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The Members of the Sub-Committee on Home Affairs, which conducted this inquiry, are listed in Appendix 1.

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Sub-Committee Staff

The current staff of the Sub-Committee are Michael Collon (Clerk), Sarah Watts (Policy Analyst) and Amanda McGrath (Committee Assistant).

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References in footnotes to the Report are as follows:
Q refers to a question in oral evidence
Witness names without a question reference refer to written evidence.

SUMMARY

This year sees the end of the EU's current eight-year Drugs Strategy and second four-year action plan. In this report we look to see what the Strategy has achieved, and what should come next.

In general, we welcome the practical application by the EU of the principle of subsidiarity in this area. We agree with our witnesses that most aspects of drugs policies should remain within the competence of the Member States. The role of the EU should continue to be to complement, and where possible to strengthen and add value to, the actions of Member States. We also welcome the cooperation in this area between cities and across national boundaries, and call for this to be increased.

We believe that the European Drugs Strategy has been of value in providing a guiding framework within which Member States can formulate their national drug policies. In our view, however, previous aims of demand reduction and supply reduction have been too broadbrush to be useful as a guide to EU policy formulation: they should not therefore be treated as the main objectives of the next EU Strategy. Instead, we recommend that the new EU Drugs Strategy should be better focused and, while respecting the present division of competences, should seek to give a useful sense of direction to national policies.

We suggest that the next Strategy should concentrate on the areas where the EU can make a major contribution.

The first of these areas is coordination of the fight against drug trafficking. On the legislative front, the EU should better focus on money laundering and strengthen provisions on the seizure of the proceeds of crime. On the operational side, through Europol and other agencies, it can directly contribute to the fight against drug trafficking. And we believe EU aid and EU research programmes should devote more resources to crop diversification away from drugs, and to drug related research projects.

The Strategy should also make clear that anti-trafficking measures must guard against displacing the problem to countries and regions not previously affected where they can cause significant damage to civil society; must have regard to the human rights of those involved; and must be subjected to evaluation as demand reduction measures have been. We believe that working on these fronts will be more productive than revising existing legislation on maximum penalties and newly developed psychoactive substances.

We were impressed by the work of the European Monitoring Centre for Drugs and Drug Addiction, and the regard in which it is held around the world. We therefore recommend that any future Strategy should seek to safeguard this agency's future and should continue to encourage the development and improvement of the collection, analysis, evaluation and distribution of information on the drugs issue so that Member States can learn from each other's experiences and benefit from each other's research.

We were struck by the evidence we heard from Portugal on the effectiveness of their public health orientated national drug strategy. We therefore recommend that the new Strategy should use the EU's public health obligations to encourage the inclusion of harm reduction measures in the national policies of the Member States. It should be recognised that health policy is as important as law enforcement policy in this field and that education also has a significant role to play.

Finally, we believe that the formulation and adoption of a new Drugs Strategy offers a golden opportunity to widen the public debate, to consider as dispassionately as possible the different policies and approaches and to narrow the gap between theory and practice, and thus to achieve a better consensus about the best way of proceeding. We urge the EU institutions, in particular the Commission and the Parliament, to make sure that this takes place.

The EU Drugs Strategy

CHAPTER 1: INTRODUCTION

1. In 2009 there were 7,600 drug-induced deaths from overdoses in the Member States of the European Union, three quarters of them from heroin, and perhaps twice as many drug-related deaths from HIV/AIDS, hepatitis C, violence, suicide, trauma and chronic health problems caused by repeated use of drugs. 78 million adults—23% of European adults—had used cannabis at some time in their lives, 12 million of them in the last month. Between 1.3 and 1.4 million Europeans are problem users of heroin.[1] Public expenditure on the drugs problem in the EU in 2008 was estimated at €34 billion.[2]

2. It is instructive to compare illegal narcotic drugs with two psychoactive drugs which are legal and openly commercially available: alcohol and tobacco. Worldwide, one person in three uses alcohol, one in four uses tobacco, whereas fewer than 5% of people declare themselves as using drugs at least once a year, and fewer than 1% use drugs on a continuing basis. Tobacco kills five million people a year, alcohol 2.5 million people a year, and drugs about 500,000 a year.[3] These are figures that need to be borne in mind when considering why some potentially harmful addictive substances are licit and some illicit. Prescribed drugs, whether or not mixed with narcotic drugs, also lead to acute cases of addiction and withdrawal, but they too are outside the scope of our inquiry and are not examined in this report.

3. We do not need to stress the harm caused by drugs, not just to the users themselves, but to their families, their communities, and society at large. It is not surprising that it raises strong emotions and arguments. Any examination of drugs related issues needs to be conducted dispassionately, and opinions need to be based on well-founded evidence. This is what we have endeavoured to do in the course of this inquiry.

4. Nowhere is this more important than in any discussion of decriminalisation. It should hardly need to be said that what is at issue is whether the possession of small quantities of narcotic drugs for personal use, and the use of those drugs, is best dealt with as a criminal offence punished by criminal sanctions, or whether it should be dealt with in some other way. It is not to our knowledge being suggested that drug trafficking—taking advantage of the weaknesses of others for financial gain—should be other than a serious criminal offence. Yet too often discussion of decriminalisation is portrayed as an attempt to suggest that drug trafficking should not be a criminal offence. The fact that we need to stress this point at the outset of our report shows the unfortunate way in which this debate is sometimes conducted.[4]

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1 EMCDDA annual report 2011, and EMCDDA *Selected Issue 2011: Mortality related to drug use in Europe: public health implications*. Most EMCDDA statistics include figures from Norway, which takes part in its activities, but this does not affect the validity of comparisons between the Member States within the EU, or between the EU and other States.

2 EMCDDA report *Towards a better understanding of drug related expenditure in Europe*, 2008. The report highlights the difficulties of making such estimates, but assesses that the 95% confidence interval is €28 billion to €40 billion.

3 UNODC *2009 World Drug Report;* Antonio Mario Costa, former Executive Director of UNODC, QQ 155 and 158

4 We examine this further in Chapter 5.

5. We explain in the following chapter the gradually increasing involvement of the EU in combating drugs problems. This year sees the end of the current EU Drugs Strategy 2005–2012. In June 2010, shortly after it was re-appointed at the beginning of this Parliament, our Home Affairs Sub-Committee decided that the autumn of 2011 would be a good time to conduct an inquiry to consider what has been achieved in the past and what should come next. The Committee, whose members are listed in Appendix 1, confirmed this decision in June 2011. The following month a call for written evidence was issued; this is published in Appendix 3. Such evidence was received from 7 persons and bodies. Between October and December 2011 the Sub-Committee held twelve oral evidence sessions and heard from 24 witnesses, a number of whom submitted supplementary written evidence. They are listed in Appendix 2.
6. At the end of November 2011 the Sub-Committee visited Brussels, where we took evidence from Vice-President Viviane Reding, the Commissioner responsible for Justice, Fundamental Rights and Citizenship, and whose responsibility includes the EU Drug Strategy, and also from José Sócrates, the former Prime Minister of Portugal who was responsible for the major change in the direction of his country's drugs policy which we describe in Chapter 5. The following day we flew to Lisbon where we visited the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and took further evidence. We are most grateful to all those who gave us written and oral evidence, and particularly grateful to the Director and officials of the EMCDDA for their help and their hospitality.
7. Throughout the course of this inquiry we have been fortunate to have as our specialist adviser Dr Caroline Chatwin, Lecturer in Criminology, School of Social Policy, Sociology and Social Research, University of Kent. We are most grateful for her expert knowledge, her guidance and her valuable contribution to this report.
8. **We make this report to the House for debate.**

CHAPTER 2: THE INTERNATIONAL, REGIONAL, NATIONAL AND LOCAL BACKGROUND

9. This report inevitably focuses on the drugs strategies and policies of the EU and its Member States, but it has to be remembered that this is also both a global and a local problem. Heroin finds its way from Afghanistan to Europe mainly through the Balkan route (Iran, Turkey and south-east Europe) but also via Pakistan, while much of the cocaine from the Andean region comes through West Africa. But it ends up on the streets of our cities, and those cities too can contribute to resolving the problem.

The United Nations and the UN Conventions

10. The main international instrument for combating the trade in illicit drugs is the UN Single Convention on Narcotic Drugs, signed on 30 March 1961. It entered into force on 13 December 1964. Article 36 requires criminalisation of "cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention". However "when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration."

11. The 1961 Single Convention is supplemented by two further Conventions. The UN Convention on Psychotropic Substances, signed on 21 February 1971, controls LSD, ecstasy, and other drugs whose special psychoactive effects exclude them from the scope of the Single Convention. The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, signed on 20 December 1988, adds additional enforcement mechanisms for fighting drug traffickers, including asset forfeiture provisions, and establishes a system of drug precursor regulation. The EU is a signatory to this Convention, but not to the Single Convention or the 1971 Convention, although all its Member States are signatories of all three. The three Conventions have been adopted by over 180 countries out of the 193 UN Member States. Amendment of the Conventions would need agreement of all signatory States, and so for practical purposes is unlikely to be achievable.[5]

12. Whether the Single Convention requires the criminalisation of personal use and possession for personal use is a vexed question. Mike Trace, the Chair of the International Drug Policy Consortium (IDPC), who was formerly Chief of the Demand Reduction Section of the United Nations Office on Drugs and Crime (UNODC), told us: "In international law terms, the conventions themselves are very complex documents and have an awful lot of flexibility and allow for all sorts of experimentation at national and regional level."[6] The majority of the bodies that have pronounced on this have taken the view that "possession" in Article 36 is in the context intended to mean possession for trafficking. In particular, the report of the International Narcotics Control Board for 2007, when discussing the principle of proportionality, concluded

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5 Q 162 (Costa)

6 Q 98

that "with offences involving the possession, purchase or cultivation of illicit drugs for the offender's personal use, the measures can be applied as complete alternatives to conviction and punishment".[7] The Portuguese Government, when formulating the policy of decriminalisation we describe in Chapter 5, was advised that taking drug possession and use out of the penal system and making it subject to administrative penalties was compatible with the Conventions.[8]

United Nations Office on Drugs and Crime (UNODC)

13. The United Nations Office on Drugs and Crime (UNODC) was established, under a different name, in 1997 by the joinder of two earlier agencies. The two main strands of its work are field-based technical cooperation projects to enhance the capacity of UN Member States to counteract illicit drugs, crime and terrorism, and research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence base for policy and operational decisions. Ninety per cent of its funding comes from the governments of UN Member States. The Home Office told us that the EU is particularly active at the UNODC and is recognised as one of the main donors to the organisation. In 2010, the EU donated US$ 15.6 million to the UNODC, which included funding for the UNODC programme to combat illicit drug trafficking in West Africa.[9]

14. One of the notable recent initiatives of the UNODC is a discussion paper issued in 2010 entitled *From Coercion to Cohesion*.[10] The then Executive Director, Antonio Maria Costa, in evidence to us described it as "a document that I consider probably one of the most important that I was ever associated with".[11] It states that "Moving from a sanction-oriented approach to a health-oriented one is consistent with the international drug control conventions", and this is the approach the paper recommends. It is a subject to which we revert in Chapter 5.

EU involvement

15. Although there had been previous demonstrations of interest in the European Community about the drugs problem,[12] it was the convening by the UN of an International Conference on Drug Abuse and Illicit Trafficking that provided the catalyst. In August 1986 the Commission proposed that the European Community should take part in the preparatory work for the UN conference to be held in Vienna in June 1987.[13] The Council decided on 26 January 1987 that the Community should take part in the conference. It did

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7 EN/INCB/2007/1, paragraph 18

8 Q 295(Goulão)

9 Home Office paragraph 15

10 *From Coercion to Cohesion: treating drug dependence through health care, not punishment.* Discussion paper based on a UNODC scientific workshop in Vienna, 28–30 October 2009.

11 Q 170

12 e.g. by the European Council in June 1985 and again in June 1986, and in a debate in the European Parliament on 9 October 1986 on a report by a "Committee of Inquiry into the Drugs Problem in the Member States of the Community", chaired by Sir Jack Stewart-Clark MEP (OJ C283, 10 November 1986, page 79). In 1991 the European Parliament set up a further "Committee of Inquiry on the spread of organised crime linked to drug trafficking", chaired by Patrick Cooney MEP, which reported on 26 April 1992 and was debated on 13 May 1992 (OJ C150 of 15 June 1992, page 41). Both Committees were divided in their views, and opinions in the Parliament were similarly divided.

13 Recommendation of 5 August 1986, COM(86)457 final

so, represented by a Commissioner, and continued to participate in the negotiations which led to the signing of the 1988 UN Convention.

16. In December 1989 a European Committee to Combat Drugs (CELAD)[14] was set up, with representatives of each of the Member States and the Commission. In June 1990 the Dublin European Council approved a study on the "need and possible scope of a European Drugs Monitoring Centre", and in June 1991 the European Council, meeting in Luxembourg, decided in principle that such a Centre should be set up, and instructed CELAD to continue with detailed work. The result was the adoption on 8 February 1993 of a Council Regulation setting up the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).[15] Its mandate was to observe, collate and disseminate—but not to judge. We discuss the valuable work of this agency in Chapter 6.

17. The other EU agency which plays a major part in the fight against drugs is the European Police Office, Europol. The Convention between the Member States setting up Europol was signed on 26 July 1995 but did not come into force until 1 October 1998. However as early as 2 June 1993 there had been Ministerial agreement on the setting up of a Europol Drugs Unit which initiated what has since become one of the prime functions of Europol, and which absorbs 30% of its resources. We consider the part played by Europol in Chapter 4.

EU Drugs Strategies and Action Plans

18. The policies for EU involvement in the fight against drugs have over the years been set out in a variety of Strategies and Action Plans. The first of these came in June 1990 when the Dublin European Council, which we mentioned in paragraph 16, approved the first Guidelines for a European Plan to Combat Drugs. This document was adopted by the Rome European Council in December that year. It was followed by the first Action Plan so called covering the years 1995–1999,[16] which accompanied the first Strategy.[17]

19. The current pattern of a Council Strategy, formulated by the Council on the initiative of the Member States, implemented by a detailed Action Plan adopted by the Council on the proposal of the Commission, began in 2000. In 1999 the Commission had presented to the Council a Communication on a European Union Action Plan to Combat Drugs (2000–2004).[18] In December 1999 the Helsinki European Council endorsed the EU Strategy on Drugs for 2000–2004,[19] and in June 2000 the European Council in Santa Maria da Feira adopted the EU Action Plan on Drugs 2000–2004[20] which translated the Strategy into over 100 actions to be taken by the Member States, the Commission, the EMCDDA and Europol.

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14 The acronym for Comité européen de la lute anti-drogue. It was formally outside the EU structure, but its functions were taken over by the Committee constituted under Article 36 TEU when this was set up after the entry into force of the Treaty of Amsterdam.

15 Regulation (EEC) No 303/93 of 8 February 1993, OJ L 36 of 12 February 1993

16 Communication from the Commission to the Council and the European Parliament on a European Union action plan to combat drugs (1995–1999), COM(1994)234 final

17 9012/99 CORDROGUE 33

18 COM(1999)239 final of 26 May 1999

19 12555/3/99, 1 December 1999

20 9283/00, 7 June 2000

20. The Justice and Home Affairs Council decided on 8 June 2004 that while Action Plans should continue to cover four years, the new EU Drugs Strategy which they implemented should cover the eight years 2005–2012, on the basis of two EU Action Plans on Drugs, each lasting four years (2005–2008 and 2009–2012) and each undergoing evaluation (in 2008 and 2012); and the Council further decided that this Strategy should be adopted at the European Council of December 2004. The Horizontal Drugs Group[21] started work on the new Strategy in July 2004, seemingly oblivious of the fact that the Commission was still busy evaluating the 2000–2004 Strategy and Action Plan. This evaluation was completed barely two months before the end of 2004,[22] and hence well after the Strategy had been drafted.

21. A report by Giusto Catania MEP to the LIBE Committee of the European Parliament dated 7 December 2004[23] pointed to the perils of preparing a new Strategy before seeing the evaluation of the previous one, and without the comments of the EMCDDA. It urged more emphasis on public health, with an emphasis on "measures totally different from those currently selected to achieve the overall EU Drugs Strategy objective, giving priority to protecting the lives and health of users of illicit substances, improving their wellbeing and protection by means of a balanced and integrated approach to the problem, since the relevant proposals are inadequate". These views came too late to be heeded: the current Strategy for 2005–2012 had already been finalised,[24] and was adopted by the European Council on 17 December 2004.

22. The first Action Plan to implement that Strategy in 2005–2008 was adopted in June 2005,[25] and it was followed in December 2008 by the Action Plan for 2009–2012.[26] The current Strategy and Action Plan are considered in the following chapter. The legislation adopted during those years—the 2004 Framework Decision on minimum penalties for trafficking, and the 2005 Decision on new psychoactive substances—are considered in Chapter 4.

Subsidiarity and the limits of EU involvement

23. The limit of the EU's competence in relation to health problems caused by drugs is clear from Article 168 TFEU, which repeats the wording of Article 152 TEC: "The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention." Subject to this, subsidiarity applies, and the drugs policies of individual Member States remain within their exclusive competence.

24. Should this continue to be the case? Although several witnesses have suggested increased activity at EU level, none have suggested that Member States should give up their primary responsibility for setting their drugs policies. For the Government Lord Henley, the Minister of State for Crime Prevention and Anti-Social Behaviour Reduction at the Home Office, told us: "We think it is right that different Member States should address these

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21 See paragraphs 148–149

22 COM(2004)707 final, 22 October 2004

23 A6–0067/2004

24 Document 15074/04 of 22 November 2004

25 OJ C168 of 8 July 2005, page 1

26 OJ C326 of 20 December 2008, page 7

things in their own way because different Member States have different problems according to their history or to the nature of where they are … but we also feel that there is a role for the EU … in making sure that there is practical co-operation between Member States …"[27]

25. Professor Cindy Fazey of the University of Liverpool thought that there were two fundamental difficulties which vitiated against a comprehensive and universal European Union drugs policy and strategy: "… the principle of subsidiarity should be applied, giving individual countries the freedom to express their own experience, values, history and pragmatic ways that they see as best for them and their citizens when dealing with the illegal drug problem."[28] João Castel-Branco Goulão, the head of the Portuguese Institute on Drugs and Drug Addiction, told us: "I think the EU Strategy must give only the framework and general principles, and Member States must be able to define their own strategies."[29]

26. **We agree with our witnesses that the health aspects, and most other aspects, of drugs policies should remain within the competence of the Member States. The role of the EU should continue to be to complement, and where possible to strengthen and add value to, the actions of Member States.**

27. **Even if this were not our view, the practical difficulties of obtaining agreement to treaty change and the reluctance of many Member States to surrender their freedom of action on issues such as decriminalisation mean that this is the only realistic position for the foreseeable future.**

28. **We welcome this instance of the practical application by the EU of the principle of subsidiarity.**

Differences at national level

29. It is in their treatment of drug use and drug users that the national drug policies of Member States are at their most acutely different. This is partly due to the diverse shape of the illicit drug problem in different Member States, which may experience varying levels of drug use or which may be predominantly affected by use of different drugs.[30] However, it is also to do with social and cultural factors within a country and with the history of the development of drug policy in each Member State. As Paul Griffiths, the Scientific Director of the EMCDDA told us: "We still have very divergent experiences of drug problems across Europe … It is also important to remember that cultural and substantive differences exist between countries, which means that policy articulation may be legitimately different at the national level."[31] For example, the drug user can be viewed by a national drug policy as, primarily, either a patient or as a criminal, which can lead to radically different strategies and implementations. These can best be understood by briefly outlining some of the more extreme policies in operation within the European Union.

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27 Q 314

28 Fazey paragraphs 1 and 9

29 Q 296

30 An example given to us by Mandie Campbell, the Director of Drugs, Alcohol and Safety at the Home Office, was that the Czech Republic had to be able to tailor their strategies to problems with methamphetamine, whereas in the United Kingdom that drug was not a problem. (Q 26)

31 Q 264

The Swedish experience

30. Sweden has long been viewed as operating a relatively tough national drug policy. The approach is one of "zero tolerance" in an effort to achieve the national aim of "a drug free society". No distinctions are made between "soft" and "hard" drugs, and users, as well as suppliers, are actively pursued. Since 1993 those who are suspected of using drugs can be subjected to blood or urine tests to determine whether use has taken place. If it has, criminal sanctions can be applied. Sweden is not the only European country to have criminalised use, but it is the only one to have empowered law enforcement officers to conduct tests to determine whether use has taken place. Emphasis is given to abstention based treatment, as opposed to those treatments that seek to reduce the harm experienced by drug users without necessarily requiring them to stop their drug use. In many respects, this national drugs policy is much stricter than in other Member States where (as in the United Kingdom) it is more usual for categorisations to be made between different drugs depending on the levels of harm associated with them, for suppliers to be pursued more actively than users, for the possession of drugs (rather than simply the use of drugs) to be illegal, and where harm reduction measures are more established.

The Netherlands contrast

31. The national drug policy in practice in the Netherlands is often conceptualised as being at the opposite end of the spectrum to drug policy as practised by Sweden. The idea of a "drug free society" is rejected by the Dutch as implausible and, instead, a pragmatic policy has been allowed to develop. At the heart of this policy is the belief that drug use should, as far as that is possible, be normalised and that drug users, rather than being ostracised or marginalised from mainstream society, should be encouraged to be in contact with service providers, whether or not they wish to cease their drug use. This pragmatism has also resulted in the Netherlands' unique "separation of the markets" policy where cannabis is viewed as less harmful than other drugs and, in an effort to keep users of cannabis away from a market awash with other more harmful drugs, the sale and use of cannabis is tolerated in coffee shop environments and has therefore effectively been decriminalised. Dutch drug policy also displays a strong commitment to the harm reduction principle that aims to reduce the harm experienced by drug users whether or not they have been successful in abstaining from drugs: the Netherlands was the first country to champion the provision of needle exchange schemes for injecting drug users, and continues to be at the forefront of harm reduction initiatives by providing safe user rooms for drug addicts and the regulated supply of heroin to heroin addicts.

32. The differences between drug policy in Sweden and the Netherlands evidence the deep divide in the way that Member States conceptualise the problem of drug use and drug users. This contrast is further compounded by the fact that both Sweden and the Netherlands report relatively low lifetime prevalence of drug use amongst their general populations.[32] Many attempts have been made to judge between the relative merits of Dutch and Swedish policy;[33] however, this diversity in national drug policy within Europe, which

[32] See EMCDDA Statistical Bulletin for 2011: http://www.emcdda.europa.eu/stats11

[33] E.g. in the Stewart-Clark and Cooney reports: see footnote 12

was supported by all those of our witnesses who gave us their views on this issue,[34] may well be an important asset.

Portuguese decriminalisation

33. In recent years, several other Member States have experimented with radical forms of drug policy that can provide valuable lessons and examples for the rest of Europe. The prime example is Portugal. In 2001 Portuguese drug policy was radically rewritten to reflect a growing desire to reduce the harm and damage experienced by drug users. The Portuguese drug law of 2001[35] decriminalised the possession of drugs for personal use and drastically improved both treatment and harm reduction measures available to drug users. We discuss this in more detail in Chapter 5: it is sufficient to say here that evaluations of the change in Portuguese drug strategy have been broadly positive and that representatives from many countries have expressed interest in these ideas.

Policy reversals in the Czech Republic

34. Much less well known than these recent changes to Portuguese drug policy are those that have taken place in the Czech Republic and which reflect the rising desire for an evidence based drug policy. In 1998 a Bill was passed in the Czech Republic to criminalise the possession of drugs for personal use.[36] Following this, a two year cost-benefit analysis was conducted to determine the effectiveness of the new criminalisation policy. The main findings of this evaluation were that, during the first two years of enforcement, the availability and use of drugs increased, as did the number of new drug users. Furthermore, the social costs of illicit drug use also increased significantly.[37] In 2010, the Czech Republic, partly on the basis of this evidence, formally decriminalised possession of illegal drugs for personal use.[38]

The position on the ground

35. If the national drug policies of Member States are to be evidence based, then it is of the utmost importance that the views of those on the ground, those working with and living in the same communities as drug users, are heard. As we have seen above, different Member States have significantly different experiences of the illicit drug problem and have developed radically different responses to it. Even within a country, different areas may have very different experiences of the drug problem and may require different styles of policy intervention. Frank Zobel, the Head of Policy in the Evaluation and Content Co-ordination Unit at the EMCDDA, explained that in Switzerland, a federal State, there was subsidiarity at national level and again in the cantons which implemented the policies they wanted. The model had the great advantage of allowing for experimentation, in that different policies could be

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34 See paragraphs 24–25

35 Decree-law 183/2001, 21 June 2001

36 Jelsma, M. 'The Development of International Drug Control: Lessons Learned and Strategic Challenges for the Future', Working Paper prepared for the first meeting of the Global Commission on Drug Policies, Geneva, 24–25 January 2011, p.10

37 Zabransky, T., Mravcik, V., Gajdosikova, H. & Miovsku, M., Impact Analysis Project of New Drugs Legislation, Summary Final Report, Secretariat of the National Drug Commission, Office of hte Czech Government, October 2001, p.11.

38 Cunningham, B. 'New Drug Guidelines are Europe's Most Liberal', The Prague Post, 23 December, 2009

compared.[39] France and Germany also leave much drug policy decision-making to the regional authorities.

36. We heard evidence from the Reverend Eric Blakebrough, the founder of the Kaleidoscope project that works with drug and alcohol users in Kingston-upon-Thames and in South Wales, who referred to these differences as experienced within the United Kingdom. In his evidence to us, Mr Blakebrough stated that "the drugs scene has a certain cultural element, and that varies from district to district. Even within the United Kingdom there is room for different approaches and different innovations".[40] For example, he attributed the main cause of drug use in Kingston-upon-Thames to be rebellion by young people against the middle class aspirations of their families whereas in Llanelli, South Wales, it was more to do with unemployment, and the boredom and lack of opportunities experienced by young people in the area. Dealing with drug users of these differing types unsurprisingly required different resources and strategies.[41]

37. This evidence provided by Mr Blakebrough is further illustrated at the European level by the foundation of sub-national city networks formed to work together to combat the illicit drug problem despite national policy differences: European Cities Against Drugs (ECAD),[42] and European Cities on Drug Policy (ECDP)[43] which favours a more libertarian approach. These networks reflect the recognition that situational factors have become increasingly important in determining drug policy responses. Generally speaking, large cities are hit the hardest by the illicit drug problem and tend to be a focal point of both drug users and drug suppliers.[44] It therefore makes sense for some cities to adhere to similar principles in responding to and dealing with the specific city-level illicit drug problem, even where vastly different traditional national philosophies of drug policy are in operation. By way of example, ECAD was initiated by Stockholm in 1994 to bring together cities opposing the legalisation of drugs, but includes among its members towns in both Portugal[45] and the Netherlands.[46]

38. The current Drug Strategy calls for consultation with "representative NGOs, civil societies and local communities", while the Drug Action Plan suggests the development of a drug policy that is "relevant to professionals and civil society while at the same time enabling these structures to provide feedback to inform policy". Vice-President Reding told us that there was a Civil Society Forum on drugs, with 35 organisations coming together from across the EU. "We encourage them to do that and, through our drug prevention and information programme, we fund many activities and organisations that contribute at the local or national level to drug policy discussions."[47]

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39 Q 264

40 Q 61

41 Q 62

42 Further information can be found at www.ECAD.net

43 Further information can be found at www.ECDP.net

44 See e.g. Bless, R., Korf, D. And Freeman, M (1995) *Open drug scenes: a cross-national comparison of concepts and urban strategies*, European Addiction Research, 1, 128–38; Kaplan, C. And Leuw, E. (1996) *A tale of two cities: drug policy instruments and city networks in the European Union*, European Journal on Criminal Policy and Research, 4, 74–89

45 Vila Real de Santo António

46 Eijsden

47 Q 231

However Mike Trace, who is a member of the Civil Society Forum, was less than complimentary about it, telling us that those invited were "the people who tend to turn up in Brussels and make a big noise." But he conceded that it was "maturing slowly".[48]

39. Mr Blakebrough welcomed this emphasis on community involvement, networking and the exchange of information in his evidence: "Europad[49] conferences have often enabled practitioners to learn from each other, and it has transformed some clinics when they have gone to one in another country, for example, and seen an atmosphere that prompts them to think, 'is our agency as good as that?'"[50] He took the view, however, that this is an area where more could be done at the European level, both to communicate the findings of drug policy evaluations to the voluntary sector and to assist with funding to allow ordinary delegates to participate in European level conferences and networking events.[51] The importance of any drugs strategy being informed by public debate, and taking full account of the experience of practitioners, is more fully explored in Chapter 8.

40. **The EU Drugs Strategy and national drugs strategies should involve and encourage direct cooperation between cities, local authorities and organisations across national boundaries, and where possible promote such activities.**

48 Q 107

49 European Opiate Addiction Treatment Association

50 Q 69

51 Q72

CHAPTER 3: THE CURRENT EU STRATEGY AND ACTION PLAN

The 2005–2012 Strategy

41. The 2005–2012 Strategy begins with a backward look at the 2000–2004 Strategy and Action Plan.

BOX 1

Summary of progress in 2000–2004

> The results of the final evaluation of the EU Drugs Strategy and Action Plan 2000–2004 indicate that progress has been made in achieving some of the targets of the current Strategy. In addition, many of the actions set out in the current Action Plan have been implemented or are in some stage of being implemented. However, the available data do not suggest that there has been a significant reduction in drug use prevalence or that the availability of drugs has been substantially reduced.[52]

42. The lack of progress in either drug use or drug availability led the Council to believe that the new Strategy should concentrate on demand reduction and supply reduction.

BOX 2

Demand reduction and supply reduction

> In the field of demand reduction the EU Drugs Strategy 2005–2012 will aim for the following concrete, identifiable result: measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States. Drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances and of poly-drug use in association with legal psychoactive substances such as tobacco, alcohol and medicines.
>
> In the field of supply reduction, the EU Drugs Strategy 2005–2012 and the Action Plans are to yield the following concrete, identifiable result by 2012: a measurable improvement in the effectiveness, efficiency and knowledge base of law enforcement interventions and actions by the EU and its Member States targeting production, trafficking of drugs, the diversion of precursors, including the diversion of synthetic drug precursors imported into the EU, drug trafficking and the financing of terrorism, money laundering in relation to drug crime. This is to be achieved by focusing on drug-related organised crime, using existing instruments and frameworks, where appropriate opting for regional or thematic cooperation and looking for ways of intensifying preventive action in relation to drug-related crime.[53]

43. The Home Office explained in its written evidence: "The strategy clarifies that the role of EU action is to support the efforts of Member States in reducing drug trafficking and misuse and the harms that they cause to individuals and society. It provides a base for the development of Action

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[52] Paragraph 9

[53] Paragraphs 22 and 26

Plans that clearly define operational responsibilities and deadlines for implementation that can be translated into clear indicators of progress." [54]

The 2009–2012 Action Plan

44. We have already noted that the Strategy provided that it should be implemented by two consecutive four-year Action Plans.[55] The second of these, covering 2009–2012, lists 24 objectives to be achieved by 72 separate actions. In the timetable, most of them are listed as "ongoing". Many are simply continuations of actions in the previous Action Plan. Some, like "The Commission and Council to ensure coherence between internal and external drug policy" and "To ensure that EU relations with third countries reflect the objectives of the EU Drugs Strategy and Action Plans" are not so much actions as simply policy guidance. We should not be taken to be saying that there is no merit in listing all these matters in one place, but in many cases we doubt whether an evaluation of them can be used or expected to show whether or not there has been progress in the fight against drugs.

45. The Plan states that in 2012 there should be "an external, independent assessment carried out of the implementation of the EU Drugs Strategy 2005–2012 and EU Drugs Action Plan 2009–2012, followed by a reflection period prior to follow-up". This evaluation is to be carried out by the Commission, Council and Member States in 2012, and there is also to be an external evaluation published in 2012. We are not aware what progress has yet been made on these evaluations.

What has the 2005–2012 Strategy achieved?

Overall

46. Lord Henley believed that the Strategy had added value because it had helped to facilitate practical cooperation to reduce demand and tackle supply, as well as to build up research; but it was clear that he regarded practical cooperation between the Member States as the main purpose of the Strategy.[56]

47. In written evidence Europol saw "certain strong points of the Strategy" such as greater coherence and convergence of drug policies between countries on a voluntary basis, guidance for sharing of best practice, and the development of common standards in many key areas. But the evidence continues: "Most objectives and actions in the Action Plans are implemented indirectly: the Action Plans aim to influence the actions of others. This, combined with the lack of relevant comparable and reliable data on the drug phenomenon, drug demand and drug supply reduction means that it is very difficult to assess how much influence in general the Strategy has had in impacting upon the drug situation in the EU."[57]

Reduction in drug demand

48. Since reductions in drug demand and supply were the two main aims of the Strategy, we particularly asked our witnesses to what extent they thought these had been achieved. Professor Susanne MacGregor from the London

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54 Home Office paragraph 3

55 Paragraph 20

56 Q 321

57 Europol

School of Hygiene and Tropical Medicine emphasised the importance of being aware that demand reduction related not only to attempts to control the use of drugs but also to addressing the harms caused by the use of drugs. "In that area of moves towards reducing the harms related to drug use, I think the strategy has been very successful. It has made many achievements in a relatively short period of time."[58]

49. The figures from the EMCDDA show that, over this period, there have been decreases in the demand for **some** drugs in **some** Member States. Ms Campbell, Director of Drugs, Alcohol and Community Safety at the Home Office, told us that "drug use is actually falling in a number of countries across Europe—certainly not everywhere".[59] She added that England was showing some of the biggest reductions of drug prevalence across the EU. While the figures we have seen bear this out, the fall is almost entirely due to reduction in the use of cannabis. She also told us that for the most serious drugs the most recent figures of the numbers of people in England who were presenting for treatment were falling.

50. Not all our witnesses were as negative as Professor Fazey, who said: "HIV has been reduced substantially among intravenous drug users and also hep[atitis] B, hep[atitis] C and other diseases associated with intravenous drug use. The rest of it is pie in the sky. It is, 'We are going to reduce demand.' How? Where is the implementation? Where are the measures? There are none."[60]

51. What is beyond doubt is that, over the EU as a whole, and over the seven years of this Strategy, there has been no overall demand reduction. The current position is summarised in the latest Annual Report of the EMCDDA.

BOX 3

EMCDDA Annual Report for 2011

In many respects, this year's report is one of contrasts. On the one hand, drug use appears to be relatively stable in Europe. Prevalence levels overall remain high by historical standards, but they are not rising. And in some important areas, such as cannabis use by young people, there are positive signs. On the other hand, there are worrying indications of developments in the synthetic drugs market and, more generally, in the way drug consumers now use a wider set of substances.[61]

Reduction in drug supply

52. It is more difficult to assess whether there has been an overall reduction in drug supply in the EU over this period. The EMCDDA and other bodies do not evaluate initiatives to combat drug supply, so there is less evidence to go on. But we have not seen evidence to suggest that there has been any measurable overall reduction in supply.

53. It is certainly the case that there have been significant successes in action against drug trafficking, and in the seizure of the proceeds of crime and the use of measures against money laundering. We look at this in Chapter 4.

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58 Q 3

59 Q 27

60 Q 3

61 *The state of the drugs problem in Europe:* Annual Report of the EMCDDA for 2011, page 13.

Clearly, without this, there might have been increases in supply. But the persistence of drug traffickers, and in particular the displacement effect which we discuss in the following chapter, mean that overall there does not seem to have been a reduction in drug supply.

The global influence of the EU

54. The Strategy aims at a "coordinated, effective and more visible action by the Union in international organisations".

BOX 4

The strategy for external relations

The EU should aim to expand its political influence in the international arena and to achieve maximum impact with the resources it devotes to combating drugs production and trafficking and reducing the demand for drugs and related negative consequences.[62]

55. Europol told us in written evidence that the Strategy was important for international cooperation: "The EU has gained influence in the international arena in the field of drugs, because it has been able to work on the basis of the consensus reflected in the Strategy and Action Plans."[63] This however was not the view of other witnesses. On the contrary, Mike Trace believed that the EU was "massively handicapped" by the fact that its Member States had different domestic policies.[64] An example given by Professor Alex Stevens, Professor in Criminal Law and Justice at the University of Kent, was of negotiations in 1999 in the Commission on Narcotic Drugs. The EU had attempted to present a common front to negotiate the insertion of the term "harm reduction" in a Declaration, but the United States negotiators had no difficulty in defeating this by putting pressure on individual Member States.[65]

56. It seems to us that the EU as such has little influence at international level, and that this will continue to be the case as long as there are such wide differences between the national policies of the Member States.

Summary

57. It is clear that there are differences of opinion between our witnesses as to the value of the current Drugs Strategy. **Like the majority of our witnesses, we believe that the Strategy has been of some value despite the fact that neither of its two main policy objectives has been achieved. Very broad brush objectives such as these are not particularly meaningful. The next Strategy needs a more focused direction.** We consider in Chapter 8 what this should be.

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62 Paragraph 30

63 Europol

64 Q 101

65 Q 17

CHAPTER 4: DRUG TRAFFICKING AND DRUG CONTROLS

The fight against drug trafficking

58. The trafficking of drugs is a serious criminal offence throughout the EU, and usually involves other serious offences—firearms, sometimes murder, too often the use of 'mules' to carry drugs who occasionally die from the drugs they are carrying. Its international dimension is as prominent as that of any other serious organised crime. The EU has legislation and agencies whose purpose is to help the Member States deal with serious crime, and which play a major part in combating drug trafficking. We consider these matters in this chapter.

59. Europol has a money laundering project, Sustrans, which was launched in 2001 to establish a pan-European platform for the analysis of suspicious transactions reports (STRs). Sustrans considers the detection and disruption of criminal monetary flows, generated from drug trafficking and leaving the EU for high risk destinations and source countries, to be a priority area. Its surveys demonstrate that drugs offences are one of the most prevalent predicate offences[66] underlying STRs, surpassed only by fraud and tax evasion.[67]

60. Ms Campbell explained to us how the fight against organised crime was run. The EU set the priorities across eight areas in Europe which were the focus for organised crime. Four of the eight priority areas were focused on drugs. There was a policy area focusing on the western Balkans; one on West Africa, where the United Kingdom played the leading part; one on container traffic, led by the French; and one on new psychoactive substances with the Dutch in the lead.[68]

61. The Home Office gave us some examples of what Ms Campbell called "some fantastic success in disrupting large amounts of cocaine coming towards the United Kingdom".[69]

BOX 5

The Maritime Analysis and Operation Centre—Narcotics

The EU-funded Maritime Analysis and Operation Centre—Narcotics (MAOC(N)), coordinates the law enforcement and military assets of the United Kingdom, Italy, Ireland, Netherlands, France, Portugal, and Spain in joint counter-drugs work in the Atlantic and off the coast of West Africa. MAOC(N) has facilitated the seizure of more than 50 tonnes of cocaine and over 45 tonnes of cannabis since 2007. In June 2011, acting on intelligence provided by SOCA and the French Customs Investigative Service, UKBA officers at Southampton seized 1.2 tonnes of 90%-pure cocaine from a pleasure cruiser from Venezuela which was being transported by container ship from the British Virgin Islands to the UK en route to the Netherlands. A Dutch law enforcement investigation was then carried out, assisted by SOCA and UKBA, to identify the group attempting to traffic the cocaine. Six arrests were made on 2 August 2011. Links with DNRED, the British Virgin Islands Police and MAOC(N) were crucial in this operation.[70]

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66 Predicate offences are the initial offences through which a person can receive criminal property, in order then to launder it.

67 Europol

68 Q 44

69 Q 28

70 Home Office paragraph 2.3

Ms Campbell told us that as a result of operations like this, the wholesale price of cocaine in this country was the highest it had ever been, and the purity levels at street level the lowest. Most of the seizures at street level had a purity level of 20% or less. She regarded this as a clear indicator of the success of law enforcement colleagues in getting cocaine off the streets of the country.[71]

The displacement effect

62. It is unfortunately too often the case that the interdiction of one drugs transit route simply leads to the opening of another. Rob Wainwright, the Director of Europol, told us: "There is significant evidence that displacement occurs. The operational success that I talked about earlier[72] in Western Europe against major cocaine trafficking entering the traditional ports of entry in Europe—Spain, Portugal and Holland—clearly led to a displacement of those routes through West Africa increasingly and, as I said earlier, there are even signs that cocaine is entering the EU through Turkey and, we know also, through other parts of Eastern Europe."[73]

63. This displacement effect is more than just a disappointment for those combating drug trafficking. Tactical success is, in the view of Dr Axel Klein from the Centre for Health Service Studies at the University of Kent, "spelling a strategic disaster for countries hitherto uninvolved in drug trafficking." Poor countries are unlikely to attract the interest of traffickers because of the modest promise of their domestic markets, but once they are woven into international trafficking networks, local consumption often takes off: "… in effect, anti trafficking measures contribute to the widening of drug markets and related problems."[74] A UNODC report states that, although there are no current reliable studies on the level of drug use in West African countries, there are many anecdotal sources claiming that "cocaine use has soared since the region began to be used as a trafficking zone."[75]

64. It is not, however, just by leading to increased drug use that the displacement of drug trafficking can cause significant problems. Youngers and Rosin (2005) in their exploration of the impact of anti-trafficking policies in Latin America conclude that "international drug trafficking breeds criminality and exacerbates political violence, greatly increasing problems of citizen security and tearing at the social fabric of communities and neighbourhoods. It has corrupted and further weakened local governments, judiciaries and police forces … it can be extremely damaging to local environments".[76] Dr Klein further explored these tensions between anti-trafficking and "the role of good governance" in his written evidence to us.[77]

Human rights implications

65. Dr Klein also told us that the law enforcement agencies of some third countries involved were poorly trained and disregarded the human rights of

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71 Q 28

72 In Q 123. This is the operation described in Box 5 above.

73 Q 141

74 Klein

75 UNODC: *The Transatlantic Cocaine Market,* Research paper, April 2011. The UNODC representative in Dakar said in June 2011 that more than a third of the cocaine passing through the region was being consumed locally.

76 Youngers, C. & Rosin, E. (Eds) (2005) *Drugs and democracy in Latin America: the impact of U.S. policy* London: Lynne Rienner

77 Klein

alleged drug traffickers and of drug addicts who returned to their countries after serving sentences abroad. He cited Nigeria as a particular example.[78] The All Party Parliamentary Group for Drug Policy Reform (APPGDPR) said they were "persuaded by the detailed and informed points set out … in his written evidence",[79] though other witnesses did not believe these allegations were justified. The Home Office told us that they had consulted colleagues working in the area, including representatives of the EU and the UNODC, and found no credible evidence to support these allegations.[80]

66. Mr Trace, without giving any specific examples, told us that there were many parts of the world where the view was taken that the drug problem was such a threat to society that "the human rights of drugs users or communities where drugs are grown and distributed are negotiable, and it is considered reasonable to say that for the achievement of drug law enforcement objectives we will work around human rights obligations."[81]

67. The APPGDPR cited to us a report from Amnesty International drawing attention to the executions in 2011 of 488 people including children for drug trafficking offences in Iran. "Most have been executed after trials with no access to a lawyer and no right of appeal. Iran has been assisted in what it calls its "war on drugs" by significant amounts of aid from the European Union, which is currently providing funding of €9.5 million over three years for a project based in Iran to strengthen regional anti-narcotics cooperation between Iran, Afghanistan and Pakistan."[82]

68. **We believe that, when measures against drug trafficking are being planned, more attention must be paid to the displacement effect, to other possible unintended consequences, and to the impact of the measures on those not previously involved.**

69. **When the EU provides assistance to third countries in anti-trafficking measures, it must make clear that the resources are to be used in a way compatible with the human rights of those involved. It should take steps to monitor the programmes it supports and to ensure that they do not result in human rights violations, in particular the application of the death penalty.**

Europol

70. As we have mentioned,[83] even before Europol was formally set up there was a Europol Drugs Unit established by ministerial agreement of 2 June 1993, which became operational in January 1994. It dealt only with international illicit drug trafficking. Its mandate was extended to deal with other serious international crime in 1995.[84] Once Europol was formally established, combating unlawful drug trafficking was one of its initial objectives.[85] The Director stressed that "drugs—or the combating of international drugs trafficking—remains the area of operational work in which we are most engaged, of all the criminal sectors that we are working in. It accounts for about 30% of our operational work."[86]

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78 Klein

79 APPGDPR paragraphs 2.5–2.6

80 Home Office paragraphs 22–23

81 Q 103

82 Amnesty International (2011): *Addicted to Death: Executions for Drug Offences in Iran*, London 2011

83 Paragraph 17

84 by 'Joint Action of 10 March 1995 adopted by the Council on the basis of Article K.3 of the Treaty on European Union concerning the Europol Drugs Unit' (95/73/JHA, OJ L62 of 23.3.1995, page 1).

85 See Art 2(2) of the Europol Convention of 26 July 1995.

86 Q 118

71. In our 2008 report on Europol[87] we expressed astonishment and concern that up to 80% of information exchanged at Europol between the liaison officers of Member States was exchanged without involving Europol at all, and we made recommendations for improvement. But in November 2011 the Director told us: "Even when the information is routed through our liaison bureau at Europol itself, the statistics show still that only 50% of that material is even cross-checked with our central databases, is even referred to our analysts. I fail to understand this, I really do, because it clearly denies an intelligence opportunity to the investigators. We have unique and very substantial databases on drug-related crime at Europol. Very often we are finding connections with criminal cases, and I am always surprised when the investigators do not have the ingenuity or the inclination to even check that database. That is something that I am focused on trying to change."[88]

72. This is only a meagre improvement. We share the Director's dismay that the use of Europol databases is still so limited. We agree with him that there needs to be pressure on national agencies to share information with Europol. **The Government should fully support the Director in seeking to improve the use of Europol's unique databases and other facilities, and should urge other governments to do the same.**

Money laundering and seizure of the proceeds of crime

73. Chasing the illicit profits from drug trafficking is a major part of Europol's strategic response to the problem, and one for which it depends on the financial institutions in their reporting of suspicious financial transactions and in their successful implementation of anti-money-laundering legislation. Europol plays a key coordinating role for asset recovery officers across Europe.[89]

74. The main international legal instrument to combat money laundering is the Council of Europe Warsaw Convention.[90] It was opened for signature in May 2005 and entered into force in May 2008. It is now in force in 22 States. The United Kingdom has not signed or ratified it. In October 2009, in their response to our Money Laundering report,[91] the previous government said that they would be signing the Convention "in the very near future". When the report was debated in the House of Lords on 7 December 2009 the Minister, Lord Brett, gave a commitment that implementation "will be finalised as soon as possible in 2010".[92]

75. In May 2011, in our report on *The EU Internal Security Strategy*,[93] we again urged the Government (by now the Coalition Government) to sign and ratify the Convention without further delay. Their response, in July 2011, was: "The UK already has robust legislation and other measures in place to combat money laundering, terrorist financing and to seize and confiscate the proceeds of crime. Indeed the UK is essentially compliant with, and largely goes beyond the minimal requirements of, the Warsaw Convention".

76. When Lord Henley gave evidence to us in December 2011, we asked him why, if the United Kingdom was "essentially compliant" with the

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87 Paragraphs 49–65

88 Q 128

89 Wainwright, Q 139

90 Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime and on the Financing of Terrorism (Council of Europe Treaty Series No 198)

91 *Money laundering and the financing of terrorism,* 19th Report, Session 2008–09, HL Paper 132

92 HL Deb 7 December 2009, col 958 at col 974

93 17th Report, Session 2010–12, HL Paper 149, paragraphs 73–74

Convention, it had still neither signed nor ratified it. He replied: "We are pretty confident that we do comply with the Convention. We are pretty sure that the Proceeds of Crime Act deals with that, and it is widely seen as a model by many countries. Put very simply, as I understand it, the real problem comes down to the fact that, to be absolutely certain that we are compliant, we will need to do a forensic article-by-article survey of the entire Convention, and that will be a fairly resource-intensive exercise." He was unwilling to give any commitment as to when the United Kingdom would sign the Convention, but hoped to do so "within the next year or so".[94] He repeated this view in a debate on 19 January 2012.[95]

77. The "entire Convention" runs to 56 articles, fewer than half of which create any rights or impose any obligations of substance. This prolonged failure of successive governments, for the most unpersuasive reasons, to sign and ratify a major international instrument in a field which they purport to regard as highly significant, sends out entirely the wrong message to other States, police forces and national and international agencies involved in the fight against serious crime. **Yet again, we urge the Government to sign and ratify the Warsaw Convention without further delay.**

EU development policy as a weapon against drug supply

78. The most radical, and potentially the most effective, way of disrupting drug trafficking is by interrupting the supply at its source. Mr Costa described to us some of the different ways in which this had been attempted in different countries, but stressed how difficult it was to correlate cause and effect. We summarise this evidence in Box 6.[96]

BOX 6

Interrupting drug supply at source

American-funded spraying of the coca cultivation in Colombia has been very effective. Over the year 2003–04 Colombian cultivation decreased from 164,000 hectares to 64,000, almost two-thirds. Now, was it spraying, which was massive? Was it because of success in counterinsurgency? Was it because of lower demand, especially in the United States? Was it because the Colombians were bumped off the market by the Mexicans, who became the biggest cartel in the world, and the Colombians basically cultivate it but do not sell it any more or bring it overseas as they used to? That is very hard to say.

In Afghanistan the Karzai type of US-inspired eradication by the paramilitary, brought in to destroy the poppies, was a disaster. Targets were 15,000 to 30,000 hectares to be eradicated yearly. Only 3,000 or 4,000 hectares were eradicated with a very significant human cost because of security problems.

Programmes based on development proved more successful. Laos was declared drug-free in terms of cultivation in 2006, mostly because the government sponsored institutions and programmes to assist the farmers. Morocco had a high of 134,000 acres of cannabis in the provinces of the north, engaged in a massive transformation of the economy of these provinces and succeeded in reducing it to marginal amounts.

94 QQ 339–340

95 Debate on the report on *The EU Internal Security Strategy*, HL Deb 19 January 2012, col 768 at col 789

96 Q 175

79. Mr Costa's view was that the development method is best, but it was slower and very costly: "it involves more than just buying whatever the farmers produce. It involves reorganising society and production at large."[97]

80. The EU is already devoting substantial resources to development policies in countries where diversification of their agricultural polices away from illegal drugs, like heroin and cocaine, is highly desirable and in the EU's interest. Dr Klein told us that under the 9th European Development Fund (EDF) funds were provided for a range of activities across demand and supply reduction, and these were to be continued under the 10th EDF. It was logical to have a regional programme combining drug control with anti crime and security measures, as drug trafficking was a transnational activity. However some developing regional institutions had yet to prove that they could handle such large sums of money.[98]

81. **We recommend that the EU and its Member States give added emphasis in their development policies to well focused projects for assisting countries to diversify their agricultural economies and stop growing illegal drugs.**

Minimum penalties for trafficking

82. Despite sometimes significantly differing national policies, one area of drug policy making where Member States have traditionally been able to reach broad agreement of purpose lies in the control of illicit drug trafficking and traffickers. Drug policy making at the European level has thus been somewhat more advanced in this area. In 2004 a Framework Decision was adopted[99] setting out minimum rules relating to the constituent elements of the offences of illicit trafficking in drugs and precursors so as to allow a common approach at European Union level to the fight against trafficking. In particular, it defines the acts that constitute criminal offences and sets the lowest level of maximum penalties that Member States must provide as sanctions for them. It specifically excludes from the list of criminal offences acts "committed by its perpetrators exclusively for their own personal consumption as defined by national law".

83. In 2009 a report was issued by the Commission on the effectiveness of the implementation of the Framework Decision.[100] The report suggests that the instrument has failed on a number of measures. Importantly, the report concedes that the Framework Decision has not achieved its main aim of approximating the definition of criminal offences and levels of sanctions imposed: "There has thus been little progress in the alignment of national measures in the fight against drug trafficking." Not all Member States implemented the provisions fully, and many others did not in fact amend their national legislation, as they already had provisions on drug trafficking as part of their drugs policies. Furthermore, the majority of Member States have lowest levels of maximum penalties that exceed those outlined in the Framework Decision, suggesting that it represents the bare minimum of sanctions in operation in Europe. For those Member States that have adopted the Framework Decision in their legislation, the possibility remains

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97 Q 175

98 Klein

99 Framework Decision 2004/757/JHA laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking (OJ L335 of 11 November 2004, page 8)

100 (COM(2009)669 final)

for them to designate which drugs they will prioritise and which amounts they will consider as "large" or "serious".

84. It is clear from its October 2011 Communication *Towards a stronger European response to drugs*, which we consider in Chapter 8, that the Commission is still committed to development of policy in this area and to replacing this Framework Decision with a "more effective" Directive. The Director of Europol also believes that establishing minimum rules on the definition of criminal offences is an area where greater harmonisation might be beneficial.[101] In our view, which accords with that of the Commission's own report, the experience of the Framework Decision has shown that the pursuit of European policy in this area is unlikely to bring significant added value at national level.

85. Given the significance of the problems with policy approximation even in this area of relative consensus, **we remain unconvinced by the case for replacing this Framework Decision by a Directive, as suggested by the Commission in its October 2011 Communication, unless and until it can be shown that a Directive will be effective and will bring added value to this area of national drug policy making.**

New psychoactive substances (NPS or legal highs)

86. Ms Campbell[102] and Professor MacGregor[103] agreed that the rapid development of new psychoactive substances (often termed 'legal highs') in recent years presents one of the most significant challenges currently facing drug policy development at both the European and the national level. In May 2005 the Council adopted a Decision on the control of new psychoactive substances[104] which establishes a mechanism for a rapid exchange of information on new psychoactive substances. It also provides for an assessment of the risks associated with new psychoactive substances. Where a significant risk is found to exist, it allows measures applicable in the Member States for the control of narcotic drugs to be applied to new psychoactive substances.[105] Effectively, this Council Decision gives the European Union the power to ban newly discovered psychoactive substances where the risks to individuals and to societies are evaluated as being high.

87. The first part of this Decision is concerned with the creation of an "early warning system" which collects information on newly developed psychoactive substances from across Member States and beyond. Ms Campbell described to us in her oral evidence the importance of this process in adding value to policy developed at the national level: "Colleagues around Europe notify each other of new substances as they are detected ... that type of information is particularly valuable to us, for anticipation and as an early warning".[106]

88. The powers to perform risk assessments based on information provided by the early warning system and, ultimately, to ban newly developed psychoactive substances, have not however been judged to be so successful. The Director of Europol told us that since 2005 115 new psychoactive

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101 Q 119

102 Q 33

103 Q 19

104 Council Decision 2005/387/JHA of 10 May 2005 on the information exchange, risk-assessment and control of new psychoactive substances, OJ L127, 20 May 2005, p.32

105 Decision, Article 8(3)

106 Q 39

substances were reported through the early warning system, 41 in 2010 alone.[107] Yet over the six years that these powers have been in place, the risk assessment process has resulted in only two of these substances being banned throughout the Member States.[108] Vice-President Reding informed us that it took one and a half years for the EU to conduct the risk assessment on mephedrone and then ban it; by this time the United Kingdom and 14 other Member States had already banned it without waiting for the EU Decision.[109]

89. In 2011 the Commission produced its own report evaluating the functioning of the 2005 Council Decision.[110] This highlights several major defects. The Decision is not able to handle the large increase in the number of newly developed psychoactive substances because it addresses them one by one. It is reactive rather than proactive, as it waits for each newly developed substance to be reported before it can take any action. These problems mean that it is too slow to take account of the rapid changes that occur in this area of drug policy. The Commissioner herself was highly critical of these powers.[111] The Commission Communication *Towards a Stronger European Drug Policy* proposes stronger EU legislation on new psychoactive substances that can provide swifter and more sustainable answers to the emergence of these substances, possibly by exploring ways to address groups of substances together, rather than on a case by case basis.

90. We question whether an automatic ban of each new substance as soon as it comes on the market is the right approach. In her evidence to us, Professor Cindy Fazey described the process whereby the producers of newly developed psychoactive substances are able to formulate new substances with highly similar molecular structures as soon as one substance is banned.[112] This makes it difficult to imagine how the EU can move from a strategy that is reactive to one that is proactive, and how it can hope to be more than one step behind the drug producers. Professor MacGregor also suggested that "cracking down too quickly on a new synthetic drug may move users to use more harmful drugs rather than to use the less harmful new synthetic drug", and that banning "does not reduce the use; it simply has moved users to the black market rather than through [legal suppliers] on the internet".[113]

91. The current Council Decision and the proposed new legislation in this area[114] focus on trying to make existing processes faster and therefore more effective, resulting in a higher number of substances that are banned throughout the Member States. However the evaluation of the Council Decision admits that "a large number of Member States wanted to consider alternative methods of control" and would like a wider range of options to be considered.

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[107] Q142; see also SEC(2011)912 final.

[108] Council Decision 2008/206/JHA, OJ L63, 7 March 2008, p.45, banned BZP (1-benzzylpiperazine) and Council Decision 2010/759/EU, OJ L322, 8 December 2010, p.45 banned mephedrone. On scrutiny of the Commission proposal for this Decision this Committee pointed out that the legal base was wrong; this was corrected by the Commission: see http://www.parliament.uk/documents/lords-committees/eu-sub-com-f/cwm/cwmsubffinalmay10-nov10.pdf

[109] Q 226

[110] SEC(2011)912 final

[111] Q 226

[112] Q 20

[113] Q 19

[114] Communication from the Commission: *Towards a Stronger European Drug Policy*, part 5

92. The United Kingdom has already adopted a different line: "Rather than, as many countries do, legislate for a particular substance, when we looked at a product called "Spice" a little while ago, a synthetic cannabinoid—like cannabis but created synthetically—we legislated for any number of related compounds to the ones we saw in the UK, so that if the chemists tried to make a slight alteration to the drug it would still be within our definition and therefore illegal."[115] The Polish Presidency seems to have agreed; in a note to the Horizontal Drugs Group[116] it suggested that any revision of the 2005 Decision should allow legislation to deal with groups of substances rather than individual substances. Poland has itself adopted such legislation,[117] and the Advisory Council on the Misuse of Drugs (ACMD) has suggested in its recent report on *Novel Psychoactive Substances* that such analogue legislation should be seriously considered.[118]

93. In supplementary written evidence the APPGDPR suggested that a regulated market, such as already exists for alcohol and tobacco, could be set up for these newly discovered psychoactive substances that could be overseen in the United Kingdom by, for example, Trading Standards legislation or the Medicines and Healthcare Products Regulatory Agency. The ACMD further suggests that "demand reduction strategies should be developed including education, prevention and treatment interventions", like those used for alcohol and tobacco, which could also be used for novel psychoactive substances.[119]

94. **We endorse the importance of the EU's "early warning system" which exists to facilitate the exchange of information on newly developed psychoactive substances within the Member States and beyond.**

95. **However the risk assessment and banning procedure of the 2005 Council Decision is so cumbersome that we doubt whether it can be cured by amendment. We believe that decisions about banning such substances are, in most cases, best left to individual Member States.**

96. **There is a strong case for the use in the United Kingdom, and indeed throughout the EU, of analogue legislation which allows drugs with similar molecular structures and similar effects to be banned as a group.**

97. **Furthermore, we support the exploration of alternatives to banning new psychoactive substances, such as placing them within regulated markets similar to those that already exist for alcohol and tobacco, which attempt to control use through education and treatment rather than criminalisation.**

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[115] Q 33 (Campbell)

[116] 16120/11, 4 November 2011

[117] See ACMD report on Novel Psychoactive Substances, October 2011, paragraph 11.20.

[118] *ibid.* chapter 11 and paragraph 12.18

[119] *ibid.* paragraph 12.45

CHAPTER 5: HARM REDUCTION AND DECRIMINALISATION, AND THEIR EFFECTS ON PUBLIC HEALTH

98. In the Call for Written Evidence which we issued in July 2011[120] we explained that the Committee's terms of reference are "to consider European Union documents … and other matters relating to the European Union", and that our inquiry would be considering the domestic drugs policies of States only as part of the context within which the EU operates.

99. Nevertheless the collective strategy of the Member States within the European Union cannot be considered independently of the national strategies of those States. It was inevitable that we should receive written evidence explaining in some detail the very divergent policies of different Member States which form the background to the EU Strategy. We also took oral evidence to enable us to understand more clearly the reasons for this divergence, and the possible consequences.

100. From our summary of the policies of Sweden, the Netherlands, Portugal and the Czech Republic[121] it will be clear that it is in the area of drug use and drug users that there is the greatest variation of practice in different Member States. Two increasing trends have been seen across Europe in recent years: harm reduction and decriminalisation. In this chapter we examine the evidence we received, and draw some conclusions on how they sit within European drug policy making as a whole.

Harm reduction

101. Over the past 30 years, harm reduction has developed as a key concept within national and international drug policy debates. The International Harm Reduction Association defines harm reduction as: "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption".[122] In their recent monograph on the subject, the EMCDDA recognise harm reduction as an important strand of drug policy encompassing "interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies".[123] More generally, it has been associated with the designation of drug addicts as patients that need help rather than criminals that need punishment.

102. Harm reduction as a drug policy strategy received attention across much of the Western world in the 1980s in direct response to concerns about HIV/AIDS. It had been noticed that levels of HIV/AIDS were particularly high amongst intravenous drug users, in part due to the practice of sharing the needles used to inject their drugs. Until this time, it had been standard practice for governments to make it as difficult as possible to obtain syringes as part of an overall drug prevention strategy. Needle exchange schemes, first introduced in the Netherlands but quickly spreading elsewhere, allowed intravenous drug users to bring back their used needles and exchange them for clean ones.

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120 See Appendix 3

121 Paragraphs 30–34

122 Harm Reduction International position statement

123 EMCDDA monograph 10: *Harm Reduction: evidence, impacts and challenges,* 2010

103. At the same time, substitution treatment was developed for heroin addicts. Those defined as not responding to other forms of treatment were offered the prescription of methadone, an opiate that can be taken orally. Controversially, this was not always as part of an overall programme that aimed to reduce drug use but could also be offered on a long-term basis, if the addict showed no willingness to begin to reduce use.

104. In the 1980s and early 1990s, measures that would actually make it easier for drug addicts to continue using drugs attracted much criticism. Today, however, the evidence suggests[124] that these kinds of initiatives have been vital in improving the health and life prospects of drug users. Needle exchange schemes and methadone maintenance programmes are no longer particularly controversial—every Member State has such programmes, and applicant States cannot join the EU until they have implemented them. Some Member States have begun to experiment with novel harm reduction measures like the provision of safe user rooms where drug addicts can use their drugs without fear of disturbing the public or being disturbed by the police, and the free prescription of heroin (rather than methadone) under supervised conditions.

105. We referred in Chapter 2[125] to the Catania report, which in 2004 suggested that the EU was not doing enough to promote harm reduction measures, but came too late to influence the 2005–2012 Strategy. To some extent this situation was rectified by the publication of the 2009–2012 Action Plan within which the underlying principles of harm reduction had gained a much stronger foothold, together with a 2010 EMCDDA research monograph focusing on the evaluation and promotion of harm reduction measures. Professor MacGregor suggested that: "the focus on harm reduction is well placed and has grown and is at the right level"[126] but also drew attention to certain areas where more work is needed: for example in relation to the prevention of hepatitis and the reduction of drug-related harm for vulnerable groups (e.g. sex workers, migrant populations and people in prison).[127] Baroness Meacher drew attention to the disparity between the provision of interventions such as needle exchange programmes between East and West Europe, pointing out that "the 12 countries that joined the EU since 2004 only account for 2% of substitution treatment in Europe as a whole … there is a tremendous need for the EU to take up this call to spread harm reduction and substitution treatment across to those mainly eastern European countries".[128] These statements are also supported by the 2010 EMCDDA annual report.[129]

Decriminalisation

106. Harm reduction measures such as those described above are part of a policy that puts the protection of public health above the enforcement of the law, at least in terms of drug use and drug users, and emphasises the important role that treatment can play in reducing both the use of drugs and the problems that drug users face. One method of harm reduction that has received much

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[124] *Ibid.*

[125] Paragraph 21

[126] Q 15

[127] Q 15

[128] Q 201

[129] EMCDDA, *2010 Annual Report on the State of the Drugs Problem in Europe,* Lisbon

attention recently within Europe is the decriminalisation of the use of drugs or the possession of drugs for personal use. This policy aims to reduce the harm done to the users of drugs by preventing them from becoming criminalised through their use.

107. Decriminalisation needs to be distinguished from legalisation, which is prohibited under the UN Conventions. Drugs are not legalised; instead, criminal penalties associated with the possession of small quantities of drugs for personal use, and the use of those drugs, are replaced by civil penalties such as requirements to attend treatment programmes. Further complicating the picture is the existence of a policy strategy of depenalisation whereby drugs remain illegal and criminalised, but the possibility of being sent to prison (again, for use or possession for personal use only) is removed.[130] Removing criminal penalties from the supply and trafficking of drugs is out of the question, and this needs to be clearly understood by those commenting on policies of decriminalisation.

108. There is no uniform way of effecting a policy of decriminalisation, as demonstrated by the variety of practice currently observable within Member States. Portugal, representing the most advanced form of decriminalisation currently in operation in Europe, has removed the possibility of criminal sanctions for the possession of all drugs for personal use, replacing them instead with a range of civil penalties. Spain, the Czech Republic and Latvia have made civil sanctions the norm for possession of all drugs for personal use. Germany, Estonia and Lithuania have written the possibility of waiving prosecution of the possession of small amounts of any drug for personal use into their penal codes.[131]

109. Other Member States have experimented with the decriminalisation of certain drugs only, usually cannabis. This is the long-standing situation in the Netherlands with its policy that tolerates the purchase and sale of small amounts of cannabis via the 'expediency principle' which stipulates that it is not in the public interest to prosecute for these offences. More recently, Belgium and Luxembourg effectively removed criminal sanctions for the possession of cannabis for personal use.[132] It can be argued that the United Kingdom operated a system of decriminalisation of cannabis between 2004 and 2009 when cannabis was downgraded to a Class C drug, although the power of arrest was retained in certain circumstances.

110. By no means all countries are attracted to decriminalisation. Sweden pursues users as much as dealers. The United Kingdom recently upgraded cannabis to a class B drug. Denmark has tightened cannabis legislation.[133] Despite the increase of countries relaxing laws around personal drug use and in particular with reference to cannabis, the latest EMCDDA annual report describes a situation where "the number of offences related to cannabis use in Europe continues to rise, against a background of stable or even declining prevalence. This highlights a possible disconnect between policy objectives and practice".[134]

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[130] For evidence on the significance of the terminology, see EMCDDA Q 282

[131] European Legal Database on Drugs www.emcdda.europa.eu/eldd

[132] *Ibid.*

[133] *Ibid.*

[134] EMCDDA, *2011 Annual Report on the State of the Drugs Problem in Europe* Lisbon, p.17

111. One example of the constructive use of the criminal law in this country was seen by some members of the Sub-Committee on a visit to West London Magistrates' Court in Hammersmith to observe one of the five (initially six) dedicated Drug Courts in England in action.[135] The judge was joined by a psychologist and a probation officer in assessing the best way forward for a drug user who had committed a criminal offence to fund his drug addiction. With the defendant on probation, and custody available as a sanction of last resort, the court was in a position to order the steps most likely to prevent him from reoffending and to keep him "clean". The expense was obvious; but we were reminded of Ms Campbell's evidence to us that "in this country for every £1 we invest in drug treatment, at least £2.50 is saved in reductions in crime and other costs."[136]

The Portuguese experience

112. As we explained in Chapter 2, Portugal is the Member State which has gone furthest in incorporating both harm reduction and decriminalisation within its national drug policy. For this reason, we took evidence specifically on the Portuguese experience.[137]

113. José Sócrates, the former Prime Minister of Portugal who, when Deputy Prime Minister, was the architect of the new policy, and João Castel-Branco Goulão, the director of the Portuguese National Drugs Agency, both described to us the history of drug use within Portugal as taking a dramatic change after the democratic revolution in 1974.[138]. Illegal drugs suddenly hit Portugal for the first time and there were no strategies in place to deal with such a problem. João Goulão described Portugal as having "one of the narrowest gaps between total prevalence of drug use and problematic drug use [with] 1 per cent of our population with problematic drug use".[139] In order to address these problems, Mr Sócrates told us, the decision was made to "put a pragmatic approach to drug issues into our law and put aside the ideological approach to get rid of all drugs and have a society free of drugs".[140]

114. Portuguese national drug law was changed in 2001 and a policy was implemented that was based around the principles of harm reduction, treatment and the decriminalisation of drug users. Under this new law, the treatment system was vastly expanded and anybody caught in possession of drugs for personal use (viewed as around ten days supply) was to be prevented from undergoing criminal prosecution, instead facing a 'dissuasion committee'. Mr Goulão told us that the new law made the assumption that "a drug addict is mainly someone who needs health and social support rather than criminal conviction".[141]

115. This change in Portuguese law was undertaken more than ten years ago and some of the consequences can now be examined. Both Mr Goulão and

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135 More information about these courts can be found in *The Dedicated Drug Courts Pilot Evaluation Process Study,* Ministry of Justice Research Series 1/11, January 2011

136 Q 52

137 For a fuller explanation of the Portuguese drug policy see the EMCDDA report *Drug Policy Profiles: Portugal* (2011)

138 Q 246 and Q 295

139 Q 295

140 Q 239

141 Q 295

Mr Sócrates told us that, although a proper costing of the change in policy had not taken place, the new policy was much cheaper as the expansions made to the treatment system were far outweighed by the savings to the criminal justice system.[142] Portugal has always had a relatively small number of drug users, in European terms,[143] and, as such, a reduction in the overall number of drug users was never an important aim of the policy. In other areas, however, Portuguese successes have been dramatic. Mr Sócrates described how the courts had benefited by having so much time freed up,[144] as had the prisons, and Mr Goulão suggested the drug users had benefited because they were not ostracised and criminalised anymore.[145] They also both cited the increased numbers in treatment and the significant reduction in numbers of drug users with HIV/AIDS.[146]

116. Since these positive evaluations of the change in Portuguese national drug policy, many governments from around the world have sent representatives to study Portuguese policy before making changes to their own national strategies. Norway, the Czech Republic and Argentina, for example, have recently expressed interest in finding out more about Portuguese drug policy.[147]

117. **We were impressed by the evidence from Portugal on the effectiveness of their public health orientated national drug strategy. Harm reduction and public health policies are increasingly being adopted internationally, nationally and locally. We believe Member States should study each other's policies and be more willing to learn from one another, and we recommend that the EU should promote and prioritise the evaluation of the effectiveness of these strategies.**

118. **We take no position on whether in this country a change towards a policy of decriminalisation would be beneficial, since this is outside our remit, but we believe the debate would benefit from a clearer understanding of precisely what policy changes would be involved, and a closer study of the experience of other countries, particularly other Member States.**

119. We consider in Chapter 8 whether and to what extent the new EU Strategy should cover harm reduction.

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142 Q 255 and Q 300

143 See EMCDDA Statistical Bulletin for 2011: http://www.emcdda.europa.eu/stats11

144 Q 248

145 Q 296

146 Q 246 and Q 305

147 Q 307

CHAPTER 6: THE EUROPEAN MONITORING CENTRE

120. As we have explained in Chapter 2,[148] the establishing of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 1993 was the first concrete initiative to have been taken by the European Community in this field. It is still by a long way the most successful.

121. The reason such a body was needed is clear from one of the Regulation's recitals: "… objective, reliable and comparable information concerning drugs, drug addiction and their consequences is required at Community level to help provide the Community and the Member States with an overall view and thus give them added value when, in their respective areas of competence, they take measures or decide on action to combat drugs."[149]

122. The 1993 Regulation was amended a number of times before being replaced in 2006 by the Regulation which now governs its work.[150] But the agency's primary task is unchanged: the collection, analysis and dissemination of data relating to all aspects of the drug problem. Among its secondary tasks, it is also the implementing agency for the early warning system for psychoactive drugs which we describe in Chapter 4.

123. The EMCDDA is also clear about what it does not do: "We are policy neutral; our task is to document and report, and never to advocate or lobby."[151] Paul Griffiths, the Scientific Director and our chief witness during our visit to the EMCDDA, put it this way: "We do not evaluate national policies but we can provide the tools to help Member States in their evaluation of their own policies. Our mandate does not ask us at present to judge the policies of Member States."[152]

Evaluation of its work

124. The EMCDDA got off to a somewhat shaky start. In its early years it was, in the view of the Home Office, "by no means as effective as it is today." An external evaluation of the first five years of the agency noted in 2000 that the EMCDDA needed to define a more focused work programme based on a limited number of priorities. Things have now changed. Our witnesses were unanimous about the value of its work and, in the view of the Home Office, "it is a tribute to the current Director Wolfgang Götz, Marcel Reimen who was until recently the Chair of its Management Board, and the scientific staff of the agency, that the EMCDDA is so highly respected today." [153]

125. Academic witnesses were equally complimentary. Professor Fazey thought that "the EMCDDA is one of the most successful European institutions in the drugs field, if not the most successful, and I would argue very strongly for its expansion." Professor Stevens added: "I think the three of us[154] are agreed on the value of the EMCDDA and its strength and contribution to this

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148 Paragraph 16

149 Regulation (EEC) No 303/93 of 8 February 1993, OJ L 36 of 12 February 1993, page 2

150 Regulation (EC) No 1920/2006 of the European Parliament and of the Council of 12 December 2006 on the European Monitoring Centre for Drugs and Drug Addiction (recast), OJ L 376 of 27 December 2006, page 1

151 EMCDDA monograph 10: *Harm reduction: evidence, impacts and challenges,* 2010, preface

152 Q 259

153 Home Office 2 para 18

154 i.e. himself, Professor Fazey and Professor Macgregor

field."[155] It is clear that other organisations also think highly of the agency. Mr Costa said: "… the work of the Lisbon-based institutions and the availability of regionally coherent data has been a very important contribution to the work of UNODC."[156] The EMCDDA is held up by the World Health Organisation as "a shining example of a regional monitoring centre which benefits individual Member States, the EU as a whole and the wider international community."[157] In 2007 an evaluation for the Commission by an outside agency[158] concluded that the annual report, its "flagship publication", was especially well received by target groups.

Reliance on national data

126. The EMCDDA relies for its work largely on data supplied by the Member States through the REITOX network.

BOX 7

REITOX

REITOX is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, Norway, the candidate countries and at the European Commission. Under the responsibility of their governments, these bodies are the main information interface between the EMCDDA and those States. They provide national drug information to the agency for EU-level analysis and act as the ambassadors for the EMCDDA in their home countries.

127. The quality of the national data is very variable. Few countries in Europe collect annual data on the prevalence of drug use among the general population (apart from England and Wales and Sweden which collect annual data on cannabis use as part of a public health survey). The most frequent data collection via surveys of drug prevalence is every other year (in countries such as Scotland, Spain and Italy) whilst in some countries, for example Germany, data collection on drug use is not part of a regular data collection routine.[159] But the main challenges are still the difficulty of attaining consensus and joint action on key indicators, and the variable quality of the national data. There are different collection methods, different policy contexts that make people more or less likely to come forward, differing definitions of what is a drug-related death or a drug-related crime. The EMCDDA is working towards standard definitions but progress is slow, and it has no powers of coercion.

128. One reason for this tardiness is that Member States like to adhere to their current methods of collection to keep them comparable historically over time; it may be more important to them that their future statistics should be comparable with their past statistics than that they should be comparable with the future statistics of other Member States. Lord Henley explained: "… one does not want to get to a position where we cannot compare our own statistics with our previous statistics if we have changed the method of

[155] Q 14

[156] Q 169

[157] Home Office para 16

[158] The Centre for Strategy and Evaluation Services (CSES)

[159] Home Office 2 para 11

doing them. However statistics are collected, we always want to make sure that we can see what the trends are."[160]

129. Despite this, the position is no longer as bad as it has been. Mr Griffiths told us that the EMCDDA had done a full assessment of the key indicator decisions. "The conclusion was quite a cheerful one: it is surprising how much of the data were comparable."[161] Nevertheless it is clear that the lack of reliable and comparable statistics hampers the understanding and effective formulation of drugs policy.

130. **We therefore recommend that a major effort should be made in the context of discussion of the next EU strategy to improve the quality and comparability of national statistics. This may require some change in the way that the United Kingdom and other Member States collect data, but we believe that the establishment of more consistent statistics would make the work of the EMCDDA even more valuable than it now is, and would amply repay the investment involved.**

131. Even between England and Scotland there are differences in the ways in which drug-related deaths are recorded. In Scotland a death has to be recorded within eight days of its taking place, but in England (where there are ten times as many drug-related deaths) only when there is a coroner's verdict, which can be many months later. Cocaine-related deaths, which inevitably are referred to coroners, typically are not registered until nine months or more after the occurrence of the death. United Kingdom statistics on drug-related deaths sent to the EMCDDA for a particular year may therefore include a number of deaths the previous year.[162]

132. **The Government should seek to ensure that the reporting of drug-related deaths is consistent across the United Kingdom, so that reports refer to the year of death and not to the year of registration of death.**

Evaluation of initiatives to deal with drug supply

133. One issue affecting all the strategies considered here is a failure fully to evaluate initiatives to disrupt drug supply, and to understand the knock-on effects they may have in other areas. Professor Stevens explained that it had always been assumed that by taking certain actions to reduce supply, one could have significant impacts on the use of drugs, so there had been no investment in evidence to test that assumption. This lack of investment both at European and at national levels arose because of the uncontroversial nature of the assumption that by controlling the supply of drugs one would have an effect on the drug market.[163]

134. Mr Griffiths told us that the EMCDDA recognised the problem; he set out at some length what they were trying to achieve, and the difficulties they faced. They were waiting for a proposal from the Commission on key indicators. "We have yet to see how that proposal is framed, and it is up to the Member States to decide what they want to do with that. We cannot make Member States provide us with data if they do not want to, so the will

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[160] Q 324

[161] Q 268

[162] Information supplied by Professor Sheila Bird, visiting professor at the University of Strathclyde Department of Mathematics and Statistics, and Principal Scientist at the Medical Research Council Biostatistics Unit

[163] QQ 3, 7

and support of Member States will be crucial to improve the quality of data."[164]

135. **There need to be thorough evaluations of measures to disrupt supply with a view to making them more effective and better focused, to determining their added value, and fully to understand their unintended consequences. The Government should support the efforts of the EMCDDA to take forward their plans on supply side indicators, and should persuade the Commission and other Member States to do likewise.**

EU research policy

136. All Member States conduct drug-related research. A proportion of these studies are captured by reports through REITOX system, but there is currently no inventory of such research. Some of this research is funded by the EU through the seventh research framework programme (FP7) which runs to 2013. The EMCDDA, though not itself a major funder of new research, has an important role to play in disseminating information on the findings of research. Its Scientific Committee has made recommendations on the priorities for future research which include the effectiveness of treatments, policy analysis of Member States' policies, the market for illicit drug supply, research to help understand the long-term course of different patterns of substance abuse, and research for estimating the size of the drug-using population.[165]

137. In their supplementary written evidence the Home Office attested to the value of drug related research under FP7 and argued that this should be a continuing priority for the EU. They told us about ERA-NET, the European Research Area Network, which sits under FP7. Its objective is to develop and strengthen the coordination of national and regional research programmes. The Commission provides funding for the process of coordination, while Member States which choose to participate fund the actual research. ERA-NET 2012 includes a call for a "Drug demand and supply reduction ERA-NET" which will support the Drug Strategy's statement that information, research and evaluation are key elements in understanding the drug problem better than at present.[166]

138. **We hope that if viable research projects can be brought forward, ways will be found of financing them through the EU research programmes. This will help to ensure that future policies are evidence-based, since one of the weaknesses until now has been the lack of sufficient evidence.**

Resources

139. The Director, Mr Wolfgang Götz, told us that over the past few years the EMCDDA had substantially increased its output with stable resources. His staff had no spare capacity. He outlined some of the work he would like to embark on if "the miracle" of additional resources happened, but accepted that this was not the time to ask for more resources. We agree that in the current economic climate this is probably the only realistic approach. But we also believe that the existing budgetary allocation of the EMCDDA should

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[164] Q 274

[165] EMCDDA 2011 Annual Report, page 25

[166] Home Office2 para 14–17

be retained in real terms, and that Member States should not attempt to reduce it. The work of the EMCDDA is too valuable to be curtailed.

Recommendations

140. **We welcome and endorse the universally high esteem in which the agency is held. We believe it should continue to work towards common definitions and a common data collection practice, and should encourage Member States to do likewise. We urge the Government to do all it can to assist in this.**
141. **We agree that the EMCDDA should play no part in grading the success or failure of the policies of the different Member States. However we believe that the agency, without compromising its policy neutrality, could do more to indicate when the evidence points to a particular policy having been successful.**
142. **During the current negotiations on the Multiannual Financial Framework 2014–2020, and during the annual budgetary negotiations, the Government should ensure that the resources of the EMCDDA are at least retained at their current level in real terms.**

CHAPTER 7: EU INSTITUTIONAL QUESTIONS

Responsibility for drugs policy in the Commission

143. Until the end of 2009 the Commission dealt with all justice and home affairs (JHA) matters in a single Directorate-General, DG JLS,[167] which was responsible for all aspects of the Commission's involvement in EU drugs policy, including its involvement in Europol and the EMCDDA. When the current Commission took over in 2010, DG JLS was split into two separate Directorates, Home Affairs (Home), and Justice, Fundamental Rights, and Citizenship (Justice). Vice-President Viviane Reding, who is the Justice Commissioner, explained to us how this had affected drugs policy: "You know we have a separation between justice and home affairs, built on the new treaty. The responsibility for the horizontal co-ordination of the whole drugs policy is with Justice, as is the development of future policies. Home Affairs has the agency, but nothing else. Criminal law is done by Justice, for instance. There are other DGs that have some responsibility, such as DG Enterprise and TAXUD for direct precursor legislation."[168]

144. We do not understand why, in the division of the responsibilities of the former DG JLS, responsibility for the EU Drugs Strategy and Action Plans should have been allocated to DG Justice, although the main specific action is, in our view rightly, the responsibility of DG Home. In any forum, action on drugs encompasses a wide range of interests. In the United Kingdom the Home Office is the lead department, and Lord Henley, a Home Office Minister, chairs the inter-departmental ministerial group on drugs, "a group of Ministers from a wide range of departments, starting with health and going on to education, work and pensions, and others."[169] Plainly there must be full consultation between all those whose responsibilities are involved. But the lead should be taken by those with the primary responsibility.

145. It can be argued, and was argued by the All Party Parliamentary Group on Drug Policy Reform, that "to reflect the importance of a health focus in EU drug policy it should be made clear in a future Strategy that the lead role for Drug Policy should be transferred from the Justice to the Health and Consumers Directorate."[170] While we do believe that more emphasis should be given to the health aspects of the drug problem, we do not agree with the wholesale transfer of responsibility suggested here. Nor do we feel, however, that DG Justice is either the most logical or the most appropriate Directorate to deal with narcotic drugs. In our view this is DG Home. It will be seen in the following chapter that the Commission's most recent initiative in this field, the Communication of October 2011, which deals mainly with action on the home affairs front, was brought out by DG Justice. Conversely, when three weeks later the EMCDDA issued its 2011 Annual Report, this was welcomed on behalf of the Commission by Cecilia Malmström, the Commissioner for Home Affairs.

146. This division of responsibilities was not thought by the Director of Europol to have caused significant problems, though he said: "When it was integrated in one Department, there was clearly greater potential for there to be a more

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[167] Justice, Liberté, Sécurité

[168] Q 219

[169] Q 312

[170] APPGDPR para 1,5,7,

efficient prosecution of the policy."[171] We however believe that the way in which the responsibilities of the former DG JLS have been divided is likely over time to have an adverse effect on the work of the Commission and its officials in the field of drugs. By way of example, it has been agreed internally in the Commission that DG Justice and DG Home will both be represented on the EMCDDA Management Board. This needed an amendment to the Commission Decision of 26 October 2009 appointing members to the Management Board. At the meeting of the Management Board on 4–5 July 2011 the Commission was represented by an official from DG Justice, with an official from DG SANCO (Health) as substitute, and an official from DG Home also attending, though not then as a full member. This is not an efficient use of Commission resources, nor can it help the work of the EMCDDA.

147. **It is not for us to make formal recommendations about the division of responsibilities within the Commission, but we believe that the current allocation of responsibilities must in the long term hamper the effective formulation and implementation of policies in the drugs field, and should be remedied.**

The Council Horizontal Drugs Group

148. Coordination of EU drugs policy in the Council takes place through the Horizontal Drugs Group (HDG), whose functions in this respect were confirmed by the current Strategy.[172] This Group, which meets monthly, consists of representatives from all the Member States, and also representatives from the Commission, Europol, the EMCDDA and others. The Group is used as a forum for the exchange of information, intelligence and best practice, and to talk about how Member States can work together to tackle the problems they are all facing. Ms Campbell told us that the HDG was particularly valuable in allowing members under the auspices of the HDG to discuss with colleagues from Latin America and the Caribbean how they might work together to tackle the drug flows coming from those areas.[173]

149. The Home Office, which sends representatives to the HDG, regards it as a useful body.[174] Professor MacGregor also thought that it had "played a very important role in co-ordinating between Member States".[175] But Mike Trace, whose experience at the UNODC might have given him some familiarity with administrative problems, was scathing about it, as indeed he was about the whole Brussels institutional setup. He thought the HDG was "much weaker now than it has been in previous years; there is not really much political strength and momentum there."[176] We do not know to what extent this criticism may be justified. We do however believe that **for an EU Drugs Strategy to have any prospect of success, representation at the Horizontal Drugs Group should be at a senior level, with expertise to match, and with power to take decisions across the whole spectrum of interested Directorates and departments.**

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171 Q 146

172 Paragraphs 17– 21

173 Q 37

174 Q 321

175 Q 10

176 Q 109

CHAPTER 8: A FUTURE EU DRUGS STRATEGY

150. We have considered in Chapter 3 the current Strategy and Action Plan, and the reasons why in our view the Strategy has fallen short of achieving its two principal aims. In this chapter we look to the future.

Does the EU need a Drugs Strategy at all?

151. Should there continue to be a strategy at all, or is it enough that the EU should agree Action Plans? The views of Vice-President Reding, who as we have said is the Commissioner responsible for the EU Drugs Strategy, are illuminating and perhaps surprising. She described the Strategy to us as "a thing of the past" and "a nice piece of literature".[177] Later she said: "You know strategy is wishful thinking whereas an action plan or a communication for action is an action."[178]

152. This dismissive attitude is at variance with earlier views of the Commission (of which she herself was a member). In June 2009 the Commission thought there **should** be a new Strategy, and said as much in its Communication which was first draft of the Stockholm Programme:[179]

BOX 8

The Commission's view on a new Drugs Strategy in June 2009

> The EU Drugs Strategy (2005–2012) advocates a global, balanced approach, based on the simultaneous reduction of supply and demand. This strategy will expire during the Stockholm Programme. It must be renewed on the basis of a detailed evaluation of the Drugs Action Plan 2009–2012, carried out by the Commission with the support of the European Monitoring Centre for Drugs and Drug Addiction and Europol.[180]

153. The Council agreed, and included this passage verbatim in the Stockholm Programme which was adopted by the European Council on 10–11 December 2009.[181] Four months later the Commission, in its Action Plan implementing the Stockholm Programme, included as one of the Actions: "Evaluation of the current EU Strategy on Drugs and EU Drugs Action Plan … and renewal of the Strategy and Action Plan".[182]

154. The current Strategy has proved helpful in encouraging countries to develop and revise their own national strategies, especially the newer Member States. We believe that there should continue to be an EU Drugs Strategy, albeit rather different from the current one.

155. **We do not share the view that a Drugs Strategy is of no value. We agree with the views of the Council, and concur in the views previously expressed by the Commission, that there should be a new Drugs Strategy 2013–2020. In formulating its action plans, the Commission needs the guidance of the Member States in showing the direction in which they wish to move.**

The Communication of October 2011

156. On 25 October 2011 the Commission published a Communication "Towards a stronger European response to drugs".[183] It seems to be influenced by the

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177 Q 209

178 Q 227

179 The five-year programme of Justice and Home Affairs work for 2010–2014

180 COM(2009)262 final, 10 June 2009, paragraph 4.3.1

181 OJ C115 of 4 May 2010, page 24, paragraph 4.4.6

182 Communication of 20 April 2010, COM(2010)171 final, Annex, page 39. By then Vice-President Reding was the Commissioner for Justice.

183 COM(2011)689 final of 25 October 2011

fact that the Treaty of Lisbon is now in force. The press release said: "With the Lisbon Treaty now in place, the EU has new tools to address the drugs scourge", and the Communication itself states as much.

BOX 9

New powers under the Lisbon Treaty?

The Lisbon Treaty defines drug trafficking as one of the "*particularly serious crimes with a cross border dimension*", which justify the adoption of directives establishing minimum rules concerning the definition of criminal offences and sanctions. This is a major step forward that will make it possible for the EU to provide a *bolder response*, with stronger involvement of the European Parliament and of national Parliaments.[184]

157. The Director of Europol told us: "… establishing minimum rules concerning the definition of criminal offences in this area and sanctions is a particular capability that has been established in the new Lisbon Treaty under Article 83, and particularly in the field of illicit drug trafficking; we could establish this to ensure that there is a minimum level of effective deterrents to combat drug trafficking."[185]

158. The view that, following the entry into force of the Treaty of Lisbon, the EU has acquired "new tools to address the drugs scourge" is not one which we share. There are certainly procedural differences which may make it easier for legislation to be adopted. The collapsing of the first and third pillars means that legislation will now be by Directive made jointly by the Parliament and Council, and with QMV, rather than by a Framework Decision requiring unanimity, with only consultation of the Parliament. A Directive, unlike a Framework Decision, is justiciable by the European Court of Justice, and its implementation is potentially subject to infraction proceedings brought by the Commission. But as to the content of the measure, if what the Justice Commissioner means by a "bolder response" is that the EU can now include provisions in legislation which it could not previously include, we do not see that this is in fact the case. The substantive powers to legislate under Article 83 TFEU are no greater than those under Article 31 TEU. We note that any Directive adopted under Article 83 TFEU will not apply to the United Kingdom unless the Government opts in.

159. The Conclusion of the Communication states that the Commission will present the following proposals for legislation:

BOX 10

Commission proposals for legislation, October 2011

The Commission will present as legislative proposals:

(1) A legislative package on drugs, proposing the revision of the Council Framework Decision on drug trafficking and the Council Decision on new psychoactive substances;
(2) Legislative proposals on drug precursors;
(3) Legislative proposals on the confiscation and recovery of criminal assets and on strengthening mutual recognition of freezing and confiscation orders;
(4) New legislative measures to combat money laundering.

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[184] Ibid. page 4. The italicised passages are also in bold type in the original.

[185] Q 119

160. For the reasons we have given in Chapter 4, which to some extent are the reasons in the Commission's own reports, we do not believe that revision of the Framework Decision on drug trafficking or of the Decision on new psychoactive substances is likely to bring much added value to the EU or its Member States. Legislative proposals on drug precursors and on money laundering are already commitments in the Stockholm Action Plan.[186] We hope proposals will be brought forward on the confiscation and recovery of criminal assets since such measures could have real value.

161. The timing of the Communication too is not easy to understand, given that the external evaluation of the 2005–2012 Strategy which the Commission had commissioned had not yet been completed, but was expected by the Commission to be completed within two months.[187] The current Drugs Action Plan then still had over a year to run. By setting out then a list of actions planned over the following years, the Communication almost seems to be aimed at denying the need for a new Strategy and pre-empting a new Action Plan.

162. **We question whether the October 2011 Communication, which does little more than repeat the intention of the Commission to bring forward at a later date legislation which has already been announced, was well timed.**

163. **In particular, for the reasons we have given, which include the reasons in the Commission's own evaluations, we are not convinced that there is any benefit to be gained from new legislation on drug trafficking or on new psychoactive substances.**

Informed public debate

164. In the introduction to this report, and again in giving our views on harm reduction and decriminalisation in Chapter 5, we stressed that any decisions on drugs strategy at national or international level should be preceded by an informed public debate and should draw upon practical experience. We have been struck by the paucity and poverty of public debate on these issues both in the United Kingdom and more widely. Views are often expressed with a totally inadequate understanding of the underlying evidence. Like the minister, we believe there is prejudice.[188] We stress again that a sensible debate on decriminalisation must start with a proper definition of exactly what is in issue.

165. The press have an important part to play, and have a duty to be objective and to base their views on the evidence. Some organs of the United Kingdom press are notoriously lacking in objectivity, and this is probably damaging not just the chances of drug addicts conquering their addiction, but also indirectly the constituency for whom they write. Baroness Meacher singled out the Daily Mail; Lord Mancroft told us that it had behaved "grossly irresponsibly".[189]

166. **We believe that the formulation and adoption of a new Drugs Strategy by the EU offers a golden opportunity to widen the public debate, to consider as dispassionately as possible the different policies and**

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[186] Communication of 20 April 2010, COM(2010)171 final, Annex, pages 38 and 39

[187] COM(2011)689 final of 25 October 2011, page 2, footnote 5

[188] Q 318

[189] Q 202