Briefing Paper for Upcoming Parliamentary Debate on the Misuse of Drugs Act 1971
17th June, 2021

Release is the national centre of expertise on drugs and drugs law in the UK. The organisation, founded in 1967, is an independent and registered charity. Release provides free non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and to drug laws. The organisation campaigns directly on issues that impact on its clients - it is their experiences that drive the policy work that Release does and why Release advocates for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach. Release is a NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

50 years of failure

The 27th May, 2021 marked the **50th anniversary** of the Misuse of Drugs Act (1971). The Misuse of Drugs Act [MDA] was supposed to eliminate illegal drug markets and the harms from drug use. Instead, this legislation has damaged individuals and communities, undermined science, and entrenched social injustice. Drug use has risen dramatically and UK drug-related deaths are at record levels. The MDA is outdated and is not fit for purpose and the need to reform the UK's approach to drugs is urgent. It is time to ensure that our response to drugs is based on evidence of what works.

Successive governments have expended considerable effort to keep evidence on drugs and drug policy out of the public domain. The suppression of the Prime Minister's Strategy Unit drugs report in 2003,[i] the Home Office Drugs Value-for-Money Review in 2007,[ii] and two Home Office drugs reports in 2014[iii] illustrate the extent to which the drug policy debate is being actively stifled. However, as demonstrated below, when UK drug policy *is* publicly scrutinised by independent, cross-party inquiries and subject to scientific peer-review, the findings demonstrating the failure of the current approach and the damage caused to individuals and communities are invariably damning.

The UK Government acknowledges the failures of current drug policy

1. In 2014, the Home Office reviewed the evidence on drug policy approaches in other countries and concluded that there is **no relationship** between tougher/punitive sanctions on drug possession and the level of drug use in a country.[iv] Despite this, tens of thousands of people are criminalised every year; it is estimated that since the Act's inception there have been over three million criminal records for possession-only offences.

2. In 2017, the Home Office evaluated its **2010 Drug Strategy** and found that "illicit drug markets are resilient and can quickly adapt to even significant drug and asset seizures" and that drug seizures had "little impact on availability". The evaluation also acknowledged the following "potential unintended consequences" of drug law enforcement:

    - increased drug market violence;
    - "fragmenting and diversifying the market" thus incentivising innovation;
    - "displacement to other drugs with associated harms" and "users purchasing more drugs";
    - "health harms from varying purity of drugs" and "overdose risks when purity levels subsequently rise"; and
    - "negative impact of involvement with the criminal justice system" including "unemployment", and "parental imprisonment" being a "risk factor for child offending, mental health problems, drug abuse and unemployment".[v]

3. In February 2019, the Home Secretary appointed Professor Dame Carol Black to undertake a two-part, **independent review** of drugs. As part of Black's published phase one report, Black states that "Government interventions to restrict supply have had limited success" and adds that it is not clear whether organisations such as the Police, Border Force, and the National Crime Agency, would

be *able* to bring about a sustained reduction in drug supply, "given the resilience and flexibility of illicit drug markets".[vi] Indeed, early findings regarding global drug markets during the COVID-19 pandemic suggest *limited* impact on drug supply overall, and reports of some *increases* in drug use; speaking directly to the resilience of this market in light of the unprecedented restrictions to movement due to national lockdowns and border closures.[vii]

Our current approach does not deter drug use and instead generates harm

4. The United Nations Office on Drugs and Crime estimates that **9 in 10** people who use drugs do not suffer from drug use disorders.[viii] Those who do may have complex needs and face significant obstacles to accessing support. Criminalising drug possession perpetuates stigma and marginalisation of people who use drugs, making it more difficult for them to access vital healthcare services and to seek support.[ix] Moreover, the evidence from countries that have 'liberalised' their approach to drugs have not experienced an increase in use[x], and specifically in relation to cannabis reforms, there is no evidence of increased adolescent use[xi],

5. **Drug-related deaths** are at an all-time high across the UK,[xii] accounting for a third of such deaths across the whole of Europe.[xiii] There were 4,393 deaths related to drug poisoning registered in 2019 in England and Wales. Almost *half* of all drug related deaths involved opiates such as heroin and morphine, and the North East has a statistically significantly higher rate of deaths relating to drug misuse than all other English regions.[xiv] Similar increases have been experienced in Scotland and Northern Ireland, and the Scottish government have declared the situation as a public health emergency.[xv]

6. There is an established link between **trauma** exposure (including childhood physical/sexual abuse, PTSD) and substance misuse. Current drug policies are criminalising people who have already suffered greatly, thereby exacerbating their trauma. For example, the prevalence of opioid use increases with the number of Adverse Childhood Experiences (ACEs) experienced – which are severe incidents of trauma in childhood linked to neglect, household dysfunction, and/or abuse.[xvi]

7. In 2017 alone nearly 38,000 people were criminalised for possession of drugs across England and Wales. Almost 3,000 of those criminalised for possession were under the age of 18 and 43% of those given criminal records were under the age of 24.[xvii] Drug law enforcement limits **young people's** life chances, including employment and educational opportunities.[xviii]

8. Drug law enforcement is almost entirely focused on **low-level possession** offences[xix] and is a key driver of ethic disparities within stop and search policing and the wider criminal justice system. Analysis of over 8,000 stop-search records conducted as part of the 2017 PEEL legitimacy Inspection found that 70% of drug searches and 45% of all stop-searches were for suspected drug possession, suggesting that such activity "is still not being targeted towards tackling priority crimes".[xx] Declines in the volume of stop and search have been witnessed over the last decade, though the decline did nothing to stop racial disparity. Home Office figures last year (2018/19) showed the first *increase* in stop and search against this backdrop of decline, and the most recent Home Office figures for 2019/20[xxi] revealed a 51% increase in searches compared to the previous year.[xxii]

9. Black and other ethnic minority groups are consistently more likely to be stopped and searched than White people. For all stop searches in 2019/20 in England and Wales,[xxiii] people self-defining as 'Black, Asian, and Minority Ethnic' were **4 times** more likely to be searched than White people. The disparity is particularly pronounced for Black people, who are **9 times** more likely to be stopped and searched than White people. Whilst disparities in stop and search at the national level can mask differences in the size and make up of local populations within each police force area, in almost every police force area, Black people endure the highest recorded stop and search rate, and this is driven by drug searches.

10. The search for drugs dominates stop and search. In 2019/20, **63% of searches** under the main police powers[xxiv] were for drugs, which dwarfs searches for offensive weapons and stolen property

(16% and 10% of searches respectively). This, in part, explains the pronounced racial disparity in stop and search data, given that we know that drug laws are often imposed most harshly against ethnic minority communities, despite prevalence rates among these groups being no higher than among the White population[xxv]

11. A 2018 report by Release, StopWatch and LSE's International Drug Policy Unit[xxvi] found that:

    - A third of all stop searches were for **cannabis** only.
    - Black people were more likely to be arrested as a result of stop and search than White people, but less likely to be given an **out of court** disposal. This means Black people are more likely to be prosecuted than white people for the same offence.
    - The rate at which stop and search identifies stolen or prohibited items is similar for all ethnic groups, though the ***'find rate'*** for drug searches is lower for Black people than White people.
    - Despite **using** cannabis at a lower rate than White people, Black and Asian people were convicted of cannabis possession at 12 and 2 times (respectively) the rate of White people.
    - More Black people were prosecuted and convicted of **cannabis possession** than the supply of Class A and B drugs combined.

12. The disproportionality in stop and search cannot be explained by existing trends in drug *use*. Repeated self-report studies[xxvii] have indicated that Black, Asian, Chinese and other minority ethnic group individuals tend to use drugs at a **lower rate** than White people, with analysis demonstrating that this is partly a function of broader lifestyle differences, including levels of alcohol consumption, culturally distinct orientations to intoxication, and religious influences.[xxviii] Analysis of the Crime Survey for England and Wales (2018/19) confirms these findings.[xxix]

13. In a recent UK survey, 85% of Black respondents were not confident that they would be **treated the same** as a White person by the police. The recent HMICFRS report on disproportionate use of police powers in England and Wales confirms that disproportionality and discrimination extend beyond who is searched to the actual *execution* of such searches and resulting arrests - including an increased likelihood of force being used against Black people - and calls for "a national debate on the policing of controlled drugs through stop and search". [xxx]

14. The latest figures show that of those 577,054 stop and searches in 2019/20, an overwhelming majority of searches (76%) resulted in **no further action taken** – 3% higher than in 2018/19. Indeed, most searches result in officers finding *nothing*. In 2019/20, only 20% of searches under the main police powers did result in an outcome that was linked to the reason for the search - for example, finding MDMA when the reason for the search was suspicion of drug possession.

15. The central **government spend** on drug law enforcement and related activities is estimated to be approximately £1.6 billion per annum[xxxi] In a comparable year, the estimated central government spend on early drug intervention was only £215 million.[xxxii] Drug treatment budgets were cut by 14% between 2015/16 and 2016/17. These cuts are a "false economy"[xxxiii] as Public Health England estimates that for every £1 invested in drug treatment there is a £4 social return.[xxxiv]

16. In the midst of a public health crisis, evidence has emerged in London - with figures not yet captured by the annually published Home Office statistics - that stop and searches in England and Wales have *increased* during the **COVID-19** pandemic. During May 2020 alone, the Metropolitan Police Service (MPS) conducted 43,913 searches in the City of London. Of these searches, 68.1% were for drugs.[xxxv] Not only was this the highest rate of the use of these powers in over 2 years, but these powers were also being used most in London boroughs suffering the highest rates of COVID-19 deaths whilst we were in a full lockdown.[xxxvi]

17. The decision to allow **medicinal cannabis** prescriptions by specialist doctors was a positive step, but

one that did not go far enough.[xxxvii] Many who use cannabis for medicinal purposes do not meet the high threshold for prescription and will continue to be prosecuted for possession, production or cultivation for personal use whilst simply trying to alleviate their pain or symptoms.

Drug policy can be improved within the current legislative framework

18. Release support a **no punishment model** for drug use and possession - just as we currently have in relation to those psychoactive substances which fall under the Psychoactive Substances Act [PSA] 2016.[xxxviii] This is the approach taken in Spain, the Netherlands, and Uruguay.[xxxix] However, in the absence of decriminalisation de jure (in law), Police forces should implement **diversion** schemes to divert people who use drugs away from the criminal justice system, improve outcomes and reduce costs. There are a handful of existing police diversion schemes in England and Wales (with some including minor drug possession offences only, and others including minor supply offences also) but they are growing in number. One example is 'Checkpoint', a scheme introduced by Durham police force which diverts people for low level offences after arrest on the condition that they undertake a four-month programme to address their offending behaviour.[xl] Initial findings from the pilot period found those who were diverted to Checkpoint had lower reoffending rates and improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances and mental health.[xli] Durham's diversion scheme was initially post-arrest for both possession and intent to supply for those who are dependent or economically deprived, however they have since adapted their scheme to allow for diversion at street level to a less intensive intervention as we have seen in other parts of the country. Avon and Somerset Police force implemented an on-the-street diversion programme in Bristol for those caught in possession of drugs for their own personal use. Findings from 'Drug Education Programme' ('DEP') are similar to that of Durham Police, with attendees of the DEP less likely to re-offend when compared to those who had gone through the criminal justice system during the baseline period.[xlii] Similar schemes are now operating in North Wales, Thames Valley and in the West Midlands police forces,

19. Local authorities need to **re-invest** in and protect drug treatment budgets. The Advisory Council on the Misuse of Drugs has rightly recommended: "mandating drug and alcohol misuse services within local authority budgets and/or placing the commissioning of drug and alcohol treatment within NHS commissioning structures" to protect current levels of investment in drug treatment.[xliii] In January, 2021, an increase of £80 million to the annual spend on drug treatment was announced - but this is not sufficient given the spending cuts experienced by the sector over the last decade, and this is particularly deficient in light of reports that Professor Dame Carol Black sought to recommend an additional *£900 million* investment in drug treatment (over three years)[xliv] following her independent review of drugs.

20. Central government should support the introduction of a Drug Consumption Room (**DCR**). Calls to introduce a Drug Consumption Room (DCR) in Glasgow[xlv] have been supported by the Scottish government,[xlvi] the Advisory Council on the Misuse of Drugs[xlvii] and Police and Crime Commissioners.[xlviii] A DCR could operate if there was agreement from local Police and Crime Commissioners and Chief Constables not to arrest and bring prosecutions for possession, in recognition of the public health outcomes. A similar situation exists for needle exchange programmes where national Crown Prosecution Service guidance states that it is not in the public interest to bring prosecutions for possession of controlled substances where a person has been accessing sterile injecting equipment provided by a drug treatment service. This guidance explicitly recognises that staff and clientele of such facilities will 'necessarily commit offences under the Act'[xlix]

21. Although services can provide equipment for safe injecting, the supply of **crack cocaine smoking equipment** is prohibited under Section 9A of the Misuse of Drugs Act 1971. Over 180,000 people use crack cocaine in the UK.[l] People who smoke crack (PWSC) are at high risk of infectious disease transmission, acute injuries (cuts and burns) and long-term respiratory problems. As pipes are not exempt from section 9A (in the same way that hypodermic syringes are), many PWSC make their

own pipes from unsafe materials (increasing respiratory harm), share pipes (a COVID-19 transmission risk) or inject the drug. Allowing for the supply of this equipment in treatment settings would provide an effective mechanism to engage people who use crack cocaine, and who often have no reason to access such services.

22. **Drug safety testing** (drug checking) allows people who use drugs to help identify the substance they intend on taking and therefore prevent harms associated with consuming an unknown substance. This emergent public health service operates in a number of countries, and holds promise in reducing drug-related harm and drug-related death, yet "remains politically, legally, operationally and financially challenging" to implement in the UK.[li] It has been piloted in the UK at a handful of music festivals, and more recently, within two city-centers. The barriers to drug checking should be removed, and such operations should receive government funding.

23. Existing harm reduction interventions need to be **scaled-up** to prevent more drug-related deaths and improve health outcomes for people who use drugs. Further premature mortality could be averted if naloxone – a medication which reverses the effects of opioid overdose – was more widely available.[lii] Whilst naloxone provision has increased, we must prioritise widening access to this life-saving medication[liii] and consideration should be given to making the medication available over the counter in pharmacies. This could remove confusion around its current status as a prescription-only medicine - which can be supplied without a prescription in certain circumstances - and has the potential to make naloxone more readily available to those who might experience or witness an opioid overdose.[liv] At the same time we must promote the use of Opioid Substitution Therapy (OST) medications, such as methadone and buprenorphine, as these are the only treatments that are proven to reduce the risk of overdose and death.[lv]

More meaningful improvements to drug policy can be achieved by ending criminal sanctions for possession offences though legislative reform

24. Decriminalisation is the ending of criminal sanctions for drug possession for personal use. Research undertaken by Release looked at countries across the **world** that no longer criminalised use or possession of drugs; none experienced increases in drug consumption linked to policy. Some countries – such as Australia (which has decriminalised cannabis possession in three states and have diversion schemes for all controlled substances in every State), Portugal, and the Czech Republic – reported improved physical and mental health outcomes when compared to individuals who were criminalised. Decriminalisation has also been associated with reduced rates of recidivism, reduced burden on police resources and savings to the public purse related to social costs.[lvi]

25. By decriminalising the possession of controlled drugs for personal use, **resources** could be diverted from the criminal justice system into health and other services for people who use drugs as well as wider community programmes, thus ensuring a greater return on investment for communities and criminal justice agencies.[lvii]

26. **Portugal** decriminalised the use and personal possession of all drugs in 2001, whilst also investing in harm reduction and treatment programmes. The number of annual drug overdose deaths reduced from 318 in 2000 to 40 in 2015.[lviii] A 2015 study found an 18% reduction in the social costs of drug use in the first ten years of decriminalisation in Portugal.[lix] The proportion of the prison population sentenced for drug offences in Portugal has fallen from over 40% to 15%, rates of drug use have remained consistently below the EU average, and Portugal has gone from accounting for over 50% of yearly HIV diagnoses linked to injecting drug use in the EU to 1.7%. [lx]

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