(DRU0019)

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2. He collaborates on a British Academy funded project titled 'Technological Shift, Drug Market Change and Supply Actors'. The project aims to understand how Brexit and the COVID-19 pandemic are impacting patterns of drug supply in the UK and how global drug market dynamics are changing more broadly. He also conducts research on drug policy in Jamaica and Brazil.
3. He declares that he received no financial benefits from any beneficiaries or stakeholders in preparing this written evidence.
4. This response focuses on evidence that highlights the inefficiency of the current UK drug framework and the need to design and implement drug policy that offers alternatives to prohibition.

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

5. The legal drug framework encompasses the Misuse of Drugs Act 1971, the Psychoactive Substances Act 2016, and the drug strategies enacted since 1995. The latest 10-year drug strategy was issued in 2021 (HM Government 2021).
6. Like every other prohibitionist drug framework (Koram 2019), the UK experience has failed to prevent drug use and drug harm. Statistics show that drug use among people aged 16-59 has not considerably varied between 1995—the year the first drug strategy was enacted—and 2020 (ONS 2020). However, as Kincová and Rolles (2022) point out in a recent policy brief, since the enactment of the Misuse of Drugs Act, ''In England alone, the number of people using heroin has risen from under 10,000 in 1971 to 260,000 today. This represents a more than 25- fold increase. Since 1971 cannabis use has increased by more than 5-fold, [and] the annual prevalence of any illegal drug use in Scotland has risen from 9% in 1996 to 13.5% in 2019.''
7. Recent numbers for drug deaths and incarceration underscore the inefficiency of the current framework. In all four UK countries, drug-related deaths have reached historical peaks in this last decade (NISRA 2020; ONS 2021).
8. According to Dame Carol Black's independent review on Drugs (2020: 16), ''over a third of the prison population (of approximately 82,000 people on a given day) are there for a drugs-related crime. Of these, 40% have been convicted of a specific drugs offence (such as trafficking), whilst 60% are serving sentences for crimes related to drug addiction, such as theft.'' Black also reports that almost 25% of the 20.000 people detained daily are arrested for minor drug policy

offences. The current framework is highly ineffective in preventing drug related offending.

9. The current framework is not effective due to the following reasons:
   1) It is predicated on outdated, stigmatised views of problematic substance use;
   2) it relies heavily on particular medical and criminological discourses and ideologies as ‘evidence’ to justify abstinence and war on drugs (Stevens 2021);
   3) It ignores the long documented best practices in health care, even those pioneered in the UK, i. e. harm reduction programmes;
   4) It ignores or dismisses the sociocultural history of drug use in the United Kingdom;
   5) It is based on moral predicaments instead of scientific evidence.
10. Removing well-known professionals from government advisory boards due to differing ideologies causes boards to lose legitimacy and the support of other professionals genuinely interested in improving drug policy. An example of this is the resignation of high-profile professor from the Advisory Council on the Misuse of Drugs (ACMD) in 2019, who resigned after the appointment of the executive director of Release UK, was vetoed by the government (Busby 2019).

Does the current framework, or a particular aspect of the framework, need to be reformed? If so, how? Could reform align with the UK’s international obligations under the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol; the Convention on Psychotropic Substances of 1971; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988?

11. The current framework needs to be completely revamped. It needs to treat drug dependency as a public health issue and dig into its own successful history of establishing and maintaining harm reduction initiatives such as needle and syringe exchange programmes (Parsons et al. 1997, Ashton and Seymour 2010). Other successful harm reduction initiatives, such as the establishment of drug consumption rooms (Holland et al. 2022) and easy access to naloxone (including training on how to administer it) for reversing the effects of opioids should also be considered (Chimbar and Moleta 2019).
12. The depenalisation of possession of drugs for personal use could also be a major step towards a fairer framework. Depenalising certain amounts for personal use would spare the government from spending huge sums of money for prosecuting and incarcerating citizens that are likely to re-offend.

13. The UK government spends almost £7 billion every year on drug-related matters across the criminal justice system in England alone (Kincová and Rolles 2022). This amount can be used to fund harm reduction and drug education programmes, and to support people who depend on drugs for underlying causes like trauma, poverty, homelessness, and lack of access to basic services. Eliminating the underlying causes of problematic drug use will be an effective measure for tackling drug-related deaths, harms, and offences (Christmas and Srivastava 2019).
14. Reform can align with UN treaties, protocols, and conventions. As of 2020, 87 Member States made explicit supportive reference to harm reduction in national policy documents: 86 has at least one needle and syringe programme operational, 84 had at least one opioid agonist therapy programme operational, 12 had at least 1 drug consumption room and 15 had peer distribution of naloxone (HRI 2020).
15. Decriminalisation of drugs has proven successful in Portugal, where drug use rates remain below the EU average, the proportion of people sentenced for drug offences has fallen sharply, and drug-related deaths have plummeted (Slade 2021). Portugal has decriminalised the individual possession of small amounts of banned substances for personal use in 2001 (e.g. 1g for heroin, 2g for cocaine and 25g for herbal cannabis). Uruguay has also legalised cannabis for personal use in 2013, followed by several US jurisdictions. In 2021, Malta and Luxembourg depenalised the possession of cannabis for personal use.
16. In 2018, on the second session of the UN System Chief Executives Board for Coordination recommended that member states should:
    - promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use;
    - address prison overcrowding and over incarceration of people accused of drug crimes;
    - support practical measures to prohibit arbitrary arrest and detention and torture
    - call for changes in laws, policies and practices that threaten the health and human rights of people (UNCEB 2019: 14).
17. Beyond aligning with conventions, protocols and policies that were drafted and enacted within the frameworks of the war on drugs and drug-free world—both understood as historical failures (UN 2019)—, the UK has the chance to lead a global reform in drug policy and influence the UN to review its conventions, schedules, and paradigms, hopefully within a framework that makes proper justice to the organisation’s declaration of human rights.

Should a ‘right to recovery’ (the right of a person dependent on drugs to seek drug treatment and services) be legally enshrined in UK law?

18. Yes, but the concept of ‘’recovery’’ cannot be arbitrarily associated with abstinence. It cannot favour rehabilitation or ‘’detox’’ clinics to the detriment of opioid agonist therapies, heroin assisted treatment, and safe consumption rooms.
19. The UK can follow the 1946 WHO constitution and guarantee ‘’the highest attainable standard of health as a fundamental right of every human being.” This includes:
    1) Rethinking the criminal justice budget and reallocating part of the funds (see point 13) currently destined to drug prohibition enforcement to public health initiatives;
    2) Looking back on its pioneering and successful history of harm reduction programmes;
    3) Commissioning an interdisciplinary team of researchers, practitioners, and people with lived experience of problematic and non-problematic drug use to design and implement a national harm reduction programme;
    4) Rethinking the intersectionality of public policies (housing, health, education, professional development).

What is your view on the UK Government’s 10-Year Drug Strategy for England and Wales, which was published in December 2021?

20. The high point of the strategy is the promise of investment in drug treatment services, but it should be taken with caution. There are a few mentions to harm reduction, naloxone, syringe and needle exchange programmes, and buprenorphine, and residential rehabilitation. There are no mentions of opioid agonist therapy, heroin assisted treatment, or drug consumption rooms. As mentioned above, an efficient strategy should cater to patients' needs, and not assume that there are one or two one-size-fits-all solutions for drug dependency.
21. Another relevant point of the strategy is the encouragement of diversion schemes, where the ‘’Police will pass on information from a positive drug test to NHS Liaison and Diversion services who work at police stations and courts to identify offenders with drug treatment and other needs, such as poor mental health, and refer them onwards to treatment’’ (HM Government 2021:41).
22. The explicit threat of going tough on adults who use ‘’recreational’’ drugs might backfire. It might discourage people who experience problematic drug use from using drug treatment services due to shame, fear of exposure, and stigma (Biancarelli et al. 2019). It might also serve as a strong justification for dangerous

practices such as using drugs alone and in hiding (Bardwell et al. 2018, Bardwell, Kerr, and McNeil 2019). Using drugs in isolation can lead to fatal overdoses that could be avoided when supervised by trained peers or paramedics if the use was disclosed and not hidden.

What is the impact of drug use? In particular, on drug users and their loved ones; local communities and wider society; the economy.

23. Not all drug use is problematic, and there are different patterns of drug use among problematic and non-problematic drug users (Ayres 2021). Drugs can be used responsibly and for pleasure, and they can have a positive impact in people's lives, while drug policies and legislation that rely on criminalisation, punishment, and incarceration have a significant negative impact on individuals', their families, communities, and whole countries (Milhet et al. 2019, Hart 2021, Araujo 2021a and 2021b).
24. Racial bias embedded in punitive drug policy, and law enforcement ''may lead to more Black, Asian and Minority Ethnic people being drawn into the criminal justice system, disrupting their education and family lives, and reducing their work opportunities'' (HMICFRS 2021: 2).
25. Racial bias in the enforcement of drug policy and legislation also damages relationships between communities and authorities. For example, the over policing of racialised citizens and communities, ''In particular, the disproportionate use of Stop and Search on BAME communities continues to drain trust in the [criminal justice system] as a whole'' (Lammy 2017: 18).
26. The criminalisation of drugs burdens the criminal system with huge costs (Eastwood, Fox and Rosmarin 2016, Kincova and Rolles 2022). It is economically unsustainable and these funds should be channeled to programmes and initiatives that are proven to reduce the harms derived from drug use.

Are there laws, policies or approaches adopted in other countries that have been effective in reducing drug use, drug related deaths, and/or drug related offending?

27. There are programmes and initiatives that have proved successful in the UK and abroad. It is important that the UK government look back on its own pioneering and successful history of controlling the spread of HIV and Hepatitis C by implementing syringe and needle exchange programmes in the late 1980s (Stimson 1995, Hope et al. 2001). More recently, the NGO The Loop has been providing the essential serving of testing drugs on site in parties and festivals

across the UK, which prevents people who use banned substances from consuming unknown doses and/or chemicals that might be present in unregulated supply.

28. Studies in Canada, the US, Australia, Norway, Germany, Switzerland, Spain, the Netherlands, and Luxembourg show that safe consumption rooms:
    - reduce the reuse of syringes and needles
    - reduce injury and death, reduce drug taking in public
    - help establishing and maintaining relationships between care providers and people who use these services, which raises the likely of people who depend on drugs to seek treatment
    - reduce crime
      (See Potier et al. 2014, Ng et al. 2017, Watson et al 2018, Newman 2019, Davidson et al. 2021, Holland et al. 2022.)
29. There is also clear evidence from South America, the US, the Caribbean, and Europe (Eastwood, Fox, and Rosmarin 2016) that the decriminalisation of drugs can significantly encourage people with drug dependency to seek treatment and reduce criminal justice costs

Recommendations for policymakers

30. With full consideration of the evidence above, policymakers should action the following policy recommendations:
    1. Invest in harm reduction programmes such as needle and syringe exchange programmes and safe consumption rooms. The UK should build on the success of previous harm prevention programmes such as those used during the HIV/AIDS epidemic.
    2. Treatment for people who use drugs should not establish total abstinence as the unique goal and should cater to individual needs.
    3. It is imperative that opioid agonist therapy and heroin assisted treatment are made widely available as treatment options.
    4. Drug dependency should be treated as a public health issue, and the UK should move towards decriminalisation of possession of every banned substance. This could be modelled on successful policies used elsewhere in the world, such as in Portugal.
    5. Cost-savings as a result of decriminalisation should be re-invested in harm reduction programmes and public health measures around drug dependency.
    6. Invest in unbiased education about drugs. Instead of a ‘’Just say no’’ approach, a ‘’Just say *know*” one is urgent.

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