'The world is a dark enough place still for too many. It can ill spare even the poorest rushlight candle of cheerfulness or the smallest fire of fellowship. We must not put out the glimmer of light which shines for so many still today through the tavern windows, unless we can put a better in its place. We need the light of a brighter cheerfulness, and the glow of a warmer fellowship.' QfP 20.39

"overall levels of poverty, inequality and social cohesion have a greater long-term impact on the prevalence of drug use and related problems in any society than do specific national drug policies." IDPC

BRIEFING PAPER FOR QAAD TRUSTEES ON THE DECRIMINALISATION OF DRUGS

"But, ultimately, the choice to decriminalize is not simply a question of the research. It is also an ethical and political choice of how the state should respond to drug use." Hughes and Stevens

"Prohibition reduces use, but creates high costs of control, including black markets. Legalization eliminates most costs of control, but risks greatly increased use and attendant problems. As Mark Kleiman (1992) puts it, you can choose your drug problem (one of use or one of control), but you can't choose not to have a problem" Caulkins and Heinz

THE DECRIMINALISATION OF DRUGS IN THE UK
SUMMARY BRIEFING FOR QAAD TRUSTEES ON ISSUES AND EVIDENCE

Table of Contents

1. Executive summary

QAAD trustees have considered the issues relating to the decriminalisation of drugs at various times, but have not been led to take a position. This paper has been prepared to assist them - and Quakers more generally - by giving an up-date on the debate, and by presenting some of the arguments and evidence that have been put forward.

It is perhaps as well to say at the outset that this briefing does not provide a yes or no response to the question of decriminalisation. This is a complicated subject with a wealth of evidence on all sides, and many options for policy. The road splits almost before you reach the junction as regards which drugs might be included, and many different interpretations of the evidence are possible, even amongst those who are bound together by the same values.

Some who believe that the law should be reformed take the libertarian view - that the state should not sanction an individual's drug use unless it becomes problematic. Others come from a reformist perspective, and simply believe that the drugs laws create more problems than they solve. On the other side of the debate, some would not like to see a softening in the law because they believe that drug use itself (not just problem use) is frankly undesirable; others come from a concern that problem drug use might increase.

In our public issues work on alcohol and gambling, QAAD has felt connections between Quaker perspectives and the modern 'whole population theory''.[1] This works from the evidence that the rate of substance problems is related to the attitudes and behaviour of the society as a whole, rather than being solely the result of individual vulnerability. Put simply and in secular terms, if we all drink or gamble more as a society, then there are likely to be more people who experience problems, including addiction. For this reason, we have argued against increases in gambling outlets, and in favour of controls on the price of alcohol. This perspective resonates with a spiritually-based sense of community, and an awareness that we are all part of an interconnected whole. However, we are also deeply concerned about the suffering of those who are drug dependent and so often marginalised, and about health risks for the more casual drug user, who may take a substance of uncertain quality, sometimes with tragic consequences.

These are extremely difficult matters to weigh. Some take a position as a matter of principle; for others it is a question of balancing competing positives carefully, and adjusting the balance as evidence emerges. Whilst no fixed position is proposed here, this briefing does suggest some practical first steps that would address some of the immediate issues the report reveals.

Part of the difficulty in dealing with this subject is that decriminalisation comes in different forms, and has different purposes and methods in different countries. Some simply aim to reduce criminal penalties for the drug user, and/or the costs to the state.

[1] LEDERMAN, 1956, SKOG, 1985, ROOM, 1999

An example of this is cannabis possession in some states in America, where fines rather than court penalties occur. Other forms are aimed at diverting drug users and/or those with drug problems ***from*** the criminal justice system and ***into*** health advice or treatment. Examples of this model are found in states in Australia that decriminalised cannabis, and in Portugal's approach, where all drugs were decriminalised in 2001 with the aim of bringing dependent users of heroin into treatment.

The other point that blurs the issue is that there has been a general movement from punishment to help for drug users, for reasons that are set out in 'From Coercion to Cohesion[2].' The result is that many countries that have not decriminalised have softened sanctions in ways that overlap with the countries that have.

This report suggests that the UK criminal justice system has reduced penalties for cannabis possession in a way that resembles Australian policies, but it has not yet offered a health-based response to cannabis users - or to some other drug users who go through the criminal justice system. It also suggests that the UK has been more successful in diverting severe drug users into treatment rather than punishment, in ways that resemble Portugal. This briefing suggests that trustees consider whether the UK could move more fully into a health-based model. It also suggests ways in which progress could be made, including in relation to issues of concern (like imprisonment for simple drug use), and proposes paths forward, either with or without decriminalisation.

This document begins with background information about drugs, then moves to a definition of decriminalisation, which outlines what it can achieve and what the limits of the policy are. It then summarises evidence about drug use and misuse in relation to decriminalisation and other legal regimes, with particular reference to the most fully researched drug, cannabis. The next section looks closely at how drug users in this country are dealt with in the criminal justice system, and compares progress here with that in decriminalising regimes in Portugal and Australia. The briefing concludes with some suggestions for consideration.

There are some areas that it has not been possible to cover. Whilst the ill-effects of the drug trade on producer countries and those that suffer the effects of trafficking is of deep and critical importance, this large area of concern was felt to be beyond the scope of the enquiry – particularly since it would not be directly affected by decriminalisation. However, some references are given.

I am aware, too, that this report is written in a way that reviews the academic evidence, and is therefore somewhat formal in style. It is hoped that this does not obscure the human realities, nor that the deep concern of QAAD is with the lived experience of those who are, or have been, affected by drug problems and dependency. It is hoped that these voices as well as those of other Friends will find this paper helpful in the dialogue.

[2] From 'Coercion to Cohesion' (2009) United Nations Office on Drugs and Crime

2. Definitions

2.1. What do we mean by illicit drugs?

In the United Kingdom illicit drugs are classified into three groups, which are related to the risks of the drug, and are treated in descending order of seriousness. Criminal penalties for both drug use and drug trafficking are related to this system. The current classifications are:

- **Class A**, which contains heroin, cocaine and crack, ecstasy, LSD, methadone, methamphetamine (crystal meth), 'magic mushrooms', and any Class B drug that is injected.
- **Class B**, which contains cannabis, amphetamine, barbiturates, and codeine.
- **Class C**, which contains anabolic steroids, minor tranquillisers obtained illicitly, gamma hydroxybutyrate (GHB) and ketamine.

In addition to these drugs, a new generation of so called 'legal highs' has emerged: 49 new substances were reported in Europe in 2011.[3] 'Legal highs' are psychoactive drugs that mimic the effects of other illicit drugs - particularly of cannabis and ecstasy/amphetamines. They are relatively easily manufactured and are often sold over the internet as other products (such as plant food), which originally put them beyond the reach of existing legislation. The Police Reform and Social Responsibility Act of 2011 enabled new drugs to be classified as illegal for 12 months whilst they are scientifically assessed.

2.2. How many people take illicit drugs?

The 2011/12 figures from England and Wales[4] show that current drug use has fallen since figures were first collected in 1996. This is mainly due to a decrease in cannabis use. The current estimates are that:

- About 1 in 3 adults (36.5% of people between 16 and 59) have ever taken an illicit drug – that is, about 12 million adults.
- 8.9% of adults had taken an illicit drug in the last year (an estimated 3 million people). In Scotland the percentage was 7.2%.[5]
- By far the most common drug taken in the last year was cannabis, at 6.9% of adults.

Taking a drug in the last month is usually taken as an index of more regular use.

- In the last month, 5.2% had taken an illicit drug - an estimated 1.7 million people.
- 4.1% of 'last month' drug taking was of cannabis.

[3] EMCDDA. (2012). News Release 26.04.2012 . http://www.emcdda.europa.eu/news/2012/2

[4] Home Office. (2012). Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales *Office of National Statistics.*

[5] Information Services Division**. (**2012**)**. Drug Misuse Statistics Scotland 2011. *National Services Scotland*, p.48.

- A large proportion of this was by young people – about a million 16-24 year olds were estimated to have taken cannabis in the last month.
- About 0.3 million young people in this age group had taken cocaine – the most frequently taken Class A drug, followed by 0.2 million who had taken ecstasy.

The England and Wales survey also asked people when they started to take drugs. The most common age for beginning cannabis was 16, and the most common age for stopping was 18. 18 was the most usual age for beginning to take cocaine. Of those who continued, people tended to take cannabis for longer than cocaine or ecstasy – roughly six years on average, compared with 4 or 3 years for the other drugs.

2.3. How many people have problems with drugs?

Problem drug use is defined quite narrowly in official statistics as people who have problems with the most heavily addictive drugs – heroin and cocaine. The UK has traditionally had a high rate of drug problems in European terms, with almost 380,000 people affected in 2009/2010.[6] However, numbers have fallen from roughly 398,000 in 2007.

There has been a significant drop in the number of young adults between 18 and 24 presenting for help for heroin problems in the UK – for example, in England the numbers fell from over 11,000 in 2005 to under 6,000 in 2010/11[7]. However, presentations for help with cannabis rose in this age group. For those under 18, cannabis is the most common problem drug, followed by alcohol.

In this paper it is assumed that the problems caused by drugs are actually much broader than these narrower indices suggest. Many who experience problems may never seek help or commit another offence, and for many drugs, some problems are related to long term or heavy use. Appendix C gives a brief summary of cannabis and health.

2.4. What is decriminalisation? What does it do and not do?

There can be some confusion about what decriminalisation actually is - and therefore about what it can achieve. Decriminalisation needs to be differentiated from de-penalisation on the one hand, and legalisation on the other.

- **De-penalisation** simply means a reduction in the severity of criminal penalties,[8] - and is often interpreted specifically as the abolition of a prison sentence for simple possession or drug use. The UK's policy thus far has been one of de-penalisation generally, though drug use is still imprisonable.

[6] Davies, C., English, L., Lodwick, A., McVeigh, J. and Bellis, M. A. eds. (2010). United Kingdom Drug Situation: Annual Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), p70.
[7] National Treatment Agency. (2011). Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2010 – 31 March 2011.
[8] Babor, T., et al. (2010). Drug Policy and the Public Good. New York: Oxford University Press Inc. p166.

- **Decriminalisation** means the removal of criminal penalties for drug use or possession, so that drug use is dealt with under civil codes in a similar way to a speeding fine. Limits on weight, quantity or what is considered a reasonable 'daily supply' are usually set, to differentiate the offence of drug possession from that of supply.
- **Legalisation,** by contrast, means the removal of all penalties, civil or criminal. It also implies at least some legalisation of the supply chain and the exertion of control through regulation and/or medical channels. It is usually stated that legalisation would not be allowable under current international law set by the Drugs Convention of 1961. [9]

De-penalisation has similar aims and methods to decriminalisation, and can have some similar results. In Germany, for example, a mixture of protocols and local discretion means that most of those apprehended for cannabis possession offences are not usually charged in court – only 19% are prosecuted.[10] One study from the USA that aimed to assess the differences in drug use between decriminalised and non-decriminalised states found that the penalties overlapped to such a degree that it concluded '*the so-called decriminalized states have been misnamed*'[11] The importance of this is that decriminalisation provides tools for modifying some of the problems that arise when drug use is a criminal offence (such as onerous penalties for the user), but there are other, allied methods, too.

One of the salient features of decriminalisation is that drug users do not attract a criminal record for their drug use. It is important to recognise, though, that decriminalisation does not extend this to the *production* or the *supply* of drugs, and the supply chain remains illegal. This has several significant consequences – most importantly, that **decriminalisation would not**:

- **Make a pure or safer source of supply for those taking drugs.** In decriminalised countries, drug users continue to gain their supply through the criminal market, with all its attendant health risks.
- **Significantly reduce the power of the criminal supply chain.** Trafficking and the criminal supply chain continue in the same way. Even in the Netherlands where some sale of cannabis is tolerated, coercion/violence persists in parts of the supply chain, and - as in other countries - some drug money is used to fund other criminal activities. [12]

[9] A hybrid form of policy is found in the Netherlands, where cannabis can be sold in coffee-shops in small quantities as long as certain conditions are observed. This is not technically decriminalisation, because possession remains a criminal offence, even through protocols state that prosecution will not normally occur.
[10] EMCDDA. (2009). Drug Offences: Sentencing and other outcomes. p15. *European Monitoring Centre for Drugs and Drug Addiction.*
[11] Pacula, R., Chriqui, J., and King, J. (2004). Marijuana Decriminalization: What Does it Mean in the United States? *Rand Health Working Paper*, p.126
[12] EMCDDA. (2012). Cannabis production and markets in Europe. *European Monitoring Centre for Drugs and Drug Addiction.*

- **Eliminate some of the costs of enforcing the drugs laws**. Decriminalised countries still investigate and prosecute those involved in the trafficking and supply chain as vigorously as non-decriminalised countries - so these customs, police, and criminal justice enforcement/prosecution costs would continue.
- **In the UK it would not significantly reduce the numbers imprisoned for drug offences.** 15% of the prison population are in custody for a drug offence, but 88% (7,397) of the 8,498 imprisonments in 2010/11 in England and Wales were for supply offences of some kind[13]. These sentences tend to be much longer than those for possession (which tend to be months or even weeks). The 2011 prison population of 10,630 drugs offenders is therefore composed of a rolling population of a relatively small proportion of short-sentence possessors, and a longer-term, larger population of those involved in supply in some way. This large latter number would not be affected by decriminalisation.

Because of these considerations, some advance arguments for a legalised market with regulation, particularly for 'softer' drugs such as cannabis. The principal argument against this – which is also advanced against decriminalisation - is that softening the law would risk a rise in drug use and in drug problems. It is to this evidence that we now turn.

[13] Ministry of Justice. (2011). Criminal Justice Statistics Volume 5, Table S5.8: Offenders convicted and sentenced at all courts.

3. Does relaxing the criminal law increase drug use and problem use?

3.1. What is the evidence about decriminalisation?

There are some difficulties in evaluating the effects of changing the drugs laws, because the law is only one influence amongst many as regards drug use. Culture – and particularly youth culture - is a major factor, as are other general influences like religion and the levels of social cohesion in a society. The 'epidemiology' of drug use can also be a confounding factor – each drug tends to have its own pattern of rise and fall, which has its own momentum.[14] On a practical level, price and availability are also significant. It is also the case that many countries that have decriminalised had already softened the drugs laws before making the change, so strong 'before and after' effects may be less likely to be observed. That said, there is a large literature that attempts to tease out the influence of the different elements.

Most of the studies about decriminalisation relate to cannabis, since that is the most widely de-penalised and decriminalised drug (for example, in a dozen states in the USA, four in Australia, and Switzerland; Portugal and the Czech Republic have decriminalised all drugs). De-penalisation does not appear to result in observable/significant changes in drug use or problem use. The general evidence also does not suggest that decriminalisation precipitates significant rises. One of the academics in the field carefully summarises the evidence as: *'There is no clear-cut case in which a reduction in the form of enforcement of the prohibition on use or possession result in a substantial change in consumption of the drug'*[15]. However, the words 'clear cut' and 'substantial' are significant, as there is some nuancing in the evidence.

In some cases there was no rise in drug use when decriminalisation was adopted. In others there was (in the Netherlands, for example), but it could not necessarily be ascribed to decriminalisation - similar rises may have occurred in other countries too. In Portugal, where all drugs were decriminalised, the results of decriminalisation showed some different patternings with different drugs. Cannabis use (which was traditionally low) increased somewhat, but the problems of heroin use were well tackled by the policy, which enabled access into treatment and healthcare. Cocaine incidence did increase, though it seems that the translation from experimental into regular use was not as strong.[16]

Decriminalisation was introduced at a time when cannabis consumption was falling in one of the Australian states, and decriminalisation did not cause a rise. However, whilst most studies there showed no increase or ascribable increase, two studies from

[14] For a fuller and extremely helpful discussion of this, see Caulkins, J.P. (2002). Law Enforcement's Role in a Harm Reduction Regime. *Crime and Justice Bulletin*: *Contemporary Issues in Crime and Justice. NSW Bureau of Crime Statistics and Research,* 64.

[15] Babor, T., et al. (2010). Drug Policy and the Public Good. New York: Oxford University Press Inc. p 175.

[16] Hughes, C. E. and Stephens, A. (2010). What Can We Learn from the Portuguese Decriminalisation of Illicit Drugs? *British Journal of Criminology*, 50, p.999-1022.

Australia tend towards caution. One looked at teenagers' cannabis use in decriminalised states:

> *'...the proportion of those aged 15 and younger who have used cannabis is 12.7% after decriminalization is introduced compared to 11.4% before decriminalization is introduced. Among the population aged 16 and younger, the proportions are 20.8% and 18.3% respectively. This suggests that decriminalization affects when a person first uses cannabis but not whether or not they ever use it.'* [17]

Another study looked at adult use and concluded:

'The study results suggest that, while the illegal status of cannabis does act to limit its use, it is not a major factor in decisions about whether to use cannabis or to cease using it. Prohibition does, however, appear to limit consumption among existing cannabis users and particularly among those who use the drug on a weekly basis or more frequently.' [18]

Since the greatest risks of cannabis use are to young people under the age of 15 and adults who use the drug regularly, these study findings are of concern.

Many academics in the drug research field seem to regard the decriminalisation of drugs as a rational step. However, as the quotations from the Parliamentary Select Committee illustrate (see Appendix A), academics and experts from the addiction and clinical fields seem more cautious. They express reservations about any measures that might increase availability and accessibility and/or lower price, thus resulting in an increase in problems – a perspective that chimes with QAAD's work on alcohol and gambling.

3.2. What is the evidence about legalisation?

There are strong advocates for legalisation, and a detailed system for adopting it in stages was advanced by the body Transform in 2009[19]. However, there is significant caution expressed in the academic literature about legalisation, which carries a much higher risk of an increase in use and problem use. It is thought that even though most incidents of drug-taking would be safer, an increase in prevalence and frequency would be likely to result in an overall increase in harm, including dependency rates.[20] A study into the legalisation of cannabis in California suggested (tentatively, in view of the 'unknowns') that it might mean a rise of 58% in consumption, and a rise in the number of problematic drug users from 525,000 to something between 669,000 and 905,000.[21]

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[17] Bretteville-Jensen, A. M., and Williams, J. (2011). Decriminalization and Initiation into Cannabis Use. University of Melbourme, Department of Economics *p.18*.

[18] Weatherburn, D., Jones, C., Donnelly, N. (2003). Prohibition and cannabis use in Australia: A survey of 18-to 29-year-olds. *Australian and New Zealand Journal of Criminology,* 36(1), p.77-93.

[19] Rolles, S. (2009). After the War on Drugs: Blueprint for Regulation. *Transform Drug Policy Foundation*.

[20] MacCoun, R.J., and Reuter, P.H. (1999). What we Do and Don't Know about the Likely Effects of Decriminalization and Legalization: A Brief Summary. Testimony before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources of the House Committee on Government Reform, July 13, 1999. RAND.

[21] Kilmer, B., Caulkins, J., Pacula, R.L., MacCoun, R.J., Reuter, P. (2010). Altered states: How Marijuana Legalization in California Could Influence Marijuana Consumption and Public Budgets. *RAND Corporation*, p. 53 and 40.

The difference legalisation might make to behaviour is illustrated by the study from Australia[22] that looked into students' attitudes at the time of decriminalisation there. Amongst those who had not used cannabis, significantly more (11%) said that they would try the drug if it were legalised, compared to 5% if 'prohibition with civil penalties' were introduced (that is, the form of decriminalisation that some Australian states adopted). Perhaps even more significantly in terms of health risks, among those who had used cannabis, 14% said they would use it more often than currently under a system of legalisation, whereas only 3% said they would use more under the 'prohibition with civil penalties' scheme.

3.3. What about the regulated cannabis market in the Netherlands?

The Netherlands system is not technically decriminalisation, because the sale of cannabis occurs under certain conditions in 'coffee shops.' This remains illegal, but it is not routinely prosecuted under a series of local protocols.

A significant benefit of the Dutch system is that it could regulate the strength of cannabis. Mental health risks are directly related to the tetrahydrocannabinol (THC) content. This is the psychoactive ingredient, which is higher in modern intensively cultivated forms. The Netherlands has proposed a law limiting THC content to 15%, but problems in acceptance ensued, and some feared that it would lead to more supply through the illicit market. How matters develop remains to be seen.

The Netherlands is the closest system to a legal one, and research from there illustrates the practical difficulties of effective control and regulation. Notwithstanding the coffee-shops, 30% of consumption there is estimated to be through 'non-tolerated' criminal outlets.[23] This 'non-tolerated' market is particularly involved in supplying those under the legal age of 18; in supplying people more cheaply or in larger quantities than restrictions allow; and in doing so outside coffee-shop hours. The data about under-age supply is particularly significant in view of evidence from the UK that 16 is the most common age for starting cannabis use.

Part of the reason for the 'non-tolerated' market in the Netherlands is that some municipalities choose not to have 'coffee-shops' where the 'tolerated' buying occurs, and the illicit market tends to be stronger in these areas. These tensions are not easily managed.

[22] Featherstone, J., and Lenton, S. (2007). Effects of the Western Australian Cannabis Infringement Notice Scheme on Public Attitudes Knowledge and Use. p.xii. *National Drug Research Institute and Curtin University of Technology*.

[23] Korf, D. (2008). An Open Front Door: The Coffee Shop Phenomenon in the Netherlands. In: A Cannabis Reader: Global Issues and Local Experiences. *Monograph* 8(1), p.150, *European Monitoring Centre for Drugs and Drug Addiction.*

3.4. Young people's access to cannabis in the UK

The aim of the Netherlands policy was to separate the 'softer' cannabis market from that for harder drugs. Recent research conducted under the auspices of the Rowntree programme has looked at young people's access to cannabis, and found that some separation has also occurred here:

> *'Young people's patterns of cannabis acquisition had little or nothing to do with 'drug markets' as they have been conventionally described, and were primarily based around friendship and social networks... Importantly, the cannabis supply mechanisms used by our respondents served to insulate or distance them from more overtly criminal drug markets. An argument often put forward for the decriminalisation or legalisation of cannabis is that such reform would protect young cannabis users against exposure to more harmful patterns of drug use and criminality. For our sample, this 'market separation' appears to have been achieved naturally.'* [24]

This informal system of 'social supply' has recently been recognised in sentencing policy. Concerns about imprisonment for this offence resulted in the Sentencing Council modifying guidelines for penalties where people buy drugs on behalf of a group of friends. If small quantities are involved the 'starting point' sentence is now a Community Order or a fine.[25]

3.5. Summary

The evidence suggests that legalisation would be likely to result in a significant rise in use. Decriminalisation does not seem to have major effects, though some evidence does give rise to particular concerns about under age and young adult regular use.

The policy adopted in the Netherlands seems to have met its goal of separating cannabis from harder drugs. Heroin use there is low. It also allows health-based regulation of strength and content. However, some problems persist with the illicit market. There are indications that a certain amount of 'market separation' may have also happened in the UK through the phenomenon of 'social supply', but the taking of cannabis by young people who are below the legal age for buying alcohol remains a problem in many 'high-use' countries.

[24] Duffy, M., Schaefer, N., Coomber, R., O'Connell, L., and Turnbull, P.J. (2008). Cannabis supply and young people 'It's a social thing'. *Joseph Rowntree Foundation*.

[25] Sentencing Council. (2012). Drug Offences: Definitive Guidelines: 'absence of any financial gain, for example joint purchase for no profit, or sharing minimal quantity between peers on non-commercial basis'. Available at: http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Definitive_Guideline_(web).pdf

4. How do other countries' experiences of decriminalisation relate to the UK?

Another way of considering the question of decriminalisation is to look at how countries with similar drug patterns have decriminalised, and compare methods and outcomes with the UK's de-penalising approach. Two have been selected because of the similarity in drug patterns.

4.1. Evidence from decriminalising regimes

4.1.1. Portugal - decriminalisation heroin, cocaine and cannabis

Portugal, like the UK, has a traditionally high level of heroin use (though in Portugal, unlike here, other drug use was comparatively low). Portugal's specific problem was with severely dependent heroin users, who were suffering from medical problems such as blood-borne diseases. It was felt that the stigma and criminality of their drug use was preventing them from gaining access to the health care they needed, and decriminalisation was introduced in 2000-01.

Those caught in possession of any drug now go before a committee of Dissuasion, consisting of a health professional, a social worker, and a legal figure. The policy accepts that some non-problematic drug use may occur, but if dependency is found, the person is referred for treatment. If not, no further action may be taken, or they may be fined or required to abide by specific conditions – and the committee has wide powers to decide these. The significant feature accompanying decriminalisation was a substantial increase in education and resources for health care, which provide robust systems to refer people for help. The result is that health indicators such as rates of blood-borne infections have fallen, and the numbers in treatment for severe drug use has risen.

Lifetime consumption of cannabis did rise in Portugal following decriminalisation, from 7.2% in 1999 to 11.7% in 2007 (the latest figure). However, 'last month' use has not risen much (3.4% in 2001, 3.7% in 2007). An increasing number of young people regard drug use as risky, and regular cannabis use as difficult to give up.[26] A widespread drug education programme for school and university students may have had a role in this.

4.1.2. Australia - decriminalisation and cannabis

Australia, like the UK, had traditionally high levels of cannabis use. Three states in Australia decriminalised cannabis in order to reduce the numbers of young people going through the courts and gaining criminal records. Like the UK, it introduced easy-to-apply street penalties that meant cannabis possession was dealt with by low-level warnings and fines – but initially the result was that the police issued more of them. Different models of penalty were adopted in different states, and over the years a tiered system of health advice and intervention has developed, which are offered as an alternative to fines or other disposals. As the evidence-base has grown, sessions targeted at the experimental, the regular, and the dependent user have developed. In some states these are voluntary, in others mandatory, sometimes for repeated offences.

[26] 2011 Report of Portugal to EMCDDA p 25http://www.emcdda.europa.eu/html.cfm/index191616EN.html

4.2. How are users of heroin and cocaine treated in the criminal justice system in the UK?

4.2.1. Facts and figures from the criminal justice system

- 53% of those found in possession of a Class A drug in England and Wales in 2011 were cautioned, and not prosecuted in court (12,001 out of 22,515 people)[27].
- Roughly half of the 10,000 people who went to court for Class A offences were fined or given some form of discharge; most others received community penalties.
- However, 549 people were imprisoned for possession of a Class A drug, albeit for relatively short sentences of 6 months or less. (It is possible that some of these may have been concurrently sentenced with other offences, and some will have had 'aggravating features' but the numbers are concerning, nonetheless.)
- Many offenders with severe drug problems commit other offences, typically theft. 81% of heroin and cocaine users in a study of arrestees had done so, as opposed to 30% of drug-using offenders generally.[28] (This does not mean that most people who take heroin commit offences, but that those who are arrested for this are more likely to have committed other offences.)
- 55% of prisoners are likely to have a drug problem,[29] though only just over 1% of people in prison are there for drug possession offences.
- There has been a considerable increase in drug treatment for offenders in England, Wales and Scotland. The number of Drug Rehabilitation/Treatment Orders increased from 4,854 in 2001-02 to 17,642 in 2008/9.[30]
- The criminal justice system now refers severely problematic drug users into treatment at all stages from arrest to imprisonment. 30% of referrals to treatment in England are from these services. Nearly 10,000 came via arrest referral schemes, nearly 6,500 from 'CARAT' workers in prison, and nearly 4,000 people were referred via Probation.[31]
- A third of the sample of drug offenders in treatment in a Scottish study[32] said they might not have sought it unless ordered by the court. (This report also reported that 37% of Scottish Drug Treatment and Testing Orders that were breached resulted in imprisonment in 2008-9. However, the re-sentencing was unlikely to have been for an original offence of drug use alone, and therefore may not be much affected by decriminalisation.)

[27] Ministry of Justice. (2011). Criminal Justice Statistics Volume 4: Cautions.
[28] Boreham, R., Cronberg, A., Dollin, L. and Pudney, S. (2007). Home Office Statistical Bulletin 12/07, The Arrestee Survey 2003-2006.
[29] Kenneth Clarke, in answer to Parliamentary questions. Hansard, 19th October 2010
[30] Prison Drug Treatment Strategy Review Group. (2009). The Patel Report. p32.
[31] National Treatment Agency. (2011). Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2010 – 31 March 2011.
[32] McCulloch, M. (2011). Interventions for Drug Users in the Criminal Justice System: Scottish Review. *Scottish Centre for Crime and Justice Research.*

4.2.2. Facts and figures from community treatment

- Investment in treatment services for drug users rose eightfold in the last decade – from £50 million in 2001 to £400 million in 2011[33].
- This does seem to have had some impact, in that the estimated number of opiate and/or crack users in England is 306,150 – a fall from 321,229 in 2008/9[34]
- 204,473 clients aged 18 and over were in treatment contact during 2010-11 – more than double the number in 2001.
- 165,000 of the estimated 300,000 heroin and crack cocaine users in England are in touch with a community treatment service[35].
- In 2010/11, self-referral was the most common form of entry into drug treatment (38% of total referrals in England)[36].
- Alcohol Concern estimated in 2010 that 58% of illicit problem drug users were in treatment, compared with 6% of problem drinkers.

4.2.3. Observations

- Like Portugal, which decriminalised all drugs with the aim of helping those with severe drug problems, the UK has put substantial resources into encouraging heroin and cocaine users into treatment.
- Although improvements could be made, this has had beneficial effects in terms of expanding treatment and reducing the rate of problems.
- The UK criminal justice system is a major conduit into treatment for those who enter it, and does not seem to be an impediment in the same way that occurred in Portugal prior to decriminalisation.
- There may be some non-offenders who are deterred from seeking help by the criminality of their drug use. However, the high rate of self-referrals into treatment indicates that at least some feel able to do so.
- Decriminalisation would not have a direct effect on the large number of drug users who commit other offences, because they would still be prosecuted in court for their other criminal acts.
- It could also be argued that criminalising their drug use only adds to their problems – though it is also the case that the criminal justice system may accelerate their entry into treatment, as the Scottish study suggests.
- The Advisory Council for the Misuse of Drugs has recommended that ecstasy be classed as a Class B drug rather than a Class A, but cocaine is regarded as correctly classified, including by Professor Nutt, the former chair.

[33] Paul Hayes, Chief Executive of the National Treatment Agency, in oral evidence to Home Affairs Select Committee 22nd March 2012.
[34] Hay, G., Gannon, M. and Casey, J. (2011). National and Regional Estimates of the Prevalence Of Opiate and/or Crack Cocaine Use 2009-10. *National Treatment Agency for Substance Misuse*.
[35] 'Progress Made, Challenges Ahead' National Treatment Agency Report 2012
[36] National Treatment Agency. (2011). Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2010 – 31 March 2011.

4.2.4. Summary of data on heroin

The UK's approach to severely problematic drug users resembles Portugal's in that it has put considerable resources into referring them into treatment – and there have been some similar effects. However, the numbers sentenced to custody is disquieting.
The 10,000 people who went through the courts in 2011 have a criminal record. On the other hand, it could be described as a positive that some of those arrested or charged, whether for drug offences or not, might not have otherwise sought help at that time.

4.3. How are users of cannabis treated in the criminal justice system in the UK?

4.3.1. Facts and figures from the criminal justice system

- Like Australia, in the last ten years England and Wales have 'diverted' cannabis possessors from prosecution through a series of warnings and notices issued by the police. People caught for the first or second time are not usually prosecuted in court. In 2011, roughly 140,000 offences were diverted from prosecution (79,700 through cannabis warnings, 16,277 via Penalty Notices for Disorder, and 46,300 with cautions).[37]
- These out-of-court warnings lessened the penalties, but resulted in a significant rise in the numbers of people processed for this offence. This 'net-widening' also occurred in some Australian states when they decriminalised.
- These out-of-court warnings and cautions involve no penalty at all or a small fine.
- Such sanctions do not appear on a standard Criminal Records Bureau check. However, they may appear on an enhanced CRB check at police discretion, which may affect job prospects and travel. I have not located any research on how many people have been directly affected, but bodies like Release have expressed concern. Obviously those who are convicted in court do get a criminal record.
- In Scotland, there were 5,379 convictions of drug possession where this was the 'main offence', of which 1,582 were for cannabis offences.
- Something in the region of 30,000 people went to court were convicted of cannabis drug possession offences in England and Wales in 2011. 4,150 young people aged 15-18 were convicted[38].
- Of those who went to court in England and Wales, most received penalties such as fines or some form of discharge, with roughly three quarters of Class B possession offences being dealt with in this way. The others received community penalties.
- However, 480 Class B drug possessors were sent to prison in 2011.

[37] Ministry of Justice. (2012). Criminal Justice Statistics Quarterly Update to December 2011. p 22. Available at: www.justice.gov.uk/downloads/statistics/criminal-justice-stats/criminal-justice-stats-dec-2011.pdf.
[38] Ministry of Justice. (2011). Criminal Justice Statistics Volume 5, Tables S5.1, S5.5 and S5.8: Offenders convicted and sentenced at all courts. www.justice.gov.uk/statistics/criminal-justice/criminal-justice-statistics

4.3.2. Observations and Recommendations

- Like Australia, the UK has reduced penalties for cannabis possession and included more people in the criminal justice 'net.' However, unlike Australia, with the possible exception of young people in the juvenile system, the UK criminal justice system does not generally respond to cannabis use as a health issue.
- In Australia, *both in decriminalised and non-decriminalised states,* diversion from court is regarded as not being **from** the criminal justice system but **into** a tiered system of cannabis awareness sessions, health advice, and dependency treatment for experimental, regular, and dependent cannabis users.[39] France, which has not decriminalised, also diverts those found in possession of small quantities to cannabis awareness sessions
- A health-based approach would be consistent with brief interventions for alcohol, which have a good evidence-base.
- Such a system could develop either with decriminalisation or without it. If with decriminalisation, it would be an alternative to civil warnings and fines, in the way that road safety classes are an alternative to a speeding fine, for example.
- If without decriminalisation, such programmes would be an alternative to out-of-court warnings/cautions and/or as an alternative to a court sentence. These could be developed on a pilot basis, perhaps initially for repeat offenders.
- The low numbers appearing in court for cannabis possession in Scotland suggest that a slightly different policy may be in operation there, which diverts more people without penalty but may also miss an opportunity for health advice.

4.3.3. Summary of data on cannabis

England and Wales have adopted similar measures to the decriminalising states of Australia in diverting cannabis offenders from court. The result is that we have seen some of the disadvantages experienced in Australia in terms of 'net widening', but people are also receiving penalties that might involve some longer term consequences in terms of criminal recording. However, we have not adopted the strengths of the Australian system - namely health advice at all stages.

It is suggested here that this be re-balanced so that health advice be made available. More generally, it appears that the criminal justice system seems to be working in a more health-focussed way for Class A drug users than it is for cannabis and other Class B or Class C drug users. Whilst Class A drugs are obviously much more dangerous, the numbers of young people presenting for help with a cannabis problem, and the fact that this number is rising, suggests that developing such services at least for a proportion of those apprehended may have benefits.

[39] Hughes, C. E. and Ritter, A. (2008). Monograph No.16: A Summary of Diversion Programs for Drug and Drug-related Offenders in Australia. *DPMP Monograph Series*. Sydney: National Drug and Alcohol Research Centre.

4.4. Cross-cutting issues: equality and the drugs laws

Social equality is a significant issue as regards the incidence of drug problems. This will come as no surprise to readers of 'The Spirit Level', where alcohol and other substance problems were included in the relationship between inequality and rates of problems in a society. The thesis is confirmed by a recent paper on drug use, which states:

> *'Analyses of international prevalence figures and studies on individual populations all point to the conclusion that overall levels of poverty, inequality and social cohesion have a greater long-term impact on the prevalence of drug use and related problems in any society than do specific national drug policies... If a government's priority is to reduce the overall level of drug dependence, then it is better advised to focus on addressing these wider social policy challenges rather than deepening social exclusion through tough drug policies'* [40]

Equality is also an issue as regards the application of the drugs laws themselves, particularly 'stop and search' practices. Professor Alex Stephens is quoted as discovering that fewer than 2 in 1,000 white people were arrested for drug offences, as opposed to more than 10 in 1,000 people from black or ethnic minorities.[41] Research undertaken under the auspices of the Rowntree programme also called attention to this problem in relation to cannabis:

> *'The over-representation of BME groups among people dealt with for cannabis possession is also a significant issue that demands further attention. Given that cannabis use among black and white people is similar the explanation for this finding is likely to lie with either the disproportionate number of BME people living in heavily policed areas or police targeting of BME groups (or a mixture of the two). Further research is needed to determine what lies behind this over representation.'* [42]

The same piece of research on the application of the cannabis laws also found wide variations between police areas, and between police officers as regards application of the drugs laws. The authors suggest more probing of the causes and effects of this are needed – but the practical effect is that apprehension for cannabis possession is likely to vary widely according to where a person is apprehended, and by which officer. This discretion may be a strength of the system in some respects, but it does make it more opaque, and the potential for inequity greater.

It has been argued that the inequality as regards people from black and ethnic minority groups increases the case for decriminalisation, particularly of cannabis, as this might remove or minimise the occasion for stopping and searching, as well as lessening penalties for those affected. However, there are likely to be underlying factors to address which would not be entirely removed by decriminalisation.

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[40] International Drug Policy Consortium, IDPC. (2010). *Drug Policy Guide*, p.13

[41] Townsend, M. (2010). Black People Six Times More Likely to Face Drug Arrest. *The Guardian*, www.guardian.co.uk/society/2010/oct/31/race-bias-drug-arrests-claim

[42] Lloyd, C., and McKeganey, N. (2010). Drugs Research: An Overview of Evidence and Questions for Policy. Joseph Rowntree Foundation.

5. Summary and discussion

QAAD's concern is with the emotional, physical, and spiritual health of those who have drug problems, with their close others, and with their wider communities. We are concerned that drug users should not be marginalised or stigmatised, and that health-care and treatment should be as accessible as possible. In our public issues work we have also argued that policy should not take directions that risk increasing the number of people suffering from dependency and addiction. Issues relating to the drugs laws go to the heart of all these concerns, and the balance between these elements involves both evidence and discernment.

This review has struggled with the central dilemma that legal regulation of an impure, criminally controlled supply chain would carry a significant risk of an overall increase in drug problems and dependency, because of the likely increase in use and problem use. The plans for legalising cannabis in Colorado and Washington, and developments in Uruguay may result in further evidence.

As regards decriminalisation, most commentators take the view that in general terms, decriminalisation has not had an ascribable or notable effect on drug use and problem use. However, some studies suggest a risk of earlier cannabis use by adolescents or more prolonged use by those in their later 20s. Decriminalisation in the UK (whether only of cannabis or of all drugs) would be likely to have most effects on cannabis users, since it is the most widely taken of the illicit drugs. Since evidence suggests that roughly 9% of these may develop some form of problem, there is an obvious need for caution. (The more widespread harm arising from alcohol use does not weaken this point.)

It was outlined in the introduction that decriminalisation is not a monolithic policy. It can simply involve moving drug possession to a civil rather than a criminal offence, or diversion into health provision. After decriminalisation had taken place in Portugal, cannabis use did rise, including among 15-16 year olds. However, so far at least, this does not appear to have fed through into prolonged or more regular use. Part of the reason may lie in the extensive education and health provision that accompanied decriminalisation: public attitudes are increasingly alert to the risks of drug use generally, including dependency on cannabis. In Portugal all those apprehended in possession of a drug are given a health assessment and help where needed, while in Australia, a tiered system of cannabis awareness and treatment sessions are offered.

It seems, therefore, that changes that involve increased health provision (rather than simply a reduction of penalty) would be the safest and most responsible model of decriminalisation. However, this kind of health-based approach can be developed without decriminalisation (as in some states in Australia) - or as a preparatory/ investigatory step on the road towards legal change.

It is notable that countries that have largely met their aims in modifying their drugs policies (the Netherlands and Portugal, for example) have done so only after a careful

analysis of which drugs are presenting what kinds of problems for their own populations. Their policies have been targeted in a clear and careful way, with resources attached. At present, no such detailed review has taken place in the UK, though several helpful reports have been published. (This detailed examination would be vital – the present report has not had the space to comment on cocaine use, for example, but it was one of the drugs whose use rose in Portugal post-decriminalisation, and the rates here are higher than there.)

The Parliamentary Home Affairs Select Committee of 2012/13 recommended that a Royal Commission be established to review drug policy, including the Misuse of Drugs Act. It is disappointing that the Prime Minister and the Home Secretary rejected this proposal, but drugs policy continues to be a subject of debate. Some of the recommendations of the Parliamentary Committee (which include useful proposals on issues highlighted in this report) are included in Appendix B. QAAD trustees have supported the Committee's call for a Royal Commission. It is hoped that the elements presented for discussion below may assist in the discernment process of QAAD, and perhaps Quakers more widely, in considering their own positions.

This report concludes that within the UK, health-based interventions for those found in possession of cannabis have not been developed for those who are cautioned and little for those who are convicted in court (perhaps because advice/treatment/supervision is 'up tariff' i.e. a more severe penalty than a discharge or a fine). However, there has been more success in offering treatment to severe users of heroin through the criminal justice system, and also via expanded community-based provision - over half of this group are now estimated to be in contact with some form of drugs service.

It has been noted that decriminalisation policies vary; that some are not health-focused; and that some of decriminalising features overlap with de-penalising measures. Rather than view decriminalisation as a binary 'yes or no' divide, then, it seems helpful to tease out the specific elements that we view as being important for future progress, and to identify promising initiatives that might have helpful lessons for the UK.

This report has sought to do that, and to identify where current penalties may be onerous or counter-productive; it has also looked at areas where decriminalisation would not have a significant impact, and considered initiatives of other kinds that might help. This is most obviously the case for high-needs drug users who commit other criminal offences, since they are usually sentenced for offences other than possession.

Finally, the most pressing threat to problem drug users (and to those with alcohol problems) is likely to be resource cuts. A significant factor is that new national funding arrangements mean that the budget for drug treatment will no longer be 'ring-fenced,' and set centrally, but decided at local level. Access to services may become more difficult, at least in some areas of the country. The Parliamentary Committee expressed some concern about this, and it is a further matter in which trustees will continue to take a close interest.

6. Summary of specific concerns and proposals for consideration

As regards the drugs laws themselves:

- A review of sanctions for drug possession, with the aim of ensuring that they do not damage or weaken inclusion in society, including employment prospects
- In specific terms, this would involve making simple drug possession a non-imprisonable offence (which could be achieved either by simple de-penalisation or by decriminalisation)
- It would also involve investigating the possibilities for health-based assessments and interventions for those found in possession (at appropriate thresholds.)
- In particular, Investigation and piloting of schemes along Australian lines could be considered, with the aim of diverting those apprehended for cannabis use into health advice/education sessions (perhaps initially as an alternative to a criminal penalty)
- Developing an evidence/practice base for interventions with experimental, regular, and dependent users would be part of this
- Similar attention should also be given to appropriate interventions for users of other drugs, most of whom are cautioned at present, and some of whom are subject to minor court penalties.
- The Home Affairs Select Committee recommended that cannabis possession cautions be regarded as instantly 'spent' (see below) which would address concerns about impairment of employment prospects.

As regards criminal law more broadly

- Investigation of the possibility of drug treatment being offered as an alternative to gaining a criminal conviction (as opposed to/in addition to it being an alternative sentence).
- Early 'spending'/suspension of criminal convictions related to drug problems if treatment is successfully engaged in, completed and sustained.
- Investigation of 'dealer exit' programmes for suppliers, such as those piloted in Baltimore.
- Exploring the use of consumer legislation to tackle some of the problems of the new psychoactive drugs

As regards medical interventions

- A consideration of supervised injection facilities for those with severe problems
- Further consideration of diamorphine for those with severe problems
- Drug clinics for night-club users in major cities, along the lines provided in Soho/Westminster.
- Investigation of cessation programmes for cannabis use, which could be developed along the lines of those for nicotine.
- A review of the evidence/policy as regards the medical use of cannabis.

Appendix A: Voices from the Parliamentary Home Affairs Select Committee on Drugs, sitting in 2012 [43]

Professor John Strang, Consultant Psychiatrist Head of Addictions Department at King's College London

Chair: What are your current views? (on decriminalisation)

Professor Strang: If you look over the fence at the alcohol and the tobacco fields, where we have much better evidence, we know this is a price-elastic commodity, that if you make it easier for people to access these products and make it more price accessible, the levels of use will increase and the levels of harm that result from that will increase. On that basis, I would not be in favour of relaxing it.

Chair: So you are not in favour. That is very helpful.

Professor David Nutt, former chair of the Advisory Committee on Drugs

Professor Nutt: I am suggesting we decriminalise possession of all drugs, frankly, but I am not suggesting we regulate access to drugs like heroin and cocaine except in medical circumstances. But I think we could certainly go down, with cannabis and the legal highs, a much more sensible, rational decriminalisation regulation route such as the Dutch and Portuguese have done.

Dame Ruth Runciman, Chair, UK Drugs Policy Commission

Dame Ruth Runciman: We think we are seeing a gradual decriminalisation in this country, particularly in respect of cannabis, at the same time as cannabis prevalence is going down, which is rather encouraging. We think that it is possibly time to be more overt about this, to look at it carefully, to take a step-by-step approach to decriminalisation, and to evaluate it carefully.

Dr Clare Gerada, Chair of the Royal College of General Practitioners

Question: In California, where they have effective decriminalisation, as you probably know there are lots of local cannabis shops that display information about the psycho harmful properties, the strength properties. Do you think that sort of information would enable people to make more rational decisions?

Dr Gerada: I suspect a 17-year-old walking past a shop is not going to make a rational decision about what they are going to use. They will want to spend their money where they can get the biggest bang for their buck. I suspect anybody in this room might make a rational decision but we are here, I think, to protect people from entering a life of substance misuse that could cause them harm. I would say cannabis is not a good drug to be using at any age. We have just spent the last 60 years sorting out tobacco, let us not drop in the same problem now with cannabis and make it much more available and pretend that it is a safe drug. It is not a safe drug.

[43] please note this evidence is 'uncorrected' and not yet an official version of the evidence given.

Niamh Eastwood of Release

Niamh Eastwood: Essentially in the UK we criminalise 80,000 people every year for drug possession. Those are primarily young people. They are disproportionately from ethnic backgrounds and a reasonably large section will be problematic drug users. So Release delivers services in the community. We see every week people who are affected by problematic drug use. Many of those have not committed acquisitive crime and their barrier, once they are in recovery to getting back into employment is very much this criminal record...

Question: Can I ask Ms Eastwood what you would do?

Niamh Eastwood: Very simple. We would decriminalise all drugs. Under that model it is still illegal but it is not a criminal offence, so it is a civil offence.

Chief Constable Tim Hollis CBE QPM, Association of Chief Police Officers

Tim Hollis: Control and regulation is different from decriminalisation. Decriminalisation is focused on the users and I just think there is overwhelming evidence that using the criminal law against users is problematic and damaging.

(Tim Hollis argued for regulation but said the structure was not yet in place for it.)

Trevor Pearce, Director General of the Serious Organised Crime Agency

Trevor Pearce: I think there will always be organised criminals who will trade in cannabis whether we have a legitimate market or illegitimate market... What we also know is that organised criminals use cannabis loads to either conceal multi-drug loads, or to even test out conduits or routes into the UK. Would I think they would ever walk away from trading in cannabis if it was legal? They would not.

Dr Owen Bowden-Jones, Chair, Faculty of Addictions, Royal College of Psychiatrists

Dr Bowden-Jones: People with health problems should not be treated as criminals. If someone has a health problem they should be treated for that health problem, and not thrown in prison. That is different from saying drugs should be legalised.

Appendix B: Some recommendations of the Home Affairs Select Committee on Drugs 2012-13

2. We recommend that the Government continue to monitor the decisions of the Health and Wellbeing Boards as to allocation of treatment places, recording each request, monitoring waiting times to enter treatment and assessing the success rate of those dependent on different drugs. The Government should publish this information in an easily accessible and understandable format and consider developing a league table of Health & Wellbeing Boards' performance on local drugs provision while taking care in selecting assessment criteria not to introduce perverse incentives into the decision making process. This will allow Boards to benchmark their provision against each other, having due regard to local need. (Paragraph 7)

NB The Committee considered evidence from the trial on the direct prescription of heroin to those with severe/entrenched problems.

3. New evidence which has emerged in the decade since our predecessor Committee's Report on drugs suggests that diamorphine is, for a small number of heroin addicts, more effective than methadone in reducing the use of street heroin. It is disappointing therefore that more progress has not been made in establishing national guidelines for the prescription of diamorphine as a heroin substitute. We recommend that the Government publish, by the end of July 2013, clear guidance on when and how diamorphine should be used in substitution therapy.

Current international drugs policy

5. The Committee saw for itself during its visit to Colombia the effect of the drugs trade on producer and transit countries—the lives lost, the destruction of the environment and the significant damage caused to governance structures by corruption and conflicts. We recognise and sympathise with the immense suffering and slaying of innocent people which tragically has taken place over the years in Colombia and other Latin American countries, as a result of the murderous rivalry between drug gangs. (Paragraph 25)

Links between drugs, organised crime and terrorism

11. We are concerned that despite significant international efforts to disrupt supply of illegal drugs and bear down on demand, the illegal drugs trade remains a hugely profitable enterprise for organised criminals and narco-terrorists. In part this is due to the highly inflated prices of the drugs in question, inevitable in a high demand underground market, and in part due to very low production costs, arising from cheap labour costs where many workers are exploited and the fact that most illicit drugs are very simple and inexpensive to make. This ultimately causes massive harm and deaths around the world. We urge the Government to continue to factor this unintended consequence into considerations on drugs policy.

15. We believe that the current, inter-departmental approach to drugs policy could be strengthened by identifying a Home Office Minister and a Department of Health Minister,

supported by a single, named official, with overall responsibility for co-ordinating drug policy across Government. We recommend that the Home Secretary and the Secretary of State for Health should be given joint overall responsibility for co-ordinating drug policy. By giving joint lead responsibility to the Home Office and Department for Health, the Government would acknowledge that the misuse of drugs is a public health problem at least as much as a criminal justice issue.

Misuse of Drugs Act 1971

25. Our predecessor Committee's recommendation for an independent assessment of the Misuse of Drugs Act 1971 was rejected on the basis that it gives effect to the UK's international obligations in this area. That is not, in our view, a compelling reason for refusing to review our own domestic legislative framework, particularly given the growing concern about the current international regime in many producer nations. The message from Colombia and other supplier and transit states is clear—what the international community is currently doing is not working. We are not suggesting that the UK should act unilaterally in these matters, but our Government's position must be informed by a thorough understanding of the global situation and possible alternative policies. (Paragraph 131)

26. This inquiry has heard views from all sides of the argument and we believe that there is now, more than ever, a case for a fundamental review of all UK drugs policy in the international context, to establish a package of measures that will be effective in combating the harm caused by drugs, both at home and abroad. We recommend the establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs in an increasingly globalised world. In order to avoid an overly long, overly expensive review process, we recommend that such a commission be set up immediately and be required to report in 2015.

The effect of having a drugs conviction

34. We believe that former drug users should be encouraged to play an active part in society, and that making it harder for them to find employment is likely to hinder that process, and make it more likely they will be unemployed and supported by the state. We therefore recommend that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in CRB checks after they become spent, or after three years, whichever is shorter. The review should, in particular, take account of those areas of employment to which drugs convictions are directly relevant. We also recommend that cannabis warnings be treated as spent immediately.

Decriminalisation and Legalisation

42. We were impressed by what we saw of the Portuguese depenalised system. It had clearly reduced public concern about drug use in that country, and was supported by all political parties and the police. The current political debate in Portugal is about how treatment is funded and its governance structures, not about depenalisation itself. Although

it is not certain that the Portuguese experience could be replicated in the UK, given societal differences, we believe this is a model that merits significantly closer consideration.

43. Following the legalisation of marijuana in the states of Washington and Colorado and the proposed state monopoly of cannabis production and sale in Uruguay, we recommend that the Government fund a detailed research project to monitor the effects of each legalisation system to measure the effectiveness of each and the overall costs and benefits of cannabis legalisation.

Implications of discussing drugs policy - politics and the media

44. Drugs policy ought to be evidence-based as much as possible but we acknowledge that there is an absence of reliable data in some areas. We therefore recommend the Government allocated ring fenced funding to drugs policy research going forward. Such a funding stream would most appropriately sit with the Medical Health and Research Council so that the evidence base for prevention and recovery aims of the Drugs Strategy can be strengthened, although cross disciplinary applications in this area will be vital. (Paragraph 257)

45. We recommend that the responsible minister from the Department of Health and the responsible minister from the Home Office together visit Portugal in order to examine its system of depenalisation and emphasis on treatment. (Paragraph 258)

46. As our predecessor Committee supported in their 2002 report, we recommend that the Government initiate a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma. (Paragraph 259)

47. We welcome the Government's efforts to make clear its commitment to reducing drug misuse and tackling the consequences of drug misuse. We also recommend that the Government instigate a public debate on all of the alternatives to the current drugs policy, as part of the Royal Commission (see paragraph 132). (Paragraph 260)

New psychoactive substances

33. The market in new psychoactive substances is changing quickly, too quickly for the current system of temporary banning orders to keep up. Forty-nine new substances were found in Europe last year, a rate of development which makes additional measures critical. At the moment, businesses are legally able to sell these products until such time as they are banned with apparently no legal consequences when they lead to death or long-term illness. We recommend that the Government issue guidance to Local Authority trading standards departments, citizens advice bureaux and other interested parties on the action which might be taken under existing trading standards and consumer protection legislation to tackle the sale of these untested substances.....Retailers who sell untested psychoactive substances must be liable for any harm the products they have sold cause. It is unacceptable that retailers should be able to use false descriptions and disclaimers such as "plant food"

and "not for human consumption" as a defence where it is clear to all concerned that the substance is being sold for its psychoactive properties and the law should be amended.

35. We believe that former drug users should be encouraged to play an active part in society, and that making it harder for them to find employment is likely to hinder that process, and make it more likely they will be unemployed and supported by the state. We therefore recommend that the Government review the inclusion of convictions for offences of simple possession of a controlled substance (as opposed to offences relating to supply, or any other drug-related crime such as burglary) in CRB checks after they become spent, or after three years, whichever is shorter. The review should, in particular, take account of those areas of employment to which drugs convictions are directly relevant. We also recommend that cannabis warnings be treated as spent immediately.
The full list of recommendations can be viewed at:
http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/18413.htm

Appendix C: Cannabis and health issues

Mental health issues

Cannabis use is associated with an increased incidence of mental health problems. One of the key studies summarised the position as:

> *'Results confirm previous suggestions that cannabis use increases the risk of both the incidence of psychosis in psychosis-free persons and a poor prognosis for those with an established vulnerability to psychotic disorder.'* [44]

A recent study suggests an odds ratio of 1.4% as the risk for people who use cannabis developing a mental illness[45]. The risk of very acute problems does not appear to be large: one study suggested cannabis consumption raised it from 7 in 1,000 to 14 in 1,000[46]. However, the consequences can be extremely serious for those affected. A study in Denmark showed that half of those who had an acute cannabis psychosis had further episodes and were diagnosed with schizophrenia three years later. [47]

The strength of cannabis is significant in relation to these health risks, and also in the development of dependency. Cannabis contains two key chemicals – THC and CBD. THC has the intoxicant effect, whilst it is believed the cabinidols (CBD) may have anti-psychotic properties. THC is present in significantly higher quantities in modern indoor grown cannabis, whilst the CBD content is lower. A 2009 UK study of patients suffering from psychosis stated:

> *'Our findings... suggest that the risk of psychosis is much greater among people who are frequent cannabis users, and among those using sinsemilla (skunk) rather than occasional users of traditional hash. It is not surprising that those who use skunk daily seem to be the group with the highest risk of all.'* [48]

Another of the key researchers summarises his view of the position:

> *'We should discourage young adults seeking treatment in mental health services from using cannabis and inform them of the probable mental health risks of*

[44] Van Os, J., Bak, M., Hanssen, M., Bijl, R.V., de Graaf, R. and Verdoux, H. (2002). Cannabis Use and Psychosis: A Longitudinal Population-based Study. *American Journal of Epidemiology,* 156 (4), p. 319-327.

[45] Moore, T.H., Zammit, S., Lingford-Hughes, A., Barnes, T.R., Jones, P.B., Burke, M. and Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. *The Lancet*, 370 (9584), p.319-328.

[46] Saha, S., Chant, D., Wellham, J. and McGrath, J. (2005). A systematic review of the prevalence of schizophrenia. PloS Medicine 2 (5).

[43] Arendt, M., Rosenberg, R., Foldager, L. and Perto, G. (2005). Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases. The British Journal of Psychiatry, **187**, p.510-515.

[48] Di Forti, M. et al. (2009). High-potency cannabis and the risk of psychosis. The British Journal of Psychiatry, 195 (6), p.488-491.

cannabis use, especially of early and frequent use. We must exercise caution in liberalizing cannabis laws in ways that may increase young individuals' access to cannabis, decrease their age of first use, or increase their frequency of cannabis use. We should consider the feasibility of reducing the availability of high-potency cannabis products.' [49]

Other medical issues

Cannabis use is also associated with memory and concentration problems, although there is some uncertainty about how long these persist. Sustained heavy/regular use is associated with some cognitive impairment in people with long-term use (average of 24 years).[50] Cannabis use is also associated with lung cancer in regular and long-term users; evidence about other respiratory effects is less clear. The impact of cannabis use on driving is receiving more attention; it is associated with a significantly increased risk of accidents, though the level is difficult to establish and alcohol use can be a confounding factor.

Risks for young people and risks of dependency

Beginning to use cannabis early is a risk factor for mental health problems: one study showed that people who used cannabis by age 15 were four times as likely to have a diagnosis of schizophrenia-type disorder at age 26 than controls, and a higher incidence than people who began at age 18.[51]

The risk of dependency also increases with early onset; one in six adolescent cannabis users are likely to develop dependency, as opposed to 9% among adults[52]. For adolescents, cannabis use is also associated with decreased concentration at school, with earlier drop-out from education, and with other learning and social problems. These children may have been vulnerable for other reasons, but cannabis use appears to be an escalating factor.

It is argued that cannabis has less dependency potential than several other drugs (the Beckley Foundation Report, for example, notes research that puts the dependency risk of other drugs as '32% for nicotine, 23% for heroin, 17% for cocaine, 15% for alcohol and 11% for stimulant users (Anthony *et al.*, 1994).'[53] Again, the numbers using the drug is a significant element.

[49] Hall, W. and Degenhardt, L. (2006). What are the policy implications of the evidence on cannabis and psychosis? *Canadian Journal of Psychiatry*, 51 (9), p.566-574

[50] Solowij, 1998; 2002

[51] Arseneault, L., Cannon, M., Poulton, R., Murray, R., Caspi, A. and Moffitt, T.E. (2002). Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. *British Medical Journal*, 325 (7374), p. 1212-1213.

[52] Swift, W., Hall, W.D. and Teesson, M. (2001). Cannabis use and dependence among Australian adults: results from the National Survey of Mental Health and Well-being. *Addiction*, 96, p.737-748.

[53] Room, R., Fischer,B., Hall, W.,Lenton, S, Reuter, P. (2008) Cannabis Policy: Moving Beyond Stalemate

Medical applications of cannabis

Cannabis also has therapeutic applications and is licensed in Canada for medical use for conditions including severe pain from multiple sclerosis, spinal injury, nausea and other conditions arising from cancer and HIV, and for severe epilepsy and arthritis.[54]

Prescription of drugs of dependence is covered in Schedule 2 of the Misuse of Drugs Act (1971). Heroin and cocaine are prescribable under certain conditions, but cannabis is not. This schedule would need legal change to amend, though this would not require decriminalisation.
Since my original briefing was written, both Washington and Colarado have voted to legalise cannabis, though there are some issues to resolve before this will reach the statute book.

The proposed system in Washington includes:

- Legal sale of small amounts of cannabis to adults over 21 (the same legal age as for buying alcohol)
- Licensed production and sale via controlled mechanisms
- Fee from licence income to go into research and treatment
- Each county in the state to decide how many outlets it will allow
- No prominent advertising or signage
- Outlets will not be able to sell anything other than marijuana
- No premises near schools
- a new offence of driving under the influence of marijuana

There is a certain similarity to the 1968 Gambling Act, although the proposed statute does not use the language of 'unstimulated demand.'

The American Society of Addiction Medicine (ASAM) has opposed the plans, stating:

> *'The marijuana legalization initiatives in Colorado, Washington, and Oregon would significantly increase marijuana use by lowering its costs and by making this widely abused drug more available and more acceptable. Given the significant adverse health consequences of marijuana use, and in particular, its addiction potential, it is not in the interest of public health to make marijuana more widely available and more acceptable...*
>
> *There is limited evidence to identify the effects of Portugal's drug policy changes, and particularly to separate the effects of decriminalization from other changes recently made and the relevance of these changes for any other country, including the United States...*
>
> *ASAM strongly supports efforts to improve state policies to reduce the use of marijuana and other illegal drugs as well as the nonmedical use of prescription drugs.* [55]

[54] Medical Marjuana http://medicalmarijuana.ca/for-patients/who-is-eligible

[55] State-Level Proposals to Legalize Marijuana July 2012 American Society of Addiction Medicine