Release's written submission to the International Commission of Jurists: "Developing principles to address the detrimental impact on health, equality and human rights of criminalisation with a focus on select conduct in the areas of sexuality, reproduction, drug use and HIV"

Core Questions

What is your interest/ the interest of your organization in this work? What specific issues do you work on in relation to the proposed topics covered?

1. 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.

2. Release believes in a just and fair society where drug policies should reduce the harms associated with drugs, and where those who use drugs are treated based on principles of human rights, dignity and equality. Release is a NGOs in Special Consultative Status with the Economic and Social Council of the United Nations.

3. Release delivers five key frontline services: legal outreach services located in drug treatment and harm reduction centres; sex workers projects and homeless centres in London; drug and alcohol counselling; expert witness testimony; a national advice service; and a youth stream which focuses on stop and search. Through the delivery of these services we hear directly from those most affected by the UK's drug laws, in particular those impacted by drugs policing, the criminal justice system more broadly, and those who use drugs problematically.

4. As Release's expertise is in drugs and drug law, this submission will not be specifically commenting on the areas of sexuality, reproduction and HIV. However, some aspects of drug policy commented on below will necessarily intersect and relate to these areas.

In your view, what concepts (human rights, moral/ethical, legal, good governance, harm etc.) are helpful in understanding whether the use of criminal law is justified in the context of the select areas? Are there some areas or conduct that should never be criminalized? On what basis?

5. There are three conventions[1] which form the core legal framework of the United Nations (UN) international drug regime. These have been central to assisting state parties in forming domestic legislation and outlining which conduct warrants criminalisation. While these UN treaties have established harmonised guidance on drug scheduling, there is mounting evidence[2] of human rights abuses in the name of drug prohibition against some of the most marginalised and disenfranchised across the Globe and in the UK.

6. Release supports the United Nations System Chief Executives Board for Coordination (UNCEB), which recently called for the decriminalization of drug possession for personal use.[3] The use of an illicit drug should not mean one must forfeit the enjoyment of rights. Where drug use is criminalised it impacts the

enjoyment of human rights, including the principle of human dignity and personal autonomy, and aggravates health and social harms. Criminalisation of drug possession also undermines the rule of law, in that the laws are inequitably applied and routinely breached by large sections of the population.

7. A coalition of UN Member States, WHO, UNAIDS, UNDP and leading human rights and drug policy experts recently published their 'International Guidelines on Human Rights and Drug Policy', which outlines drug policy requirements to ensure human rights compliance. We would like to draw attention to the following human rights standards, which are currently undermined by the UK's drug laws:

- The 'Right to the Highest Attainable Standard of Health,' as enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights 1966 ('ICESCR');
- The 'Right to benefit from scientific progress and its applications', as enshrined in in Article 15, ICESCR; and
- The 'Right to be Free from Discrimination,' as enshrined in Article 26 of the International Covenant on Civil and Political Rights 1966 ('ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination 1965 ('CERD').

What would your topline recommendations be to States on the use of criminal law in the areas you work in? How do you think a set of principles will help support the work you do? How will you use them?

8. Release would respectfully recommend that the Committee consider the evidence for decriminalisation of personal use offences, including possession, and make a recommendation that the UK government, and governments generally, adopt this approach.

9. Central government needs to re-invest in, and mandate, drug treatment and harm reduction services, to ensure that they are adequately funded and able to deliver high-quality and evidence-based treatment. This means a person-focused treatment system, which is gender and race appropriate, and delivered in line with national clinical guidelines.

10. Harm reduction interventions need to be urgently developed and expanded to protect PWUDs from premature mortality, such as by monitoring NSP coverage in England, scaling up naloxone distribution, securing central funding for Heroin Assisted Treatment, and ceasing efforts to block the introduction of a Drug Consumption Rooms.

<u>Thematic questions</u>

Given the scope of this project (the select areas), should any of the conducts in focus be criminalized? If so, which aspects and why? If not, why not? Please refer to paragraphs 11-20.

What effect do you think criminalizing such conducts can have on the persons whose conduct is criminalized? • Has criminal law impacted you or your community? If so, how?

11. The UK's prohibitionist stance against drug use aggravates health-related harms experienced by people who use drugs (PWUD), thereby engaging the right to health. An enforcement-led approach increases fear and fuels high-risk drug taking behaviours, including: sharing (and use of) nonsterile injecting equipment[4]; rushed consumption of drugs in unsanitary and unsupervised spaces[5] enhancing the threat of contracting a blood-borne virus (BBV) infection, overdose or injury; and pre-loading drugs before entering a venue to avoid detection[6]. An impact of the approach taken by the UK's is that drug related deaths are at an all-time high and account for 1 in 3 drug related deaths in Europe.[7] At the same time

hospital admissions for drug related mental health issues have increased 9 per cent in the last ten years.[8] Added to this there has been an outbreak of HIV cases amongst people who inject drugs in Glasgow.

12. PWUD continue to be penalised for their drug use. Over the last 10 years - 732,406 people have been criminalised for simple possession of drugs during this period in England and Wales. In 2017 alone, 1,017 people were given immediate custodial sentences for simple drug possession offences. [9] Consequentially have a large impact on their personal and family life.

13. Negative assumptions held about PWUD is directly driven by the criminalisation of drugs, thereby engaging the foundational principles of human dignity, equality and non-discrimination. The use of inhumane language, discriminatory practices and stigma has bred policies which seek to exclude those who use drugs including mandatory drug testing by employers. Such attitudes can be a significant barrier for those who have a history of drug use in engaging health services. This is particularly true for women who fear that they will be deemed unfit as mothers consequentially losing custody of their children.[10]

What do you think these criminal laws are aiming to achieve (what are the goals of criminalizing such conduct?)

14. According to the 2017 UK Drug Strategy the main aims are to "prevent people from becoming drug users in the first place", reduce illicit drug use, increase the rate of people recovering from their dependence and restrict the supply of drugs[11]. In November 2017, the Prime Minister, Theresa May MP, reaffirmed her Governments commitment to the "war on drugs".[12]

Do you consider the objectives of the criminal law (these objectives typically include the protection of public order, public health or morals or the prevention of harm to others) are being met effectively and fairly in the areas you work in (please note the areas you are referring to)? Why or why not?

15. The criminal law is ineffective in its purpose to deter drug use. In an evaluation of its own 2010 Drug Strategy, the Home Office recognised that drug law enforcement has "little impact on availability" and "Illicit drug markets are resilient and can adapt to even significant drug and asset seizures".[13] The evaluation also acknowledged the following "potential unintended consequences" of drug law enforcement: increased drug market violence; "fragmenting and diversifying the market"; "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".[14]

16. In an evaluation of international approaches to drug policy, the Home Office also concluded in 2014 that "there is no relationship between tougher/punitive sanctions on drug possession and the level of drug use in a country".[15] This warrants further exploration as to why the UK government continue with an enforcement-led approach, despite their own evidence highlighting the failure of the current approach and the antecedent damage caused to individuals and communities

17. The criminal law is also unfairly applied, as drug policing disproportionately targets Black and Minority Ethnic (BME) communities despite lower rates of self-reported drug use, and targets people living in areas of deprivation, young people and sex workers. Please refer to paragraphs 25-29 for more information on this.

Even if perceived social misconduct is not criminalized, do you still think that there is a need for the State to address it?

18. According to the United Nations (UNODC), 89 per cent of people who use drugs do not experience a drug use disorder. For the small percentage who become dependent, this is often related to trauma, either experienced in childhood or in adulthood, or to alleviate mental health problems. Other risk factors include "stressful life events" and/or determinates which have been present over prolonged periods of time such as "homelessness or poverty".[16]

19. Instead of criminalising PWUDs, the state should increase efforts to provide low-threshold high-quality trauma-informed services for people who experience drug use disorder and for those at risk, especially, children and young people

Are there other ways for the State to address perceived social misconduct through legal or other frameworks, aside from criminalization? If so, what are they?

20. Release advocates for the ending of criminal sanctions for personal use offences, known as decriminalisation, in recognition that the evidence from other countries demonstrates that better health outcomes can be achieved. Research undertaken by the organisation looked at 25 countries across the globe that had decriminalised personal use and possession of drugs and found ending criminal sanctions for such activities did not lead to an increase in consumption of controlled drugs.[17] Portugal abolished criminal sanctions for possession of drugs in 2001; at the same time the Portuguese government invested heavily in harm reduction initiatives, treatment and prevention, which had a profound effect. It is worth noting that the drug-related death rate in Portugal is 4 per million of the population[18], compared to 70 deaths per million in the UK[19]. Other positive outcomes have included: a decrease in problematic use; a 40% reduction in injecting drug use; increased treatment engagement; and significant falls in HIV and TB transmission rates.[20] The rate of drug-related deaths is 19 per million in the Netherlands, 13 per million in Spain, 4 per million in the Czech Republic, 7 per million in Italy, and 24 per million in Germany.[21] While the lower rates of drug-related deaths in these countries will not necessarily stem from the legal framework, it is nonetheless noteworthy that all of these countries have ended criminal sanctions for drug possession offences under various models of decriminalisation. Better health and social outcomes can be achieved when drug dependency is viewed through the lens of public health rather than criminal justice.

21. In the absence of decriminalisation, some police forces have implemented diversion schemes to divert people who use drugs away from the criminal justice system, thereby improve health and social outcomes for PWUDs. Please refer to paragraph 23 for more information on police diversion schemes.

22. Drug-related deaths are at a record high across the UK - in 2017 there were 3,756 registered drug-related deaths in England and Wales alone.[22] Many of these deaths could have been prevented with widespread access to high-quality and evidence-based harm reduction interventions for PWUDs, such as Opioid Substitution Therapy (OST), Needle and Syringe Programmes (NSP), Take-Home Naloxone (THN) programmes, and Drug Consumption Rooms (DCRs). Despite being a protective factor against premature mortality, OST is not always prescribed in line with clinical guidelines[23] due to sub-optimal dosing and over-supervision[24], NSP coverage is not monitored nationally in England, THN is not widely available[25] and the UK government continues to block the introduction of a DCR[26]. Additionally, net expenditure on

adult drug and alcohol services has decreased by 19 per cent in real terms between 2014/15 and 2018/19.[27] These cuts are a "false economy"[28] – Public Health England estimates that for every £1 invested in drug treatment there is a £4 social return.[29] An efficient drug policy, which prioritised health, would divert resources away from drug law enforcement and back into drug treatment and harm reduction for PWUDs. Release is gravely concerned that the UK is in violation of its core obligation of non-retrogression to progressively realise the right to the highest attainable standard of health[30], which cannot be justified on the grounds of resource scarcity[31], given its "misallocation of public resources"[32].

Can you provide examples of how this is done effectively in the areas you work in?

23. At present there are three police forces which have introduced a diversion scheme in England. 'Checkpoint' in Durham diverts people after arrest on the condition that they undertake a four month programme to address their offending behaviour. Participants in Checkpoint reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances; and mental health.[33] Avon and Somerset police have introduced 'Drug Education Programme' (DEP) which diverts people on-the-street caught in possession of a controlled drug. Findings from DEP are similar to that of Durham Police.[34] Thames Valley Police have also recently introduced a similar programme to Avon and Somerset.

24. DCRs are already saving lives in 9 European countries, Canada, and Australia.[35] In Germany, 200,000 injections are supervised annually across four facilities and one DCR in Norway, has overseen "300,000 injections since opening".[36] In 2015 a HIV outbreak was identified amongst

    PWID in Glasgow – numbers of new infections had almost tripled from the previous year.[37] In an effort to respond to the outbreak, the Scottish government had proposed to trial DCRs and open the UK's first facility in Glasgow. Despite the well-evidenced benefits of DCRs the proposal was blocked by the Home Office[38].

Do you feel that the criminal law in the areas you work in has been applied in a proportionate manner? Why or why not? Are there particular subgroups of people impacted more by criminal law in areas you work on?

25. Ethnic disparities are fuelled by black and ethnic minority groups being policed for drugs at a higher rate. In 2016/17, black people were stopped and searched for drugs at almost nine times the rate of white people, while Asian people and those in the 'mixed' group were searched for drugs at three times the rate of whites.[39] This is despite lower rates of self-reported drug use and lower find rates for drug searches.

26. Black people are more likely to be arrested as a result of a drugs stop and search than white people this is as a result of them being less likely to be given an on the street disposal. Arrests from drug searches halved for white people between 2010/11 and 2016/17, but remained stable for black people. Black people were also prosecuted for drug offences at more than eight times the rate of white people.[40]

27. Those who live in areas where there are higher levels of deprivation are subjected to higher rates of drug searches, conversely those living in affluent areas experience lower rates of drug stop and searches.

However, rates of racial disparity are much higher in wealthier communities. This indicates that police are both individual profiling and geographical profiling people. [41]

28. Young people who are found to be in possession of drugs are given a criminal record consequentially diminishing future education, employment and life opportunities. Many further education institutions have disciplinary measures for students who are found in possession of drugs, which can include temporary exclusion and permanent expulsion from studies.[42] This leaves international students particularly vulnerable to having their visa revoked.

29. Sex workers who use drugs face substantial vulnerabilities including harassment from police, stigma and discrimination.[43] This further perpetuates the marginalisation of sex workers which undercuts the safety, protection and enjoyment of rights afforded to all people.

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[1] United Nations Office for Drug Control [UNODC] *Legal Framework for Drug Trafficking*.
[2] Csete, J., *et al* (2016) Public Health and Drug Policy, Lancet 2016; 387: 1427–80
[3] United Nations Chief Executives Board for Co-ordination [UNCEB] (2018) *Summary of deliberations: Second regular session of 2018*, UN doc. CEB/2018/2, p. 14.
[4] UNODC (2017) *World Drug Report 2016*, pp. 71-2.
[5] British Medical Association (2013) Drugs of Dependence: The role of medical professionals, p. 102.
[6] Fisher, H. & Measham, F. (2018) Night Lives: Reducing Drug-Related Harm in the Night Time Economy, p. 43.
[7] Transform (2019) Drug-Related Deaths in England: Local Authorities and How They Are Responding.
[8] National Health Service (2018) Decline in number of hospital admissions for drug-related mental and behavioural disorders.
[9] Office for National Statistics [ONS] (2017) Criminal Justice System statistics quarterly: December 2017, Outcomes by Offence Data Tool.
[10] UNAIDS (2015) "Do No Harm: Health, Human Rights and People Who Use Drugs," p. 35; UNODC (2018) Women and Drug: Drug use, drug supply and their consequences, p. 22.
[11] Her Majesty's [HM Government (2017) 2017 Drug Strategy, p. 16. Available at:
[12] HC Deb 22 November 2017 Vol 631
[13] HM Government (2017) An evaluation of the Government's Drug Strategy 2010.
[14] Ibid., pp. 99-100.
[15] Public Health England [PHE] (2018) 'Alcohol and drug prevention, treatment and recovery: why invest?'.
[16] Advisory Council on the Misuse of Drugs [ACMD] (2018) Vulnerabilities and Drug Use Report, p. 17.
[17] Eastwood, N. and Rosmarin, A., (2012) A Quite Revolution: Drug Decriminalisation Across the Globe.
[18] European Monitoring Centre for Drug and Drug Addiction [EMCDDA] (2018) *Portugal Drug Report 2018*.
[19] EMCDDA (2018) *United Kingdom Drug Report 2018*.
[20] Hughes, C. & Stevens, A. (2010) 'What can we learn from the Portuguese decriminalization of illicit drugs?, *British Journal of Criminology*, 50, 1002.
[21] EMCDDA (2018) *Netherlands Drug Report 2018*; EMCDDA (2018) *Spain Drug Report 2018*; EMCDDA (2018) *Czech Republic Drug Report 2018*; EMCDDA (2018) *Italy Drug Report 2018*; EMCDDA (2018) *Germany Drug Report 2018*.
[22] Office for National Statistics [ONS] (2018) Deaths related to drug poisoning in England and Wales: 2017 registrations
[23] Department of Health (2017) Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group
[24] ACMD (2016) *Reducing Opioid-Related Deaths in the UK*.
[25] Carre, Z. & Ali, A. (2019) *Finding a Needle in a Haystack: Take-Home Naloxone in England 2017/18*, Release.
[26] HC Deb 7 March 2019 c 187139
[27] Finch, D., et al. (2018) *Taking our health for granted: Plugging the public health grant funding gap*, The Health Foundation.
[28] Drummond, C. (25 May 2017) 'Cuts to addiction services are a false economy', *The BMJ Opinion.*

[29] PHE (2018) *Alcohol and drug prevention, treatment and recovery: why invest?*.
[30] United Nations Committee on Economic, Social and Cultural Rights, (1990) General Comment No. 3: The Nature of States Parties' Obligations, un Doc E/1991/23, para 9.
[31] United Nations Committee on Economic, Social and Cultural Rights (2007) *An evaluation of the obligation to take steps to the maximum use of available resources under an optional protocol to the covenant*, UN Doc E/C.12.2007/1, para 8.
[32] United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (11 August 2000) E/C.12/2000/4, para 52.
[33] Durham Constabulary & Durham Police and Crime Commissioner (2017) 'Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Findings', Durham PCC (provided via email by Durham PCC on 16 March 2018)
[34] Luckwell J. (2017) 'Drug Education Programme Pilot: Evaluation Report', Avon and Somerset Constabulary, 17 March 2017, 4- 5 (provided by Avon and Somerset police by email 15 March 2018)
[35] EMCDDA (2018) Drug consumption rooms: an overview of provision and evidence
[36] Harm Reduction International [HRI] (2018) *The Global State of Harm Reduction 2018*, p. 69.
[37] Scottish Drugs Forum (2018) *HIV in Glasgow: Responding to an outbreak*, pp. 5-6.
[38] HC Deb 7 March 2019 c 187139
[39] Shiner, M. Carre, Z. Delsol, R. and Eastwood, N., (2018) The Colour of Injustice: 'Race', drugs and law enforcement in England and Wales, p. 9.
[40] Ibid., pp. 35-37.
[41] Ibid., p. 25.
[42] Release and NUS (2017) Taking the Hit: Student drug use and how institutions respond, p. 7.
[43] Lucy Platt et al., "Associations between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies," *PLOS Medicine* 15, no. 12 (December 11, 2018): e1002680.