

SETTING UP A DRUG CONSUMPTION ROOM

LEGAL ISSUES

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This paper revises and assimilates two papers (Paper E and Paper F) written by the author and published in 2006 by the Joseph Rowntree Foundation as part of the work of the Independent Working Group on Drug Consumption Rooms, chaired by Dame Ruth Runciman (Report, 23rd May 2006²).

The law is stated as at October 2017.

NOTE: This document is intended only for guidance and discussion. Anyone contemplating setting up a Drug Consumption Room should first seek independent professional legal advice.

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² <https://www.jrf.org.uk/report/drug-consumption-rooms-summary-report-independent-working-group>

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Abstract

The aim of a professionally run Drug Consumption Room (DCR) is to reduce harms associated with non-medicinal drug-taking. Drug users self-administer, on-site, illicitly obtained drug substances (e.g. heroin and cocaine) under competent medical and healthcare supervision. Many such facilities exist across Europe and elsewhere but not, yet, in the United Kingdom. Given that the overarching aim of the three main UN drug Conventions is the health and welfare of human beings, the operation of a DCR is consistent with the UNCs providing that it aims at “effectively reducing the negative consequences of drug abuse and lead to treatment and rehabilitation, without condoning or encouraging drug abuse and drug trafficking.”³

However, in establishing a DCR in the UK, a number of legal issues need to be considered and addressed, including, (a) the simple possession of the drug in question (e.g. traces on paraphernalia or drugs that are abandoned), (b) assisting or facilitating the drug-user’s continued possession of the drug, (c) the conundrum of whether acts of drug preparation by the user constitute the “production” of the drug, (d) whether the occupier/manager of a DCR permits or suffers (with knowledge) the user to “produce” the drug on the premises and, (e) anti-smoking laws.

Such issues can be addressed by legislation (the ideal option) or by way of a multi-agency approach (including service design) by which police, prosecutorial, and administrative discretion is sensibly and pragmatically exercised in the interests of personal and public health and welfare. There is no absolute discretion in an authority charged with enforcing the law and there could be circumstances in which the legality of a DCR might be challenged. However, the courts will not lightly interfere with the exercise of discretion that was reasonable and rational. Alternatively, it would be open to stakeholders of a multi-agency DCR (in any part of the UK) to be signatories to a document – whether styled a ‘protocol’, ‘terms of engagement’, or a ‘comfort letter’ - with regards to the establishment and running of a DCR.

Introduction and background

This paper considers a number of legal issues that might arise were premises to be established in the United Kingdom⁴ that enable persons to self-administer, on-site, illicitly obtained drug substances (notably, heroin) under professional medical and healthcare supervision. The ‘service model’ is – as the EMCDDA points out – to attract “hard-to-reach populations of users, especially marginalised groups and those who use on the streets or in other risky and unhygienic conditions”:⁵

One of their primary goals is to reduce morbidity and mortality by providing a safe environment for more hygienic use and by training clients in safer use. At the same time, they seek to reduce drug use in public and improve public amenity in areas surrounding urban drug markets. A further aim is to promote access to social, health and drug treatment facilities.⁶

³ UNIS/NAR/1311, 2 March 2017: <http://www.unis.unvienna.org/unis/en/pressrels/2017/unisnar1311.html>

⁴ The legal system of England, Wales, and Northern Ireland differs from the system in Scotland. However, the Misuse of Drugs Act 1971 applies in each part of the UK.

⁵ See the paper by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA): “*Perspectives on Drugs: Drug consumption rooms: an overview of provision and evidence*”, 2017 (updated).

http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf_en

⁶ EMCDDA: “*Perspectives on Drugs: Drug consumption rooms: an overview of provision and evidence*”, 2017 (updated).

Such premises/sites are variously styled ‘drug consumption rooms’, ‘drug injection rooms’, ‘safe injecting centres’, ‘supervised consumption sites’, ‘Supervised Injecting Sites’ and ‘safe injecting facilities’. For convenience, this paper will refer to these facilities as ‘drug consumption rooms’ (DCRs).

This paper is *not* concerned with ‘shooting galleries’ where users pay to inject on-site. The use of premises for such purposes, and the actions taking place there, are unsanctioned by any national or local government body or agency, and medical supervision is slight to non-existent.

The first medically supervised DCR was opened in Bern in 1986⁷ by *Contact Netz*⁸ (a drug relief organisation). Initially, its existence was not officially sanctioned. It sought to address the deteriorating health of Swiss drug users.⁹ In the late-1980s, the rapidly expanding open drug scene in *Platzspitz* (a central park in Zurich) became increasingly problematic and a risk to public health as well as to the users (e.g. by reason of contaminated drug ‘litter’).¹⁰ Although the majority of local agencies were initially reluctant to support such a facility, the profound impact of the HIV epidemic on Swiss drug users and concerns around public nuisance, brought about a striking change in attitude.¹¹ Given that the provision of syringes for drug users was prohibited, various local authorities revoked the ban and devised new regulations allowing for the creation of DCRs.¹² Following extensive consultation and a legal assessment (commissioned by the Swiss Federal Office for Public Health) it was concluded that the establishment of state-controlled DCRs would not violate the Swiss drugs policy *provided that* the DCRs maintained hygienic conditions and provided medical supervision when in operation.¹³ The DCRs were classed as medical institutions and therefore exempted from police intervention.¹⁴ The first *official* DCR in Switzerland was tolerated in July 1988¹⁵ in order to reach addicted and long-term users.¹⁶ Other DCRs emerged “to provide an alternative space where addicts could use drugs”.¹⁷

The 2017 EMCDDA paper reports that a total of 78 drug consumption facilities currently operate in seven EMCDDA reporting countries.¹⁸ Twelve such facilities exist in Switzerland, 31 in the Netherlands, 24 in Germany,¹⁹ 5 in Denmark,²⁰ 13 in Spain, 2 in Norway, 2 in

⁷ European Harm Reduction Network, *op.cit.*, (2014), p.4.

⁸ International Network of Drug Consumption Rooms, *Switzerland Overview*, (Amsterdam: Regenboog Groep, 2015). <http://www.drugconsumptionroom-international.org/index.php/locations/2015-09-27-13-40-35/location-switzerland>

⁹ “The professional acceptance of drug use: a closer look at drug consumption rooms in the Netherlands, Germany and Switzerland”; Wouter De Jong, Urban Weber (1999); *International Journal of Drug Policy* 10 (1999) 99–108.

¹⁰ Hedrich, Dagmar., EMCDDA (2004), p.22. The open drug scene was dismantled up by the police in late-1992 and six DCRs had been established in order to provide an alternative space for addicts.

¹¹ “The professional acceptance of drug use: a closer look at drug consumption rooms in the Netherlands, Germany and Switzerland”; Wouter De Jong, Urban Weber (1999); *International Journal of Drug Policy* 10 (1999) 99–108.

¹² “The professional acceptance of drug use: a closer look at drug consumption rooms in the Netherlands, Germany and Switzerland”; Wouter De Jong, Urban Weber (1999); *International Journal of Drug Policy* 10 (1999) 99–108.

¹³ Hedrich, Dagmar., EMCDDA., (2004), p.15.

¹⁴ Hedrich, Dagmar., EMCDDA., (2004).

¹⁵ Hedrich, Dagmar., EMCDDA., (2004), p.15 (citing Hämmig, R.B. (1992b) “Overseas experience: Switzerland”. In: Fox, R.J. and Mathews, I. (eds) *Drugs Policy. Fact, Fiction, and the Future*. Annandale, NSW: The Federation Press, pp. 206–209.

¹⁶ Hedrich, Dagmar., EMCDDA., (2004), p.9.

¹⁷ Hedrich, Dagmar., EMCDDA., (2004), p.22.

¹⁸ EMCDDA: “*Perspectives on Drugs: Drug consumption rooms: an overview of provision and evidence*”, 2017 (updated).

¹⁹ One paper reports that (as of July 2011) there were, “25 drug consumption rooms operating in 16 cities and six German states (Berlin, Hamburg, Hesse, Lower Saxony, North Rhine-Westphalia and the Saarland). While Hamburg operates five and Frankfurt am Main four drug consumption rooms, many other cities have to manage with fewer facilities and also with considerably restricted opening hours. As such, two ambulatory consumption rooms each are operated in Berlin and Cologne. All of the other cities such as Aachen, Bielefeld, Bochum, Bonn, Dortmund,

France, and 1 in Luxembourg (with another planned).²¹ Sydney (Australia) operates a “Medically Supervised Injecting Centre” (MSIC).²² *Health Canada*²³ has published a list of currently active DCRs operating in that country.²⁴ An unsanctioned “Supervised Injection Site” exists in the United States of America (at the time of writing), but its legal status appears to be unclear.²⁵ A useful ‘briefing paper’ has been published by the *International Drug Policy Consortium* (2012) that provides a “world overview” of drug consumption rooms.²⁶

The UK stance on DCRs

The foregoing is in marked contrast to the position in the UK that has - to date - no such facilities. Despite a BBC report that the “green light” was given to operate “self-injection rooms” in Glasgow,²⁷ no such facility was in existence by September 2017.

In 2012, the *Safe in the City Partnership* (Brighton and Hove, England) responded to a proposal from the local MP, Caroline Lucas, to set up an ‘Independent Drugs Commission’ to look at the current state of drug problems in the city, “and the various efforts to address them”. The aim was “...to suggest ways in which the local agencies could be more successful in reducing the drug related problems that mattered to the citizens of Brighton and Hove”.²⁸ The Commission concluded that it was important “that local drug services provide facilities that encourage use in safer ways, and where things do go wrong, to provide emergency medical help”. The Commission recommended that the *Health and Wellbeing Board* and the *Safe in the City Partnership* should convene a working group led by the local authority, NHS and Police, “to explore and make recommendations about the feasibility of establishing a form of consumption room as part of the range of drug treatment services in the city”.²⁹

However, in June 2014, the *Board* concluded that it was not feasible, at that time, to

Dusseldorf, Essen, Hannover, Münster, Saarbrücken Troisdorf and Wuppertal are limited to one drug consumption room each”: *Drug Consumption Rooms in Germany A Situational Assessment* by the AK Konsumraum, Deutsche AIDS-Hilfe e.V., September 2011.

²⁰ “A qualitative study of how Danish drug consumption rooms influence health and well-being among people who use drugs” Nanna Kappel, Eva Toth, Jette Tegner, and Sigurd Lauridsen; *Harm Reduction Journal* (2016).

²¹ EMCDDA: “*Perspectives on Drugs: Drug consumption rooms: an overview of provision and evidence*”, 2017 (updated).

²² <http://www.drugconsumptionroom-international.org/index.php/locations/australia2/australia-overview>

²³ *Health Canada* has approved 3 facilities in Toronto, at least 2 in Vancouver, a mobile consumption site in Montreal, and it has approved 1 site in Ottawa. <http://www.cbc.ca/news/canada/ottawa/sandy-hill-injection-site-health-canada-1.4222710>

²⁴ <https://www.canada.ca/en/health-canada/services/substance-abuse/supervised-consumption-sites/status-application.html>

²⁵ “*Addressing the Nation’s Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.*”, Alex H. Kral, Peter J. Davidson, *American Journal of Preventive Medicine* (Am J Prev Med 2017); [http://www.ajpmonline.org/article/S0749-3797\(17\)30316-1/pdf](http://www.ajpmonline.org/article/S0749-3797(17)30316-1/pdf)

²⁶ “Drug consumption rooms Evidence and practice”, Eberhard Schatz and Marie Nougier (June 2012); http://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf

²⁷ <http://www.bbc.co.uk/news/uk-scotland-glasgow-west-37817622>

²⁸ Report of the Independent Drugs Commission for Brighton & Hove, April 2013.

²⁹ “These facilities are usually referred to as ‘consumption rooms’, which can be controversial, as they involve the toleration by health workers of the use of illegal drugs. The international evidence is clear that the provision of these facilities can significantly reduce overdose death rates, as well as the inconvenience associated with the use of drugs in public, whilst not increasing overall rates of drug use. The Commission believes that, where it is not possible to stop users from taking risks, it is better that they have access to safe, clean premises, rather than to administer drugs on the streets or in residential settings. The Safe in the City Partnership should consider initiating a feasibility process on how to incorporate the provision of consumption rooms into the existing range of drug treatment services in the city.”: Report of the Independent Drugs Commission for Brighton & Hove, April 2013, p.9

establish a DCR:³⁰

The evidence suggests that a DCR could meet the needs of some injecting drug users in Brighton and Hove. However, at the present time the overall need of the local community, not just injecting drug users, is not considered to be sufficient by local organisations to agree to support establishing a DCR. This includes the lack of support for a local accord (regarding the implementation of the law) which would be required to allow the DCR to operate. The discussions and work continue but currently the conclusion is that it is not feasible to establish a DCR.

The Board identified “the key legal issues which currently could prevent a drug consumption room from being established and what is required for a drug consumption room to operate within the law”:

- In October 2013 the Home Office stated: “The Government has no plans to allow drug consumption rooms, which [would break] laws whereby possession of controlled drugs is illegal.”
- The Association of Chief Police Officers (ACPO) is also clear on its position: “Recent evidence suggests that overall drug misuse in the UK is falling. Government policy on drugs enforcement is very clear and our job as police officers is to enforce the law. Drug Consumption Rooms or ‘Shooting Galleries’ as they are often referred to as are illegal in the UK. Such facilities would have the potential to impact on local communities as a whole, attracting drug users to one area and also create a hotspot for associated criminality and anti-social behaviour.”
- Sussex Police is currently in agreement with both the Home Office and ACPO positions and would not support a DCR where illicit drug use and supervision of drug use took place. Whilst the service supports officers to use their discretion when undertaking their duties, a principle equally applicable when considering how to reduce the harm caused by illegal drug use, there are a fundamental concerns around the proposal and rationale for introducing DCRs. These include: DCRs are unlawful; there is not a clear evidence base from elsewhere in the UK setting out the benefits of introducing DCRs in Brighton and Hove; there is insufficient evidence of community/public support for the introduction of DCRs in Brighton and Hove; there is the potential for an increase in crime and disorder/anti social behaviour in areas where DCRs are introduced not only impacting local residents and businesses but the wider community as neighbourhood policing resources are diverted from other areas of the city.

No analysis was provided in that document to support the sweeping statement by ACPO and by Sussex Police that “DCRs are unlawful” *per se* and it is a fundamental error to treat DCRs and so-called ‘shooting galleries’ as being the same thing: they are not.

However, certain actions that might be performed by a staff-member of a DCR³¹ could breach certain UK statutory laws giving rise to criminal liability (notably under the Misuse of Drugs Act 1971 (UK) or Part 2 of the Serious Crime Act 2007 [encouraging or assisting crime]). These statutory rules are considered later in this document.

In 2016, the Advisory Council on the Misuse of Drugs (ACMD), recommended that:³²

³⁰ [https://present.brighton-hove.gov.uk/Published/C00000826/M00005106/AI00039428/\\$20140606144942_005874_0024114_HWBBupdate10thJune2014.doc.pdf](https://present.brighton-hove.gov.uk/Published/C00000826/M00005106/AI00039428/$20140606144942_005874_0024114_HWBBupdate10thJune2014.doc.pdf)

³¹ Noting s.21 of the Misuse of Drugs Act 1971 (UK): “or committed with the consent or connivance of, or attributable to any neglect on the part of any director, manager, secretary or other similar officer of a body corporate, or any person purporting to act in any such capacity.”

³² ACMD, “*Reducing Opioid-related Deaths in the UK*”, 2016, para.5.5.18.

“...consideration be given – by the governments of each UK country and by local commissioners of drug treatment services – to the potential to reduce DRDs [drug related deaths] and other harms through the provision of medically-supervised drug consumption clinics in localities with a high concentration of injecting drug use.”

However, in 2017, the Government stated that it had “no plans to introduce drug consumption rooms” but, importantly, it added that “It is for local areas in the UK to consider, with those responsible for law enforcement, how best to deliver services to meet their local population needs”:³³

We are committed to taking action to prevent the harms caused by drug use and our approach remains clear: we must prevent drug use in our communities, help dependent individuals recover, while ensuring our drugs laws are enforced.

In the same document, the UK Government said that it recognised “the need for a range of treatment and other interventions that meet the needs of people who misuse drugs and help them recover from drug dependence”:

Drug consumption rooms were considered as part of the Home Office led International Comparators Study in 2014.³⁴ This concluded that there was:

“...some evidence for the effectiveness of drug consumption rooms in addressing the problems of public nuisance associated with open drug scenes, and in reducing health risks for drug users. Drug consumption rooms overseas have been controversial and legally problematic, and have been most successful where they have been a locally-led initiative to local problems.”

In October 2017, the respected journalist Mark Easton reported for BBC News that the Police and Crime commissioner for North Wales, Arfon Jones, had been working on plans to open a DCR in Wrexham (UK), “He had been impressed by the crime reduction credited to a DCR he visited in Geneva in Switzerland earlier this year”.³⁵ But when Mr Easton telephoned the Home Office for a response to the consumption room plans, “the tone and substance of their response was very different to the one they had given to the ACMD”:³⁶

"A range of offences are likely to be committed in the operation of drug consumption rooms. It is for local police forces to enforce the law in such circumstances and, as with other offences of this type, we would expect them to do so."

The stance taken by the UK Government is not as helpful as it ought to be. It has tones of a desire to ‘sit on the fence’ until such time as a person or body operates a DCR at their own risk, and then monitor outcomes. But, as we shall see, unless there is at least some declaration of support from the UK Government for the establishment of a DCR on the grounds of health and welfare, or legislative action, those who contemplate establishing a DCR will face resistance and exposure to the risk of a legal challenge to the legitimacy of a DCR programme.³⁷

³³ “Drug misuse and dependency: government responses to ACMD reports”, Appendix B, p.5, 2017.

³⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368489/DrugsInternationalComparators.pdf

³⁵ <http://www.bbc.co.uk/news/uk-41596222>

³⁶ <http://www.bbc.co.uk/news/uk-41596222>

³⁷ Consider the experience in New South Wales: *Kings Cross Chamber of Commerce and Tourism Inc v The Uniting Church of Australia Property Trust (NSW) and ors* [2001] NSWSC 245; *Spanswick v The Honourable Robert John Carr, Mp* [2003] NSWSC 393; and *Duncan v Allen and Unwin* [2004] NSWSC 1069.

The stance of the Republic of Ireland towards DCRs

In contrast to the UK position, the Republic of Ireland, on the 16th May 2017, enacted the *Misuse of Drugs (Supervised Injecting Facilities) Act 2017*.³⁸ The expectation is that the “new service” will be “in place by late 2017”.³⁹ The Long Title states that the Act provides:

“...for the establishment, licensing, operation and regulations of supervised injecting facilities for the purposes of reducing harm to people who inject drugs; to enhance the dignity, health and well-being of people who inject drugs in public places; to reduce the incidence of drug injection and drug-related litter in public places and thereby to enhance the public amenity for the wider community; and to provide for matters related thereto.”

The Irish MD(SIF)A 2017 permits a “Supervised Injecting Facility” to be operated under licence if the Minister of Health is satisfied that:⁴⁰

- (a) The licence holder complies with the legislation,
- (b) The premises concerned are suitable for the operation of a supervised injecting facility,
- (c) The licence holder is capable of complying with any conditions imposed by the Minister on the licence and any requirements imposed by or under any enactment,
- (d) The experience and expertise of the licence holder is relevant to the operation of a supervised injecting facility, and
- (e) The licence holder is a fit and proper person to hold a licence.

The Minister of Health must not grant a licence without having consulted the Health Service Executive that

- (a) Appropriate protocols are in place for the operation and clinical governance of the supervised injecting facility,
- (b) The premises are fit for the purpose, and
- (c) The level and nature of drug use is such that it would be appropriate for the Minister to grant a licence, or
- (d) any available information “relating to the number of persons who consume drugs by injection, or the number of overdoses or deaths that occur as a result of the consumption of drugs, if any, suggests that the consumption of drugs by injection is such that it would be appropriate for the Minister to grant a licence to the applicant for those premises” (see section 3(3)).

The Minister of Health may attach to the licence such conditions as he or she opines to be necessary.

Examining the legal base for DCRs

There is a wealth of published material concerning DCRs but little information exists concerning their legal status in the jurisdictions where they operate.

This paper draws on the experiences of DCR’s in two jurisdictions (New South Wales [Australia] and Canada). They were chosen because the legal system in each jurisdiction is similar to that of the United Kingdom. The first is the Medical Supervised Injecting Centre (MSIC) in Sydney, and the second is based on the experience of the *Insite* project in Vancouver, Canada.

An outline of the legal framework in Germany appears in a paper written by the AK

³⁸ <http://www.irishstatutebook.ie/eli/2017/act/7/enacted/en/pdf>

³⁹ <http://idpc.net/blog/2017/06/ireland-set-to-open-first-supervised-injection-facility>

⁴⁰ See section 3.

Konsumraum (2011).⁴¹

Setting up a DCR is not a matter to be undertaken lightly. As Kerr, Oleson and Wood have pointed out,⁴² there is a need for “(a) a careful consideration of risks for those providing and accessing the harm-reduction service being operated; and (b) at times, legal support for activists”.

It is important that:

- (i) A DCR meets legal requirements; and
- (ii) That managers and staff receive the protection of the law in relation to acts which they must perform if the facility is to be viable and effective.

Both the MSIC and the Vancouver facility have a formal legal base, that is to say each facility is formally sanctioned by the state to provide services in accordance with domestic legal rules (those rules having been adjusted, where necessary, to afford the facility a degree of legal protection). In Sydney, changes were made to primary and secondary legislation. In Vancouver, legal adjustment has been achieved by ministerial order.

The MSIC, Sydney⁴³

A drug summit was held in May 1999 with a recommendation that a *Medically Supervised Injecting Centre* (MSIC) should be piloted in New South Wales. It seems that the ‘Sisters of Charity health service’ had been the original intended operators of the MSIC.

The *Drug Summit Legislative Response Act 1999* inserted Part 2A (entitled “Medically supervised injecting centres”) into the *Drug Misuse and Trafficking Act 1985*, which permitted the licensing and operation of the centre for a trial period of 18 months. Several sections from Part 2A are reproduced in this paper (**Appendix A**). In the event, the Sisters of Charity health service withdrew “after advice from Vatican”.⁴⁴

In December 1999, the NSW Government invited the Uniting Church in Australia to apply for a licence to operate the MSIC at 66 Darlinghurst Road, Kings Cross, which the latter did in June 2000 after months of community consultation. The licence was to permit the use of the premises for persons wishing to self-inject “any drug which is prohibited or otherwise prescribed by regulation” and to “do so with impunity, provided that the quantity of the particular drug which is self-injected does not exceed an ‘exempt quantity’ as defined in the Act”.⁴⁵ An application by the *Kings Cross Chamber of Commerce and Tourism*, to prevent the coming into operation of a licence, failed.⁴⁶

The MSIC opened on the 6 May 2001.

The trial period was extended by primary legislation,⁴⁷ and it ended in 2010⁴⁸ with the

⁴¹ ‘Drug Consumption Rooms in Germany A Situational Assessment’ by the AK Konsumraum, Deutsche AIDS-Hilfe e.V., September 2011.

⁴² “Harm-reduction activism: a case study of an unsanctioned user-run safe injection site”, Canadian HIV/AIDS Policy Review, Volume 9, Number 2, August 2004.

⁴³ The history of this site is provided by ‘Uniting’ - “The MSIC Story”: <https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story>; by Uniting.

⁴⁴ “The MSIC Story”: <https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story>; by Uniting.

⁴⁵ See the judgment in *Kings Cross Chamber of Commerce and Tourism Inc v The Uniting Church of Australia Property Trust (NSW) and ors* [2001] NSWSC 245, at [1].

⁴⁶ *Kings Cross Chamber of Commerce and Tourism Inc v The Uniting Church of Australia Property Trust (NSW) and ors* [2001] NSWSC 245.

⁴⁷ For example, by the *Drug Summit Legislative Response Amendment (Trial Period Extension) Act 2003*. That Act was

passing of the *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Act 2010 No 81*.⁴⁹

The 2010 Act made significant amendments to Part 2A of the *Drug Misuse and Trafficking Act 1985*. The position, at the time of writing, is that the MSIC must hold a current licence that is granted subject to conditions. Protocols must be established, and no child must be admitted to the area used for the administration of drugs. Section 36N protects users from prosecution for possessing specified amounts of a drug, or possessing drug paraphernalia for use in connection with the administration of a drug. Section 36O exempts from *criminal liability* persons engaged in conduct of a licensed injecting centre. Section 36P gives similar exemption for *civil liability* in connection with conduct of a licensed injecting centre.

Summary and Indictable drug offences in New South Wales (NSW)

A range of *summary* and *indictable* offences in NSW (see the tables below) would fall to be considered by a person or entity proposing to set up a DCR in that jurisdiction.

Summary offences include:

Section 10(1)	Possession of prohibited drugs
Section 11(1)	Possession of equipment for administration of prohibited drugs
Section 11A	Sale, supply and display of waterpipes and ice pipes
Section 11B	Possession of tablet press or drug encapsulator
Section 11C	Possession of instructions for manufacture or production of prohibited drugs
Section 12(1)	Self-administration of prohibited drugs (or attempting to do so)
Section 13(1)	Administration of prohibited drugs to others (or attempting to do so)
Section 14(1)	Permitting another to administer prohibited drugs (or attempting to do so)
Section 18A(1) (a)	Advertising or holding out that premises are available for use for unlawful administration of prohibited drugs
Section 18A(1)(b)	cause/suffer/permit person to advertise/hold out that premises are available for use for the administration of prohibited drugs
Section 18B	Manufacture, production, possession and supply of certain Schedule 9 substances
Section 19	Aiding, abetting etc commission of offence in New South Wales
Section 20	Aiding, abetting etc commission of offence outside New South Wales

By section 21 of the 1985 Act, the penalty for the aforementioned summary offences, “is a fine of 20 penalty units or imprisonment for a term of 2 years, or both, except as otherwise expressly provided....”.

The following offences are *indictable* under the 1985 Act:

Section 23	Offences of cultivating, supplying or possession “prohibited plants”
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later repealed by the Statute Law (Miscellaneous Provisions) Act 2004 – an exercise to tidy up the statute book – and the amendments made to the 1985 Act therefore endure.

⁴⁸ *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Act 2010 No 81*.

⁴⁹ See “The MSIC Story”: <https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story>; by Uniting.

Section 23A	Offences with respect to enhanced indoor cultivation of prohibited plants in presence of children
Section 24	Manufacture and production of prohibited drugs
Section 24A	Possession of precursors and certain apparatus for manufacture or production of prohibited drugs
Section 24B	Possession of prohibited drug precursors
Section 25	Supply of prohibited drugs
Section 25A	Offence of supplying prohibited drugs on an ongoing basis
Section 26	Conspiracy
Section 27	Aiding, abetting etc commission of offence in New South Wales
Section 28	Conspiring to commit and aiding etc commission of offence outside New South Wales

Vancouver (and other Canadian sites)

Decisions taken to permit a “Supervised Consumption Site” (SCS) to operate in Canada followed extensive consultation and a degree of judicial scrutiny. In 2002, *Health Canada* published an *Interim Guidance Document*,⁵⁰ in which it was made clear that because there were no regulations applicable to SCS’s, the operation of a SCS, “would be considered illegal under the CDSA, as would the activities of drug users in respect of possession of substances controlled under the CDSA”:⁵¹

....However, section 56 of the CDSA gives the Minister the authority to exempt, on such terms and conditions as the Minister deems necessary, persons from the application of all or some of the provisions of the Act if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Health Canada will use this provision to enable the conduct of the pilot scientific, medical research projects recommended to evaluate SISs as a means to reduce the harm associated with injection drug use.

The Canadian government was and remains mindful of the three main United Nations drug control Conventions⁵² (UNCs) to which Canada is a signatory.⁵³

Section 56.1(1) of the *Controlled Drugs and Substances Act (CDSA) 1996* (extracts appear at **Appendix B**) makes provision to empower a Minister to allow certain activities to take place at a “supervised consumption site” (SCS) for a necessary medical purpose, on “any

⁵⁰ Interim Guidance Document “*Application For an Exemption Under Section 56 of the Controlled Drugs and Substances Act, for a Scientific Purpose, for a Pilot Supervised Injection Site Research Project*”; 29 December 2002, ver.5.1.

⁵¹ Interim Guidance Document “*Application For an Exemption Under Section 56 of the Controlled Drugs and Substances Act, for a Scientific Purpose, for a Pilot Supervised Injection Site Research Project*”; 29 December 2002, ver.5.1, page 3.

⁵² The Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances, 1971, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

⁵³ “Health Canada is a partner in strategies directed at the appropriate management of controlled drugs and substances, both at the international and national levels. At the international level, Canada is a signatory to three international drug control conventions: the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances, 1971, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. As such, Canada must comply with the requirements of these conventions. Health Canada is the designated Canadian ‘competent authority’ for the administration of these conventions in Canada.” (Interim Guidance Document “*Application For an Exemption Under Section 56 of the Controlled Drugs and Substances Act, for a Scientific Purpose, for a Pilot Supervised Injection Site Research Project*”; 29 December 2002, ver.5.1, page 2).

terms and conditions that the Minister considers necessary”. The exemption thus applies in respect of:

... (a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or (b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.

Guidance notes for making an Application to operate a Supervised Consumption Site (available online) provides useful insight as to the conditions on which such a site must operate.⁵⁴

At a minimum, operating procedures should describe the following:

- Responsibilities of staff members with regards to supervised consumption activities;
- Site operational procedures (e.g., how the client enters and moves through the site, conflict management protocols);
- Disposal procedures for anything left behind by clients such as illicit substances, including how to transfer them to a police officer when necessary;
- Information about site security, including:
 - how access to the site will be controlled (e.g., fobs, check-in, reception, etc.);
 - how the loss, theft, or trafficking of illicit substances will be prevented; and,
 - the measures for securing the facility, including how and where controlled substances that may be on-site will be stored (either medications kept in stock within the site or unidentified substances left behind).
- Information on record keeping and reporting, including:
 - record keeping procedures for the disposal, loss, theft, and transfer of illicit substances and used equipment left at the site; and,
 - reporting procedures for any loss or theft of illicit substances at the supervised consumption site to the local police department and to Health Canada.

DCRs: the three UN Conventions, and international commitment

In 1999 and 2000, the International Narcotics Control Board (INCB) asserted that DCRs are not Convention compliant (with the three UNCs) because, by facilitating “the abuse of drugs”, they also “facilitate illicit drug trafficking”.⁵⁵ However, more recently, the INCB has

⁵⁴ <https://www.canada.ca/en/health-canada/services/substance-abuse/supervised-consumption-sites/guidance-document.html>

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

177. The Board, recognizing that the spread of drug abuse, human immunodeficiency virus (HIV) infection and hepatitis are serious concerns, encourages Governments to provide a wide range of facilities for the treatment of drug abuse, including the medically supervised administration of prescription drugs in line with sound medical practice and the international drug control treaties, instead of establishing drug injection rooms or similar outlets that facilitate drug abuse.” (INCB Report 1999, page 26/27). See also Report 2000, para.176, page 26.

significantly modified its stance [emphasis added].⁵⁶

720. With respect to “drug consumption rooms”, the Board wishes to reiterate its frequently expressed concern that, in order for the operation of such facilities to be consistent with the international drug conventions, certain conditions must be fulfilled. Chief among those conditions is that the ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking. “*Drug consumption rooms*” must be operated within a framework that offers treatment and rehabilitation services as well as social reintegration measures, either directly or by active referral for access, and must not be a substitute for demand reduction programmes, in particular prevention and treatment activities.

Whether DCRs “facilitate the abuse of drugs” and thus “drug trafficking”

Incidence of ‘drug trafficking’

In 2004, the EMCDDA’s Report on drug consumption rooms⁵⁷ noted that several studies found that “small-scale drug trafficking” took place “in the immediate vicinity of consumption rooms (e.g. Geense, 1997;⁵⁸ Dubois-Arber *et al.*, 1999;⁵⁹ Kimber *et al.*, 2001;⁶⁰ Zurhold *et al.*, 2001;⁶¹ Reyes Fuentes, 2003⁶²)”.

The EMCDDA remarked that it is “quite possible that drug users sell drugs to other drug users whom they first meet at consumption facilities”. However, it added that because “many rooms are deliberately located near places where illicit drugs are sold, it is difficult to claim that the existence of such rooms leads per se to drug dealing”.⁶³

Two years later, Wood *et al.*⁶⁴ examined crime rates in the neighbourhood where the facility is located in the year before and the year after it opened. No increases were seen “with respect to drug trafficking (124 vs. 116) or assaults/robbery (174 vs. 180), although a decline in vehicle break-ins/vehicle theft was observed (302 vs. 227). The SIF was not associated with increased drug trafficking or crimes commonly linked to drug use”.

Similarly, in a Q&A document, by Dr Alex Wodak,⁶⁵ it is stated that “Supervised Injecting

⁵⁶ Report 2016: https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf

⁵⁷ “*European report on drug consumption rooms*”, 2004, author: Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction.

⁵⁸ Geense, R. (1997) *Evaluation of the Federal Measures to Reduce Problems Related to Drug Use. To Have or Have Not: That’s the Question*. A Qualitative Study on Four Low-threshold Needle Exchange Services for Drug Users in Switzerland. Lausanne: University of Social and Preventive Medicine, Prevention Programmes Evaluation Unit (Cah Rech Doc IUMSP, no. 111.11).

⁵⁹ Dubois-Arber, F., Jeannin, A., Spencer, B., *et al.* (1999) *Evaluation of the AIDS Prevention Strategy in Switzerland* (6th synthesis report 1996–1998). Lausanne: Institut universitaire de médecine sociale e preventive.

⁶⁰ Kimber, J., Dolan, K. and Wodak, A. (2001) *International Survey of Supervised Injecting Centres (1999–2000)*. Technical Report No. 126, National Drug and Alcohol Research Centre. Sydney: University of New South Wales.

⁶¹ Zurhold, H., Kreuzfeld, N., Degkwitz, P. and Verthein, U. (2001) *Drogenkonsumräume. Gesundheitsförderung und Minderung öffentlicher Belastungen in europäischen Grossstädten*. Freiburg: Lambertus

⁶² Reyes Fuentes, V.C. (2003) *15 Jahre Fixerraum Bern. Auswirkungen auf soziale und medizinische Aspekte bei Drogenabhängigen*. Dissertation at the medical faculty of the University in Bern, under the supervision of Dr med Robert Hämmig.

⁶³ *European report on drug consumption rooms*, 2004, author: Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction; para. 5.2.2 “Drug dealing in the vicinity of consumption rooms”.

⁶⁴ Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S. G. and Kerr, T. (2006), ‘*Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime*’, *Substance Abuse Treatment, Prevention and Policy* 4, pp. 1–4.

⁶⁵ “*Frequently Asked Questions about Supervised Injecting Facilities*”, 24 July 2014; Australian Drug Law Reform

Facilities are established in areas that already are major drug trafficking neighbourhoods. There is no good evidence that Supervised Injecting Facilities make this problem any worse”.⁶⁶

Incidence of drug misuse

The aim of a professionally run DCR is to reduce harms associated with drug taking - not to promote or to encourage drug misuse, still less drug trafficking. The Canadian courts have recognised the value of a professionally run DCR. In *Canada (A.G.) v. Phs Comm. Serv. Soc.*,⁶⁷ the Court commented favourably on the *Insite* program:

Insite received a conditional exemption in September 2003, and opened its doors days later. North America’s first government-sanctioned safe injection facility, it has operated constantly since then. It is a strictly regulated health facility, and its personnel are guided by strict policies and procedures. It does not provide drugs to its clients, who must check in, sign a waiver, and are closely monitored during and after injection. Its clients are provided with health care information, counselling, and referrals to various service providers or an on-site, on demand detox centre. The experiment has proven successful. *Insite* has saved lives and improved health without increasing the incidence of drug use and crime in the surrounding area. It is supported by the Vancouver police, the city and provincial governments.

In contrast with *Insite*, another Court in Canada observed, “there is a real public interest in not allowing public washrooms to become habitually used as injection sites”: *R. v. Wegner*.⁶⁸

A wealth of literature supports the proposition that a competently run and efficient DCR produces positive improvements in hygiene and reduced drug related harms. For example, the EMCDDA remarked:

The effectiveness of drug consumption facilities to reach and stay in contact with highly marginalised target populations has been widely documented (Hedrich et al., 2010;⁶⁹ Potier et al., 2014⁷⁰). This contact has resulted in immediate improvements in hygiene and safer use for clients (e.g. Small et al., 2008, 2009;⁷¹ Lloyd-Smith et al., 2009⁷²), as well as wider health and public order benefits.

Foundation: <http://adlrf.org.au/wp-content/uploads/2014/07/FAQsFinalSIFs240714.docx.pdf>

⁶⁶ A FAQs Sheet by the Canadian Centre on Substance Abuse (2005) on Supervised Injection Facilities (SIFs), stated, “There are fears that IDUs will migrate to neighbourhoods where SIFs are located and that there will be an increase in drug dealing and public disorder in proximity to SIFs. However, these concerns are not substantiated in the scientific literature, which suggests that IDUs will only travel very short distances (i.e., a few city blocks) to obtain health services. SIFs have been associated with improvements in public order rather than increases in public disorder” (prepared by Dr. John Weekes, Senior Research Analyst; Leah Percy, Research Assistant; and Karen Cumberland, Policy Officer).

⁶⁷ [2011] 3 S.C.R. 134

⁶⁸ 2016 ONCJ 228.

⁶⁹ Hedrich, D., Kerr, T. and Dubois-Arber, F. (2010), ‘Drug consumption facilities in Europe and beyond’, in Rhodes, T. and Hedrich, D. (eds), *Harm reduction: evidence, impacts and challenges*, EMCDDA Scientific Monograph Series No. 10, Publications Office of the European Union, Luxembourg, pp. 305–31:

www.emcdda.europa.eu/attachelements.cfm/att_157300_EN_emcdda-harm%20red-mon-ch11-web.pdf

⁷⁰ Potier, C., Laprévote, V., Dubois-Arber, F., Cottencin, O. and Rolland, B. (2014), ‘Supervised injection services: what has been demonstrated? A systematic literature review’, *Drug and Alcohol Dependence* 145, pp. 48–68.

⁷¹ Small, W., Wood, E., Lloyd-Smith, E., Tyndall, M. and Kerr, T. (2008), ‘Accessing care for injection-related infections through a medically supervised injecting facility: a qualitative study’, *Drug and Alcohol Dependence* 98(1–2), pp. 159–62. I Small, W., Van Borek, N., Fairbairn, N., Wood, E. and Kerr, T. (2009), ‘Access to health and social services for IDU: the impact of a medically supervised injection facility’, *Drug and Alcohol Review* 28(4), pp. 341–6.

⁷² Lloyd-Smith, E., Wood, E., Zhang, R., et al. (2009), ‘Determinants of cutaneous injection related infection care at a supervised injecting facility’, *Annals of Epidemiology* 19(6), pp. 404–9.

Research has also shown that the use of supervised drug consumption facilities is associated with self-reported reductions in injecting risk behaviour such as syringe sharing. This reduces behaviours that increase the risk of HIV transmission and overdose death (e.g. Stoltz et al., 2007;⁷³ Milloy and Wood, 2009⁷⁴). Nevertheless, the impact of drug consumption rooms on the reduction of HIV or hepatitis C virus incidence among the wider population of injecting drug users remains unclear and hard to estimate (Hedrich et al., 2010; Kimber et al., 2010⁷⁵), due in part to the facilities' limited coverage of the target population and also to methodological problems with isolating their effect from other interventions.

Some evidence has been provided by ecological studies suggesting that, where coverage is adequate, drug consumption rooms may contribute to reducing drug-related deaths at city level (Poschadel et al., 2003;⁷⁶ Marshall et al., 2011⁷⁷). A study in Sydney showed that there were fewer emergency service call-outs related to overdoses at the times the safe injecting site was open (Salmon et al., 2010⁷⁸).

In addition, the use of consumption facilities is associated with increased uptake both of detoxification and drug dependence treatment, including opioid substitution. For example, the Canadian cohort study documented that attendance at the Vancouver facility was associated with increased rates of referral to addiction care centres and increased rates of uptake of detoxification treatment and methadone maintenance (Wood et al., 2007;⁷⁹ DeBeck et al., 2011⁸⁰). Evaluation studies have found an overall positive impact on the communities where these facilities are located. However, as with needle and syringe programmes, consultation with local key actors is essential to minimise community resistance or counter-productive police responses.

The EMCDDA concluded that:

....the benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting.

Whether the UNC's prohibit DCRs

The status of UNC's and domestic law

It is a mistake to construe treaty provisions as if they were statutory provisions. The three

⁷³ Stoltz, J. A., Wood, E., Small, W., et al. (2007), 'Changes in injecting practices associated with the use of a medically supervised safer injection facility', *Journal of Public Health (Oxford)* 29(1), pp. 35–9

⁷⁴ Milloy, M. J. and Wood, E. (2009), 'Emerging role of supervised injecting facilities in human immunodeficiency virus prevention', *Addiction* 104(4), pp. 620–1.

⁷⁵ Kimber, J., Palmateer, N., Hutchinson, S., et al. (2010), 'Harm reduction among injecting drug users: evidence of effectiveness', in Rhodes, T. and Hedrich, D. (eds), *Harm reduction: evidence, impacts and challenges*, EMCDDA Scientific Monograph Series No.10, Publications Office of the European Union, Luxembourg, pp. 115–63.

⁷⁶ Poschadel, S., Höger, R., Schnitzler, J. and Schreckenber, D. (2003), 'Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland', Nr 149, Schriftenreihe des Bundesministeriums für Gesundheit und Soziale Sicherheit, Baden-Baden

⁷⁷ Marshall, B. D., Milloy, M. J., Wood, E., Montaner, J. S. and Kerr, T. (2011), 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', *The Lancet* 23 April, 377(9775), pp. 1429–37.

⁷⁸ Salmon, A. M., Van Beek, I., Amin, J., Kaldor, J. and Maher, L. (2010), 'The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia', *Addiction* 105, pp. 676–83.

⁷⁹ Wood, E., Tyndall, M. W., Zhang, R., Montaner, J. S. and Kerr, T. (2007), 'Rate of detoxification service use and its impact among a cohort of supervised injecting facility users', *Addiction* 102(6), pp. 916–19.

⁸⁰ DeBeck, K., Kerr, T., Bird, L., et al. (2011), 'Injection drug use cessation and use of North America's first medically supervised safer injecting facility', *Drug and Alcohol Dependence* 15 January, 113(2–3), pp. 172–6.

UNCs, in common with many treaties, embody political goals and aspirations. The language of such instruments tends to be diplomatic rather than legalistic. Furthermore, in English law, all Acts of Parliament are presumed to be local in their reach unless a contrary indication is given in the Act in question. Even when a statute purports to give effect to a treaty, domestic courts will look, first, to the language of the statute. The UK courts will assume that the Legislature was alive to its international obligations. None of the three UNCs has direct application in the United Kingdom, and each of the three UN Conventions expressly provides that it is open to Parties to enact measures more severe than those required under the Convention in question.⁸¹ In any event, there is no general principle of UK law that requires statutes to be construed no wider than an article of an international treaty.

The overarching aim of each drug UNC is the health and welfare of human beings. Although a number of Articles of the UNCs require Contracting Parties to prohibit or to restrict a specified activity, other articles are open-textured and speak of what is “desirable” or that a Party will have “due regard to their constitutional, legal and administrative systems”. Given the above, it follows that a distinction should be drawn between (i) the constitutional position of the State and (ii) a legal person who is subject to legally imposed rights and obligations. The latter must comply with domestic laws. Legislators, on the other hand, have choices as to whether (i) to seek to modify a Convention, (ii) to disregard a provision of a Convention, or (iii) to seek to justify a policy/programme by giving a provision a purposive construction.

The *Runciman Independent Inquiry into the Misuse of Drugs Act 1971*⁸² commissioned a substantial comparative study of drug law in several EU countries⁸³ which revealed that the three UNCs leave greater room for manoeuvre than might be supposed. Thus, for example, the precise wording of a statutory offence, its fault elements, and the penalties to be imposed on offenders (or whether there should be a prosecution at all) are matters that are usually left to the discretion of Contracting States. Again, the three UNCs make provision to prohibit the unsanctioned production and distribution of scheduled substances. But, in relation to the “use” and “consumption” of drugs, each Party is competent to impose measures that may be required to reduce demand, and to reduce personal harm (“degradation and social disruption”⁸⁴). To that end, each Party enjoys a margin of appreciation with regards to the intensity of legal controls that it may exert over drug actions that take place within its jurisdiction.

Drug possession and the UNCs

There has been much discussion as to whether or not the UNCs require Parties to create *criminal* offences in respect of the *simple* possession of scheduled drugs for personal (recreational) use. Given the terms of the 1988 UNC, the short answer appears to be in the affirmative even though – before that date – the UNCs of 1961 and 1971 arguably did not

⁸¹ See Article 23, UNC 1971, and Article 24, UNC 1988.

⁸² “Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971”, Chair: Viscountess Ruth Runciman DBE, Police Foundation Report, 2000.

⁸³ “*European Drug Laws: Room to Manoeuvre*”, published by DrugScope, edited by Nicholas Dorn and Alison Jamieson. See also the article by Neil Boister, *Decriminalising the personal use of cannabis in the United Kingdom: does international law leave room to manoeuvre?* [2001] Crim.L.R.171.

⁸⁴ Resolutions Adopted By the United Nations Conference To Consider Amendments to the Single Convention on Narcotic Drugs, 1961, Resolution III, Single Convention 1961.

have that effect (see below). However, important as this issue is, it is not necessary (for present purposes) to resolve it. Even if possession for personal use is criminalised, it is not a legal or constitutional requirement *in the UK* that every criminal violation that comes to the attention of a law enforcement agency must be prosecuted to conviction. There is wide latitude with regard to case-disposal. The UK police, prosecuting authorities, and the courts, enjoy a significant degree of discretion in the administration of criminal justice.⁸⁵

Article 33 of the 1961 UN Single Convention states, under the heading “Possession of Drugs”, “*The Parties shall not permit the possession of drugs except under legal authority*”. The proviso is crucial.

Article 36 of the 1961 UNC – headed “Penal Provisions” – states [emphasis added]:

1. a) **Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that** 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, and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, **shall be punishable offences when committed intentionally**, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

b) Notwithstanding the preceding subparagraph, 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 in conformity with paragraph 1 of article 38.

At first sight, *article 36.1(a)* may be read as imposing a treaty obligation to criminalise simple possession in cases that include the personal consumption of scheduled drugs (i.e. recreational non-medicinal consumption). However, the Official Commentary to this Article made it clear that different governments would hold different views as to whether they are bound to punish persons who illegally possess drugs for personal use [emphasis added].⁸⁶

17. Some Governments seem to hold that they are not bound to punish addicts who illegally possess drugs for their personal use. This view appears to be based on the consideration that the provisions of article 36, which in its paragraph 1 requires Parties, subject to their constitutional limitations, to penalize the possession of drugs held contrary to the provisions of the Single Convention, are intended to fight the illicit traffic, and not to require the punishment of addicts not participating in that traffic. Article 45 of the Third Draft, which served as working document of the Plenipotentiary Conference, enumerated in its paragraph 1, subparagraph (a) “possession” among the actions for which punishment would be required. This paragraph is identical with the first part of paragraph 1 of article 36 of the Single Convention, dealing with “possession” as one of the punishable offences. Article 45 of the Third Draft is included in chapter IX, headed “Measures against illicit traffickers”. This would appear to support the opinion of those who believe that only possession for distribution, and not that for personal consumption, is a punishable offence

⁸⁵ See, for example, *R v Commissioner of the Police of the Metropolis ex parte Blackburn* [1968] 2 QB 118, and *R (Banks) v Tower Hamlets London Borough Council* [2009] EWHC 242 (Admin).

⁸⁶ Commentary to Article 36, para.8, which directs the reader to the commentary in respect of Article 4: *Commentary on The Single Convention on Narcotic Drugs, 1961* (Prepared by the Secretary-General in accordance with paragraph 1 of Economic and Social Council resolution 914 D (XXXIV) of 3 August 1962).

under article 36 of the Single Convention. The Draft's division into chapters was not taken over by the Single Convention, and this was the only reason why the chapter heading just mentioned was deleted, as were all the other chapter headings. Article 36 is still in that part of the Single Convention which deals with the illicit traffic. It is preceded by article 35, entitled "Action against the illicit traffic", and followed by article 37, entitled "Seizure and confiscation".

18. Parties which do not share this view, and which hold that possession of drugs for personal consumption must be punished under article 36, paragraph 1, may undoubtedly choose not to provide for imprisonment of persons found in such possession, but to impose only minor penalties such as fines or even censure. Possession of a small quantity of drugs for personal consumption may be held not to be a "serious" offence under article 36, paragraph 1, and only a "serious" offence is liable to "adequate punishment particularly by imprisonment or other penalties of deprivation of liberty".

Arguably, *article 36.1(b)* only makes sense if the 1961 UNC requires the possession of a drug for personal consumption to be a criminal offence. However, as originally drafted, the 1961 Convention did not include this provision. It was added by the 1972 Protocol. The provision is relevant to those governments that have *chosen to criminalise* non-medical (recreational) use. The provision ensures that such use is not seen only as a 'crime' issue but also as a health and education issue. Similar provision exists in the 1971 Convention in respect of psychotropic substances. It therefore made good sense to make the Single Convention consistent in that regard.⁸⁷

The issue now needs to be considered in the light of article 3.2 of the 1988 UNC which reads:

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

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

The Official Commentary to the 1988 UNC states (in effect) that although that Convention

⁸⁷ See Noll, *Drug Abuse and Penal Provisions of the International Drug Control Treaties*, Bulletin on Narcotics, Issue 4-003, 1977

does not require drug *use* to be made a criminal offence, it does require the possession, purchase or cultivation *for* consumption to be criminalised.

3.95 It will be noted that, as with the 1961 and 1971 Conventions, para-graph 2 does not require drug consumption as such to be established as a punishable offence. Rather, it approaches the issue of non-medical consumption indirectly by referring to the intentional possession, purchase or cultivation of controlled substances for personal consumption. In contrast to the position under the 1961 and 1971 Conventions, however, paragraph 2 clearly requires parties to criminalize such acts unless it would be contrary to the constitutional principles and basic concepts of their legal systems to do so.

Premises and paraphernalia

Certain activities and situations are not expressly dealt with by the UNCs. One example relates to section 8 of the Misuse of Drugs Act 1971 (UK) under which it is an offence for occupiers or those concerned in the management of premises, to knowingly permit or to suffer specified actions to take place there.⁸⁸

The UNCs do not require the supply of (or offering to supply) drug paraphernalia for the consumption or administration of scheduled drugs, to be prohibited. However, any drugs, or materials and equipment used in or intended for the commission of any of the offences, referred to in *article 36* of the Single Convention 1961 (see above), shall be liable to seizure and confiscation (*article 37*; similarly, see Article 22.3 of the 1971 UNC). Article 13 of the 1988 UNC requires Contracting Parties to “take such measures as they deem appropriate to prevent trade in and the diversion of materials and equipment” but only in the context of “illicit *production* or *manufacture* of narcotic drugs and psychotropic substances”.

UNCs, DCRs, and harm-minimisation

As already stated, the thrust of all three UNCs is the health and welfare of persons. Accordingly, *article 38(1)* of the 1961 Single Convention⁸⁹ places a general responsibility on all Parties to take practical measures for the prevention of drug abuse, and to advance rehabilitation and social reintegration.⁹⁰ The health and welfare of addicts was in the mind of delegates who attended the 1972 UN Conference⁹¹ for the purpose of amending the 1961 Single Convention. They resolved (*Resolution III*) that [emphasis added]:

Recalling that the Preamble to the Single Convention on Narcotic Drugs, 1961, states the Parties to the Convention are “concerned with the health and welfare of mankind” and “are conscious of their duty to prevent and combat” the evil of drug addiction,

Considering that the discussions at the conference have given evidence of the desire to take effective steps to prevent drug addiction;

Considering that, while drug addiction leads to personal degradation and social disruption, it happens very often that the deplorable social and economic conditions in

⁸⁸ By section 8 of the MDA 1971, the specified activities are “(a) producing or attempting to produce a controlled drug....; (b) supplying or attempting to supply a controlled drug to another...., or offering to supply a controlled drug to another....; (c) preparing opium for smoking; and (d) smoking cannabis, cannabis resin or prepared opium.

⁸⁹ Mirrored in Art.20 of the 1971 Convention.

⁹⁰ “The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.”

⁹¹ Geneva: between the 6th and 24th March 1972.

which certain individuals and certain groups are living predispose them to drug addiction, *Recognising* that social factors have a certain and sometime preponderant influence on the behaviour of individuals and groups,

Recommends that the Parties:

1. Should bear in mind that drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live;
2. Should do everything in their power to combat the spread of the illicit use of drugs;
3. Should develop leisure and other activities conducive to the sound physical and psychological health of young people.

The aims of DCRs are to:

- (1) promote a safer and cleaner injection environment;
- (2) prevent the spread of highly infectious diseases (some of which may be life threatening);
- (3) prevent drug related deaths or physical harm;
- (4) “provide a gateway through which injecting drug users can access the healthcare system” [Perry Bulwer, *Compelling the Government to Act*].⁹²

Whether, by establishing and sanctioning a DCR, a government acts contrary to obligations under the three UN conventions depends partly on the actual purpose of the DCR and how it is managed and the functions performed there. Regard must be given to the effect that a DCR will have on the community.

The three UNCs ask for the “*rehabilitation and social reintegration*” of drug misusers.⁹³ If the only test for compliance with the UNCs is whether a particular DCR is conducive to the “*rehabilitation and social reintegration*”, the position would be as stated by the Swiss Institute of Comparative Law in 2002 [emphasis added]:⁹⁴

The 1961 and 1971 Conventions simply ask for the rehabilitation and social reintegration of addicts, without indicating how these objectives should be attained. Art.14 of the 1988 Convention is entitled, “Measures to ... eliminate illicit demand for narcotic drugs and psychotropic substances” and might be expected to contain concrete policy choices. Unfortunately, para. 4 simply exhorts States Parties to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic sub-stances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic” and the choice of such measures is left entirely to the discretion of States Parties. **No guidance at all is provided to the persons who must decide whether or not state-controlled public injection rooms are conducive to the rehabilitation and social reintegration of addicts, to the reduction of human suffering and to the elimination of financial incentives for illicit traffic. This is indeed not a legal question at all, in the sense that medical experts, social workers and health policy makers are much better equipped than lawyers to provide reliable responses.** Our Institute is certainly not in any position to provide a concrete response. The recent letter of the International Narcotics Control Board addressed to the Danish Minister for Health must be read in the same light.^[95] The operative third paragraph,^[96] considering

⁹² <https://perry-bulwer.blogspot.co.uk/p/safe-injection-sites-bc.html>

⁹³ Articles 36.1, 38, UNC 1961; articles 21.1, 22.1, UNC 1971; article 3.4, UNC 1988.

⁹⁴ Swiss Institute of Comparative Law, AVIS 99-121c January 7, 2000. *Use of Narcotic Drugs in Public Injection Rooms under Public International Law*.

⁹⁵ The reference to the letter of the INCB, dated 18 May 1999, is cited (in part) by Astrid Skretting, ‘Public injection

public injection rooms, is an opinion on drug policy, reflecting certain implicit policy choices as to optimal policing practice and socio-medical treatment of drug users. It is neither a statement of public international law, nor, in the quality of an opinion of the INCB, itself legally binding upon Denmark or any other State.

However, since the above opinion was written, many years of practical experience of DCRs have been gained. In any event, the “rehabilitation and social integration” of drug users/addicts are not the only matters to be considered. As we have seen, the *overarching* objective of the UNCs is the “health and welfare of mankind”.⁹⁷ It is this objective that has motivated a number of governments or public agencies to sanction DCRs within their respective jurisdictions. Accordingly, the argument that the operation of DCRs is incompatible with the terms of the UNCs is not convincing.

Is a government duty bound to support the existence of a DCR?

The issue here is whether a government is duty bound to support the existence of a DCR in order to comply with its domestic and international human rights obligations.

In a well-researched article, Richard Elliott, Ian Malkin, and Jennifer Gold argue “the conventions themselves permit the establishment of such facilities as a step toward fulfilling our international human rights obligations”.⁹⁸ Perry Bulwer goes further⁹⁹ stating that:

Under the human rights legislation the basic argument is that the government has a duty to accommodate IDU’s [intravenous drug users] as disabled persons by establishing SIF’s and thereby removing the discriminatory effect of lack of access to necessary medical services.

Article 55 of the *Charter of the United Nations* states that:

With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

- a. higher standards of living, full employment, and conditions of economic and social progress and development;
- b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
- c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

rooms, a help to heroin addicts?

<http://www.nordicwelfare.org/PageFiles/9432/Public%20injection%20rooms,%20a%20help%20to%20heroin%20addicts.pdf>

“The Board’s view is that permission given by any state or local authority for the establishment and operation of public injection rooms or shooting galleries would also facilitate and encourage illicit trafficking, while governments have the obligation to combat illicit trafficking in all forms. In fact, the creation of such outlets for illicit drug use is contrary to international drug control conventions. As opposed to any open drug scene which may escape from law enforcement actions, a Government, by sanctioning shooting galleries, would implicitly also enhance trafficking.” (INCB 1999)

⁹⁶ The author understands the reference to the “third paragraph” to be a reference to Art.3(4)(c) of the 1988 UNC, “...in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.”

⁹⁷ To use the language of Resolution III.

⁹⁸ Establishing Safe Injection Facilities in Canada, Canadian HIV/AIDS Legal Network.

⁹⁹ Perry Bulwer, “Safe Injection Sites: Compelling the Government to Act” <http://www.pivotlegal.org/research/PerryBulwer-CompellingAction.html>.

Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, states [emphasis added]:¹⁰⁰

1. The States Parties to the present Covenant recognize **the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.**
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The UK takes its responsibilities under the ICESCR seriously.¹⁰¹

A further instrument - the European Convention on Human Rights - has been incorporated into the law of the United Kingdom by the Human Rights Act 1998. The following Articles are usually cited in support of the existence of a DCR:

Article 2(1) provides that:

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 3 (degrading treatment) provides that:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 5(1) (liberty and security) provides that:

Everyone has the right to liberty and security of the person ...

Article 8 provides that:

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

It is to be noted that the Human Rights Act 1998 imposes a duty on “public authorities” to comply with articles of the ECHR that have been incorporated into United Kingdom law.

Government departments as ‘public authorities’

The definition of a ‘public authority’, within the meaning of the Human Rights Act 1998, is widely construed, and includes services provided or regulated by government.¹⁰² However

¹⁰⁰ And see *General Comment No. 14*; <http://www.refworld.org/pdfid/4538838d0.pdf>

¹⁰¹ See the *United Nations International Covenant on Economic, Social and Cultural Rights United Kingdom, British Overseas Territories, Crown Dependencies, 6th periodic report*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398255/ICESCR-sixth-periodic-report.pdf

¹⁰² Neither House of Parliament is a ‘public authority’ except to the extent that the House of Lords acts in its judicial capacity; section 6 (3), (4), Human Rights Act 1998.

the provisions of the European Convention of Human Rights do not necessarily bind individuals, or legal persons, unless they perform functions of a public nature [see section 6(3)(b), section 6(5), Human Rights Act 1998].

There is some support for the view that the failure of a public authority to provide proper care, in a case where someone is suffering from serious illness, could in certain circumstances amount to ‘treatment’, contrary to Article 3 of the European Convention on Human Rights: *Tanko v Finland* (Commission, May 19th, 1994).

In *D v United Kingdom* (ECtHR, 27th April, 1997), the court held that to return D to St Kitts from with the United Kingdom would hasten his death on account of the unavailability of similar treatment for AIDS in St Kitts, and therefore breach Article 3. The court described the facts in a ‘D’ as “exceptional”.

It must be noted that the level of protection afforded by the articles of the ECHR represents an irreducible minimum, allowing for a margin of consideration between member states to regulate their own affairs having regard to the resources available to them (among other considerations).

In the context of Canadian law, Perry Bulwer advances an attractive argument that existing laws in that country might “support an action against the government compelling it to establish SIFs”.¹⁰³ Bulwer cites the Canadian cases of *Morgentaler*, *Rodriguez v British Columbia*, and *Parker*.

In *Regina v Morgentaler*, Beetz J. said:¹⁰⁴

...“Security of the person” must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.

In *Rodriguez v British Columbia (A.G.)*,¹⁰⁵ Sopinka J, speaking for the majority, said:

There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.

In *R v Parker* (Ontario, Court Appeal),¹⁰⁶ the appellant used marijuana for medical purposes. Rosenberg J.A., referred to *Morgentaler* and *Rodriguez*, and remarked:

...deprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health constitutes a deprivation of the security of the person... Depriving a patient of medication in such circumstances, through a criminal sanction, also constitutes a serious interference with both physical and psychological integrity.

In Canada, there has been some judicial comment that drug addicts suffer from a disability: *Regina v Nguyen*;¹⁰⁷ *Regina v Ping Li*.¹⁰⁸

However, governments have a margin of appreciation with regards to the health services they provide to meet international treaty obligations. In the context of the *International*

¹⁰³ Perry Bulwer, “Compelling the Government to Act”, <http://www.pivotlegal.org/research/PerryBulwer-CompellingAction.html>

¹⁰⁴ [1988] 1 SCR 30

¹⁰⁵ [1993] 3 S.C.R. 519

¹⁰⁶ [2000] O.J. No.2787

¹⁰⁷ (1995) 56 BCAC 290

¹⁰⁸ Unreported, 19th November, 1993.

Covenant on Economic, Social and Cultural Rights, the *General Comment No. 14*¹⁰⁹ makes it clear that “The right to health is not to be understood as a right to be healthy” and that “there are a number of aspects which cannot be addressed solely within the relationship between States and individuals”. These include “the adoption of unhealthy or risky lifestyles” which “may play an important role with respect to an individual’s health”.¹¹⁰ Not every service that might be beneficial to health must be made available. For example, in Canada (in the context of its *Charter of Rights and Freedoms*) the Superior Court of Justice (Ontario) held in *Tanudjaja v. Attorney General (Canada) (Application)*¹¹¹ that there was no positive obligation on Canada or Ontario to act to reduce homelessness and there were no special circumstances that suggested that such an obligation could be imposed in that case.

It is unlikely that a UK court would hold that the absence of a DCR in any of the jurisdictions of the UK (England, Wales, Scotland, and Northern Ireland) would infringe the ICESCR, the ECHR, or the Human Rights Act 1998. Neither is it likely that the courts of the United Kingdom would treat those instruments as affording persons *general* defences to a ‘criminal charge’, or a ‘civil action’, brought against a person who participated in the running of a DCR. The answer would probably be the same even if it could be established that DCRs are preferable to unhealthy injecting practices currently employed by many drug users. The UK already provides treatment programmes in connection with drug misuse and drug addiction, including needle exchange schemes. In any event, Canadian cases are at best persuasive in the courts of the United Kingdom: they do not bind them. As the Court of Appeal remarked in *Quayle* (see below):¹¹²

We are also not the same position, evidentially or above all legally, as the Canadian courts. This is apart from obvious distinctions between the terms of, and the role and powers of the Canadian court under, the Canadian Charter compared with those of, and of the English court under, the Human Rights Act 1998 incorporating the European Convention on Human Rights into United Kingdom law.

UK courts have largely supported Parliament’s approach to drug control and, in a series of cases, the courts have held that United Kingdom drug laws are ECHR compliant.¹¹³

In *Quayle*,¹¹⁴ the Court of Appeal rejected the contention that conduct unlawful under the MDA 1971 could be “excused or justified by the need to avoid a greater evil”. *Quayle* examined complex issues about the availability and extent of any defence of medical necessity. Three of the appellants (‘Q’, ‘W’ and ‘K’) used cannabis to alleviate pain:

- ‘Q’ cultivated cannabis following a bi-lateral below-knee amputation;
- ‘W’ fractured two vertebrae in the Navy. He broke five further vertebrae in a traffic accident in 1981. He contracted tuberculosis resulting in lung scars and breathing problems in 1983. He had a further accident lacerating his tendons and breaking his left wrist. He later developed chronic pancreatitis for alcohol-related reasons, depression, and chronic (‘life-threatening’) pain. His liver was

¹⁰⁹ *General Comment No. 14*; Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4); International Covenant on Economic, Social and Cultural Rights.

¹¹⁰ *General Comment No. 14*, para.9.

¹¹¹ 2013 ONSC 5410.

¹¹² [2005] EWCA Crim 1415 Para.65.

¹¹³ The one exception relates to a reverse burden provision in the MDA 1971, namely s.28, and even here the House of Lords was able to read down the section so that it imposes an evidential burden only: *Lambert* [2001] UKHL 37.

¹¹⁴ *Quayle* [2005] EWCA Crim 1415.

damaged by hepatitis B. He was suffering from rheumatoid arthritis, osteoporosis and osteoarthritis;

- ‘K’ injured his back picking up a piece of glass at work.

Following a detailed review of the case-law, the legislative framework, and authoritative reports,¹¹⁵ the Court of Appeal said:

66. We have not had put directly before us....any issue as to the compatibility or otherwise of any aspect of the United Kingdom’s current drug legislation with the European Convention on Human Rights. We have not been put in a position procedurally in which we could determine any such issue. Nor has it been suggested that the legislation can be read down or qualified, so as to create an exception permitting self-prescription or prescription by persons other than doctors in cases of exceptional pain where cannabis offers the only or the best means of avoiding or alleviating the pain. The suggestion is that, whatever the legislative policy and scheme, we should interpret or extend the common law defence of necessity so as to avoid a suggested inconsistency with article 8

67. The legislative policy and scheme are clear. We have accepted that this does not mean that a common law defence of duress by threats or necessity by extraneous circumstances can never have a place (paragraph 57 above). But its role cannot be to legitimise conduct contrary to the clear legislative policy and scheme, as would in our view be the effect of the defences suggested in the appeals and reference before us for reasons given in paragraph 56 above. We see no basis in article 8 for altering our conclusions regarding the scope and the inapplicability of the common law defence of necessity by extraneous circumstances in the context of the present appeals and reference.

68. We add only this with regard to the evidence before us. We have been shown a good deal of material, much of it summarised earlier in this judgment. The issues which would be involved in considering the compatibility with the Convention of the United Kingdom’s drug legislation if there is no relevant common law defence of necessity are not straightforward. Interference with the right to respect for private life is permissible under article 8(2) if ‘in accordance with the law and ... necessary in a democratic society ... for the prevention of disorder or crime, for the protection of health or morals, or the protection of the rights and freedoms of others’. Within the limits indicated in *Taylor (Joseph) v. Lancashire County Council* [2005] EWCA Civ 284, the court’s decision would involve an evaluation of the medical and scientific evidence, a weighing of the competing arguments for and against the immediate change recommended by the Select Committee and the Runciman Committee, a greater understanding of the nature and progress of the tests of cannabis which have taken and are taking place, and a recognition that, in certain matters of social, medical and legislative policy, the elected government of the day and Parliament are entitled to form overall policy views about what is best not just for particular individuals, but for the country as a whole, in relation to which the courts should be cautious before disagreeing.

69. On the material before us, so far as it is appropriate for us to express any view, we would not feel justified in concluding that the present legislative policy and scheme conflict with the Convention. That is so, even if there is no common law defence of medical necessity such as that for which the appellants and Mr Ditchfield contend. We would not feel justified in concluding that either Parliament or the Secretary of State has acted inappropriately or delayed unduly in maintaining the present general policy and scheme up to the present date pending the outcome of and decisions on the basis of tests which are, we are told, still ongoing.

70. For these reasons, we do not consider that the submissions based on the European

¹¹⁵ For example, the Runciman Independent Inquiry Report, into the Misuse of Drugs Act 1971 (2000, Police Foundation).

Convention on Human Rights assist the appellants.

The Court held that the defences of “necessity” or “duress of circumstances” should be confined to cases where there was a compelling need to avoid *imminent* danger of physical injury.

UK Drug Laws – not all about prohibition

The United Kingdom has introduced legislation that exceeds the requirements of the three UNCs.

Three statutory drug-regulation regimes currently co-exist, namely,

- (i) The Misuse of Drugs Act 1971 (MDA) in respect of “controlled drugs”,
- (ii) The Psychoactive Substances Act 2016 (PSA)¹¹⁶ and,
- (iii) The medicines legislation (notably, the Human Medicines Regulations 2012 together with the Medicines Act 1968).

The MDA imposes general prohibitions in respect of particular actions (e.g. possession, supply, exportation and importation). However, numerous Regulations made under the 1971 Act¹¹⁷ grant exemptions and exceptions to those prohibitions. The MDA 1971 is not all about prohibition. On the contrary, the Act was intended to be a flexible drug control mechanism but, in practice, it is as flexible as the will of the government allows it to be.

Save in respect of “exempted activities”, the PSA 2016 imposes a ‘blanket’ prohibition on acts of producing (s.12(1)(a)), supplying (s.12(1)(b)), offering to supply (s.12(1)(c)), importing or exporting (s.12(1)(d), (e)), a non-exempted “psychoactive substance” (s.2) that is “likely to be consumed by individuals [humans] for its psychoactive effect”. It is also a “prohibited activity” to assist or to encourage the carrying on of any of the aforementioned activities (s.12(1)(f)).

“Controlled drugs” (MDA), and “psychoactive substances” (PSA), are mutually exclusive categories (as indeed are “medicinal products” and “psychoactive substances”). Crucially, section 61(1) PSA 2016 empowers the Secretary of State to make regulations in respect of any provision of that Act. The power is exercisable by statutory instrument, and includes the power to amend, repeal, revoke or otherwise modify any provision made by or under primary legislation passed before the PSA or in the same legislative session.

Thus, all three statutory regimes have a degree of flexibility built into them. Even section 7(4) of the MDA 1971 - which empowers the Secretary of State to prohibit (in the public interest) the production, supply and possession of certain ‘designated’ drugs – makes provision for those drugs to be handled “for purposes of research or other special purposes” or “under a licence or other authority issued by the Secretary of State”.

Accordingly, the UK Government cannot simply assert that the setting up of a DCR in the UK would be contrary to one or more of the three legislative regimes. If there was governmental ‘will’ to sanction a DCR, a legislative way could be found to do so.

In any event, government agencies - as well as the police, prosecutors, and the courts - enjoy a degree of discretion over actions it may take (e.g. whether to enforce laws or to prosecute). The exercise of discretion is not unfettered: it must be reasonable, it must be

¹¹⁶ See R. Fortson, “*The Psychoactive Substances Act 2016*”, [2016] Crim LR 303.

¹¹⁷ Notably the detailed Misuse of Drugs Regulations 2001 (which have been heavily amended).

rational, and (depending on context) it must be in the public interest (consider, albeit in relation to Canada, the interesting case of *Canada (Attorney General) v. PHS Community Services Society*¹¹⁸). However, discretion provides a precarious basis on which to mount and to maintain a DCR not least because it is open to a person to bring judicial proceedings to challenge the legality of a DCR and/or to require a public body to enforce certain laws.¹¹⁹ The courts, however, will not lightly interfere with an exercise of discretion that was reasonable and rational. Cases will be fact and context specific.

Basic scheme of the Misuse of Drugs Act and the M.D. Regulations 2001.¹²⁰

The MDA 1971 provides the basic legal framework for controlling the distribution and use of drugs specified in three Classes (A, B, and C) in Schedule 2. The Act:

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

The MDA 1971 tends to follow a two-stage approach in the creation of offences. First, certain activities are made “unlawful” (e.g. possession, s.5(1)). Secondly, the unlawful act is then made an “offence” (e.g. possession, s.5(2)) subject to certain exceptions or exemptions.

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

It would therefore be theoretically possible to devise a scheme (e.g., under the MDA 1971) by which the distribution and possession of particular controlled drugs remain unlawful (i.e. in that sense ‘not legalised’), but where a breach of the scheme would not amount to a criminal offence (in that sense “decriminalised”). Certain harm-reduction schemes would thus fall within the sphere of health and education (and enforced largely through civil processes) but a prosecution would not result. Some commentators might go further and argue that some acts should not be regulated at all (e.g. possession for personal use).

As we have seen, the MDA 1971 is not all about prohibition: what the Misuse of Drugs Act prohibits, the Misuse of Drugs Regulations 2001 permit. By working the MDA and the Regulations together, many different results can be achieved, and achieved reasonably quickly: usually by secondary legislation.

¹¹⁸ [2011] 3 SCR 134, 2011 SCC 44

¹¹⁹ See, for example, *R v Commissioner of the Police of the Metropolis ex parte Blackburn* [1968] 2 QB 118, and *R (Banks) v Tower Hamlets London Borough Council* [2009] EWHC 242 (Admin).

¹²⁰ For a summary of offences, and a summary of the Regulations, see Appendix ‘C’.

The mechanism for making regulations under the MDA provides considerable scope for sensible and flexible approaches to drug issues, including harm-reduction schemes. As the *Independent Inquiry on the Misuse of Drugs 1971* observed, much could be achieved without the need for changes to primary legislation.¹²¹ It concluded that the Conventions and the MDA “are thus flexible regulatory instruments under which much remains permitted. Those instruments should not be regarded as being solely repressive.”¹²²

Note that even if the MDA 1971 was repealed (and the PSA 2016), the medicines legislation is likely to remain. A number of offences exist under the latter legislation, for example, selling or supplying, or offering to sell or supply, an “unauthorised medicinal product”.¹²³

The Main MDA 1971 Offences

Offences

The main offences under the Misuse of Drugs Act 1971 are:

- (1) Simple possession: section 5.
- (2) Supply: section 4.
- (3) Being concerned in the supply of a controlled drug: section 4.
- (4) Offering to supply a controlled drug: section 4.
- (5) Production of a controlled drug: section 4.
- (6) Providing paraphernalia for Class A drug consumption: section 9A.
- (7) Permitting or suffering premises to be used for certain prohibited purposes: section 8.
- (8) Exporting or importing controlled drugs: section 3.
- (9) Incitement to commit a Misuse of Drugs Act offence: section 19.

Other relevant offences (not under the MDA) are:

- (1) Offences under the Psychoactive Substances Act 2016
- (2) Various offences under the Human Medicines Regulations 2012.
- (3) Three offences of encouraging or assisting crime pursuant to Part 2 of the Serious Crime Act 2007.
- (4) Administering a noxious substance: section 23, Offences Against the Person Act 1861.
- (5) Manslaughter by an unlawful and dangerous Act, or by gross negligence.

Other actions relevant to the MDA 1971

“Preparations” and “products” containing a controlled drug are also controlled under the Misuse of Drugs Act 1971.

A “preparation” is any act performed by a human being that puts a substance into a form ready for consumption.¹²⁴ The act of mixing heroin, water, and citric acid, is an act of preparation.

Preparing a drug may or may not be an act of “production” (contrary to section 4 of the

¹²¹ Ruth Runciman DBE (Chair), Police Foundation, March 2000.

¹²² Chapter 1, para.3.

¹²³ See regs. 46 and 47 of the Human Medicines Regulations 2012.

¹²⁴ See *R v Aziz* [2012] EWCA Crim 1063 and the commentary by this author [2012] Crim LR 800; and see *Stevens* [1981] Crim. L.R. 568; *Cuncliffe* [1986] Crim. L.R. 547; *Hodder v DPP* [1990] Crim.L.R. 261.

Misuse of Drugs Act 1971: a drug trafficking offence). Heroin in solution is a “preparation”. It may also be a “product” if (for example) it is bottled, or perhaps stored in a fridge.¹²⁵ Crushing pills to put them into a form ready for consumption will also be an act of “preparation”. In *R v Russell*,¹²⁶ the Court of Appeal held that the conversion of one form of Class A drug into another form (e.g. “salt” to “base”) of the same genus (e.g. cocaine) may constitute “production” within the meaning of s.4 of the MDA 1971.

More contentious is the decision in *R v Williams and McCollin*¹²⁷ which held that adding a substance (e.g. caffeine and paracetamol) to heroin and/or cocaine to bulk up the drugs, was an act of “production”.

Equally contentious is the statement of the Court of Appeal in *R v Aziz* that “making an infusion out of the B Caapi and the Chacruna amounted to producing by making a preparation”.¹²⁸

The law in relation to “preparations” and “products” is not as well developed as it might be.

The above matters (not least in the context of DCRs) when considering section 8 of the Misuse of Drugs Act 1971 (that prohibits managers and occupiers of premises knowingly “permitting or suffering” the *production* of drugs on premises). It is arguably somewhat contrived to contend that a person who prepares his or her heroin, ready for injection, has produced heroin within the meaning of the MDA. In any event, a further question is whether arrest or prosecution would be in the public interest in respect of a professionally run DCR that has as its object harm reduction and the well-being of human kind.

The offence of unlawful possession

As a general rule, a person is in possession of an item when he has custody of it, or when he exercises control over it.¹²⁹ The person must know of the existence of the item, but a mistake as to its quality (for example, mistaking cocaine for amphetamine) will only be a defence if he¹³⁰ neither believed nor suspected nor had ‘reason to suspect’ that the substance was a controlled drug.¹³¹

It is likely that a member of staff employed by a DCR would come into possession of controlled drug at some stage (e.g. finding a controlled drug that had been abandoned or left behind by a user).

Possession is a continuing state of affairs. An offence may be committed by “aiding” (assisting) or “abetting” (encouraging) it. The question that arises is whether a person who works in, or who operates a DCR, knowing that D is in unlawful possession of a controlled drug, at least “aids” D’s continued possession by facilitating D’s use of it. It would be rash to rule out the possibility of a conviction on that basis, but a prosecutor would need to carefully consider whether it a prosecution is in the public interest. The position is made more difficult and perilous by virtue of Part 2 of the Serious Crime Act 2007 (encouraging or

¹²⁵ Consider *Hodder v DPP* [1990] Crim.L.R. 261 albeit in the context of psilocybin mushrooms.

¹²⁶ (1992) 94 Cr.App. R. 351

¹²⁷ [2011] EWCA Crim 232

¹²⁸ *R v Aziz* [2012] EWCA Crim 1063 and the commentary by this author [2012] Crim LR 800, at [4].

¹²⁹ See section 37 of the Misuse of Drugs Act 1971.

¹³⁰ References to the masculine include the feminine gender.

¹³¹ See the statutory defence under section 28 of the Misuse of Drugs Act 1971. Section 28 imposes an evidential burden only: i.e. a defendant need only raise the issue as to whether he suspected, or had reason to suspect that what he was handling was a controlled drug of some description.

assisting the commission of crime: see below).

The jurisdiction of the courts to stay prosecutions as an ‘abuse of process’ is sparingly applied.

Making provision in the *Misuse of Drugs Regulations* 2001 to disapply section 5(1) of the MDA 1917 in respect of staff at a DCR (when acting in the course of their employment) would be a straightforward way of protecting them from criminal liability under that provision.

A member of staff, who comes into possession of a controlled drug that had been obtained unlawfully by a visitor to a DCR, should not return it as this would be a clear act of supply *unless* that action was expressly exempted under Regulations.

Note that it is not an offence to be in simple possession of a “psychoactive substance” within the meaning of the Psychoactive Substances Act 2016 (other than in a custodial institution¹³²).

No general offence of “using” a controlled drug (MDA 1971)

The three main United Nations conventions do not require signatories to treat, as criminal offences, the *use*, or the self-administration, of any scheduled/controlled drug. However, Parties are free to criminalise “use” if they wish to do so. In New South Wales, an offence of “use” does exist.¹³³

The MDA 1971 does not create a *general* offence of using a controlled drug – probably because there has been no pressing need to do so. In the vast majority of cases a person cannot use a drug without first being in possession of it. There has been an understandable reluctance on the part of prosecutors to rely on evidence of a drug trace to prove past possession: the problems of proving possession at some earlier time are evidential rather than conceptual.

However, there are two circumstances in which the personal use of a controlled drug is a criminal offence. The first is in relation to the smoking of “or otherwise [to] use” prepared opium (section 9, MDA 1971). The second situation is the prohibition on the supply of articles for administering or preparing controlled drugs “where the administration is unlawful”. By section 9A(4), *any* administration of a controlled drug is unlawful for the purposes of the section (save for the exceptions in s.9A(4)), and this would seem to include self-administration.

Supply

“Supply” is not defined by the Misuse of Drugs Act 1971 beyond the fact that “supplying” includes “distributing” [section 37(1)]. Supplying is the physical transfer of the drug with the intention of enabling the recipient to use it for his/her own purposes: *Maginnis*.¹³⁴

Staff at a DCR must decline a request from a drug user to assist him or her to inject an

¹³² See section 9 of the Psychoactive Substances Act 2016.

¹³³ Section 12 of the Drug Misuse and Trafficking Act 1985 No 226 provides that “(1) A person who administers or attempts to administer a prohibited drug to himself or herself is guilty of an offence. (2) Nothing in this section renders unlawful the administration or attempted administration by a person to himself or herself of a prohibited drug which has been lawfully prescribed for or supplied to the person.”

¹³⁴ [1987] AC 303.

illicitly obtained drug.

The following points should be noted:

- (a) It is no offence for 'A' to inject himself,¹³⁵ but 'A' will be in unlawful possession of the drug (at least until he injects it).
- (b) If 'B' shares some of his heroin with 'A', which the latter uses to self-inject, there will be an unlawful supply of the drug by 'B' to 'A'. Occupiers and managers of a DCR must prevent that occurrence, or risk falling foul of section 8 of the Misuse of Drugs Act 1971 (knowingly permitting premises to be used for supply). However, B has not jointly (with A) "administered" a noxious thing contrary to s.23 of the Offences Against the Person Act 1861 (see *R v Kennedy No.2*, below).
- (c) If 'A' was too ill to inject, and requested 'B' to inject him, and 'B' did so, then 'B' will be guilty of administering a "noxious thing" (heroin) contrary to section 23 of the Offences Against the Person Act 1861 (see below). Consent is not a defence: *Cato*.¹³⁶
- (d) If 'A' loaded his own heroin into a syringe, but asked 'B' to inject him, it seems that 'B' has not supplied 'A' with the drug: *Cato*,¹³⁷ applying *Harris*.¹³⁸
- (e) If 'A' asked 'B' to inject him with B's heroin, and 'B' did so, then 'B' is guilty of the section 23 offence (OAPA 1861), *as well as* unlawfully supplying the drug. A manager or occupier of a drug consumption room may be guilty under section 8 (MDA 1971) if he/she knows that supplying has taken place on their premises.

Administering a noxious thing

Section 23 of the offences Against the Person Act 1861 provides:

...whosoever shall unlawfully and maliciously administer to, or cause to be administered to or taken by any other person any poison, or other destructive or noxious thing, so as thereby to endanger the life of such person, ... shall be guilty of an offence.

Heroin is a "noxious thing": *Cato*.¹³⁹

There is no doubt that illicitly obtained heroin, mixed with water, is also a "noxious thing".

'A' and 'B' act jointly to "administer" a drug

Consider two situations:

Example 1: 'A' prepared a syringe containing heroin, and handed the syringe to 'B', who injected himself.

Where B made a voluntary and informed decision to self-inject, B acts autonomously and thus A has not acted jointly with B: see *R v Kennedy No.2* (below).

Example 2: 'A' holds a tourniquet around 'B's arm while the latter self-injects.

¹³⁵ The masculine includes the feminine gender.

¹³⁶ [1976] 1 WLR 110, 1 All ER 260.

¹³⁷ [1976] 1 WLR 110, 1 All ER 260

¹³⁸ [1968] 1 W.L.R. 769

¹³⁹ [1976] 1 WLR 110, 1 All ER 260. Some commentators have queried that heroin of good quality is "noxious", but it is unlikely that the courts of the United Kingdom will say that *Cato* is wrong.

This situation is more difficult. There can be cases where A and B act jointly in the administration of a drug or noxious thing.

In *R v Kennedy No.2*,¹⁴⁰ the House of Lords (the forerunner to the UK Supreme Court) held that informed adults of sound mind were treated by the law as autonomous beings able to make their own decisions about how they would act. After K had supplied the heroin and prepared the syringe, the deceased had, knowing what he was doing, chosen whether to inject himself or not and, therefore, K could not have “caused” the drug to be administered to the deceased. Accordingly, for the purposes of the offence of unlawfully administering a drug contrary to section 23 of the 1861 Act, the question was *not* whether K had facilitated or contributed to the administration of the drug *but whether* K had gone further and actually “administered” it. On the facts of that case, the deceased had made a voluntary and informed decision to administer the drug to himself and thus K had not jointly administered the drug with him. Consequently, K had committed no offence under section 23 of 1861 Act. Furthermore, because K had committed no criminal act which had been a significant cause of the deceased's death, K's conviction for manslaughter was quashed.

However, the House of Lords observed that it is possible “to imagine factual scenarios in which two people could properly be regarded as acting together to administer an injection”. Thus the question is whether a drug is self-administered or jointly administered. The latter situation could attract criminal liability on the part of the person giving assistance.

*Unlawful act manslaughter*¹⁴¹

Applying *R v Kennedy No.2* (above), where a person supplied a drug to the deceased, and the drug caused death, the chain of causation might be broken if the deceased had a free choice, knowing the facts, whether to inject himself or not. In those circumstances the supplier is not guilty of “unlawful act manslaughter” (but the facts may disclose “gross negligence manslaughter”: see *R v Evans*¹⁴²). However, as stated above, a drug (unlawfully obtained and supplied by D to the deceased) that caused death, might render D liable in manslaughter if D had acted jointly to administer the drug: see *R v Burgess and another*,¹⁴³ *R v Keen*,¹⁴⁴ *R v Craven and another*,¹⁴⁵ and *R v Finlay*.¹⁴⁶

A DCR practitioner would be well advised to make it clear that the action of self-administration is not condoned by the DCR, that the decision to inject (or to inject in a particular way) is that of the visitor alone.

Paraphernalia

Section 9A of the Misuse of Drugs Act 1971 provides:

- (1) A person who supplies or offers to supply any article which may be used or adapted to be used (whether by itself or in combination with another article or other articles) in the administration by any person of a controlled drug to himself or another, believing

¹⁴⁰ [2008] 1 A.C. 269.

¹⁴¹ See D. Ormerod and R. Fortson, “*Drug Suppliers as Manslaughterers (Again)*” [2005] Crim LR 819.

¹⁴² [2009] EWCA Crim 650

¹⁴³ [2008] EWCA Crim 516

¹⁴⁴ [2008] EWCA Crim 1000

¹⁴⁵ [2008] EWCA Crim 1742

¹⁴⁶ [2009] EWCA Crim 1493

- that the article (or the article as adapted) is to be so used in circumstances where the administration is unlawful, is guilty of an offence.
- (2) It is not an offence under subsection (1) above to supply or offer to supply a hypodermic syringe, or any part of one.
 - (3) A person who supplies or offers to supply any article which may be used to prepare a controlled drug for administration by any person to himself or another believing that the article is to be so used in circumstances where the administration is unlawful is guilty of an offence.
 - (4) For the purposes of this section, any administration of a controlled drug is unlawful except—
 - (a) the administration by any person of a controlled drug to another in circumstances where the administration of the drug is not unlawful under section 4(1) of this Act,
 - (b) the administration by any person of a controlled drug, other than a temporary class drug, to himself in circumstances where having the controlled drug in his possession is not unlawful under section 5(1) of this Act, or
 - (c) the administration by any person of a temporary class drug to himself in circumstances where having the drug in his possession is to be treated as excepted possession for the purposes of this Act (see section 7A(2)(c)).
 - (5) In this section, references to administration by any person of a controlled drug to himself include a reference to his administering it to himself with the assistance of another.

Section 9A creates two offences in respect of two situations:

- i. articles that may be used, or adapted to be used, in the **administration** of a controlled drug by any person to himself or herself, and the person supplying the article *believes* that it will be so used;
- ii. articles used to **prepare** a controlled drug for administration/consumption, believing that the article will be so used.

The offence is summary only, that is to say it is triable only in a Magistrates' Court. Section 9A was intended to prohibit the sale/provision of so-called 'drug kits' – particularly those sold for the snorting of cocaine. In practice, it is an offence that is rarely charged.

Note the mental element that must be proved: belief is a state of mind that falls short of knowledge but is greater than having suspicion.

An offence is committed if 'A' provides 'B' with an article in the belief that 'C' will use it to a unlawfully administer a controlled drug to himself (or even to "another", for example 'D').

No money need change hands: no considerations/value of any sort need be involved.

Section 9A(1) and (3) are disapplied in the circumstances specified by reg. 6A of the Misuse of Drugs Regulations 2001 (as amended). The savings/exceptions apply to (a) a practitioner; (b) a pharmacist; (c) "a person employed or engaged in the lawful provision of drug treatment services", (d) "a supplementary prescriber acting under and in accordance with the terms of a clinical management plan", and (e) a nurse independent prescriber. Such persons (when acting in a professional capacity) may supply:

- (a) a swab;
- (b) utensils for the preparation of a controlled drug;
- (c) citric acid;
- (d) a filter;
- (e) ampoules of water for injection, only when supplied or offered for supply in

accordance with the Medicines Act 1968.

(f) ascorbic acid.¹⁴⁷

As recently as 5 September 2014 a person employed or engaged “in the lawful provision of drug treatment services may, when acting in that capacity, supply or offer to supply *aluminium foil* in the context of structured steps, (a) to engage a patient in a drug treatment plan, or (b) which form part of a patient's drug treatment plan.”¹⁴⁸

The provision of articles for consumption – *other than those permitted by section 9A (and by the 2001 Regulations)* – contravenes section 9A.

It is not entirely clear what is included within the expression “utensils for the preparation of a controlled drug”. The expression presumably embraces mixing utensils, but would a candle, spoon, or a lighter (to cook heroin) come within that definition? Is the process of cooking heroin an act of “preparation”? There is a strong argument for saying that it is.

The provision of an article to be used as a tourniquet is not permitted under the Regulations. This is because the Regulations prohibit the provision of utensils for the *administration or consumption* of a controlled drug (unless excepted by the Regulations).

Note: it is not an offence contrary to section 8 of the Misuse of Drugs Act to permit/suffer articles to be supplied in contravention of section 9A.

Implications of section 9A for drug consumption rooms

There is no difficulty if a worker within a DCR can bring himself or herself within regulation 6A. However, note that a “drug treatment service” is one that is “lawful”. There would be no ambiguity over the status of a DCR if it was licenced or authorised under legislation to operate as such. Thus the preferred (safest) options are (i) that DCRs be licenced or approved, (ii) that the 2001 Regulations be further amended to enable drug consumption rooms to provide a wider range of articles, or (iii) that section 9A be disapplied in respect of a DCR.

Note that the provision of “water for injection” continues to be problematic because its use remains regulated by the medicines legislation. If a user asked a member of staff for (and is given) a bottle of water, section 9A will presumably be contravened if the employee believes that the water will be used to prepare a drug for consumption, or that it will be used for the purpose of administering the drug.

Premises: Permits or suffers: managers and occupiers

Section 8 of the MDA as originally drafted, provides:

8. A person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises, that is to say:

- (a) producing or attempting to produce a controlled drug in contravention of section 4(1) of this Act;
- (b) supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in

¹⁴⁷ Added by the Misuse of Drugs and the Misuse of Drugs (Supply to Addicts) (Amendment) Regulations SI 2005 No.2864.

¹⁴⁸ Reg.6A of the MD Regs 2001 as amended by the Misuse of Drugs (Amendment No. 2) (England, Wales and Scotland) Regulations SI 2014 No.2081.

- contravention of section 4(1);
- (c) preparing opium for smoking;
- (d) smoking cannabis, cannabis resin or prepared opium.

Section 8 of the MDA 1971¹⁴⁹ was the subject of amendment (s.38 of the Criminal Justice and Police Act 2001). Had it come into force, it would be an offence for an occupier or manager of premises to have knowingly permitted or suffered “administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used”. The amendment never came into force and, indeed, it was repealed by the Drugs Act 2005.¹⁵⁰

Inciting an MDA 1971 offence: section 19

The definition of incitement is broad – perhaps as broad as encompassing “suggestion, proposal, request, exhortation, gesture, argument, persuasion, inducement, goading, or arousal of cupidity”.¹⁵¹ However, prosecutions under s.19 MDA are rare.

The Legal Affairs Section of the UNDCP has stated (albeit in the context of the UNCs) that where a government permits or tolerates the operation of a DCR, it would be difficult to assert that it is the government’s intention to “actually incite to or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs” –

“On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options”.¹⁵²

Encouraging or assisting a crime: Serious Crime Act 2007

Part 2 of the Act creates three offences (ss.44-46) - none of which applies to Scotland. The offences are broadly drawn. The three offences are described (actually misdescribed) in the respective headings to ss.44-46 as:

- i) Intentionally encouraging or assisting an offence: s.44
- ii) Encouraging or assisting an offence believing it will be committed: s.45
- iii) Encouraging or assisting offences believing one or more will be committed: s.46.

The three offences are complex and cannot adequately be explained in a few words.¹⁵³ However, the following points should be noted:

1. The common law offence of incitement is abolished (s.59, SCA) but the MDA offence of incitement (s.19 MDA) is retained.

¹⁴⁹ Section 8 of the MDA 1971 provides, “A person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises, that is to say— (a) producing or attempting to produce a controlled drug in contravention of section 4(1) of this Act; (b) supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in contravention of section 4(1); (c) preparing opium for smoking; (d) smoking cannabis, cannabis resin or prepared opium.”

¹⁵⁰ SI 2005 No. 2223.

¹⁵¹ *Nkosiyana* 1966(4) SA 655 AD.

¹⁵² E/INCB/2002/W.13/SS.5, paras. 27 and 28; see <http://www.communityinsite.ca/INCB-HarmReduction.pdf>

¹⁵³ However, see R. Fortson: “*Blackstone's Guide to the Serious Crime Act 2007*” (Oxford: Oxford University Press, 2008); D. Ormerod and R. Fortson: “*Serious Crime Act 2007: The Part 2 Offences*” [2009] Crim L.R. 389; see R. Fortson: “*Inchoate Liability and the Part 2 Offences under the Serious Crime Act 2007*” in A. Reed and M. Bohlander (eds), *Participation in Crime* (Farnham: Ashgate, 2013), Ch.10, at pp.183-185.

2. The three Part 2 SCA offences apply regardless of whether or not the offender who was assisted or encouraged, went on to commit the anticipated offence.
3. The offender is liable to any penalty for which he would be liable on conviction of the “anticipated or reference offence”.

The SCA 2007 presents a further potential difficulty for those operating a DCR or who contemplate establishing one. The argument that might be run is that the DCR is assisting users (i) to be in continued possession of a controlled drug until such time as the drug is consumed, and/or (ii) that the DCR has assisted the user to “prepare” a controlled drug for consumption. Liability will be fact-specific.

Determining the legality of a DCR: a worked example

A worked example illustrates the legal issues that could arise under United Kingdom laws.¹⁵⁴

X attends a DCR. Some members of staff are medically trained, but not all of them. The staff know that X intends to use, within the DCR, heroin that he/she had obtained illicitly. The DCR does *not* allow the smoking of prepared opium on the premises. The staff provide no controlled drugs (e.g. heroin or cocaine) to attendees. Clean utensils (paraphernalia) are provided to X to facilitate safer drug use. The utensils, left by X, carry residual traces of controlled drugs. The staff collect and place the items into waste bins. The content of the bins may be disposed of hours or days later. The policy of the DCR is not to deliver the contaminated items into the possession of the police despite the latter’s request for them along with information concerning the identity of the attendees and the drugs that each had used. The DCR provides literature to attendees that advise them of safer drug use techniques.

Applying the principles to the example

- (1) *Possession by X*: X was in unlawful possession of heroin. The existence of a trace might be cogent evidence that X was in possession of a larger quantity of heroin at an earlier time: *Pragliola*.¹⁵⁵ The view that the police cannot prosecute past possession is a myth, but public interest considerations come into play. The DCR will have to decide on policy regarding client confidentiality and the circumstances in which a DCR will co-operate with police (if at all) if the latter are investigating an offence.
- (2) *Possession by staff*: staff members who receive a controlled drug into their possession will be acting unlawfully unless either they, or the drug, falls within a category specified by the Misuse of Drugs Regulations as being excepted from liability. Staff who handle used syringes and needles (knowing that they must contain something) will be in possession of any remnants of controlled drugs contained in or on those items if the remnants are large enough to amount to ‘something’.¹⁵⁶ Such possession might be unlawful unless exempted under the MDA

¹⁵⁴ Based on a perception of a Needle Exchange scheme canvassed in *Harm Reduction Programmes and the Russian Legal System*, Professor William Butler, published by International Family Health.

¹⁵⁵ [1977] Crim LR 612.

¹⁵⁶ Consider *Boyesen* [1982] A.C. 768, [1982] Crim. L.R. 596.

and its regulations or the possessor has a defence under section 5(4) of the Misuse of Drugs Act.¹⁵⁷ The defences offer very limited protection.¹⁵⁸ Section 5(4) is unlikely to avail the staff on the facts stated in the example because they did not receive the items for the purpose of preventing the commission of an offence in connection with the drug, or for the purpose of handing the drug to a person lawfully entitled to possess it. However, public interest considerations come into play when police or a prosecuting authority is contemplating an arrest or prosecution.

- (3) *Possession with intent*: holding an item that the possessor knows contains something (when that ‘something’ is in fact a controlled drug/trace), intending to transfer that item to another (e.g., another employee at a DCR) is to have the intention of supplying the drug. There is the risk of liability unless the possessor can rely on an exemption under the MDA or regulations, or he/she has a defence under section 28 MDA (proof of lack of knowledge). However, again, it would surely not be in the public interest to prosecute unless the person acted in bad faith. The preferred solution is for staff to be protected by Regulations made by Government. The statutory defence under section 5(4)(b) MDA 1971 would not be available because it is limited to the offence of simple possession.
- (4) *Permitting premises*: In the above example, the staff did not supply the controlled drug that the attendee seeks to use. The smoking of prepared opium was not allowed in the DCR. The one moot area is whether the act of the attendee in putting the controlled drug into a state ready for his/her consumption, constitutes an act of “producing” the drug (consider *R v Aziz*¹⁵⁹) and, thus, whether the DCR permits or suffers that activity to take place (if the owner/occupier has knowledge of that activity). Each case will be fact-specific.
- (5) *Incitement*: The purpose in distributing the literature was not, in the above example, to encourage others to commit offences. The content of the literature probably suggests a contrary intention.

Apart from criminal offences, there exist a number of civil powers and civil law rules that could impede the running or setting up of a DCR. This paper cannot address or even allude to all of them. Local planning laws and other local laws may need to be considered.

¹⁵⁷ "In any proceedings for an offence under [section 5(2)] above in which it is proved that the accused had a controlled drug in his possession, it shall be a defence for him to prove:

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

¹⁵⁸ *R v X* [1994] Crim LR 827

¹⁵⁹ [2012] EWCA Crim 1063

The Anti-social Behaviour, Crime and Policing Act 2014

Community Protection Notices

Section 43 of the Anti-social Behaviour, Crime and Policing Act 2014 empowers an “authorised person”¹⁶⁰ (e.g. a local authority) to issue a “*Community Protection Notice*” (CPN) to an individual aged 16 or over, or to a body, if satisfied on reasonable grounds that the conduct of the individual or body (of a persistent or continuing nature) is having a detrimental effect on the quality of life of those in the locality, *and* the conduct is unreasonable. The Notice may include a requirement to stop doing specified things or to do specified things, or to require reasonable steps to be taken to achieve specified results. The section applies to conduct on, or affecting, premises that a person owns, leases, occupies, controls, operates, or maintains (section 44). It is an offence to fail to comply with a CPN (section 48).

Closure Notices

Chapter 3 of the 2014 Act makes provision for the *closure of premises associated with nuisance or disorder*. Before issuing a *Closure Notice*, the police officer or local authority must ensure that any appropriate body or individual has been consulted (section 76(7)). Whenever a *Closure Notice* is issued, an application must be made to a magistrates’ court for a *Closure Order* (unless the notice has been cancelled): section 80.

Public Spaces Protection Notices

It is conceivable that the running of a DCR could be impeded by the making of a *Public Spaces Protection Order* (depending on its terms and reach). A *Public Spaces Protection Order* is an order that *prohibits* specified things being done in the restricted area, *or requires specified things to be done* by persons carrying on specified activities in that area, (or both). The prohibition or requirement may be framed so as to apply to all persons, or only to persons in specified categories, and to apply at specified times and/or in specified circumstances. A local authority may make a *Public Spaces Protection Order* if satisfied on reasonable grounds that (section 59):

- (1) Activities carried on in a public place within the authority's area have had a detrimental effect on the quality of life of those in the locality, or it is likely that activities will be carried on in a public place within that area and that they will have such an effect.
- (2) The effect, or likely effect, of the activities is, or is likely to be, of a persistent or continuing nature, or is likely to be such as to make the activities unreasonable, and justifies the restrictions imposed by the notice.

Negligence - and health and safety

There is no reason to suppose that the courts of civil jurisdiction would develop and apply principles unique to DCRs (either for or against them). Those managing and controlling a DCR would need to be mindful of the areas of operation that might reasonably give rise to legitimate complaint.

¹⁶⁰ See section 53.

It is no answer for a DCR to say that in seeking to address one set of social problems, it is entitled to be protected from liability by the common law if its negligent actions cause loss or damage.

Those who operate a DCR will have to meet health and safety requirements. Employers will be required to exercise reasonable skill and care in protecting its employees from loss or injury, whilst (perhaps) being vicariously liable for acts performed by them in the ordinary course of their employment.

The UK Health Act 2006 makes it an offence to smoke “tobacco or anything which contains tobacco” or to smoke “any other substance” (s.1(2)) in a “smoke-free place” (s.7). It is also an offence for any person who controls or is concerned in the management of smoke-free premises to fail to cause a person smoking there to stop smoking (s.8). There are exemptions made by regulations (see the Smoke-free (Exemptions and Vehicles) Regulations SI 2007 No. 765). The smoking of (e.g. heroin) would thus not be permissible unless exempted under regulations.

It will be seen that the MSIC (Australia) is protected by statute (requiring primary legislation) in respect of civil liability. Section 36P of the Australian Drug Misuse and Trafficking Act 1985 provides:

36P Exemption from civil liability in connection with conduct of licensed injecting centre

- (1) Anything done or omitted to be done in connection with the conduct of a licensed injecting centre does not subject:
 - (a) the person by whom that thing was done or omitted, or
 - (b) any other person (including the licensee, the State and any Minister of the Crown in right of the State),
to any action, liability, claim or demand if the thing was done or omitted to be done in good faith for the purpose of executing this Part, and was not done or omitted to be done in a reckless or grossly negligent manner.
- (2) This section does not affect any rights or obligations as between a member of the staff of a licensed injecting centre and his or her employer.

Section 9 of the Irish *Misuse of Drugs (Supervised Injecting Facilities) Act 2017* provides that:

“A licence holder or any person acting under the direction of the licence holder shall not be liable for any act done or omitted to be done in a supervised injecting facility, in relation to the provision of assistance or advice to, or care of, an authorised user and no person shall have a cause of action in respect of that act.”

Town and Country Planning, public involvement, and sensible policing

This is a complex topic. In setting up a DCR it is essential that the local community is consulted and involved in decisions relating to the proposed use of a site for a harm reduction scheme.

The police, and the local authority, will wish to ensure that a DCR does not give rise to disorder, or a serious nuisance, or import into the area social problems on a scale that did not exist before the drug consumption room opened.

There is some anecdotal information that police officers have occasionally targeted persons who have left a drug consumption room, or who were about to enter one. That type of conduct is to be deprecated.

Tensions between the police, and a drug consumption room, are best dealt with by way of protocols that represent the consensus of as many relevant interested parties as possible.

Various statutory bodies (not just the police) are empowered to call for the production of records kept by an organisation or facility. Although records may or may not speak against the author, the absence of records and documentation pertaining to the running of a DCR (e.g. policy documents, logs, incident reports) could be equally damaging.¹⁶¹

Drug Quality Control

The hypothetical situation here is the provision of a drug testing service by the DCR to determine whether, for example, the substance intended to be used by an attendee is adulterated. In the absence of legal authority (e.g. by way of Regulations made under the MDA) there is no doubt that any scheme that involves taking from a user an illicitly acquired substance from a user ('X'), testing it for 'purity' by another ('DCR'), *and then knowingly returning it to the user* constitutes an unlawful supply. In the absence of statutory legal protection, the answer is *not* to return a controlled drug to the user.

The manager and/or an occupier of the premises, who knowingly permits the supply of a controlled drug (e.g. to a user) commits an offence contrary to section 8 of the MDA. Whether the drug testing service is provided in a house, boat, car, or tent – all are 'premises' for the purposes of the Act. It is doubtful that such a service would constitute incitement to commit an MDA offence (s.19, MDA), but much would depend on how the scheme was run and promoted. Such a service could be permitted and controlled legally by Regulations made under the MDA.

What can be done?

Some commentators draw parallels between drug consumption rooms and needle exchange centres in terms of their rights, duties, and liabilities under the law. But there are obvious significant differences between the two services.

Although the experience of needle exchange centres and the experience of existing drug consumption rooms, will be instructive, persons who contemplate setting up a DCR in the United Kingdom would be well-advised to draw up proposals and policies mindful of:

- (i) the law as it exists in the United Kingdom;
- (ii) the policy considerations that appear to underpin the relevant legal principles; and
- (iii) the drug services that already exist in respect of the target population.

The commentary, "*Unsupervised Fixing Rooms, Supervised Injectable Maintenance Clinics - Understanding the Difference*"¹⁶² attracted much interest, but correspondents did not adequately address one passage:

For the open access supervised injecting centre, there are major operational issues. Should the attendee be prohibited from choosing certain drug mixtures, doses, or sites of injecting considered too dangerous-for example, injecting barbiturates or temazepam, or ground-up tablets of methadone, Diconal (dipipanone / cyclizine) or Ritalin (methylphenidate), or injecting dangerous doses, or injecting in femoral or neck veins?

¹⁶¹ Consider the *Winter Comfort* case (*R v Wyner and Brock*, Court of Appeal, 21st December 2000).

¹⁶² J. Strang and R. Fortson, 100 BMJ Volume 328, 10 January 2004.

Would there be a lower age limit? When deaths occur (inevitable, eventually), where will medico-legal liability lie? Both action and inaction may leave the doctor and organisation liable. And what of charges (already made) of aiding and abetting, and even fostering more frequent and more excessive drug use? When dealing occurs (inevitable, to some extent), will agencies and staff be open to prosecution, as with the imprisoned staff from Winter Comfort day centre? These obstacles may not be insuperable, but they cannot just be ignored.

Without legal protection, a DCR will routinely face medico-legal dilemmas.

As we have seen, many of the aforementioned issues could be resolved by giving DCRs statutory protection, but this would require some primary legislation and amendments being made to secondary legislation. Thus, statutory protection could be given to DCRs by amending the Misuse of Drugs Regulations 2001 so as to exempt managers and staff from the provisions of section 5(2) [possession], section 5(3) [possession with intent to supply], section 4(3)(a) [supply or making an offer to supply], section 4(3)(b) [being concerned in the supplying of a controlled drug], section 4(3)(c) [being concerned in the making of an offer to supply], section 4(2) [production], section 9A [providing paraphernalia for administration], and section 8 [premises].

The United Kingdom could follow the model provided by the *Misuse of Drugs (Supervised Injecting Facilities) Act 2017*¹⁶³ (Republic of Ireland: see above); and see section 36O of the Drug Misuse and Trafficking Act 1985 (Australia):

36O Exemption from criminal liability for persons engaged in conduct of licensed injecting centre

Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

- (a) it is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed injecting centre, and
- (b) in particular, a person who is engaged, participates or is otherwise involved in the conduct of a licensed injecting centre does not commit an offence under section 14 or 19, or any other offence prescribed by the regulations, just because of that fact.

Alternatively, given that the police, prosecuting and administrative agencies, may exercise discretion in the performance of their functions, it would be open to stakeholders of a multi-agency DCR¹⁶⁴ (in any part of the UK) to be signatories to a document (whether styled a 'protocol', 'terms of engagement', or a 'comfort letter') with regards to the establishment and running of a DCR.

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¹⁶³ <http://www.irishstatutebook.ie/eli/2017/act/7/enacted/en/pdf>

¹⁶⁴ For example, Police and Crime Commissioners, Chief Constables, and relevant representatives of the local authority where the DCR is, or is to be, situated.

Appendix A – Re Sydney

Drug Misuse and Trafficking Act 1985 No 226 (as amended)¹⁶⁵

Part 2A – Medically supervised injecting centres

Division 1 – Preliminary

36A Limited operation of Part

- (1) Despite any other provision of this Part, this Part operates to allow the responsible authorities to issue only one licence in respect of only one premises.
- (2) However, nothing in this Part prevents the responsible authorities:
 - (a) from issuing a further licence to a person other than the holder of an earlier licence, or
 - (b) from issuing a further licence in respect of premises other than those specified in an earlier licence, so long as the earlier licence is surrendered or revoked before the further licence takes effect.
- (3) (Repealed)

36B Objects of Part

The objects of this Part are as follows:

- (a) to reduce the number of deaths from drug overdoses,
- (b) to provide a gateway to treatment and counselling for clients of the licensed injecting centre,
- (c) to reduce the number of discarded needles and syringes and the incidence of drug injecting in public places,
- (d) to assist in reducing the spread of blood-borne diseases, such as HIV infection or Hepatitis C.

36C Review of Part

- (1) The Minister is to review this Part to determine whether the policy objectives of this Part remain valid and whether the terms of this Part remain appropriate for securing those objectives.
- (2) The review is to be undertaken as soon as possible after the period of 5 years from the commencement of the Drug Misuse and Trafficking Amendment (Medically Supervised Injecting centre) Act 2010.
- (3) A report of the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the period of 5 years.

36D Definitions

In this Part:

“child” means a person who is under the age of 18 years.

“director”, in relation to a licensed injecting centre, means a medical practitioner appointed as director of the centre, and includes any other medical practitioner appointed to act as director of the centre during the illness or absence of the director or during a vacancy in the office of the director.

“internal management protocols”, in relation to a licensed injecting centre, means the protocols finalised for the centre as referred to in section 36F or, if the protocols are amended or replaced as referred to in section 36M, the protocols as so amended or

¹⁶⁵ Significant amendments were made by the *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Act 2010 No 81* (New South Wales).

replaced.

“law” includes common law.

“licence” means a licence in force under this Part.

“licensed injecting centre” means the premises that are the subject of a licence.

“prescribed drug” means a prohibited drug or a substance prescribed by the regulations for the purposes of this definition.

“qualified health professional” means a medical practitioner, a registered nurse or a person having qualifications or experience specified or described by order of the Minister published in the Gazette.

“responsible authorities” means the Commissioner of Police and the Director-General of the Department of Health.

“staff”, in relation to a licensed injecting centre, includes:

- (a) all persons engaged to provide services at the centre, whether under a contract of employment or otherwise, and
- (b) all persons authorised to provide voluntary assistance at the centre in accordance with the centre's licence conditions and internal management protocols.

The employer of a person referred to in paragraph (a) or (b) is the person by or on whose behalf the person so referred to is engaged to provide services or authorised to provide voluntary assistance, as the case requires.

“supervisor”, in relation to a licensed injecting centre, means the director of the centre or a qualified health professional nominated by the director to supervise the centre.

Division 2 – Licensing of injecting centres

36E Licence

- (1) The responsible authorities may issue a licence authorising the holder of the licence to conduct specified premises as an injecting centre.
- (2) Nothing in this Part entitles a person to be issued with a licence, and the responsible authorities may refuse an application for a licence if the requirements of section 36F are not satisfied or for any other reason.

36F Restrictions on issue of licence

- (1) A licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:
 - (a) that the internal management protocols for the proposed centre have been finalised and are of a satisfactory standard, and
 - (b) that there is a sufficient level of acceptance, at community and local government level, for the establishment of an injecting centre at the premises, and
 - (c) that the premises are suitable for use as an injecting centre, having regard to all relevant matters including the following:
 - (i) public health and safety,
 - (ii) the visibility of the premises from the street,
 - (iii) the proximity of the premises to schools, child care centres and community centres,
 - (iv) any matters prescribed by the regulations for the purposes of this section.
- (2) If a community drug action plan is in force in relation to the area within which the premises of the proposed injecting centre are situated, the responsible authorities must have regard to that plan in forming an opinion as to the matters referred to in subsection (1) (b) and (c).
- (3) Without limiting subsection (1), a licence for the conduct of premises as an injecting centre must not be issued unless the responsible authorities are of the opinion:

- (a) that any building work that is carried out for the purposes of the centre will be carried out in accordance with the Building Code of Australia, and
 - (b) that any building that is used for the purposes of the centre will comply with the Building Code of Australia.
- (4) In subsection (3), “building”, “Building Code of Australia” and “building work” have the same meanings as they have in the Environmental Planning and Assessment Act 1979.

36G Duration of licence

- (1) Except during any period of suspension, a licence remains in force until it is surrendered or revoked.
- (2) The holder of a licence may, after consultation with the responsible authorities or their representatives, surrender the licence.

36H Conditions of licences generally

- (1) A licence is subject to such conditions as may be imposed from time to time by the responsible authorities, either in the licence or in a separate order in writing served on the holder of the licence.
- (2) Conditions of the kind referred to in subsection (1) may not be imposed without prior consultation with the holder or proposed holder of the licence.
- (3) A licence is also subject to such conditions as are imposed by or under this Part or the regulations.

36I Statutory conditions of licences

The following provisions are conditions of a licence for an injecting centre:

- (a) No child is to be admitted to that part of the centre that is used for the purpose of the administration of prescribed drugs.
- (b) The centre's internal management protocols are to be observed.

36J Contraventions

- (1) A contravention of this Division or the regulations in relation to a licensed injecting centre, or of the licence conditions for a licensed injecting centre, may be dealt with:
 - (a) by one or more of the following:
 - (i) a warning or reprimand administered in writing by the responsible authorities,
 - (ii) a fine (not exceeding an amount equal to 100 penalty units) imposed by the responsible authorities,
 - (iii) suspension of the licence by the responsible authorities for a specified period or until further notice, or
 - (b) by revocation of the licence by the responsible authorities.
- (2) If the contravention also gives rise to an offence:
 - (a) the fact that action has been taken under this section in relation to the contravention does not prevent a penalty from being imposed for the offence, and
 - (b) the fact that a penalty has been imposed for the offence does not prevent action from being taken under this section in relation to the contravention.
- (3) A fine imposed under this section is payable to either responsible authority within the period specified by the responsible authorities, and is to be paid into the Consolidated Fund.
- (4) If a licensee fails to pay a fine imposed under this section (in whole or in part), the responsible authorities may suspend or revoke the licence.
- (5) Nothing in this section prevents the responsible authorities from amending or imposing a condition as a consequence of a contravention referred to in subsection (1).
- (6) The responsible authorities are authorised to suspend or revoke a licence for the

purposes of this section.

- (7) A contravention referred to in subsection (1):
 - (a) does not limit the operation of section 36O, except to the extent that the contravention gives rise to an offence under the regulations made for the purposes of this Part, and
 - (b) does not limit the operation of section 36P.
- (8) A contravention relating to the admission of a child to a licensed injecting centre is not committed if the licensee establishes that, having regard to the relevant provisions of the centre's internal management protocols, it was not apparent to the centre's staff that the person concerned was a child.

36K Reviews of licence

- (1) The responsible authorities may arrange for the ongoing or periodical review of any licensed injecting centre.
- (2) The responsible authorities must arrange for the review of the economic viability of a licensed injecting centre if they are satisfied that the service activity level of the centre has dropped below 75 per cent of the service activity level prescribed by the regulations.¹⁶⁶
- (3) Regulations referred to in subsection (2) may express the level of service activity as a specified number of client visits in any period or may express that level in any other manner.
- (4) The responsible authorities may revoke a licence if, after considering the results of a review under subsection (2), they are of the opinion that the licensed injecting centre has ceased to be economically viable.

36KA Revocation of licence

- (1) The responsible authorities may revoke a licence for any of the following reasons:
 - (a) the responsible authorities are satisfied that it is more appropriate for a licence to be issued in respect of different premises,
 - (b) the responsible authorities are satisfied that the licence holder is not a fit and proper person to hold the licence or, if the licence holder is a corporation, a director or person concerned in the management of the corporation is not a fit and proper person to hold a licence,
 - (c) such other reasons as may be prescribed by the regulations.
- (2) A licence may also be revoked under section 36J or 36K.

Division 3 – Internal management protocols

36L Matters for consideration in relation to internal management protocols

In considering the internal management protocols for a proposed injecting centre for the purposes of section 36F, the responsible authorities must have regard to whether provision needs to be made to ensure that any or all of the following requirements are met:

- (a) The centre must be under the supervision of a supervisor.
- (b) The supervisor must have a general overseeing role of the centre's clinical operations and responsibility for ensuring the adequacy of the clinical procedures used in the centre. This paragraph does not prevent the supervisor from being personally involved in clinical activities in the centre.
- (c) All staff directly supervising injecting activities in the centre must be qualified health professionals.

¹⁶⁶ By Regulation 23 of the Drug Misuse and Trafficking Regulation 2011, "For the purposes of section 36K (2) of the Act, the prescribed service activity level for the licensed injecting centre is an average of at least 208 client visits per day in each month."

- (d) The centre must contain or have satisfactory access to:
 - (i) primary health care services, including medical consultation and medical assessment services, and
 - (ii) drug and alcohol counselling services, and
 - (iii) health education services, and
 - (iv) drug and alcohol detoxification and rehabilitation services, and
 - (v) the services of a methadone provider, and
 - (vi) services for testing for blood-borne and sexually transmissible diseases, and
 - (vii) services involving a needle and syringe exchange program.
- (e) Procedures are to be established to enable staff to ascertain in appropriate cases whether a person seeking admission to the centre is a child.
- (f) At least one member of staff:
 - (i) must be a person with satisfactory qualifications or experience in child protection and youth support, and
 - (ii) must be in attendance at the centre, or available on call to attend the centre, at all times while it is being used as an injecting centre.
- (g) The health and safety of staff and users of the centre are to be protected, having regard to the design and services of the centre.
- (h) Services are to be available and procedures established to ensure compliance or ability to comply, at or in connection with the centre, with the relevant requirements of:
 - (i) this Part, and
 - (ii) the regulations, and
 - (iii) the centre's licence conditions, and
 - (iv) any other provisions of the centre's internal management protocols.
- (i) Any requirements prescribed by the regulations for the purposes of this section.

36M Amendment and replacement of internal management protocols

A licensed injecting centre's internal management protocols may be amended or replaced, subject to the regulations and the centre's licence conditions.

Division 4 – Exemptions from liability

36N Exemption from criminal liability for users of licensed injecting centre

- (1) In this section: “exempt quantity”, in relation to a prescribed drug, means:
 - (a) in the case of a prohibited drug, a small quantity of the drug (subject to paragraph (b)), or
 - (b) in any case, such quantity of the drug as is prescribed by the regulations.
- (2) Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):
 - (a) it is not unlawful for a person at a licensed injecting centre:
 - (i) to be in possession of (otherwise than for supply) no more than an exempt quantity of a prescribed drug, or
 - (ii) to be in possession of an item of equipment for use in the administration of a prescribed drug, or
 - (iii) to administer or attempt to administer to himself or herself no more than an exempt quantity of a prescribed drug, and
 - (b) in particular, a person at a licensed injecting centre:
 - (i) who has in his or her possession (otherwise than for supply) no more than an exempt quantity of a prescribed drug, or
 - (ii) who has in his or her possession an item of equipment for use in the administration of a prescribed drug, or
 - (iii) who administers or attempts to administer to himself or herself no more than an exempt quantity of a prescribed drug,

does not commit an offence under section 10, 11 or 12, or any other offence prescribed by the regulations, just because of that fact.

- (3) Subsection (2) does not affect the operation of:
 - (a) the conditions of any recognizance to which a person is subject (whether under the Crimes Act 1900 or otherwise), or
 - (b) any bail conditions to which a person is subject under the Bail Act 2013, or
 - (c) the conditions of any program to which a person is subject under the Drug Court Act 1998.
- (4) Nothing in this section prevents a police officer from exercising a discretion not to charge a person with an offence under section 10 or 11:
 - (a) in respect of the possession of a prescribed drug, or
 - (b) in respect of the possession of an item of equipment for use in the administration of a prescribed drug,
while the person is travelling to or from, or is in the vicinity of, a licensed injecting centre.
- (5) The reference in subsection (4) to a discretion includes a reference to a discretion referred to in any guidelines applicable to police discretions.

36O Exemption from criminal liability for persons engaged in conduct of licensed injecting centre

Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

- (a) it is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed injecting centre, and
- (b) in particular, a person who is engaged, participates or is otherwise involved in the conduct of a licensed injecting centre does not commit an offence under section 14 or 19, or any other offence prescribed by the regulations, just because of that fact.

36P Exemption from civil liability in connection with conduct of licensed injecting centre

- (1) Anything done or omitted to be done in connection with the conduct of a licensed injecting centre does not subject:
 - (a) the person by whom that thing was done or omitted, or
 - (b) any other person (including the licensee, the State and any Minister of the Crown in right of the State),
to any action, liability, claim or demand if the thing was done or omitted to be done in good faith for the purpose of executing this Part, and was not done or omitted to be done in a reckless or grossly negligent manner.
- (2) This section does not affect any rights or obligations as between a member of the staff of a licensed injecting centre and his or her employer.

Division 5 – Miscellaneous

36Q Application of Environmental Planning and Assessment Act 1979

- (1) Development for the purposes of a licensed injecting centre is permissible without the need for development consent under the Environmental Planning and Assessment Act 1979.
- (2) Part 5 of the Environmental Planning and Assessment Act 1979 does not apply to or in respect of development for the purposes of a licensed injecting centre.

36R Certificate evidence

In any legal proceedings under this Act, a certificate purporting to be signed by either of the responsible authorities:

- (a) that premises specified in the certificate were or were not, on a date so specified, a licensed injecting centre, or
 - (b) that a person specified in the certificate was or was not, on a date so specified, engaged in the conduct of a licensed injecting centre,
- is prima facie evidence of the fact stated in the certificate without proof of the signature or of the official character of the person purporting to have signed the certificate.

36S Regulations

Without limiting section 45, the regulations may make provision, for the purposes of this Part, for or with respect to any of the following matters:

- (a) the standards for a licensed injecting centre, including the elaboration of internal management protocols for a licensed injecting centre,
- (b) the provisions to be observed in the operation of a licensed injecting centre,
- (c) the rules of conduct to be observed by persons using a licensed injecting centre,
- (d) the qualifications of persons engaged in the conduct of a licensed injecting centre,
- (e) the functions of persons engaged in the conduct of a licensed injecting centre,
- (f) the preparation, form and content of a community drug action plan,
- (g) the maintenance and amendment of a community drug action plan,
- (h) the public and community consultation processes to be undertaken with respect to the development and review of a community drug action plan.

36T Application of Drug Misuse and Trafficking Amendment (Medically Supervised Injecting centre) Act 2010

The amendments made to this Part by the Drug Misuse and Trafficking Amendment (Medically Supervised Injecting centre) Act 2010 extend to a licence in force under this Part immediately before the commencement of that Act.

Appendix B – Re Canada

Exemption by Minister

56(1) The Minister may, on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

Exception

56(2) The Minister is not authorized under subsection (1) to grant an exemption for a medical purpose that would allow activities in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act to take place at a supervised consumption site.

Exemption for medical purpose — supervised consumption site

56.1(1) For the purpose of allowing certain activities to take place at a supervised consumption site, the Minister may, on any terms and conditions that the Minister considers necessary, exempt the following from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical purpose:

- (a) any person or class of persons in relation to a controlled substance or precursor that is obtained in a manner not authorized under this Act; or
- (b) any controlled substance or precursor or any class of either of them that is obtained in a manner not authorized under this Act.

Application

56.1(2) An application for an exemption under subsection (1) shall include information, submitted in the form and manner determined by the Minister, regarding the intended public health benefits of the site and information, if any, related to

- (a) the impact of the site on crime rates;
- (b) the local conditions indicating a need for the site;
- (c) the administrative structure in place to support the site;
- (d) the resources available to support the maintenance of the site; and
- (e) expressions of community support or opposition.

Subsequent application

56.1(3) An application for an exemption under subsection (1) that would allow certain activities to continue to take place at a supervised consumption site shall include any update to the information provided to the Minister since the previous exemption was granted, including any information related to the public health impacts of the activities at the site.

Notice

56.1(4) The Minister may give notice, in the form and manner determined by the Minister, of any application for an exemption under subsection (1). The notice shall indicate the period of time — not less than 45 days or more than 90 days — in which members of the public may provide the Minister with comments.

Public decision

56.1(5) After making a decision under subsection (1), the Minister shall, in writing, make the decision public and, if the decision is a refusal, include the reasons for it.

56.2 A person who is responsible for the direct supervision, at a supervised consumption site, of the consumption of controlled substances, may offer a person using the site alternative pharmaceutical therapy before that person consumes a controlled substance that is obtained in a manner not authorized under this Act.

APPENDIX C: Mapping the MDA 1971

Mapping the MDA 1971, and basic legal principles

Since the M.D.A. is designed and intended to regulate the flow of drugs and their use, the following structure is enacted:

- (i) Drugs are specified as being “controlled”: see Schedule 2.
- (ii) As a general rule, it is unlawful to:
 - (a) import or export controlled drugs: section 3;
 - (b) produce controlled drugs: section 4;
 - (c) supply controlled drugs: section 4
 - It is an offence to be concerned in the supplying of a controlled drug to another.
 - It is an offence to be concerned in the making to another of an offer to supply a controlled drug.
 - “supply” includes “distributing”: section 37 (1). Supply a means “enabling the recipient to apply the thing for the recipient's own benefits: *Maginnis*.¹⁶⁷
 - (d) possess controlled drugs: section 5;

A person who has a controlled drug in his custody, or has it under his control, and knows or ought reasonably to have known of the existence of the drug, is in possession of it. This is subject to a statutory provision that a person is to be acquitted if he neither knew, nor suspected, nor had reason to suspect that the substance existed, or if it did, that it was a controlled drug: section 28 MDA, as interpreted by the House of Lords in *Lambert*.¹⁶⁸
 - (e) possess controlled drugs with intent to supply them to another:

This is possession, but with the additional mental component. In this situation the possession of a drug might be lawful, but it will be an offence to supply the drug to another without lawful authority
 - (f) cultivate the cannabis plant: section 6;
 - (g) permit premises to be used for the purposes listed above: section 8;¹⁶⁹

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

 - (i) “*knowledge or grounds for reasonable suspicion* on the part of the occupier that the premises will be used by someone for that purpose, and
 - (ii) “*...an unwillingness on his part to take means available* to him to prevent it... “: *Sweet v. Parsley*,¹⁷⁰ Lord Diplock.
 - (iii) a failure to take reasonable steps readily available to prevent the prohibited activity”.
 - (iv) “A belief by a defendant that he has taken reasonable steps does not afford any defence.... It is not for the defendant to judge his own conduct”; *per* Rose L.J., *Brock and Wyner*.¹⁷¹

¹⁶⁷ [1987] 1 All ER 907, HL.

¹⁶⁸ [2001] UKHL 37

¹⁶⁹ Namely, (a) producing or attempting to produce a controlled drug in contravention of section 4(1) of this Act; (b) supplying or attempting to supply a controlled drug to another in contravention of section 4(1) of this Act, or offering to supply a controlled drug to another in contravention of section 4(1); (c) preparing opium for smoking; (d) smoking cannabis, cannabis resin or prepared opium. [*administering or using a controlled drug which is unlawfully in any person's possession at or immediately before the time when it is administered or used*] - The italicised words were inserted by s.38 of the Criminal Justice and Police Act 2001, but they have yet to be brought into force.

¹⁷⁰ [1970] A.C. 132

¹⁷¹ December 21, 2000; [2001] Cr.App.R. 3.

- (v) allowing an activity to continue “not caring whether an offence was committed or not”: see Edmund Davies L.J. in *Souter*¹⁷² who approved the words of Lord Parker C.J. in *Gray’s Haulage Co. Ltd. v. Arnold*¹⁷³ who said “actual knowledge or knowledge of circumstances so that it could be said that they had *shut their eyes to the obvious*, or had allowed something to go on, *not caring whether an offence was committed or not*”; and see *James v. Smee*.¹⁷⁴

Can managers have knowledge imputed to them?

A difficult question remains unresolved, namely, whether an offence under section 8 can be committed by a person concerned in the management of premises, who although himself unaware of what was happening, delegated tasks to others who did know. Can the knowledge of subordinates be imputed to the manager? In *Ferguson v. Weaving*,¹⁷⁵ Lord Goddard C.J. said:

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

The principle was said to be based “on the fact that the person who is responsible in law, as for example, a licensee under the Licensing Acts, has chosen to delegate his duties, powers and authority to another”: *per* Lord Goddard C.J., *Linnet v. Metropolitan Police Commissioner*,¹⁷⁶ cited in the judgment of *Ferguson v. Weaving* (above, at 821). However, on the facts in *Ferguson v. Weaving*, the relevant provisions in the Licensing Act 1921 did not create an offence of “knowingly permitting” drinking after hours, and the Court was not prepared to widen liability so as to convict a licensee of counselling and procuring on the basis of knowledge imputed to him. In *James v. Smee* it was said that “knowledge ... includes the state of mind of a man who shuts his eyes to the obvious or allows his servant to do something in the circumstances where a contravention is likely, not caring whether a contravention takes place or not”: *per* Parker J. This is much closer to the present position (see *Brock v Wyner*)¹⁷⁷ and see the opinion of Lord Diplock in *Sweet v. Parsley*.¹⁷⁸

- (h) to smoke or use prepared opium: section 9;
- (i) to frequent a place used for the purpose of opium smoking: s.9(1)(b)
- (j) to have in his possession pipes or other utensils that he has used, or intends to use, or has allowed others to use, in connection with the smoking of opium: section 9(c);
- (k) to supply or offer to supply any article believing that it may be used or adapted to be used by another for the unlawful self-administration of any controlled drug: s.9A(1);¹⁷⁹
- (l) to supply, or offer to supply, any article believing that it is to be used by another for the preparation and unlawful administration of any controlled drug: s.9A(3).
- (iii) It is an offence to incite another to commit an MDA offence: s.19.

¹⁷² (1971) 55 Cr.App.R. 403

¹⁷³ [1966] 1 W.L.R. 534

¹⁷⁴ [1955] 1 Q.B. 89

¹⁷⁵ [1951] K. B. 814

¹⁷⁶ [1946] K. B. 290

¹⁷⁷ [2001] Cr.App.R. 3

¹⁷⁸ [1970] A.C. 132 at 163

¹⁷⁹ It is not an offence to supply or offer to supply a hypodermic syringe, or any part of one [s.9A(2)].

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

Construed literally, the section is nonsense, because it would mean that it is an offence for one person, to incite another, to incite another! This is a drafting error and the Court of Appeal has held that the section means what it obviously means, namely, that it is an offence for a person to commit *any* offence under the MDA 1971.¹⁸⁰

Prosecutions under section 19 are rare. *Marlow*¹⁸¹ is a good example:

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

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

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

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

Held: the judge should not have introduced the word “may”. However, taken as a whole there was no misdirection, and the conviction was not unsafe (the court considered *Invicta Plastics Ltd v. Clare*;¹⁸² *R. v. Higgins*;¹⁸³ *R. v. Nkosiyana*¹⁸⁴; and see the *Law Commission’s Working Paper on Incitement (1993)*).¹⁸⁵

- (iv) It is an offence to aid, abet, counsel or procure, the commission of some or all offences under the MDA.

A person joins an offence if he/she gives encouragement to another to commit it. Arguably, there are some statutory offences in respect of which it is not logically possible to “aid, and abet” or to “counsel or to procure” - for example, the offence of “being concerned” in the supply of a drug. One is either concerned in the offence, or one is not.

- (v) It is unlawful for a person in the United Kingdom to assist in or induce the commission of a “corresponding offence” abroad: section 20.

- (vi) Companies may also be guilty of committing offences: section 21.

¹⁸⁰ The original wording of the 1971 Act (including the italicised words) was, “It is an offence for a person [*to attempt to commit an offence under any other provision of this Act*] or to incite [*or attempt to incite*] another to commit such an offence.” The words within square parentheses were deleted by Schedule I of the Criminal Attempts Act 1981, but the draftsperson had deleted too many words!

¹⁸¹ [1997] Crim.L.R. 897 (judgment July 14, 1997).

¹⁸² *Invicta Plastics Limited v Clare* [1976] RTR 251.

¹⁸³ (1801) 2 East 5

¹⁸⁴ 1966 (4) S.A. 655, 688 (SA)

¹⁸⁵ The Law Commission (England and Wales) C.P. 131, “Assisting and Encouraging Crime”.

The M.D. Regulations 2001

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

The Government may by Regulations:

- (a) restrict certain controlled drugs to research use only: section 7(4)(a);
- (b) require medical practitioners, etc., to hold a licence before supplying or possessing certain controlled drugs: section 7(4)(b).

2. Regulations may be made under the MDA for any of the following purposes:

- i) The Secretary of State may at any time make activities with respect to specified controlled drugs **unlawful** by laying a Statutory Instrument before Parliament. Where the Secretary of State takes that step the Instrument is titled a “Designation Order”.
- ii) The Secretary of State may **restrict** activities with respect to controlled drugs. He can achieve this result by transferring a drug (e.g. temazepam) from one schedule in the Regulations to schedule of a lower number. Regulations that did not apply to the substance in question are brought into operation.
- iii) The Secretary of State may make Regulations that **permit** the cultivation, production, supply, or possession of drugs. His permission may be conditional (e.g. a licence is required) or unconditional (in the case of some very weak preparations);
- iv) Regulations designed to **prevent** the misuse of controlled drugs by imposing administrative obligations or requirements e.g. by regulating the issuing of prescriptions, record-keeping; rules relating to safe-custody of drugs etc.

3. It should be noted that various factors determine the scope of an exemption (or authorisation) under the Regulations, for example,

- the degree of harm/risk associated with the drug/product [see below];
- the category of person handling the substance (e.g. a police officer seizing heroin, a patient prescribed heroin);
- the circumstances in which the drug is to be handled or used (e.g. a doctor who wishes to administer a drug to another; or where any person is asked to administer a drug under the directions of a doctor, e.g. at a road-side pile up);
- international obligations;
- the toxic effect versus therapeutic value of a substance, etc.

4. The Regulations contain five schedules. Each schedule takes into account the risk of harm, or degree of harm, associated with the drug in question (*or product* containing a controlled drug). As a general rule, the lower the number of the schedule, the greater the intensity of control.

The Schedules to the 2001 Regulations

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

Note that all the drugs that appear in this schedule also appear in yet another schedule annexed to the *Misuse of Drugs (Designation) Order 1986*, as amended. **Designation Orders** are made by the Secretary of State for the Home Office pursuant to section 7(4) of the MDA 1971. Their purpose is to specify those controlled drugs (i.e. Class A, B, or C drugs) that are not permitted to be used for medical purposes. It is not clear why the Legislature considers that it is necessary to specify the same drugs (that are deemed to have no medicinal value) in two separate Statutory Instruments (i.e. Sch.1, 1985 Regs., and in a Designation Order) is not entirely clear.

Sch.2: **Drugs that have a medicinal value but which are liable to be misused/abused.** This is the largest schedule in the Regulations. Most of the drugs are opiates and the major stimulants. Accordingly, drugs in this group include a number of Class A drugs e.g. cocaine, and Class B substances, e.g. amphetamine. Many of the Regulations relevant to this schedule are designed to ensure that the drugs are used for medicinal, scientific purposes, or handled for law enforcement purposes. A doctor must act in his capacity as a doctor. A conveyor/courier of a sch.2 drug must deliver it to a person lawfully entitled to possess it. Records must be kept at every stage. A doctor can supply or administer a drug directly to the patient but additional records, prescriptions, and books must be kept if drugs are to be taken away from the hospital or surgery. Bottles of pills etc. must be labelled. Prescriptions must be written in indelible form recording the total quantity of the drug supplied (in words and figures), dosage units etc. Pharmacists can only supply on the back of a prescription issued by a practitioner. Special rules apply in situations where doctors or pharmacists may not be found e.g. on a ship, oilrig, residential home (more paperwork).

Sch.3: **Drugs that have a medicinal value but warrant fewer controls over their distribution.** Many of the drugs in schedule 3 are barbiturates. The controls imposed under the 2001 Regulations are less onerous than drugs listed in Sch.2 and the amount of paperwork is reduced.

Sch.4: **Drugs subject to fewer controls than Sch.3 drugs.**

- Drugs in this schedule are divided into two categories.
- Drugs in Sch.4.I may lawfully be possessed by any person for administration for medical, dental, or veterinary purposes, in accordance with the directions of a practitioner [see Reg.10(2)].
- Drugs in Sch.4.II being “medicinal products”, may be freely imported, exported, and possessed by any person [see Reg. 4(2), (3)].

Sch.5: **Very weak preparations or products.** Drugs in this schedule may be freely imported, exported, or possessed by anyone. Note that some products specified in this schedule may contain one or more Class A drugs e.g. cocaine (but the amount of cocaine must not exceed 0.1%). Note also the observations mentioned above in respect of Schedule 4 drugs.