to justify arrest in the pursuit of other police objectives (e.g. dispersing a crowd, and gathering intelligence by questioning the suspect), but in the absence of evidence of a causal link between the taking of cannabis and the commission of criminal offences, the only logical explanation for the move is that (ironically) cannabis is the most popular controlled drug of choice used by the greatest number. If cannabis lost its popularity overnight, that particular justification for arresting an individual would disappear, and thus the means by which intelligence is gathered falls away.

³³ *Misuse of Drugs (Amendment) (No.2) Regulation 2003*, SI 2003/1653.

³⁴ Prescription Only Medicines (Human Use) Order 1997.

³⁵ *Misuse of Drugs (Amendment) (No. 3) Regulations 2003*, SI 2003/2429. The earlier *Misuse of Drugs Regulations 1973* and its amending instruments have been revoked, and similarly, the *Misuse of Drugs Regulations 1985* [SI 1985 No. 2066], as amended by SI 1986 No. 2330, SI 1988 No. 916, SI 1989 No. 1460, SI 1990 No. 2630, SI 1995 No. 2048 and SI 1995 No. 3244, have been repealed.

Basic scheme of the Misuse of Drugs Act and the M.D. Regulations 2001.³⁶

The MDA provides the basic legal framework for controlling the distribution and use of drugs specified in three Classes (A, B and C) in Schedule 2. The Act:

- (i) makes certain activities unlawful
- (ii) makes unlawful acts criminal offences
- (iii) empowers the Secretary of State to make Regulations
- (iv) empowers the Secretary of State to take other administrative steps regarding the use, custody, and distribution of controlled drugs
- (v) grants powers of law enforcement.

The Misuse of Drugs Act tends to follow a two-stage approach in the creation of offences. Firstly, certain activities are made ‘unlawful’ (e.g. possession, s.5(1)). Second, the unlawful act is then made an ‘offence’ (e.g. possession, s.5(2)) subject to certain exceptions or exemptions.

This two-stage approach is unusual in the creation of criminal offences. However, it is important to bear in mind that although many unlawful acts are criminal offences, it does not follow that every ‘unlawful’ act must be ‘criminal’. For example, leaving a roller-skate on a busy staircase causing injury to another, is unlawful because the act is negligent, but it is unlikely to be criminal unless the act was deliberately intended to cause bodily harm. Unlawful acts may give rise to remedies in the civil courts (e.g. damages or an injunction), whereas unlawful acts that are criminal offences are triable in criminal courts where a penalty might be imposed if the offender is convicted.

It would therefore be theoretically possible to devise a scheme (under the Misuse of Drugs Act) by which the distribution of particular controlled drugs remains unlawful (i.e. in that sense ‘not legalised’), but where a breach of the scheme would not amount to a criminal offence (in that sense ‘decriminalised’). Redress would be available in civil proceedings but a prosecution would not result. Some commentators might go further and argue that some acts should not be regulated at all (e.g. possession for personal use). This is sometimes described, in its purest sense, as ‘legalisation’.³⁷ Harm reduction regimes would thus be health, safety, and education causes, enforced largely through civil processes.

As mentioned above, even if the Misuse of Drugs Act was swept away, the Medicines Act 1968 is likely to remain. That Act, too, creates a number of offences albeit largely against persons engaged in the unauthorised retail/supply of particular substances.

Although the MDA 1971 is sometimes described as an instrument of ‘prohibition’, what tends to be neglected is the impact of Regulations made under the Act, particularly the Misuse of Drugs Regulations 2001.³⁸ Their effect can be shortly stated: what the Misuse of Drugs Act prohibits, the Misuse of Drugs Regulations 2001 permit.

The mechanism for making regulations under the MDA provides considerable scope for sensible and flexible approaches to drug issues, including harm reduction schemes. As the *Independent Inquiry on the Misuse of Drugs 1971* observed, much could be achieved without the need for changes to primary legislation.³⁹ It concluded that the Conventions and the MDA “are thus flexible

³⁶ For a summary of offences, and a summary of the Regulations, see Appendix.

³⁷ Unfortunately, the terms ‘decriminalisation’, ‘depenalisation’ and ‘legalisation’ are often used interchangeably, or in a muddled way. Nevertheless, those who argue for “legalisation” or “decriminalisation” often overlook that the law may exist in layers.

³⁸ SI 2001 No. 3998; as amended by SI 2003/1432; SI 2003/1653.

³⁹ Viscountess Ruth Runciman, DBE (Chair), Police Foundation, March 2000.

regulatory instruments under which much remains permitted. They should not be regarded as solely repressive.”⁴⁰ The merit of the United Kingdom statutory scheme should therefore not be belittled. It should be noted that it will be by Modification Order that *cannabis* and *cannabis resin* are reclassified, and it will be by Regulation that the medicinal use of *cannabis* might be permitted.

By working the MDA and the Regulations together, many different results can be achieved, and achieved quite quickly: usually by secondary legislation.

Purpose(s) of the MDA 1971

With the above in mind, it is instructive to turn to the Long Title of the Misuse of Drugs Act 1971,⁴¹ which describes the Act as making “provision with respect to dangers or otherwise harmful drugs and related matters, and for purposes connected therewith”.

Section 1 sheds more light on the purpose of the MDA, and it creates the Advisory Council on the Misuse of Drugs. The ACMD (is given the task of advising ministers on “*measures (whether or not involving alteration of the law) which... ought to be taken for preventing the misuse of... drugs or dealing with social problems connected with their Misuse*”). The reference to “drugs” is not confined to controlled drugs, but includes any drug “likely to be misused and which the misuse is having or... capable of having harmful effects sufficient to constitute a social problem” (section 1(2)).

Measures are to be taken for (a) restricting the availability of drugs or supervising the arrangements for their supply; (b) enabling persons affected by the misuse of such drugs to obtain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and after-care of such persons; (c) for promoting co-operation between the various professional and community services; (d) for educating the public in the dangers of misusing such drugs and (e) promoting research.

In order to deal with issues concerning commitments under treaty to which the United Kingdom is a party, section 1(3) empowers the Secretary of State (the Home Secretary) to be advised by the ACMD about appropriate legislative measures which should be taken following any decision, or point, taken by any organisation created under any treaty.⁴²

It will be noted that the measures referred to in section 1 of the MDA do not insist on abstinence or zero tolerance.

Recent initiatives and developments in the United Kingdom and elsewhere

In the 1994 Report, by the Advisory Council on the Misuse of Drugs,⁴³ it said that the elimination of drug misuse is “generally regarded as an unobtainable goal”,⁴⁴ and that containment rather than elimination of drug misuse, is the more “realistic objective”.⁴⁵ The Council recommended the wider adoption of harm reduction principles in developing enforcement strategies:

- (iii) Enforcement should support the efforts of other agencies working to reduce the harm caused by drug misuse.

⁴⁰ Idem, Chapter 1, para. 3.

⁴¹ For completeness, it is appropriate at this stage to record that the MDA 1971 applies – with some modifications – to England, Wales, Scotland, and Northern Ireland.

⁴² The creation of the ACMD was an astute attempt to give the Misuse of Drugs Act life-blood in the hope that it would make the Act a living instrument.

⁴³ Part II: Police, Drug Misusers and the Community.

⁴⁴ Para. 1.1.

⁴⁵ Para. 4.1.

- (iv) A recognition that harm reduction has a part to play in returning areas to normality through improvements to the environment, such as better street lighting, public buildings and amenities.

In assessing the room for manoeuvre/options, we should also consider positive statements made within the institutions of the UN and EU (emphasis has been added by way of italicised type):

- (i) UN System Strategic Plan for HIV/AIDS 2001–2005
“Joint action to establish evidence-based guidelines for effective HIV prevention and care interventions, programmes and policies targeting IDUs, with a focus on how to package multi-component approaches and ensure appropriate linkages with programmes for overlapping vulnerable groups (including sex workers, prisoners, street youth), to be undertaken by WHO and **GRN**.
Production and dissemination of intervention and training guidelines with a particular emphasis on outreach, HIV risk reduction counselling, needle and syringe programming and drug dependence treatment (including methadone and other substitution therapy), to be undertaken by WHO and UNDCP.”
- (ii) UN Administrative Committee on Coordination – paper Sept 2000
“25. *Protection of human rights is critical for the success of prevention of HIV/AIDS*. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic.
29. *Drug demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes*. Specific interventions for reducing the demand for drugs and preventing HIV should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including poverty reduction and opportunities for education and employment. It is desirable to include multidisciplinary activities and provide appropriate training and support to facilitate joint working.
30. *Drug abuse problems cannot be solved simply by criminal justice initiatives. A punitive approach may drive the people most in need of prevention and care services underground*. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important components in preventing the transmission of HIV.”
- (iii) EU Action Plan 2000–2004
“2. Action on demand reduction
The highest priority should be given to health, education, research and training activities and on instruments to combat social exclusion... A comprehensive approach is still considered to be the best strategy to meet future problems. Such an approach should cover all areas of drug abuse prevention, from discouraging the initial use to *reducing* the negative health and social consequences of drug abuse. Community based prevention programmes and peer education projects should be implemented on a wider scale in the Member States.”
- (iv) On the Mid-Term Evaluation of the EU Action Plan on Drugs (2000–2004)
- Needle exchange and methadone substitution treatment feature particularly prominently amongst the measures in place in Member States in view of reducing the risks associated with drug dependence.
 - Treatment for drug addicts in prisons is also being taken seriously. Drug-free sections in prisons are becoming more common.

- (v) Framework and the Instruments of the EU in the field of Drugs 2002
 “Regarding the protection and improvement of public health, Article 152 of the EC Treaty, as amended at Amsterdam, stipulates that ‘The Community shall complement the Member States’ action in reducing drugs-related health damage, including information and prevention.’ The subsidiarity principle is fully applicable and there is no scope for harmonizing the Member States’ health policies. But the new Treaty generally strengthens the possibilities for Community projects in the field by adding improvement to the public health prevention aspect. That opens up the possibility of Community action under the risk reduction approach.”
- (vi) Draft Report European Parliament, 11th Nov. 2002 Amendment 2, Paragraph 2, subparagraph 1 Amendments by Parliament
 (1) lower the threshold for drug users to seek help by providing information and counselling to promote risk and harm reduction and by facilitating their access to appropriate services at a local level.
- (vii) National Action Plan – Portugal – Horizon 2004
 Harm reduction policies should help not only to prevent the risk of propagation of infectious and contagious diseases (in particular, contamination by AIDS and hepatitis B and C), but also prevent social marginalization and delinquency, as well as help to create an environment in which drug addicts are motivated to attend treatment programmes.
Aims and overall guidelines
 1. Create a primary national network for harm reduction, comprising street teams, contact and information points, needle exchange schemes and low threshold methadone substitution programmes, in 100% of districts and a secondary national harm reduction network covering all municipalities with critical high consumption areas, with more appropriately designed harm reduction programmes;
 ...
 3. Provide harm reduction programmes accessible to 100% of drug addicted prisoners...”

The development and deployment of harm reduction schemes are well advanced in many jurisdictions. As the *Swiss Institute of Comparative Law* has noted:

All three of the relevant international conventions contain provisions of an essentially programmatic nature which specifically refer to ‘drug abusers’. Art.36, subpara.1(b) and Art.38 of the 1961 Convention, Art. 20 and Art. 22, subpara.1(b) of the 1971 Convention and Art.3, para.4 of the 1988 Convention uniformly refer to the ‘treatment, education, aftercare, rehabilitation and social reintegration’ of abusers. The obligations of States Parties in this respect are formulated in very flexible and vague terms. They are required to ‘take all practicable measures’ for the benefit of abusers, but such measures are not further specified.

Determining the legality of a harm reduction scheme

A worked example usefully illustrates the legal issues that might arise under United Kingdom laws.⁴⁶

X attends a Needle Exchange Centre (NEC). The staff know that X uses heroin from illegal sources. The staff also know that X has registered at the centre in order to receive paraphernalia that he will use to continue his illegal drug use. The items X exchanges contain residual traces of controlled drugs. The staff are not medically trained – some are drug users. The staff handle the contaminated items. Sometimes items are stored longer than necessary before being destroyed. Items are routinely handed to others for disposal. The

⁴⁶ Based on a perception of a Needle Exchange scheme canvassed in *Harm Reduction Programmes and the Russian Legal System*, Professor William Butler, published by International Family Health, 2003.

policy of the NEC is not to deliver the contaminated items into the possession of the police despite the latter's request for information. The NEC distributes literature that promotes safer drug use techniques. It is known to staff that X occasionally uses the toilet facilities to inject heroin. The staff permit that to happen as the NEC serves as a drug injection room.

Applying the principles to the example

(1) *possession by X*: X has been in unlawful possession of heroin. The presence of traces of heroin in the syringe might not be sufficient to sustain a charge of unlawfully possessing the drug unless the traces are large enough to amount to 'something': *Boyesen* [1982] A E C 768, H L. In any event, the existence of a trace might be cogent evidence that X was in possession of a larger quantity of heroin at an earlier time: *Pragliola* [1977] Criminal Law Review 612. The view that the police cannot prosecute past possession, is a myth. The NEC will have to decide what its policy is going to be regarding client confidentiality and in what circumstances NEC will co-operate with police.

(2) *possession by staff*: the staff who received a controlled drug into their possession will also be acting unlawfully unless either they, or the drug, fall within a category specified by the Misuse of Drugs Regulations as being excepted from liability. The staff received syringes and needles from X contaminated with residues of illicit heroin. If the traces are large enough to amount to 'something', and therefore large enough to 'possess', staff members who handle the items are in possession of the drug, and they are liable to prosecution unless they can bring themselves within Regulations that authorise their conduct. Section 5(4) of the Misuse of Drugs Act provides two defences to a charge of possession (and only to simple possession⁴⁷) but the defences offer very limited protection.⁴⁸ The subsection is unlikely to avail the staff on this point because they did not receive the items for the purpose of preventing the commission of an offence in connection with the drug, or for the purpose of handing the drug to a person lawfully entitled to possess it.

(3) *possession with intent*: handing the items containing traces of a controlled drug to another is to supply that drug. Intending to deliver the items to another is having an intention to supply. Even if the technical position is that staff members possess minute amounts of heroin intending to deliver it to another, it is inconceivable that a prosecution would result. It would not be in the public interest to prosecute unless the NEC acted in bad faith. However, the preferred solution is for staff to be protected by Regulations made by government. The statutory defence under section 5(4)(b) would not be available being limited to the offence of simple possession only.

(4) *permitting premises*: section 8 will be engaged on the facts of this particular example if section 8 (d) as amended by s.38 of the Criminal Justice and Police Act 2001 comes into force. The situation under consideration concerns premises where intravenous drug users are permitted to inject

⁴⁷ "In any proceedings for an offence under [section 5(2)] above in which it is proved that the accused had a controlled drug in his possession, it shall be a defence for him to prove:

(a) that, knowing or suspecting it to be a controlled drug, he took possession of it for the purpose of preventing another from committing or continuing to commit an offence in connection with that drug and that as soon as possible after taking possession of it he took all such steps as were reasonably open to him to destroy the drug or to deliver it into the custody of a person lawfully entitled to take custody of it; or

(b) that, knowing or suspecting it to be a controlled drug, he took possession of it for the purpose of delivering it into the custody of a person lawfully entitled to take custody of it and that as soon as possible after taking possession of it he took all such steps as were reasonably open to him to deliver it into the custody of such a person."

⁴⁸ *R v X* [1994] Crim LR 827.

themselves with drugs that they have acquired (assuming from illegal sources) but are permitted to inject themselves using sterile equipment and other paraphernalia in hygienic circumstances.

The Legal Affairs Section of the UNDCP has opined that “to be consistent with a comprehensive demand reduction strategy, any such approach would also require counselling and other health and welfare services, aimed at promoting healthier lifestyles and, eventually, abstinence.”⁴⁹ There is much force in that observation.

The Legal Affairs Section state that it would be difficult to assert that the running of such rooms evinces an intent to encourage the commission of an offence – “on the contrary... the intention of governments is to provide healthier conditions”.⁵⁰

Section 8 of the MDA (as amended), would make it an offence for an occupier, or any person concerned in the management of a drug injection room to knowingly permit or suffer “administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used”. Without some form of safety net, such rooms would always fall foul of that provision. Furthermore, an offence under section 8 of the Act is now a ‘drug trafficking offence’ that triggers confiscation proceedings on the basis that the offender has a ‘criminal lifestyle’.⁵¹ This, in turn, triggers statutory assumptions regarding the assets held by the offender at the time of confiscation proceedings, as well as assets passing through his/her hands in the period of six years before being charged with the offence. Property might include all that the offender holds as his/hers, which might, of course, extend to the drug injection location itself (depending on who owns it).

The problems might be resolved in a number of ways: (i) by not bringing the amendment to s.8(d) into force; (ii) by repealing s.8 in its entirety, and to rely on civil enforcement measures – e.g. closure orders; (iii) by making Regulations under the MDA that safeguard actions taken by suitably qualified staff in respect of drug injection rooms, e.g. so as to disapply section 8, section 5(2) [possession], and as appropriate, s.5(3), and s.4 [possession with intent to supply, and supplying offences].

Consideration will need to be given to other related issues including confidentiality of information, the extent to which the police are entitled to inspect records, the circumstances in which police may obtain information and evidence about persons attending the rooms. It might be said that some of these issues can be resolved at local level as part of a consultation/partnership process between police and managers of drug injection rooms. That is an option; however, it suffers from a number of obvious potential disadvantages: (i) different areas/localities are likely to have different policies; (ii) policies are liable to change at the hands of newly appointed managers/officers; (iii) the absence of a legal base might expose the police/drug room managers to private legal action.

(5) *incitement*: the definition of incitement is broad – perhaps as broad as encompassing “suggestion, proposal, request, exhortation, gesture, argument, persuasion, inducement, goading, or arousal of cupidity”.⁵² However, such prosecutions are rare. The purpose in distributing the literature is not to encourage others to commit offences. The content of the literature probably suggests a contrary intention.

⁴⁹ E/INCB/2002/W.13/SS.5; para.24.

⁵⁰ E/INCB/2002/W.13/SS.5; para.28.

⁵¹ Proceeds of Crime Act 2002.

⁵² Nkosiyana 1966(4)SA 655 AD.

(6) *use of non-medically trained staff*: persons who act in a capacity specified in the Regulations are obviously going to be protected from prosecution. However, there are also civil law issues. These are not straightforward.

A controversial recommendation is made in *Harm Reduction Programmes and the Russian Legal System* (No.15), that

...outreach workers employed under a labour contract or acting as volunteers at needle exchange centres and similar facilities be required, as a condition of employment, to have been 'narcotics free' for a period where the probability for relapse is considered to be minimal. The employer's internal procedures for dealing with abuse of narcotics should include provisions for ensuring compliance. In some circumstances this could include verification procedures such as drug testing.

This short statement raises a number of important issues that deserve detailed analysis in another paper. One concern (implied by the recommendation) is that agencies that employ addicts, in the belief that they are better placed to penetrate hidden populations of IDUs, may leave employers exposed to legal risks. The recommendation is framed in the context of Russian law (which in a number of respects is markedly different from United Kingdom law). However, hypothetically, if a manager employs X on the basis that X is an addict (who obtains illicit supplies) and the manager expressly or impliedly represents that X's employment will continue for as long as he remains an addict, is that incitement (i.e. to carry on possessing illicitly acquired drugs)? There are also interesting questions as to whether (by the laws of the United Kingdom) it is permissible for employers to filter job applications in the manner suggested by the recommendation, or to require abstinence as a condition of employment.

(7) *town and country planning*: these are issues of some complexity; the need for the local community to be involved in decisions relating to the proposed use of a site for a harm reduction scheme is perhaps obvious. The risk of creating public nuisance also needs to be addressed.

Drug Quality Control

This is a topic considered by the Legal Affairs Section of the UNDCP who state that this strategy is "perhaps the hardest to reconcile with the obligations set forth in article 18 of the 1961 Convention and article 20 of the 1971 Convention".⁵³ It is difficult to reconcile with the 1988 Convention as well, because such a scheme would involve the supply of a drug (should the test prove positive for a scheduled substance). Thus Article 3(a)(i) provides that "the production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, *delivery on any terms whatsoever*, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention" are to be established as criminal offences. The conduct must of course be committed intentionally, but intention means deliberately/consciously performing the offending act. Intention is not to be confused with motive – which may be laudable.

However, this scheme is one of the easiest strategies to explain so far as the United Kingdom position is concerned. In the absence of legal authority, by way of Regulations under the MDA, there is no doubt that any scheme that involves taking an illicitly acquired substance from a user ('X'), testing it for 'purity' by another ('Y'), and then returning it to the user if unadulterated, will result in the commission of a number of offences. If the substance turns out to be an illicitly

⁵³ E/INCB/2002/W.13/SS.5; para.33.

acquired controlled drug, X arguably supplies Y with it contrary to section 4 of the MDA (subject to a legal nicety as to where the latter is a mere custodian so that X does not 'supply').⁵⁴ In any event, Y supplies X with the drug by returning it to him.

The manager of the premises, as well as those who are 'occupiers' (for the purposes of section 8 of the Act) knowingly permit the supply of a controlled drug in the event that the drugs are returned to the users. Whether the service is provided in a house, boat, car, or tent – all are 'premises' for the purposes of the Act. It is doubtful that such a service would constitute incitement to commit an MDA offence (s.19, MDA), but much would depend on how the scheme was run and promoted.

Such a scheme could be permitted and controlled legally by Regulations made under the MDA. Civil arrangements between managers of such schemes and police forces, are fraught with risk.

Rudi Fortson

⁵⁴ *Maginnis* [1987] 1 All E R 907, H L.

APPENDIX

Mapping the MDA 1971, and basic legal principles

Since the MDA is designed and intended to regulate the flow of drugs and their use, the following structure is enacted:

- (i) Drugs are specified as being “controlled”: see Schedule 2.
- (ii) As a general rule, it is unlawful to:
 - (a) import or export controlled drugs: section 3
 - (b) produce controlled drugs: section 4
 - (c) supply controlled drugs: section 4
 - It is an offence to be concerned in the supplying of a controlled drug to another.
 - It is an offence to be concerned in the making to another of an offer to supply a controlled drug.
 - “supply” includes “distributing”: section 37 (1). Supply means “enabling the recipient to apply the thing for the recipient’s own benefits”: *Maginnis* [1987] 1 All E R 907, H L.
 - (d) possess controlled drugs: section 5

A person who has a controlled drug in his custody, or has it under his control, and knows or ought reasonably to have known of the existence of the drug, is in possession of it. This is subject to a statutory provision that a person is to be acquitted if he neither knew, nor suspected, nor had reason to suspect that the substance existed, or if it did, that it was a controlled drug: section 28 MDA, as interpreted by the House of Lords in *Lambert* [2001] U K H L 37.
 - (e) possess controlled drugs with intent to supply them to another

This is possession, but with the additional mental component. In this situation the possession of a drug might be lawful, but it will be an offence to supply the drug to another without lawful authority
 - (f) cultivate the cannabis plant: section 6
 - (g) permit premises to be used for the purposes listed above: section 8⁵⁵

“Permits” and “suffers” has been held by the courts to mean the same thing (although one can see a distinction between the two states of mind), namely,

 - (i) “*knowledge or grounds for reasonable suspicion* on the part of the occupier that the premises will be used by someone for that purpose, and
 - (ii) *...an unwillingness on his part to take means available to him to prevent it...*” : *Sweet v. Parsley* [1970] A.C. 132, Lord Diplock.

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Section 8 reads:

- “A person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises, that is to say:
- (a) producing or attempting to produce a controlled drug in contravention of section 4(1) of this Act;
 - (b) supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in contravention of section 4(1);
 - (c) preparing opium for smoking;
 - (d) smoking cannabis, cannabis resin or prepared opium. [*administering or using a controlled drug which is unlawfully in any person’s possession at or immediately before the time when it is administered or used*] - The italicised words were inserted by s.38 of the Criminal Justice and Police Act 2001, but they have yet to be brought into force.”

- (iii) “a failure to take reasonable steps readily available to prevent the prohibited activity”.
- (iv) “a belief by a defendant that he has taken reasonable steps does not afford any defence... It is not for the defendant to judge his own conduct”; *per* Rose L.J., *Brock and Wyner* (December 21, 2000).
- (v) allowing an activity to continue “not caring whether an offence was committed or not”: see Edmund Davies L.J. in *Souter* (1971) 55 Cr.App.R. 403 who approved the words of Lord Parker C.J. in *Gray’s Haulage Co. Ltd. v. Arnold* [1966 1 W.L.R. 534, who said “actual knowledge or knowledge of circumstances so that it could be said that they had *shut their eyes to the obvious*, or had allowed something to go on, *not caring whether an offence was committed or not*”, and see *James v. Smee* [1955] 1 Q.B. 89.

Can managers have knowledge imputed to them?

A difficult question remains unresolved, namely whether an offence under section 8 can be committed by a person concerned in the management of premises, who although himself unaware of what was happening, delegated tasks to others who did know. Can the knowledge of subordinates be imputed to the manager? In *Ferguson v. Weaving* [1951] K. B. 814, Lord Goddard C.J. said:

“...if the [Licensing Act 1921] had made it an offence for a licensee knowingly to permit liquor to be consumed after hours, then the fact that she had delegated the management and control of the concert room to the waiters would have made their knowledge her knowledge.”

The principle was said to be based “on the fact that the person who is responsible in law, for example, a licensee under the Licensing Acts, has chosen to delegate his duties, powers and authority to another”: *per* Lord Goddard C.J., *Linnet v. Metropolitan Police Commissioner* [1946] K. B. 290, cited in the judgment of *Ferguson v. Weaving* (above, at 821). However, on the facts in *Ferguson v. Weaving*, the relevant provisions in the Licensing Act 1921 did not create an offence of “knowingly permitting” drinking after hours, and the Court was not prepared to widen liability so as to convict a licensee of counselling and procuring on the basis of knowledge imputed to him. In *James v. Smee* it was said that “knowledge... includes the state of mind of a man who shuts his eyes to the obvious or allows his servant to do something in the circumstances where a contravention is likely, not caring whether a contravention takes place or not”: *per* Parker J. This is much closer to the present position (see *Brock v. Wyner* [2001] Cr.App.R. 3) and see the opinion of Lord Diplock in *Sweet v. Parsley* [1970] A.C. 132 at 163.

- (h) to smoke or use prepared opium: section 9
- (i) to frequent a place used for the purpose of opium smoking: s.9(1)(b)
- (j) to have in his possession pipes or other utensils that he has used, or intends to use, or has allowed others to use, in connection with the smoking of opium: section 9(c)
- (k) to supply or offer to supply any article believing that it may be used or adapted to be used by another for the unlawful self-administration of any controlled drug: s.9A(1)⁵⁶
- (l) to supply, or offer to supply, any article believing that it is to be used by another for the preparation and unlawful administration of any controlled drug: s.9A(3).

- (iii) It is an offence to incite another to commit an MDA offence: s.19.
Section 19 of the Misuse of Drugs Act (as amended) says that, “It is an offence for a person to incite another to commit such an offence.”

⁵⁶ It is not an offence to supply or offer to supply a hypodermic syringe, or any part of one [s.9A(2)].

Construed literally, the section is nonsense, because it would mean that it is an offence for one person, to incite another, to incite another! This is a drafting error and the Court of Appeal has held that the section means what it obviously means, namely, that it is an offence for a person to commit *any* offence under the MDA 1971.⁵⁷

Prosecutions under section 19 are rare. The most recent case is *Marlow* [1997] Crim.L.R. 897 (judgment July 14, 1997). The facts, and the reasoning of the court, are of interest:

Marlow wrote and published a book relating to the cultivation of cannabis, which he advertised for sale and sold about 500 copies. The prosecution contended that the book was not a bona fide textbook but amounted to an incitement – of those who bought it – to cultivate cannabis which is an offence if charged under section 4(2) (production) and/or section 6 (cultivation of cannabis) of the Misuse of Drugs Act 1971.

The defence contended that the book was a genuine contribution to the debate about legalisation of cannabis, and it only contained general advice and information freely available elsewhere. Marlow told the police that he had no intention of inciting people to do anything. The book contained a proposal to change the law. He realised that incitement was illegal and that unauthorised supply was illegal.

The judge directed the jury that they had to be sure that it was a book which *may* “encourage or persuade or... is capable of encouraging and persuading other people to produce the drug.”

Marlow’s lawyer complained that this was a misdirection as to the definition of ‘incitement’.

Held: the judge should not have introduced the word “may”. However, taken as a whole there was no misdirection, and the conviction was not unsafe (the court considered *Invicta Plastics Ltd v. Clare* R.T.R. 251; *R. v. Higgins* (1801) 2 East 5; *R. v. Nkosiyana* 1966 (4) S.A. 655, 688 (SA); and see the *Law Commission's Working Paper on Incitement* (1993)).

- (iv) It is an offence to aid, abet, counsel or procure, the commission of some or all offences under the MDA.
A person joins an offence if he/she gives encouragement to another to commit it. Arguably, there are some statutory offences in respect of which it is not logically possible to “aid, and abet” or to “counsel or to procure” for example the offence of “being concerned” in the supply of a drug. One is either concerned in the offence, or one is not.
- (v) It is unlawful for a person in the United Kingdom to assist in or induce the commission of a “corresponding offence” abroad: section 20.
- (vi) Companies may also be guilty of committing offences: section 21.

The MD Regulations 2001

1. The Government may, by Regulations, create exceptions to the general rule and:
 - (a) allow certain controlled drugs to be imported/exported, produced, supplied or possessed: section 7(1)(a)
 - (b) allow certain persons to use controlled drugs under licence: section 7(1)(b) and section 7(2)
 - (c) allow practitioners in the medical and veterinary professions to supply drugs: section 7(3)(a)
 - (d) allow those practitioners to possess certain controlled drugs: section 7(3)(b)
2. The Government may, by Regulations:
 - (a) restrict certain controlled drugs to research use only: section 7(4)(a)

⁵⁷ The original wording of the 1971 Act (including the italicised words) was, “It is an offence for a person [to attempt to commit an offence under any other provision of this Act] or to incite [or attempt to incite] another to commit such an offence.” The words within square parentheses were deleted by Schedule I of the Criminal Attempts Act 1981, but the draftsman deleted too many words!

- (b) require medical practitioners, etc., to hold a licence before supplying or possessing certain controlled drugs: section 7(4)(b).
3. Regulations may be made under the MDA for any of the following purposes:
- i) The Secretary of State may at any time make activities with respect to specified controlled drugs **unlawful** by laying a Statutory Instrument before Parliament. Where the Secretary of State takes that step the Instrument is titled a “Designation Order”.
 - ii) The Secretary of State may **restrict** activities with respect to controlled drugs. He can achieve this result by transferring a drug (e.g. temazepam) from one schedule in the Regulations to schedule of a lower number. Regulations that did not apply to the substance in question are brought into operation.
 - iii) The Secretary of State may make Regulations that **permit** the cultivation, production, supply, or possession of drugs. His permission may be conditional (e.g. a licence is required) or unconditional (in the case of some very weak preparations).
 - iv) Regulations designed to **prevent** the misuse of controlled drugs by imposing administrative obligations or requirements, e.g. by regulating the issuing of prescriptions, record-keeping; rules relating to safe-custody of drugs etc.
4. It should be noted that various factors determine the scope of an exemption (or authorisation) under the Regulations, for example:
- the degree of harm/risk associated with the drug/product (see below);
 - the category of person handling the substance (e.g. a police officer seizing heroin, a patient prescribed heroin);
 - the circumstances in which the drug is to be handled or used (e.g. a doctor who wishes to administer a drug to another; or where any person is asked to administer a drug under the directions of a doctor, e.g. at a road-side pile up);
 - international obligations;
 - the toxic effect versus therapeutic value of a substance, etc.
5. The Regulations contain five schedules. Each schedule takes into account the risk of harm, or degree of harm, associated with the drug in question (*or product* containing a controlled drug). As a general rule, the lower the number of the schedule, the greater the intensity of control.

The Schedules to the 2001 Regulations

Sch.1: **Drugs that have little or no medicinal/therapeutic value but which may have research uses** [e.g. LSD, psilocin (found in so-called magic mushrooms) cannabis and cannabis resin]. Medical practitioners cannot prescribe drugs in this schedule. The Secretary of State may, by licence, authorise the production, supply, and possession of any controlled drug in accordance with the terms of the licence [Reg. 5]. This provision is intended to facilitate research (including clinical trials). Although a practitioner cannot “prescribe” a Sch.1 drug, a researcher could supply the substance to another providing (i) he is in possession of a licence that permits clinical trials on humans in respect of that drug and (ii) the licence expressly permits the researcher to administer the drug to the subject.

Note that all the drugs that appear in this schedule also appear in yet another schedule annexed to the *Misuse of Drugs (Designation) Order 1986*, as amended. **Designation Orders** are made by the Secretary of State for the Home Office pursuant to section 7(4) of the MDA 1971. Their purpose is to specify those controlled drugs (i.e. Class A, B, or C

drugs) that are not permitted to be used for medical purposes. It is not clear why the Legislature considers that it is necessary to specify the same drugs (that are deemed to have no medicinal value) in two separate Statutory Instruments (i.e. Sch.1, 1985 Regs., and in a Designation Order).

- Sch.2: **Drugs that have a medicinal value but which are liable to be misused/abused.** This is the largest schedule in the Regulations. Most of the drugs are opiates and the major stimulants. Accordingly, drugs in this group include a number of Class A drugs, e.g. cocaine, and Class B substances, e.g. amphetamine. Many of the Regulations relevant to this schedule are designed to ensure that the drugs are used for medicinal, scientific purposes, or handled for law enforcement purposes. A doctor must act in his capacity as a doctor. A conveyor/courier of a Sch.2 drug must deliver it to a person lawfully entitled to possess it. Records must be kept at every stage. A doctor can supply or administer a drug directly to the patient but additional records, prescriptions, and books must be kept if drugs are to be taken away from the hospital or surgery. Bottles of pills etc. must be labelled. Prescriptions must be written in indelible form recording the total quantity of the drug supplied (in words and figures), dosage units etc. Pharmacists can only supply on the back of a prescription issued by a practitioner. Special rules apply in situations where doctors or pharmacists may not be found, e.g. on a ship, oilrig, residential home (more paperwork).
- Sch.3: **Drugs that have a medicinal value but warrant fewer controls over their distribution.** Many of the drugs in Schedule 3 are barbiturates. The controls imposed under the 2001 Regulations are less onerous than drugs listed in Sch.2 and the amount of paperwork is reduced.
- Sch.4: **Drugs subject to fewer controls than Sch.3 drugs.**
- Drugs in this schedule are divided into two categories.
 - Drugs in Sch.4.I may lawfully be possessed by any person for administration for medical, dental, or veterinary purposes, in accordance with the directions of a practitioner [see Reg.10(2)].
 - Drugs in Sch.4.II being “medicinal products”, may be freely imported, exported, and possessed by any person [see Reg.4(2), (3)].
- Sch.5: **Very weak preparations or products.** Drugs in this schedule may be freely imported, exported, or possessed by anyone. Note that some products specified in this schedule may contain one or more Class A drugs, e.g. cocaine (but the amount of cocaine must not exceed 0.1%). Note also the observations mentioned above in respect of Schedule 4 drugs.