Evidence submitted by the Criminal Justice Alliance (DRU0090)

Response to the Home Affairs Select Committee's Drugs Inquiry

February2022

Introduction

1. The Criminal Justice Alliance (CJA) is a network of over 180 organisations working towards a fair and effective criminal justice system. Many of our member organisations deliver frontline drug treatment services and develop evidence-based approaches to drug policy reform. Our members also work on drug-related issues, such as stop and search, child criminal exploitation and county lines.

2. We welcome the opportunity to respond to the Home Affairs Select Committee's drugs inquiry. Our response draws on roundtables and discussions with 14 CJA members during March 2022 regarding the inquiry's terms of reference. It also draws on a CJA Members Meeting with Dame Carol Black regarding her Independent Review of Drugs, held in June 2021, in partnership with Transform Drug Policy Foundation.[1]

3. Some of the members we consulted with included: Anglia Care Trust, Catch 22, Centre for Justice Innovation, Cranstoun, Druglink, Fresh Youth Perspectives, Humankind, Transform Drug Policy Foundation, Release, Revolving Doors Agency (RDA), UNJUST and We Are With You. We also spoke to members of RDA's National Expert Citizen's Group who have lived experience of multiple disadvantages, including drug and alcohol dependency.[2]

The UK drug framework

How effective is the UK drug framework in today's society?

4. Drug use is primarily a public health matter that is often made worse by a criminal justice approach, as set out in the Misuse of Drugs Act 1971 (referred to as 'the MDA'). The MDA established criminal offences for a range of activities including possession, supply and production of specified controlled drugs, in order to reduce drug availability, drug use and drug-related harms. Extensive financial and police resources have been directed towards enforcing the MDA.

5. Despite these enforcement efforts, drugs have become cheaper, more available and increased in purity under the MDA. The UK's illegal drug market and related-crime have increased, and the illegal drug trade is now worth an estimated £9.4 billion a year.[3] Levels of drug use have risen dramatically in the UK and are the highest of any country in Western Europe.[4] Similarly, drug deaths have increased dramatically under the MDA and have reached an all-time high: the UK drug-related death rate is 4.5 times the EU average. The

> failings of the MDA have been well established by independent reviews: science, justice, health and culture Select Committees; national and international health organisations; and expert NGOs, among others.[5]

6. Enforcement efforts are often ineffective, counterproductive and disproportionately impact on Black, Asian and minority ethnic communities. Dame Carol Black found in her Independent

Review of Drugs that even if enforcement agencies were given more resources, 'it is not clear that they would be able to bring about a sustained reduction in drug supply.' Black also stated that enforcement activity can have unintended and negative consequences, such as increasing levels of drug-related violence and involving more people in the criminal justice system.[6]

7. The proportion of stops and searches targeting drug offences in England and Wales is increasing, despite a very small number leading to arrest. Analysis from CJA member Transform Drugs Policy Foundation shows that the proportion of overall stop and searches that are drug-related have doubled from one-third in 2000, to nearly two-thirds in 2020 and only 10 percent of these stop and searches have led to an arrest as most are for minor possession offences.[7] Black, Asian and minority ethnic groups, particularly young Black men, have long experienced disproportionate levels of drug-related stop and search, arrest and prosecution. Research from CJA member Release has shown how the current drug laws drive racial disparities in policing.[8] For example, Black people in England and Wales constitute 16 percent of all stops and searches for drugs in 2019/20, despite making up only 3 percent of the population and levels of drug use being similar to or less than white people's usage. According to recent government data, Black people are ten times more likely than white people to be sent to prison for a first-time drug possession offence, mostly for possession of cannabis.[9]

8. Dame Carol Black's Independent Review of Drugs found that children and young adults have been swept into the supply of illicit drugs at an alarming rate, especially at the most violent end of the market. Evidence shows strong associations between children being drawn into county lines with child poverty, increasing numbers of children in care and school exclusions.[10] Members tell us that the current legal framework criminalises young adults for drug offences but does not sufficiently recognise them as victims of child criminal exploitation, who need to be effectively safeguarded. Although guidance on the National Referral Mechanism exists for criminal justice agencies, many young people involved in illegal drug markets will not meet the threshold for referral and safeguarding support.

9. Women and girls tend to be most involved in the lower levels of the illegal drug trade, but this is also where the greatest number of arrests occur. Many of these women and girls have often been coerced, intimidated or threatened, or have experienced sexual exploitation.[11]

10. Our members tell us that the UK drug legislation is now an active cause of the problem. Research shows the current framework makes drug use more unsafe, which leads to drug-related health issues and deaths. The risk of criminalisation is an obstacle to accessing treatment, particularly for young adults and the stigma of using drugs prevents access to evidence-based

drugs education. Some of our members reported to us that the harms caused by contact with the criminal justice system, and the impact criminalisation and imprisonment can have on life chances, outweigh any harms caused by drug use itself.

11. **We recommend responsibility for drugs policy is transferred from the Home Office to the Department of Health and Social Care (DHSC), as was 'strongly recommended' by the Health and Social Care Committee in 2019.12 A Minister for Drugs should be appointed to DHSC to lead on drug policy, with potential for cross departmental working with the Minister for Crime and Policing in the Home Office and Ministry of Justice.**

Does the current framework, or a particular aspect of the framework, need to be reformed? If so, how?

12. The MDA is 50 years old but has never been subject to a formal government evaluation or review: the terms of reference for Dame Carol Black's Independent Review of Drugs clearly stated that changes to the existing legislative framework would be 'out of scope'.[13] This is despite calls for a Royal Commission on Drugs and more recent demands by cross-party MPs for a full legislative review.[14]

13. As such, **we recommend the government commission Dame Carol Black to undertake a third part of her Independent Review of Drugs, which should focus on the potential for licensing, decriminalisation, legalisation, regulation and taxation of drugs in the UK. Her remit should specifically include the ability to make recommendations for legislative change.**[15] The terms of reference should also include how the government can move towards repairing the harms caused by disproportionate drug policing and enforcement, particularly on Black communities. Consideration should be given to social equity principles.[16]

14. In the short and medium term, we would suggest the government consider the following to lessen the harms of the MDA within the existing legal framework and to make national progress on our drug policy:
    - Establishing agreements and guidelines for police and judges to create a presumption to use drug diversion schemes and Community Sentence Treatment Requirements (CSTRs) wherever possible.
    - Increasing the use of licensing, including creating dedicated licensing schemes, and local agreements so that more harm reduction interventions (such as drug checking services) can operate with legal certainty.
    - Issue guidance to confirm that the operation of Overdose Prevention Centres (OPCs) is a decision for local police forces and local authorities who commission drug treatment services, which would allow pilot centres to run.
    - Consulting on the decriminalisation of the possession of all drugs, as part of the call for evidence to support phase three of Dame Carol Black's review. Both the Health and Social Care and the Scottish Affairs Select Committees have recommended that the decriminalisation of possession should be consulted on.[17] Decriminalisation is supported by

      the World Health Organisation, the Royal Society for Public Health, all 31 UN agencies and the UN Office on Drugs and Crime, among others.
      Internationally, several countries have adopted a non-criminal justice response to the possession of drugs for personal use.[18] In England and Wales, the Psychoactive Substances Act 2016 does not criminalise possession of some drugs.[19]
    - Introduce and pass regulations which would amend the MDA's jurisdiction, so that the devolved administrations are no longer restricted by it and can pilot harm reduction interventions.

15. In the longer term, we would suggest the government consider:
    - Reviewing the failings of the MDA and introducing a new legislative framework by implementing any evidence-based legislative change recommended by phase three of the Independent Review of Drugs. Any draft legislation is to be developed by the Department of Health and Social Care and the new legislative framework is to be introduced to parliament by the Secretary of State for Health.
    - Publishing a green paper and opening a public consultation which precedes any legislative change. The green paper should be actively promoted to people who use drugs. A robust Equality Impact Assessment (EIA) should also be consulted on and published prior to any legislative change.

UK drug policy

What is your view on the UK government's 10-year drug strategy for England and Wales, which was published in December 2021?

16. The government's 10-year drug strategy (referred to as 'the 10-year drug strategy') was broadly welcomed by many CJA members, particularly the funding for treatment services, although they were clear that this investment must be sustained.[20] Members also welcomed the acknowledgment that drug dependency is a complex issue that can be driven by social issues, such as poverty, mental health, housing, unemployment and domestic abuse and that a strategy which effectively enables recovery from drug dependency must encompass more than just treatment, but also addresses these issues.

17. Under the Equality Act 2010, government departments have an ongoing legal duty (the Public Sector Equality Duty – PSED) to assess any risks that proposed policies may have on those with protected characteristics, through an EIA. The EIA should also address how any equality issues identified will be effectively mitigated against. No EIA was published alongside the 10-year drug strategy. CJA have raised ongoing concerns about the government's lack of published EIAs and their 'lack of transparency and accountability' regarding their policy decisions.[21]

18. Some CJA members have criticised the 10-year drug strategy's continued focus on the enforcement of the MDA and the 'tough consequences' for people who use drugs, despite the evidence that this approach has limited effectiveness, and is counterproductive, in reducing drug availability, drug use and drug-related harms.[22]

19. CJA members also criticised the 10-year drug strategy's lack of endorsement of some evidence-based harm-reduction measures, including OPCs. Recent government strategies have mainly focused on abstinence treatment and recovery.[23] Members tell us that harm reduction services are a vital springboard to detoxification and abstinence, and research supports this. In addition, if people detox, harm reduction support still needs to be available when they finish abstinence-based treatments, as people can lose their tolerance for some drugs. This could put people at greater risk of dying if they start to use drugs again unsafely.[24] Members also told us that thresholds to access abstinence-based recovery programmes are often too high, as people need to have stopped using drugs for several weeks to be eligible.

20. A wide, evidence-based range of drug treatment, services and education is needed to provide appropriate care for people who are dependent on drugs. Therefore, **we recommend local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population, in line with national clinical guidelines and commissioning standards.** This was also recommended by Dame Carol Black.[25]

21. CJA members welcomed the 10-year drug strategy's mention of CSTRs, drug diversion schemes, drug courts and the role of naloxone in preventing drug- related deaths. However, the government can go further in these areas and do more to promote good practice, and to support national co-ordination and oversight of these initiatives in order to address the significant variation of support across the UK.[26]

Community Sentence Treatment Requirements

22. In England and Wales, drug and alcohol testing and treatments can be ordered by the courts through CSTRs, which include the Drug Rehabilitation Requirement (DRRs) and the Alcohol Treatment Requirement. CSTRs can be given to adults convicted of an offence which would warrant a non-custodial sentence, who also have a drug or alcohol dependency and require treatment.[27]

23. There is substantial evidence that court-ordered drug treatment and testing for people who are drug dependent can be effective at reducing re- offending.[28] Despite this evidence, treatment requirements are rarely used and treatment services have degraded. The latest government statistics show that, on average, both drug treatment and alcohol treatment requirements were part of only 3 percent of suspended sentence and community orders between July 2020–21.[29]

24. It is therefore welcome to see the 10-year drug strategy committing to increasing the use of DRRs.[30] To effectively widen the use of CSTRs, including DRRs, the government need to address the barriers identified in the evaluation of the new CSTR protocol, such as increasing judicial confidence and treatment capacity, which were both issues also raised by CJA members in our recent roundtables.[31]

25. The judiciary being aware of and having confidence in CSTRs is vital to them being used. For example, previous training for the judiciary on Mental Health Treatment Requirements (MHTRs) was found to increase their use.[32] However, this training was not centrally funded or provided, and only delivered on an ad-hoc basis. Effective judicial training requires adequate and sustained funding. In the CSTR evaluation, the judiciary felt that 'there should be proper resources put in place [for training] so that the judiciary is properly supported'.[33] Members told us that the judiciary also need to better understand the realities of people who are drug dependent and their engagement in treatment programmes; people can be referred to treatment several times before they choose to accept treatment.

26. The 10-year drug strategy commits to providing specialist drug workers who will improve sentencers' confidence in treatment requirements, as treatment will be available. However, during the CSTR evaluation, every site reported that unsustainable funding was a major challenge and one site stated that they would have to stop accepting new CSTR patients due to a lack of funds. One CJA member described how a person with drug dependency received a treatment requirement, but as no treatment was available at that current time, they reoffended. When the availability and quality of local drug treatment services are questionable, the judiciary will use custodial sentences.[34] The planned increase in CSTR use needs to be met with increased funding to make sure there is treatment available.

27. **We recommend the government expand the availability of high quality CSTRs, including DRRs, so they are available for judges in every court across England and Wales by 2024.**[35] To make sure the increase in availability of DRRs is successful, **we recommend the government provide dedicated resources to train and support the judiciary on using CSTRs.**

Drug courts

28. Drug courts – also known as substance misuse courts – deliver tailored community sentences to reduce the drug use of people who are dependent and their complex, repeat offending that is driven by drug dependency. The judge and court staff work together with drug treatment staff and other agencies to change their behaviour and hold them accountable through regular and consistent judicial monitoring, and sanctions and incentives.[36] There is strong evidence that adult drug courts reduce drug and alcohol dependency and reoffending,

compared with other forms of probation or traditional court processes. Research shows drug courts are particularly effective with those who present a 'high risk' of reoffending.[37]

29. We welcome the government's restated commitment to piloting drug courts in the 10-year drug strategy. However, the strategy states that following legislative changes in the Police, Crime, Sentencing and Courts Bill, judges who sit in drug courts will be given the ability to order drug testing of any person whose offending is related to their use of drugs, whether they agree or not. If they test positive for drugs, they may be in breach of their order and the judge can then impose a custodial sentence.[38]

30. However, evidence from drug courts shows that there does not seem to be a link between more severe sanctions and improved outcomes.[39] In fact, international good practice increasingly shows the power of incentives and non-custodial sanctions to improve compliance and avoid the use of custody as it undermines desistance and interrupts contact with important multi-agency and rehabilitative services.[40] As well as limiting the effectiveness of treatment, concerns have been raised regarding court-mandated and compulsory treatment programmes as punishment for people who are drug dependent, as coercion is medically unethical.[41] CJA member Centre for Justice Innovation has highlighted how judges can use rewards to improve compliance. For example, the importance of judges and practitioners, such as drug misuse specialists, recognising and acknowledging people's progress and achievements through ceremonies, which can motivate people.[42]

31. **We recommend this provision is repealed.** If this provision is passed, **we recommend guidance for judges is clear that custody is only used as a sanction in exceptional circumstances.** The government should follow good practice principles for drug courts and the wide range of incentives they can offer, in order for them to be as effective as possible at reducing drug dependency and repeat drug-related-offending.

Drug diversion schemes

32. Drug diversion schemes are police-led programmes, where people caught committing minor drug offences – such as the possession of illegal drugs for personal use, or minor supply offences – are referred to drug treatment programmes or awareness courses, instead of being arrested, prosecuted or formally cautioned, avoiding a criminal record.[43]

33. Drug diversion schemes are already in place in over ten UK police authorities. Evidence shows that diversion schemes can lead to reduced re-offending and arrest rates, while connecting those who are drug dependent with treatment services. For example:

- Durham Constabulary divert people found in possession of illegal drugs and low-level supply offences at the point of arrest through their Checkpoint scheme. As part of Checkpoint, police offer eligible individuals a four-month 'contract' as an alternative to prosecution if they engage with partner agencies who deliver tailored services and agree to not reoffend during that time.[44] A pilot evaluation showed that those who were diverted had a lower re-arrest rate compared to those who had received other out-of-court disposals and their reoffending rate reduced by 10.3 percent.[45]
- Thames Valley Police operated a Drugs Diversion Pilot (DDP) for people caught in possession of any illegal drug. This scheme refers people to a voluntary assessment with treatment services which can lead to further referrals to a range of treatment options. Of those who engaged with the drug service provider through DDP, all underwent an initial assessment and 92 percent undertook following treatment sessions. Some reported being drug-free three months later.[46]

34. Police forces across the UK have developed different approaches and there is no national co-ordination or oversight of diversion schemes. Although the

government's recent sentencing white paper announced a commitment to an increased use of police diversion schemes as alternatives to custody, these schemes are only briefly mentioned in the 10-year-drugs strategy. **We recommend that drug diversion schemes should be expanded to every police force across the UK as part of a nationally co-ordinated approach, which considers good practice principles and learning from more established diversion schemes.**[47] Expanding diversion schemes has previously been recommended by Dame Carol Black, the Health and Social Care Committee and the Advisory Committee on the Misuse of Drugs (ACMD), among others.[48]

35. **We support The Strategic Review of Policing 2022 recommendation that where a stop and search leads to a drug find, and a charge of possession would otherwise be made, that people are consistently diverted toward an intervention outside of the criminal justice system rather than being prosecuted.**[49]

36. **We recommend the government provides sustained investment so local treatment services can accommodate people who are being diverted through DRRs, drug courts and drug diversion schemes. The government should reallocate funding earmarked for prison expansion to fund these services.**

Naloxone programmes

37. Naloxone is an emergency drug that reverses the effects of an opioid overdose. Despite its life-saving benefits, members tell us the supply and distribution of naloxone to people who use drugs is inconsistent, and it is not routinely carried by the police or emergency services. However, there is some good practice:
    - Durham Police frontline officers have been trained in administering naloxone. Officers also administer naloxone to people in police custody who are experiencing an opiate overdose, as well as distributing it to people being released.[50]
    - Similarly, West Midlands police have trained officers to administer naloxone, which they now carry.[51]

38. We welcome the government's commitment to review legislation to make naloxone more easily available to people who use drugs and are at-risk of overdose and supplying naloxone to more frontline workers, such as prison staff.[52] **We recommend the government introduce a national naloxone programme in England to end the variation in provision, which would bring England in line with Wales, Scotland and Northern Ireland.** This has also been recommended by the London Assembly Health Committee which recently investigated the use of naloxone.[53]

National good practice and international comparisons

Are there particular policies at national or local level across the four UK nations that have been effective in reducing drug use, drug related deaths, and/or drug related offending?

Are there laws, policies or approaches adopted in other countries that have been effective in reducing drug use, drug related deaths, and/or drug related offending? If so, could they reasonably be expected to work in the UK?

39. There are pockets of good practice across the UK which are tailored to address local challenges. However, these good practice principles are often not replicated, scaled up and rolled out at a national scale.

A presumption against short custodial sentences

40. Over one-third of people in prison are there due to crimes relating to drug use, and most are serving short sentences for acquisitive crimes related to their drug dependency, largely for theft. CJA member Revolving Doors Agency has found that three in five people who receive custodial sentences of less than six months report having a drug or alcohol dependency on arrival at prison.[54] There is strong evidence suggesting that short sentences are not effective at reducing reoffending or addressing the causes of crime, particularly when drug dependency is the cause. Due to their short sentences, people in prison who are drug dependent spend little time in treatment; many people only receive treatment for two weeks or less.[55]

41. Scotland introduced a presumption against short custodial sentences of less than three months in 2011, which has recently been increased to sentences of up to 12 months, in order to reduce prison 'churn' and increase the use of community sentences.[56] **We recommend the government introduce a presumption against the use of short custodial sentences of less than six months, with a view to increasing this to 12 months.**

Overdose prevention centres

42. Overdose prevention centres (OPCs) – also known as drug consumption rooms or safe injecting facilities – are professionally supervised healthcare facilities, where people can consume their own drugs in a safe environment and access clean equipment and medical support.[57] OPCs aim to prevent drug-related overdose deaths as staff can respond immediately, reduce the transmission of diseases through unhygienic injecting, and connect drug users with treatment and other healthcare services.[58] There are currently around 200 OPCs in operation across 14 countries.

43. Research shows that internationally, OPCs have helped to reduce overdose deaths, unsafe injecting behaviour, such as needle-sharing, and the transmission of blood-borne viruses, such as HIV and hepatitis.[59] Evidence also shows that OPCs increase the number of people entering treatment and help to reach people with drug dependency in marginalised groups, who may not access medical support or healthcare in other ways.

44. As such, there is significant support for piloting OPCs in the UK from many health bodies, parliamentary select committees, cross-party MPs, the government's drug advisors and a broad range of third sector organisations, including several CJA members. For example, the ACMD recommended the introduction of OPCs in areas with a high concentration of people who inject

drugs.[60] More recently, the London Assembly Health Committee, the House of Commons Health and Social Care and the Scottish Affairs Committees have recommended piloting OPCs.[61]

45. There is currently no legal framework for the provision of OPCs in the UK and there are no plans to introduce them.[62] Under the current legal framework, OPCs would be illegal as they would breach provisions in the MDA.[63] However, potential criminal offences under the MDA are already managed in relation to other drug treatment interventions, such as needle exchange programmes where people can access sterile injecting equipment. The view of the Crown Prosecution Service is that those who access and run needle exchange programmes 'necessarily' commit offences under the MDA, and that the public health grounds, such as preventing the transmission of disease, override the need for a prosecution. The government has also just committed to expanding needle exchange programmes in their 10-year drug strategy.[64] As CJA member Release have stated, the current law is not an 'insurmountable' barrier to establishing an OPC.[65]

46. The government have previously claimed that OPCs would encourage drug use. Numerous reviews, including by the European Monitoring Centre on Drugs and Drug Addiction and the ACMD, have found that internationally, OPCs have not increased injecting drug use or local crime rates. **We recommend the government pilot drug consumption rooms, and if successful, amend legislation to allow the introduction of OPCs in areas of high injecting drug-use and drug-related deaths across the UK.** Work has already been done to set out what an OPC could look like in the UK, including by CJA members.[66]

Opioid treatment programmes

47. People who have become dependent on opioids often struggle to stop using them without taking a prescribed medication containing an opioid. Opioid substitution treatment (OST), or opioid agonist therapy, is the globally recognised way to reduce risks of drug deaths. Evidence shows that OST is effective at retaining clients, reducing use of street heroin, reducing offending and reducing the transmission of viruses and death; the UK's clinical guidelines for managing drug misuse acknowledges the well-established evidence base for OST.[67] Despite this evidence, funding for OST and Heroin Assisted Treatment (HAT) has been substantially cut, and services have been 'rationed'.[68]

48. HAT is where dependent users can be prescribed diamorphine (medical heroin) for self-administered use in a clinical setting under medical supervision and where they can access other healthcare agencies and social services. HAT is usually used for people who have not responded successfully to any other medication in OST. Evidence shows that it has successfully reduced fatal overdoses, transmission of diseases such as HIV and hepatitis, acquisitive crime and demand for illegal heroin, while increasing take-up and retention in drug treatment.[69] These findings have been widely reproduced in UK and international HAT trials.[70]

- The HAT programme in Middlesbrough (which had the highest rate of opiate use in England) is for people with long-term dependency on

  heroin. It aims to reduce reoffending and tackle problems linked to sustained drug dependency.[71] Participants reported that their use of illegal opioids had reduced by almost 98 percent and overall substance use had decreased by 48 percent.[72] There was a vast improvement in their psychological and physical health, and overall quality of life.[73]

We recommend that adequate funding be provided to support heroin-assisted treatment for people who have not had success with other drug treatments, as previously recommended by the ACMD.[74]

Drug safety testing and drug checking services

49. Drug checking services allow people to voluntarily submit a sample of their drugs for testing without fear of arrest. These tests provide information regarding the chemical make-up of their drugs, including what it contains, any adulterants, and its purity.[75] This is especially important when unprecedented purity levels in certain drugs are contributing to rises in drug- related deaths. Drug checking also provides emergency services with useful intelligence on local drug markets.[76]

50. Research has shown that drug checking services reduce drug use, drug poisoning and overdose. They increase people's contact with health services and the likelihood that people will discard of unsafe drugs. There is minimal evidence that drug checking leads people to buy more drugs or take larger doses after using the service.[77]

- WEDINOS is a drug checking project in Wales that allows people to submit a drug sample
  anonymously for testing. Results and legal information are then made available online.[78]
- The Loop's Multi Agency Safety Testing (MAST) is a drug safety testing service where people can submit drugs for analysis. Their results are made available as part of a confidential, individually tailored 'harm reduction package' delivered by experienced practitioners.[79] Evidence suggests there is a 10 to 25 percent reduction in drug-related harm when The Loop operates at festivals, and there have been no drug- related deaths.[80]

51. There is significant support for drug checking services in the UK. Most recently, the Health and Social Care Committee concluded that the strength of the evidence for drug checking was strong and some drug checking services have been endorsed by numerous police forces. The Digital, Culture, Media and Sport Select Committee, the London Assembly Health Committee, the Royal Society for Public Health, DrugWise and several CJA members have all recommended that drug checking services be rolled out across the UK.[81]

52. The government's position on drug checking nationally appears to be mixed and there is a lack of clarity in both the legal and licensing framework. Drug checking services that wish to legally operate can already apply for a Home Office license. However, this expensive licensing process is often unsuitable for drug checking services, as the license only covers the checking and not the handling of controlled substances and it is for fixed, not mobile sites (most festival drug checking services are mobile).

53. Most drug checking services can only operate with the agreement of local police.[82] In New Zealand, a dedicated licensing scheme for drug checking services has been created.[83] While the scheme was set-up, the New Zealand Misuse of Drugs Act 1975 was temporarily amended to allow drug checking services to operate legally.[84] The government have stated that they are unable to support the use of drug checking until further assessments into 'the potential unintended consequences' are carried out. However, the Home Office have also stated that they are 'not standing in [chief constables'] way' to make local operational decisions regarding drug testing.[85]

54. **We recommend the government establish a dedicated licensing scheme for drug checking services, which sets out a clear legal framework and minimum operating standards, in order for them to be rolled out across the UK.** This framework should follow international examples and be drawn up in consultation with drug testing services to replicate good practice.

The views expressed in this response are not necessarily those of any individual CJA member or funder.

March 2022

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