Briefing Paper

Decriminalisation of the possession of all drugs for personal use.

Executive summary

Cornwall Area Meeting has raised a concern about the negative consequences of criminalising personal drug use. This concern focusses on the need to decriminalise the possession of all drugs for personal use. The concern does not address the production, importing or selling of drugs, nor does it address drug related crime (crimes committed to enable the purchase of drugs).

Criminalising personal drug use exacerbates the social exclusion of vulnerable individuals, as it impacts negatively on educational attainment, employment, travel and generally on life chances and future wellbeing.

Substantial numbers of people are criminalised in the UK for their drug use. In the years 2011/12, 42,067 people were sentenced for the possession of an illegal drug: 1,247 people were sentenced to immediate custody; 655 were given a suspended sentence; 8,136 were sentenced to community service, 21,862 were fined; 10,167 received other disposals. All received a criminal record. Recent studies show that people from BAME communities are disproportionally affected at all stages of the criminal justice process, from arrest to sentencing.

A substantial minority of the UK population uses, or has used, drugs recreationally. For a much smaller group of people recreational use may develop into problematic use. This latter group of people are the ones who are in need of support. The major determinants of drug use becoming problematic are deprivation and childhood abuse or trauma. In 2013 – 2014 there were estimated to be over 293,000 opiate and crack cocaine users in England. Of these 193,000 were in contact with treatment services.

A range of international studies conclude there is little or no relationship between the legal status of drug use of a country and the rate of drug use within it. Removing penalties for drug use does not result in an increase in overall drug use. It is accepted by many analysts that the prevalence of drug use tends to rise and fall in line with broader cultural, social or economic trends. Portugal is perhaps the clearest and most relevant demonstration that

decriminalisation does not increase the prevalence drug use. The whole administration addressing drug use is under the healthcare sphere with a consistent and coherent policy which has been functioning since 2001.

A decriminalisation approach coupled with investment in harm reduction and treatment services can have a positive impact on both individual drug users and society as a whole. Decriminalisation does appear to direct more drug users into treatment, reduce criminal justice costs and shield many drug users from the devastating impact of a criminal conviction.

Calls for reform to the drugs policy framework have come from a number of eminent sources. They include the United Nations, the World Health Organisation, the Global Commission on Drug Policy, the UK Drug Policy Commission, the UK Advisory Committee on the Misuse of Drugs, the International Federation of Red Cross and Red Crescent Societies, Human Rights Watch and eminent medics. Many authoritative voices call for the end of the criminalisation of drug users.

We raise this concern as Quakers because it is not ethical to punish people for their vulnerability and we feel deep concern and compassion for those harmed by criminalisation. By advocating for this concern we are expressing our love in action.

1. Purpose of the paper

The purpose of this paper is to draw together a range of information on the subject of drug use to support and inform Friends in their consideration of current UK policy regarding the personal use of drugs. We hope the paper also helps Friends to understand why Cornwall Area Meeting has raised this concern.

2. Introduction

The prohibition of drugs presents a large scale contemporary problem which affects the lives of hundreds of thousands of people in the UK and the lives of whole communities locally, nationally and globally. The production and supply of drugs is in the hands of organised crime and so is associated with other areas of criminal activity such as human trafficking, the arms trade, prostitution, gambling, pornography and money laundering.

Our Quaker concern, adopted by Cornwall Area Meeting, relates solely to the criminalisation of the possession of controlled drugs for personal use. It does not relate to the issues of supplying and selling drugs, producing drugs or trafficking drugs. It also does not relate to drug-related inquisitional crime (i.e. crime committed to enable the purchase of drugs). Drug use is prohibited under the **Misuse of Drugs Act, 1971**. Possession of Class A drugs can attract 7 year's imprisonment plus a fine; supply carries maximum sentences of life imprisonment plus a fine. Possession of Classes B and C can incur prison terms of 5 and 2 years respectively (plus fines), while supply of either carries maximum sentences of 14 years and fine (see Appendix A). It is clear that the harms caused by pursuing this approach to drug use have been significant: more than 1,000 people are imprisoned each year solely for the possession of drugs for personal use. The Home Office states that 3% of those found guilty of possession are sentenced to prison[1]. In 2011, nearly 80,000 people in the UK were found guilty or cautioned for possession of an illegal drug - most were young, black or poor[2]. The policy is costly for taxpayers and damaging for communities. Criminalising people who use drugs intensifies the social exclusion of vulnerable individuals and communities. Criminalisation has a negative impact upon educational attainment and employment and therefore upon life chances and future wellbeing. The policing and prosecutions of drug

[1] Home Office
[2] information from **Release**

possession offences in England and Wales is unduly focused on black and minority communities. There is racial disparity rates at stop and search, arrest, prosecution and sentencing and the drug laws in the UK are a major driver of the disproportionality that exists in our criminal justice system in relation to the Black and Ethnic Minority community (see Appendix B).

It is important to recognise the two defining elements which relate to drug use: recreational drug use and dependent drug use.

3. Recreational drug use

Recreational drug use is by no means a new social phenomenon, although the particular form it takes varies significantly according to time, place and cultural context. As far as it is possible to discern, human beings have always experimented with a wide range of substances since pre-history. Drugs, including alcohol and tobacco, have been used to alter mood, thought, and perception. Sometimes their use has been embedded into spiritual or religious practices. Sometimes substances have been used to cope with fatiguing and monotonous work. Sometimes drugs have been used to promote sociability, togetherness and celebration. And sometimes, very importantly, drugs have been used for pleasure and enjoyment. It is essential to recognise the implications of the all-pervasiveness of substance use throughout human history. As such, substance use cannot be seen simply as a set of deviant or pathological behaviours.

Within any given population it will be true that at least a sizeable minority, and sometimes an actual majority, of people will have used a range of substances at least once. Experimentation is widespread and could be considered to be a normal and predictable part of the repertoire of many people in their adolescence. For some people the first experience of a substance may be their last in that they find their experience of its effects to contain no compelling reason to seek them again. Some people, again a minority, will choose to use the substance on future occasions because they like and value its effects. Their use of the substance will fit in and around the rest of their life – family, work, education, pastimes. As such their use can be best described as recreational. Recreational patterns will persist for many throughout adolescence and early adulthood and then typically will decline and virtually extinguish as the person moves into adult roles.

4. Dependent drug use

For a small minority, what was once recreational use will become problematic use in the sense that dependency, whether psychological or physical, will develop. Life will start to become dominated by either the use of the substance or the activities that become necessary to acquire a steady and reliable source of it. In 2011/12 there were known to be over 300,000[3] opiate and cocaine dependent users in England. The UN suggests that the threat of synthetic drugs is one of the most significant drug problems worldwide: after cannabis, amphetamine-type stimulants (ATS) are the most widely used drugs across the globe. Since the mid 1990's the Internet has been increasingly used by drug traffickers to sell illicit drugs or the chemical precursors required to manufacture such drugs[4]. The key determinants of problematic drug use are deprivation and abuse.

There is an established link between childhood trauma and psychiatric symptoms in adult life and evidence suggests a link between such early life experiences of and substance use. Research undertaken in Cornwall (2000) shows that of 111 randomly selected patients seen by the drug team, 46% of males and 73% of females, reported childhood abuse.[5] A Quaker Friend runs a rehabilitation service in Cornwall[6] states, *"A personal reflection from the evaluations of some 300 client I have worked with: it is possible that maybe 2 or 3 % have NOT suffered abuse, neglect and trauma at some time in their lives".*

A random Google search pulls up several academic studies which substantiate the correlation between childhood abuse and problematic drug use:

[3] source: National Treatment Agency

[4] UN Commission on Narcotic Drugs: Background documentation for the interactive discussions on high level segments to be held during the special session of the General Assembly on the world drug problem in 2016.

[5] Drug dependence and child abuse
B. Charnaud, V. Griffiths
The British Journal of Psychiatry Jul 2000, 177 (1) 84
Drug dependence and child abuse
B. Charnaud, V. Griffiths
http://bjp.rcpsych.org/content/177/1/84.2

[6] http://www.sailadayok.co.uk/about-sailaday-ok

A study of sexual abuse, shows significant correlations between variables such as family drug use, first age of sexual abuse, age of first depression and age of first illicit drug use[7].

An analysis links molestation history to suicidality, substance abuse, sexual difficulties and multiple psychiatric diagnoses.[8]

A study shows that, for male and female youths, physical abuse and sexual victimisation has a direct effect on self-derogation and drug use[9].

A study shows results which are consistent with the hypothesis that Childhood Sexual Abuse is causally related to an increased risk for psychiatric and substance abuse disorders[10].

A study collected data on 178 patients – 101 in the USA and 77 in Australia – in treatment for drug / alcohol addiction. The study determined that 84% of the sample reported a history of child abuse / neglect[11].

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[7] The Antecedents of Women's Crack Cocaine Abuse: family substance use, sexual abuse, depression and illicit drug use. Boyd, C. (1993) Journal of Substance Abuse Treatment

[8] J Briere, LY Zaidi (1989) Sexual abuse histories and sequelae in female psychiatric emergency room patients. American Journal of Psychiatry Volume 146 Issue 12, December 1989, pp. 1602-1606

[9] Dembo, Richard[1]; Williams, Linda[2]; La Voie, Lawrence[3]; Berry, Estrellita[4]; Getreu, Alan[4]; Wish, Eric D.[5]; Schmeidler, James[6]; Washburn, Mark[4] Physical Abuse, Sexual Victimisation and Illicit Drug Use: Replication of a Structural Analysis Among a New Sample of High Risk Groups. Violence and Victims, Volume 4, Number 2, 1989, pp. 121-138(18)

[10] Kenneth S. Kendler, MD; Cynthia M. Bulik, PhD; Judy Silberg, PhD; John M. Hettema, PhD, MD; John Myers, MS; Carol A. Prescott, PhD (2000) Childhood Sexual Abuse and Adult Psychiatric and Substance Use Disorders in Women, An Epidemiological and Cotwin Control Analysis (2000) Jama Psychiatry. October 1, 2000, Vol 57, No. 10

[11] Cohen FS, Densen-Gerber J. (1982) Child Abuse Neglect. 1982;6(4):383-7.A study of the relationship between child abuse and drug addiction in 178 patients: preliminary results:

A study collected data gathered from a study of youths in a regional detention center. The results indicate that the youths' physical and sexual abuse experiences are significantly and positively related to their use of illicit drugs[12].

A study looks at the influence of child physical and sexual abuse on self-derogation and drug use. Results suggest that for male and female youths, physical abuse and sexual victimization had a direct effect on self-derogation and illicit drug use[13].

5. Having possession of a controlled drug

In 2011/12 there were 229,103 drug offences[14] of which 86% relate to drug possession (mainly cannabis which is 70% of all drug offences). The overall number of drug offences has markedly increased up to 2008/09 but has since stabilized. However, the increase has been greatest in respect of cannabis possession, the numbers of which have almost doubled since 2004/05 which reflects police activity rather than prevalence as cannabis use reduced during this period[15].

1,247 people were imprisoned for having possession of a controlled drug. 21,862 people are fined which makes little sense if they are dependent on drugs. Having a criminal record prevents people from fulfilling their personal potential. In addition, are the significant related issues of social and economic exclusion and inequality, particularly in relation to young people from Black and Ethnic Minority communities, people living in poverty and vulnerable people. There is a huge racial disparity in rates of stop and search, arrest, prosecution and sentencing outcomes.

[12] R Dembo, M Dertke, S Borders, M. Washburn & J. Schmeidler (1988) The Relationship Between Physical and Sexual Abuse and Tobacco, Alcohol, and Illicit Drug Use Among Youths in a Juvenile Detention Center. International Journal of the Addictions. Volume23, Issue 4, 1988:

[13] FS Cohen, J Densen-Gerber (1982) - Child Abuse & Neglect: 6(4):383-7:

[14] A Fresh Approach to Drugs. The final report of the UK Drug Policy Commission. (2012)

[15] A Fresh Approach to Drugs. The final report of the UK Drug Policy Commission. (2012)

The table below sets out the statistics for 2011/12 regarding sentencing for the possession of an illegal drug[16]

Type of disposal	Possession	
	Number	percentage
Immediate custody	1,247	3%
Suspended sentence	655	2%
Community service	8,136	19%
Fine	21,862	52%
Other disposal	10,167	24%
Total sentenced	42,067	100%

6. Imprisonment

Most Quakers agree that imprisonment should only be used when there is a danger to people which cannot otherwise be contained or removed. The information which follows is specifically about substance use and imprisonment, particularly in relation to deprivation and inequality.

The Prison Reform Trust[17] suggests that between a third and a half of new receptions into prison are estimated to be problem drug users (between 45,000 and 65,000 prisoners in England and Wales)[18]. In June 2014, 14% of men and women in prison were serving sentences for drug offences[19] (i.e. possession, supply, trafficking) and 66% of women and 38% of men in prison reported committing offences e.g. theft in order to get money to buy drugs.

37,527 people entered prison in 2013 to serve sentences of less than or equal to 6 months.

[16] A Fresh Approach to Drugs. The final report of the UK Drug Policy Commission. (2012)

[17] Prison Reform Trust. Prison the facts: Bromley Briefings Summer 2014
[18] sPrison Reform Trust. Prison: the facts. Bromley BREIFINGS Summer 2014
[19] The Prison Reform Trust (2014) Response to the Ministry of Justice consultation , Punishment and reform: effective community sentences.

46% of adults are reconvicted within one year of release. For those serving sentences of less than 12 months this increases to 58%. 67% of under 18 year olds are reconvicted within a year of release.

81% of women entering custody under sentence in 2013 were there for non-violent crimes and 37% were there for theft and handling stolen goods. (It is well documented that many have young children and many have themselves been the victims of serious crime, including domestic violence, sexual abuse and rape). Women serving custodial sentences are twice as likely as men (21% v 10%) to have no previous convictions or cautions. In 2013 60% of sentenced women (4,134) were serving sentences of 6 months or less.

Two thirds of women sent to prison are mothers and over 17,000 children are separated from their mothers by imprisonment every year. Imprisonment has a devastating impact upon the life chances of children who are more likely to experience homelessness, disruption to their family and home lives, problems at school and local authority care. Fewer than 1% of all children are in care but looked after children make up 33% of boys and 66% of girls in custody[20]. 12% of children in prison had experienced the death of a sibling or parent. 76% had an absent father, 33% an absent mother and 39% had been on the child protection register or had experienced neglect or abuse[21]. Boys who reported having been in care are more likely than other young men to report problems with drugs (50%) and alcohol (13%) and to report having mental health problems (26%).

In 2013 there were 215 deaths in custody, the highest number on record. The use of drugs and alcohol can be a risk factor for suicidal behaviour[22]

On March 2014, 26% of the prison population (21,769 prisoners) was from a minority ethic group, compared to 10% of the general population[23].

[20] HM Inspectorate of Prisons and Youth Justice Board cited by Prison Reform Trust
[21] Prison Reform Trust research
[22] Prison and Probation Ombudsman (2014) Learning from PHO investigations cited iby Prison Reform Trust
[23] Equality and Human Rights Commission cited by Prison Reform Trust

19% of those prisoners who said they have ever used heroin reported having used heroin for the first time in prison. The Prison Trust extrapolates this to be 7-8% of all prisoners in their sample.

Community sentences such as diversion from custody are available to the courts. However, only 7.9% of orders involve drug rehabilitation. This is despite a high percentage of offenders having a drug dependency problem. The Prison Reform Trust maintains that, *"there are some groups of offenders for whom a particular emphasis on punitive punishment would be especially counter-productive: offenders with mental health needs and learning difficulties and disabilities; offenders with drug and alcohol addictions; young adults with low levels of maturity; vulnerable women with complex and multiple needs; offenders with primary care responsibilities."*[24]

The annual cost of a prison place in England and Wales for 2012-2013 was £36,808[25]. Rehabilitation for one year costs about the same. There are gains associated with treatment as opposed to prison. The financial cost to society every year of drug dependency is £15,400,000,000[26]. Drug treatment prevents an estimated 4.9m crimes per year saving an estimated £960,000,000 costs to the public, businesses, criminal justice services and the NHS.

One former offender with an eight year old boy said to researchers from the Prison Reform Trust,

"Once you come out of prison you've got that hanging over you for the rest of your life... it's like stigma. It follows you around. It's hard to get a job, a bank account when you can't prove the last three years in your history... little things like that. Having a criminal record is going to affect your life."

[24] The Prison Reform Trust (2014) Response to the Ministry of Justice consultation , Punishment and reform: effective community sentences.
[25] Ministry of Justice cited by Prison Reform Trust
[26] NTA Why invest? How drug treatment and recovery services work for individuals, community and society

7. Decriminalisation of personal use

Release refers to many commentators in the UK who argue that cannabis possession has effectively been decriminalised, with the introduction of non-criminal sanctions in 2004 for possession offences. However, **Release** argue that the impact of *de facto* decriminalisation has essentially been a net-widening effect.

Dr. Michael Shiner, Associate Professor of the **London School of Economics** has recently published a paper which also shows that the initial reclassification of cannabis led to an intensification of police efforts targeting minor possession because the police were given new powers to issue formal on-the-spot street warnings and penalty warnings (which remain on the criminal record). This resulted in a sharp increase in the number of people given sanctions for minor possession offences. The number of cannabis offences recorded by the police almost doubled between 2004/5 and 2011/12. The number of stop searches for all drugs more than doubled between 2000/01 and 2010/11, with most of this increase occurring after the initial reclassification of cannabis. Shiner states that this represents an increase from one third to a half of all stop searches, at the expense of stolen goods which accounted for around two fifth of stop-searches in 200/01 but only one fifth in 2010/11. The inclusion of cannabis warnings as a sanction detection created a fast track to achieving targets. The study concludes that *"many otherwise law abiding, mainly young people are still being criminalised to the detriment of their future; and the drug policing continues to be disproportionately targeted at minority ethnic communities".* Shiner suggests that in the short term the best administrative decision would be to remove drug possession from police indicators.

The decriminalisation of drug use does not solve all of the problems associated with drug use but what emerges from the complexity of evidence collected,[27] is that the harms of criminalisation for personal use far outweigh those of decriminalisation. Decriminalisation does appear to direct more drug users into treatment, reduce criminal justice costs and shield

[27] referenced by **Release**

many drug users from the devastating impact of a criminal conviction. A decriminalisation approach coupled with investment in harm reduction and treatment services can have a positive impact on both individual drug users and society as a whole. Decriminalisation does not increase the prevalence drug use.

8. Prevalence

A range of international studies show that overall there is little or no relationship between the legal status of drug use of a country and the rate of drug use. Instead, drug use tends to rise and fall in line with broader cultural, social or economic trends. Removing criminal penalties for drug use does not therefore result in an increase of drug use. **The European Monitoring Centre for Drugs and Drug Addiction** (EMCDDA)[28] looked at levels of drug use in countries which had increased or decreased penalties for cannabis possession. It found no evidence that increasing penalties reduces use, or that reducing penalties increases it:

"*the model implemented in Portugal, where the whole administration addressing drug users is under the healthcare sphere, with several rehabilitative measures available, has a consistent and coherent policy. This approach has been functioning since 2001. There has been no major increase in drug problems that can be attributed to the new system".*
European Monitoring Centre for Drugs and Drug Addiction.

Professor Alex Stevens[29] similarly suggests there is little correlation between the level of punishment for drug offences and the rate of drug use or drug problems.

We need, though, to be looking beyond prevalence and redefine "the drug problem" as more than just how many people use drugs. Measuring the effectiveness of drug policy requires a far broader range of indicators that include public health, crime, civil rights, community safety, international development and conflict. In Portugal drug related deaths have fallen, HIV, AIDS, Hep C, Hep B and TB rates have fallen. Young people (or any person) are not criminalised or stigmatised or imprisoned for the recreational use of any drug. Every parent may worry about their child taking drugs but evidence from Portugal and elsewhere shows

[28] European Monitoring Centre for Drugs and Drug Addiction (2011b) 'Looking for a relationship between penalties and cannabis use'

[29] Alex Stevens Drugs, Crime and Public Health' Routledge, 2011,

that decriminalisation does not increase the likelihood risk of them taking drugs. It does, however, decrease the risk of harm if they do.

9. Policy reform

Calls for reform to the drugs policy framework have come from a number of eminent sources: the **United Nations**, the **World Health Organisation**, the **Global Commission on Drug Policy**, the **UK Drug Policy Commission**, the **UK Advisory Commission on the Misuse of Drugs**, the **International Federation of Red Cross and Red Crescent Societies**, the **Human Rights Watch** and others**.** Many authoritative voices call for the end of the criminalisation of drug users (please see Appendix C).

The United Nations Office for Drugs and Criminal Justice in "From Coercion to Cohesion".(2010)[30] calls, on the basis of extensive evidence, for health based treatment for illegal drug users instead of punitive criminal justice measures. They state that evidence suggests that the most effective response to drug dependence and the health related harms associated with it require treating drug dependency as a health condition. As with all healthcare conditions, treatment requires to be offered on a voluntary basis.

The **United Nations** argues that we must identify the best ways of balancing the drug control system, in particular focusing on health and respect for human rights, emphasising evidence based prevention and treatment, giving due consideration to the needs of drug dependent persons and countering cultural stereotypes, stigma and discrimination which limit drug users access to health services.

In 2011, the decriminalisation policy model received a major endorsement when **the Global Commission on Drug Policy** published its report War on Drugs. This commission was composed of current and former heads of state, human rights and global health experts, economists, United Nations leaders and business leaders. The report included a recommendation that countries adopt decriminalisation policies, among other initiatives including investment in harm reduction services.

[30] United Nations Office on Drugs and Crime (2010) *From Coercion to Cohesion: Treating Drug Dependence Through Health Care, Not Punishment*

In the UK the **All Parliamentary Group for Drug Policy Reform,** reporting in 2013, provides a measured appraisal of current drug policy[31]. The report concludes that, in aiming to reduce the harms associated with illicit drugs, criminalisation is not only ineffective but also causes additional harms. The report concludes that current drugs policy, both domestic and international, has failed to tackle the problems associated with drug use:

"Far from diminishing over time, the global use of traditional illicit drugs has increased dramatically. Over the last 30 years the global illicit supply of opiates increased by over 4 times from 1000 metric tonnes in 1980 to 4,800 metric tonnes in 20102. In England, the number of dependent heroin users increased from around 5,000 in 1975 to an estimated 281,000 in England by 2007.3 The Conventions and the UK Misuse of Drugs Act have failed to achieve their objectives."

The **All Parliamentary Group for Drug Policy Reform** refer to the increasing recognition of the failure of prohibition**:** "The Global Commission on Drug Policy issued their widely publicised report 'War on Drugs' in June 2011 urging the World to recognise that the war on drugs has failed, with devastating consequences for individuals and societies across the globe. A number of Countries have explored and evaluated alternative policies."

The **All Parliamentary Group for Drug Policy** Reform report identifies that the UK application of the **Misuse of Drugs Act 1971** lags behind the drug policies of a number of European Countries (such as the Czech Republic, Spain, Estonia and Portugal). These countries have decriminalised the possession and use of small quantities of drugs. Many other countries have never criminalised possession and use of drugs. The report notes that the policy has produced positive results in terms of employment, family relationships, housing and savings to the taxpayer. The **All Parliamentary Group for Drug Policy Reform** concludes that decriminalisation has not significantly affected the level of drug use.

Release submitted a petition to the government in 2012 which was signed by many eminent people (see Appendix D).

[31] All Parliamentary Group for Drug Policy Reform (2013) ;

The 2015 background documentation paper of the **UN Commission on Narcotic Drugs**[32], concludes that drug disorders are multi factorial conditions caused by a complex interplay of neurological, psychological and environmental vulnerabilities and that people dependent on drugs should not be stigmatised and punished but should receive support for recovery, social cohesion and integration. The report maintains that drug use and its consequences such as HIV, hepatitis and overdoses are a public health issue that can be prevented and should be dealt with by the appropriate institutions with effort directed towards the prevention of drug use and drug related crime. The report endorses the need for good quality drug dependence treatment and rehabilitation services that are voluntary and based on scientific evidence and medical standards with multiple pathways to recovery to support rehabilitation and recovery. The report stresses the need to build evidence based services for vulnerable groups: young people, children and youth exposed to drug use at a very early age, women, sex workers, street children, women with children, pregnant women, lesbian, gay, bisexual and transgender (LGBT) populations, refugees, displaced populations and people living in post-conflict or fragile countries.

10. Treatment services

The UK has a network of treatment services across the country. Access to treatment is via two routes: self-referral and referral from the criminal justice system. The data collected nationally does not differentiate between these two routes when analysing treatment outcomes. The 2013/2014 data collected by the National Treatment Monitoring System (NDTMS) shows that the most common routes into treatment for clients starting treatment in 2013-14 were self-referrals (44%) and referrals from the criminal justice system (27%). Onward referrals from other drug services together accounted for 11%.

In 2013-14 there were estimated to be 293,879 Opiate/Crack users in England and during that year 193,192 adults were in contact with treatment services. Most clients in contact with treatment were using opiates (79%). Cannabis was the primary drug for 9% of clients and powder cocaine for 5% of clients.

[32] **UN Commission on Narcotic Drugs**[32] (2015) Background documentation for the interactive discussions on high level segments to be held during the special session of the General Assembly on the world drug problem in 2016

The number of adults engaged and retained in treatment for 12 weeks or more (or if leaving treatment did so free of dependency) was 181,420 (94%). The number of adults successfully completing drug treatment free of dependency was 29,150 (45% of those exiting treatment in this year)[33].

The number of under 18's accessing substance misuse services was 20,032. It should be noted that young people's treatment figures are not comparable with statistics relating to adult drug treatment. This is because access to treatment for young people requires a 'lower severity of drug use and associated problems'

Clients' median age at their first point of contact in their latest treatment journey in 2013-14 was 36 and 74% of clients in treatment were male.

Most clients were white British (83%), the next most common ethnicity was 'white - other' (4%). No other ethnic groups accounted for more than 2% of clients

85% of the clients starting new treatment journeys in 2013-14 were either in treatment for 12 weeks or more or completed treatment free of dependency before 12 weeks

Nearly all clients waited less than three weeks to commence treatment (98%). However, it is not clear whether this means initial assessment or the start of actual treatment.

Given that 70% of all drug offences relate to cannabis, and treatment services are prioritised for those dependent upon heroin and cocaine, there is a clear mismatch between the use of resources with police and court resources being used for those least in need.

11. Portugal

Hughes and Stevens[34] conducted a study of evidence regarded decriminalisation of the possession of all drugs in Portugal and concluded that evidence from Portugal shows:

- Small increases in reported illicit drug use among adults
- Reduced illicit drug use among problematic drug users and adolescents (since 2003)

[33] Every year the NDTMS counts the number of people who leave structured treatment either free of dependency with no drug use or free of dependency with occasional use of a drug that they are not dependent on eg cannabis.

[34] Hughes, C. & Stevens, A. (2010) What Can We Learn From The Portuguese Decriminalisation of Illicit Drugs? *British Journal of Criminology*, 50, p, 999-1022

- Reduced burden of drug offenders on the criminal justice system
- Increased uptake of drug treatment
- Reduction in opiate-related deaths and infectious diseases
- Increases in the amount of drugs seized by the authorities
- Reductions in the retail prices of drugs
- No signs of a mass expansion of the drug market

On a recent visit to Lisbon two members of Cornwall Area Meeting took the opportunity to find out first hand exactly what the Portuguese system is and how it works in practice[35]. They met with Nuno Capaz, **Vice-President, Lisbon Dissuasion Commission** and M.D. Joao Goulao, **General-Director of Intervention on Addictive Behaviours and Dependencies, Portugal**, who generously made themselves available to answer their questions. They were interested to compare the UK and Portuguese systems and so felt that it was important to understand the administrative and legal processes in Portugal.

From 1932 to 1974 Portugal was a dictatorship and Portugal's borders were closed. Consequently few drugs were available in the country. When Portugal's borders were reopened the sudden availability of a number of drugs, including heroin, resulted in widespread harm. The highly visible street use of heroin in Lisbon bought the issue suddenly to public and political attention, causing alarm and concern. A Government panel concluded that a paradigm change was needed in the way that the problem was approached. The principle of this paradigm shift was that the addicted drug user was considered to be a sick person in need of health care. A drug strategy was developed and considerable investment was made in treatment and harm reduction measures.

The Portuguese legal framework on drugs changed in July 2001. Drug trafficking is still a criminal offence but personal use of any substance is no longer a criminal offence. 'Dissuasion' is the core process to dissuade from consumption, prevent the use and abuse of drugs, ensure health protection of users and the community and guide drug users to more adequate responses regarding their personal situation. Above all 'dissuasion' emphasises and

[35] article in The Friend, 21 August 2015

prioritises the health approach. Dissuasion Commissions were set up across Portugal. If a person is found possessing a small quantity of a substance for personal use in a public place the Police refer to the dissuasion commission. The professional staff under-take an evaluation hearing with the referred drug user. They assess whether the person's use is problematic (addicted) or is likely to become problematic. People who are addicted to drugs are referred to treatment which is immediately available. Support interventions are offered to non-problematic drug users (who constitute 90% of those referred by the police) who are seen to have health and social care needs – such as unemployment, family problems, psychological problems. There are administrative penalties which the Dissuasion Commission can impose for example, attendance at a specified place such as a youth club or unemployment centre, a ban on being at certain places or a fine which can be in the form of a donation to a charity of the person's choice. However, the Dissuasion Commission is not permitted to charge a monetary fee for an addicted person.

The outcomes have been rigorously monitored by the *European Monitoring Centre for Drugs and Drug Addiction*. Basically, de-criminalisation has had little or no impact upon prevalence which has fluctuated in Portugal since 2001 in common with the rest of Europe.

The two members of Cornwall Area Meeting were highly impressed by the system in Portugal in terms of the humane and rational approach. They were particularly impressed by the paradigm shift towards the health and well-being of the drug user. In their opinion the *big thing* is that Portugal have introduced a truly health based system. There has been a change of culture and belief as well as a change of policy which has led to a coherent and sustainable drug strategy which incorporates the adequate resourcing of treatment and harm reduction measures.

A less tangible benefit is that drug use becomes less stigmatised and that drug policy issues can be discussed publicly. Perhaps the final word should go to Dr. Joao Goulao, the architect of Portugal's decriminalisation policy. *"It's very difficult to establish a causal link between decriminalisation and the positive tendencies we've seen….it's a total package. The biggest effect has been to allow the stigma of drug addiction to fall, to let people speak clearly and to pursue professional help without fear."*

12. QAAD

QAAD published a briefing paper for QAAD Trustees in 2012[36] which presented arguments and evidence about decriminalisation. QAAD had, "not been led to take a position."
The QAAD Trustees did not anticipate doing further work on this issue.

There are a number of differences between the views of QAAD and Quakers who advocate for the decriminalisation of drug use. We differ in that those of us who advocate for the decriminalisation (of the possession, for personal use, of all drugs) accept the clear evidence regarding the harms of the criminalisation and accept the clear evidence that decriminalisation does not lead to greater prevalence. We believe that the harms of criminalisation cannot be removed under the current criminal justice approach.

13. Quaker concern

Our concern arises from the magnitude of harm caused by the current drug policy to each individual affected, to their families and to their communities. Each individual is precious - individual lives are blighted by this policy.

We raise this issue as a concern as Quakers because we feel deep compassion for those hurt and harmed by the criminalisation of their personal drug use and by advocating for this concern we are expressing our love in action.

"What is love? What shall I say of it or how shall I in words express its nature? It is the sweetness of life; it is the sweet tender, melting nature of God, flowing up through his seed of life into the creature and of all things making the creature most like unto himself, both in nature and operation. It fulfils the law, it fulfils the gospel; it wraps up all in one and brings forth all in oneness. It excludes all evil out of the heart, it perfects all good in the heart.. A touch of love doth this in measure; perfect love doth this in fullness."

Isaac Penington, 1663 *(Quaker faith and practice. Fifth edition. 26.30).*

[36] Briefing Paper for QAAD Trustees on the Decriminalisation of Drugs written by Helena Chambers 2012

We maintain that this issue is a moral issue and a human rights issue:

Judith Baker, writing on the international aspects of Quaker Human Rights work asks, does it have to be the Quakers who work on these issues? Why should the **Religious Society of Friends** be involved with these secular 'rights?

"*From slavery to stopping the British export of leg irons in the 1980's, from child soldiers in Uganda to the exploitation of under-18's in the British armed forces, from prison reform and Elizabeth Fry to children of imprisoned mothers today, Quakers do not work alone. Many people of all faiths and none are represented by non-governmental organisations and by diplomats from around the world in the UN for fora which consider human rights and in work on the ground trying to rectify abuses. Much work involves legal processes and much of it requires considerable expertise. However, it seems that other organisations and indeed victims of human rights abuses not only appreciate the unique Quaker way of working and respect Quaker experience, they also acknowledge the deeply held beliefs which underpin the work, the sense of doing things not for our own advantage, but because they are right.*"[37]

We ask that Quakers should consider the issue of the decriminalisation of drug use and add an informed, discerning, constructive and compassionate voice guided by Quaker principles to the debate about the way our society responds to the issues of drugs, drug users and those affected by the consequences of drug use. This drugs policy debate is so often plagued by the polarization of views and misinformation which makes rational dialogue difficult. We believe that the voice of Quakers can be distinctive in this debate and can add weight to the views of others who wish to bring about constructive reform.

We ask that Quakers view the positive outcomes of the Portuguese decriminalisation experience together with the significant investment in public health initiatives, including needle exchanges and opiate substitute-prescribing. We ask Quakers to speak out for the decriminalisation of drug use.

[37] *Nonsense on Stilts? Quaker view on Human Rights* (2008) ed by Nigel Dower. William Sessions Limited, York

Focusing on policy serves to enhance our concern for the individual. Quaker Faith and Practice reminds us of the links between the individual and the wider society (23.47)

"Compassion, to be effective, requires detailed knowledge and understanding of how society works. Any social system in turn requires man and women in it of imagination and goodwill. What would be fatal would be for those with exceptional human insight and concern to concentrate on ministering to individuals, while those accepting responsibility for the design and management of organisations were left to become technocrats. What is important is that institutions and their administration be constantly tested against human values, and that those who are concerned about these values be prepared to grapple with the complex realities of modern society as it is."

As Quakers we should be asking the fundamental questions: *is it right to criminalise a person for the recreational use of drugs? is it right to criminalise a person who has a health related need? should we be providing care and treatment or responding punitively to people's needs?* It is simply not ethical in our view to punish people for their vulnerability and in consequence have tens of thousands of people in prison. We ask Friends to examine the need to take action on this issue in order to abide by the principles of truth, equality and compassion.

As Quakers we long for peace and justice.

Cornwall Area Meeting

Appendix A

Class A: heroin, cocaine, crack, ecstasy, LSD, methadone, crystal meth, magic mushrooms and any class B drug that is injected

Class B: cannabis, amphetamine, barbiturates, codeine

Class C: anabolic steroids, minor tranquillisers GHB, ketamine

Appendix B

A report by LSE and Release shows that drug policing is dominating stop and search, that much of this activity is focused on low level drug possession offences, and that black and Asian people are being disproportionately targeted. Niamh Eastwood, Executive Director of Release and co-author of the report, states "this research shows that stop and search is not about finding guns or knives but about the police going out and actively looking for people who are in possession of a small amount of drugs, mainly cannabis".

- Over 50% of stop and searches are for drugs, 10% are for offensive weapons and less than 1% are for guns.
- The police in England and Wales stop and search someone for drugs every 58 seconds.
- Of the more than half million stop and searches for drugs carried out in 2009/10 only 7% resulted in arrest.
- In 2009/10 there were 10 stop and searches for drugs for every 1,000 people in England and Wales. Black people were stopped and searched for drugs at 6.3 times the rate of white people, while Asian people were stopped and searched for drugs at 2.5 times the rate and those identifying as mixed race were stopped and searched for drugs at twice the rate of white people. This is despite the fact that drug use is lower amongst black and Asian people when compared to their white counterparts.
- Black people are arrested for a drugs offence at 6 times the rate of white people, and Asian people are arrested at almost twice the rate of the white.
- Black people are more likely to receive a harsher police response for possession of drugs. In 2009/10 78% of black people caught in possession of cocaine by the Metropolitan Police were charged for this offence and only 22% received cautions. In comparison 44% of white people were charged for the same offence and 56% received cautions.
- Black people caught in possession of cannabis by the Metropolitan Police are less likely to receive a cannabis warning than white people, and are charged at 5 times the rate of whites.

- Prosecutions for drug possession are at an all-time high and this is primarily being driven by cannabis possession. In 2010, the Crown Prosecution Service brought more prosecutions for possession of drugs than in any other year since the introduction of the Misuse of Drugs Act 1971 - 43,406 people were found guilty of drug possession. 60% of these prosecutions were for cannabis.
- Black people are subject to court proceedings for drug possession offences at 4.5 times the rate of whites, are found guilty of this offence at 4.5 times the rate, and are subject to immediate custody at 5 times the rate of white people.
- Once they have been taken to court black people are less likely to be given a suspended prison sentence for drug offences than white people.
- Every year approximately 80,000 people in England and Wales are convicted or cautioned for possession of drugs. In the 15 year period, 1996 to 2011, 1.2 million criminal records have been generated as a result of drug possession laws.

Michael Shiner, co-author of the report and a senior lecturer in the department of social policy at the London School of Economics said: "It's shocking that police officers are spending so much time targeting minor drug offences, rather than focusing on more serious matters. This is not the result of a carefully considered strategy, but is the unintended consequence of reforms that have created a perverse incentive structure, rewarding officers for going after easy pickings rather than doing good police work. While it is hard to see any benefits in terms of tackling serious crime or promoting public safety, there are real costs, including unnecessary infringements on people's liberty, discrimination against minorities and loss of trust and confidence in the police."

Eastwood goes on to say: "Black people are more likely to get a criminal record than white people, are more likely to be taken to court and are more likely to be fined or imprisoned for drug offences because of the way in which they are policed, rather than because they are more likely to use drugs. Despite calls for police reform of stop and search little has changed in the last 3 decades, this is why the Government needs to take action and change the

law. Decriminalisation of drug possession offences would end the needless stop and search of hundreds of thousands of innocent people every year and eliminate a significant source of discrimination with all its damaging consequences."

Appendix C

In 2011 the then **United Nations** Secretary General, Ban Ki-moon stated in 2011, "Drug dependent people should not be treated with discrimination; they should be treated by medical experts and counsellors. Drug addiction is a disease, not a crime." (launch of 2011 World Drug Report, June 2011) and “We must consider alternatives to criminalization and incarceration of people who use drugs”.

“Countries should work toward developing policies and laws that decriminalize injection and other use of drugs and, thereby, reduce incarceration”. World Health Organisation.

“Punitive laws and policies, whether by prohibiting the possession of sterile injecting equipment and opiod substitution therapy, criminalizing drug use, possession of injecting paraphernalia, or denying HIV treatment to people who use drugs, violate people’s right to health and harm the community…Responses to HIV should transcend ideology and be based on scientific evidence and sound human rights principles; they should support, not punish, those affected”. UNAIDS

“Laws criminalizing drug use/possession of small amounts of drugs for personal use impede the access of people who use drugs to basic services such as housing, education, health care, employment, social protection and treatment”. The UN Development Programme (UNDP)

“Countries must decriminalize the possession of drugs for personal use, in recognition that the net impact of such sanctions is often harmful to society”. The UN Development Programme (UNDP) / UNAIDS Global Commission and the Law.

People who develop a drug problem, “should be viewed as patients in need of treatment and not as criminals. In what other areas of public health do we criminalise patients in need of help? ….Decriminalise drug use. Punitive measures do not work and put lots of people in prison where their drug use may actually get worse”. Kofi Annan, former UN Secretary-General.

“Decriminalization of drug use needs to be considered as a core element in any public health strategy”. Organisation of American States.

“Criminalising people for the possession and use of drugs is wasteful and counterproductive. It increases health harms and stigmatizes vulnerable populations, and contributes to an exploding prison population. Ending criminalization is a perquisite of any genuinely health-centred drug policy”. Global Commission on Drug Policy.

“The law on the possession of small amounts of controlled drugs for personal use only could be changed so that it is no longer a criminal offence”. UK Drug Policy Commission.

“Policy 7121 first expressed APHA’s belief that people who use drugs should not be criminalised, ‘because substance abuse is viewed primarily as a public health problem, this Association recommends that no punitive measures be taken against users of alcohol, marijuana or other substances when no other illegal act has been committed”. American Public Health Association (APHA).

“The ACMD also believe that there is an opportunity to be more creative in dealing with those who have committed an offence by possession of drugs. For people found to be in possession of drugs (any) for personal use (and involved in no other criminal offences), they should not be processed through the criminal justice system”. The UK government’s Advisory Council on the Misuse of Drugs.

“the evidence tells us that until we see drug use as an issue for society and not one for our criminal justice system, we will be condemned to worsening, not improving, the lives of those who come into contact with drugs. Why is criminalisation not the answer? There is no reliable evidence that tougher criminal sanctions deter drug use or offending. On the contrary, criminalisation worsens the health and well-being of drug users”. Richard Horton, Editor of The Lancet.

“In a beautifully argued essay Stephen Rolles[38] calls on us to envisage an alternative to the hopelessly failed war on drugs. He says, and I agree, that we must regulate drug use, not criminalise it”. Fiona Godlee, Editor of the British Medical Journal.

“I personally back the chairman of the UK Bar Council, Nicholas Green QC, when he calls for drug laws to be reconsidered with a view to decriminalizing illicit drugs use. This could drastically reduce crime and improve health”. Professor Sir Ian Gilmore, Then- President of the Royal College of Physicians.

“To conclude, the IFRC, on behalf of the most vulnerable people affected by drug use, strongly calls upon key stakeholders and donors to exert all possible efforts to gather knowledge on the scale of the drug use epidemic at country level and decide on the proper response accordingly. Criminalization, discrimination and stigmatization are not such responses. Laws and prosecutions do not stop people from taking drugs”. International Federation of Red Cross and Red Crescent Societies (IFRC).

“Subjecting people to criminal sanctions for the personal use of drugs or for possession of drugs for personal use, infringes on their autonomy and right to privacy… Human Rights Watch research around the world has (also) found that the criminalization of drug use has undermined the right to health. Fear of criminal penalties deters people who use drugs from using health services and treatment and increases their risk of violence, discrimination and serious illness”. Human Rights Watch.

“Decriminalise drug users, scale up evidence-based drug dependency treatment options and abolish compulsory drug treatment centres that violate the Universal Declaration of Human Rights”. The Vienna Declaration of the International AIDS Society (which has over 20,000 endorsements).

[38] Transform

Appendix D

Letter to David Cameron in June 2011

Dear Prime Minister

We, the signatories of this letter, call on the Coalition Government to undertake a swift and transparent review of the effectiveness of current drug policies. Should such a review of the evidence demonstrate the failure of the current position we would call for the decriminalisation of drug possession.

This week marks the 40th anniversary of the Misuse of Drugs Act 1971. In the past forty years use of illicit drugs in the UK has grown rapidly. It is clear that the present system of applying the criminal law to the personal use and possession of drugs has failed in its aim. Conversely, the harms caused by pursuing this approach to drug use have been significant.

In the last year alone nearly 80,000 people in the UK were found guilty or cautioned for possession of an illegal drug - most were young, black or poor. This policy is costly for taxpayers and damaging for communities. Criminalising people who use drugs leads to greater social exclusion and stigmatisation making it much more difficult for them to gain employment and to play a productive role in society. It creates a society full of wasted resources.

In 2010 the Vienna Declaration was launched at the International AIDS conference, the Declaration called for a more evidence based health focused approach to drug policy and for the decriminalisation of drug possession. To date the Declaration has been signed by over 20,000 people worldwide including former presidents of several South American countries, Nobel Prize winners in the fields of science and literature, members of the judiciary and senior law enforcement officials. In the UK there have been repeated calls for a review of the current system from members of the Bar Council, the medical profession and members of both Houses of Parliament, notably the former Minister responsible for drugs.

In 2001 Portugal decriminalised the possession of all drugs and, despite sensationalist predictions to the contrary, this has led to a decrease in the number of young people using illicit drugs, an overall reduction in the number of people using drugs problematically, fewer drug related deaths, and an increase in people accessing treatment voluntarily, things we

would all like to see happen in the UK. Whilst there are other factors to take into account, it is clear from the Portuguese experience, and from other jurisdictions, that the of drug possession and use does not lead to an increase in drug use or related harms.

The failure of the current UK system of criminalisation is clear - alternatives must be considered. It is time for the UK to review its policy, to reduce its reliance on an overburdened criminal justice system, and to adopt an evidence based and health focused approach to drug use.

Yours sincerely,

Bob Ainsworth MP
Desmond Banks, Consultant Solicitor, Fisher Meredith LLP
Dr. Adrian Barton, Associate Professor in Public Policy, University of Plymouth
Sir Geoffrey Bindman QC, Founder and Senior Consultant, Bindman's LLP
Baroness Tessa Blackstone
Professor Ben Bowling, School of Law, King's College, London
Kathy Burke, Director and Actor
Julie Christie, Actor
Nic Dakin, MP
Dame Judi Dench, Actor
Toby Faber, Publisher and Author
D. Chris Ford, Chair of Substance Misuse Management GPs
Professor Graham Foster, Professor of Hepatology at Queen Mary, University of London
Paul Flyn, MP
Edward Henry, Barrister, QEB Hollis Whiteman
Jane Hickman, Partner, Hickman and Rose Solicitors
Ronald Hooberman, Chair of Release
Peter Hughman, Partner, Hughman Solicitors
Lord Layard,
Mike Leigh, Film Director
Baroness Ruth Lister

Tony Lloyd, MP

Tom Lloyd, Former Chief Constable of Cambridgeshire

Caroline Lucas, MP

Professor Susanne MacGregor, London School of Hygiene and Tropical Medicine

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Baroness Molly Meacher, Chair of the Drug Policy Reform All Party Parliamentary Group

Paul Mendelle QC, Barrister, Joint Head of 26 Bedford Row

Baroness Elaine Murphy

Baroness Nuala O'Loan

Lord Ramsbottom

Dr. Michael Shiner, Senior lecturer and Assistant Director of the Mannheim Centre for Criminology, LSE

Professor Alex Stevens, Professor in Criminal Justice, University of Kent

Sting, Musician and Actor

Polly Toynbee, Journalist and Columnist

The Countess of Wemyss

Paul Whitehouse, Former Chief Constable of Sussex

Francis Wilkinson, Former Chief Constable of Gwent

Simon Woodroffe OBE, Entrepreneur and Founder Yo-Sushi

Sir Richard Branson, Entrepreneur and Founder of Virgin Group